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~~XXXXXXXXXX~~
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Education: Indiana University, Bloomington: French Horn & Comparative Religious Studies
B.S. 1977 Music Performance Scholarship Award
St. Mary's College; Moraga, Ca. Management B.A. 1995

Professional History: Henry Mancini Orchestra 1974-77 Barry White Orchestra 1975
San Francisco Chamber Orchestra 1979 Oakland East Bay Symphony 1980
San Francisco Pocket Opera 1980 Positions Offered: Jerusalem Symphony
Israel ; Kassel Opera Germany; Stockholm Brass Quintet Sweden

New York Public Interest Research Group 1981-82 Canvass Supervisor

San Francisco Police Department 1982-2004
Patrol Division Mission Station 1982-1986
Narcotics Division 1987-1989 Organized Crime Drug Enforcement
Task Force U.S. Attorney's Office
Bureau of Investigations 1989-2004 Sergeant/Inspector
Narcotics Division
Financial Crimes Section
Elder Abuse Task Force Inspector in Charge*
Homicide Section Elder Abuse Crimes
Child Abuse Section
Supervisor- Cargo Theft Task Force San
Francisco Airport
Sexual Assault Section

P.O.S.T Certifications: Basic, Intermediary, Advanced, Supervisory
Narcotics Investigation
Financial Crimes Investigation
Homicide Investigation
Child Abuse Investigation
Sexual Assault Investigation

*Co-designed & Implemented Multi-Disciplinary Protocol for SFPD, Adult Protective Service,
Public Guardians Office, District Attorney's Office response to Elder Abuse Allegations

Philip Tummarello

Awards: California Attorney General Excellence in Performance Award
Honolulu Police Department Service Award
San Francisco Police Department: Medal of Valor
Meritorious Conduct Award
Police Commission Commendations (4)
Citation for Exemplary Service Award
Captain's Complimentary Award (42)

Civilian Awards: American Institute of Architects Appreciation Certificate
Justice for Murder Victims Community Service Award

Elder Abuse Education: Presenter/Panel member Elder Abuse Dynamics & Investigation
California Assembly Public Safety Committee
California Senate Public Safety Committee

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ROBERT M. HERTZBERG
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MEMBER, LOCAL GOVERNMENT

March 14, 1997

Deputy Chief John Willett
Chief of Inspectors
Hall of Justice
850 Bryant Street Room 400
San Francisco, CA 94102

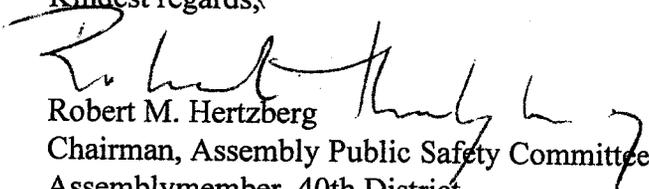
Dear Mr. Willett:

I wish to request the testimony of Sergeant Inspector Phillip Tummarello Star # 803 before the Assembly Public Safety Committee on Tuesday April 8, 1997. I am chair of the Committee and will be presenting AB 870, a measure to help prevent the increasing incidence of white collar crimes committed against the elderly. Attached is a copy of the bill and a brief summary of the legislation.

Mr. Tummarello's testimony would greatly contribute to the committee's understanding of the breadth of scams which are committed against the elderly in the San Francisco Bay Area and throughout California. Please inform Elise Thurau (916) 445-7644 of your decision concerning Mr. Tummarello's attendance and testimony at this upcoming hearing.

Thank you for your consideration.

Kindest regards,


Robert M. Hertzberg
Chairman, Assembly Public Safety Committee
Assemblymember, 40th District

RMH:et

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SUE HIGHLAND

November 24, 1997

Philip Tummarello, Inspector
Department of Justice
2720 Taylor Street, #300
San Francisco, CA 94133

Dear Inspector Tummarello:

Thank you for your valuable participation at our hearing, "Invisible Crimes: What Can the Legislature Do to Prevent the Physical or Financial Abuse of the Elderly."

Our Committee members and staff felt the hearing was extremely informative and educational, and provided the Committee with many ideas about ways in which to combat the problem of elder abuse. We believe we were successful in creating significant awareness of the problem and in educating Assembly members and staff regarding the complexities of the issue.

I hope that you continue to work with us on solving problems in this very important area of public policy. If you have a legislative idea (or ideas), I urge you to submit them in writing to the Assembly Committee on Public Safety (P.O. box 942849, Sacramento, CA 94249-0001).

I hope you will stay in touch with Committee staff and keep us informed. I look forward to working with you in the future.

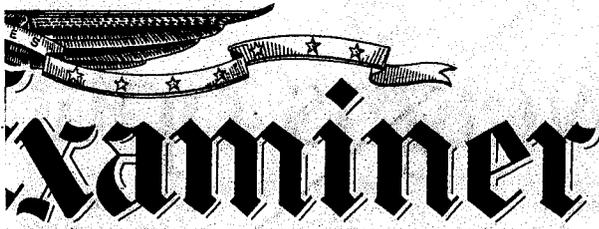
Sincerely,

A handwritten signature in black ink, appearing to read "Robert M. Hertzberg".

ROBERT M. HERTZBERG
Chair

RMH/JT:slh





Examiner

[★ ★]
Friday afternoon

NOVEMBER 7, 1997

HOME DELIVERY
EDITION

TWENTY-FIVE CENTS
NEWSSTAND PRICE

solve homelessness, v
u expect me to do?"
rown set a standard fo
cellence in the field.

'Mad City'

Hoffman, Travolta star in
remake by Costa-Gavras [C-1]

8 accused of plotting poison murders

Foxglove indictments
come after 4-year
probe; cops say old
men were targeted
for their assets

FOXGLOVE CHRONOLOGY

ht indicted in th conspiracy

rested as of late Thursday. Department sources said investigators and prosecutors had debated for years whether they could convince a jury that any of the men were actually murdered. No traces of digitalis were found in the bodies of five alleged victims. It was originally determined they died of natural causes, according to law enforcement officials.

Coroner reports on all the victims have been sealed at the request of investigators for more than three years.

The five alleged victims were all indicted not long before their deaths by members of a group that included Angela Tene, also known as Angela Bufford; her mother, Mary Tene Steiner; her brother, Danny Tene; and Angela's boyfriend, George Lama, police said.

Police officials said George Lama, 37, and Angela Bufford, 37, were arrested on six counts of conspiracy to commit murder and more than a dozen counts of stealing from a dependent adult. Mary Tene Steiner, 57, was booked on charges of conspiracy to commit murder and two counts of cruelty to a dependent adult.

Danny Tene, 35, was arrested on more than a dozen counts of stealing from a dependent adult and one count of theft of property.

Teddy Tene, 27, was booked on more than a dozen counts of stealing from a dependent adult. His involvement in the group and the alleged crimes were not clear late Thursday.

Police arrested Lama and Bufford at 10:25 a.m. at their home at 14th Avenue and Moraga Street. Mary Tene Steiner, Danny Tene and Teddy Tene were all taken into custody just after noon at 22nd Avenue and Taraval Street. The five were being held at the

The alleged murder-for-profit scam in San Francisco goes back at least 14 years. The following is based on court records and interviews with law enforcement agents:

► **APRIL 1983:** Mary Tene, 42, marries Philip H. Steiner Jr., 89, a former hotel maintenance employee, and becomes a joint tenant on the deed to Steiner's 33rd Avenue home.

► **MAY 1984:** Angela Tene, Mary Tene's daughter, goes with Nicholas Bufford to the county courthouse, where she registers as his granddaughter on the deed of trust for his 14th Avenue home. Three months later, Angela Tene, then 24, marries Bufford, 87, and is designated his sole beneficiary and executor of his estate. In November, Bufford dies of uremia, complicated by heart disease. Angela Tene inherits his entire estate, including savings of \$125,000.

► **1986:** While still married to Steiner, investigators believe that Mary Tene moved in with Konstantin Liotweizen, an 89-year-old retired dell owner with a broken hip. She becomes a joint tenant on the deed to Liotweizen's Funston Avenue apartment complex, later valued at \$937,000.

► **1987:** Steiner dies of cardiopulmonary arrest, brought on by pneumonia. Mary Tene inherits his Sunset District house, his stock investments and half of his bank accounts. George Lama, who has been called Angela's boyfriend by investigators, begins buying digitalis, a heart drug, from the West Portal Pharmacy, according to police records.

► **1989:** Liotweizen dies of heart failure, according to coroner's records. As the surviving joint tenant, Mary Tene inherits the building. Some \$77,000 in other assets is split between Mary Tene and Liotweizen's son, Michael. Angela Tene and Lama meet Stephen Storvick, 88, and begin to bring him food in his apartment above the dell. Storvick receives numerous anonymous telephone threats and agrees to Angela Tene's suggestion to make her his heir.

► **MARCH 1991:** Storvick tells police he suspects that Angela Tene and Lama are trying to kill him by drugging his food. Later, suspecting he is being manipulated, Storvick alters his will again, designating his relatives in Norway as beneficiaries.

► **1992:** Storvick dies of respiratory failure brought on by

pneumonia.

► **1993:** Lama and Angela Tene meet and befriend Harry Glover Hughes, 94, and begin bringing him food. Lama's name later appears on the title to Hughes' Mercedes. By March 1994, Lama and Angela Tene's names are discovered on at least three of Hughes' bank accounts. That year, police inspectors Gregory Ovanessian and Daniel Yawczak begin investigating, based on tips from informants and private investigators.

► **MARCH 1994:** Hughes' nephew David Payne wins conservatorship of his uncle and his \$1.2 million estate. In court documents, Payne's attorney asserts Hughes "was being manipulated and controlled, and his assets stolen and converted by a young couple who were preying on him due to his age and infirmities." Two weeks later, Hughes dies of a cerebral hemorrhage. His death certificate lists the cause of death as "pending further investigation and/or testing."

► **JUNE 1994:** San Francisco police confirm the bodies of Liotweizen, Bufford, Storvick and Steiner have been exhumed for autopsies and toxicological tests. Steiner was exhumed in Oakland. A new autopsy is also arranged for Hughes, who had not yet been buried.

► **JULY 1994:** The Foxglove investigation is transferred to the homicide detail from the fraud unit. Ovanessian and Yawczak are taken off the case and soon are investigated for wrongdoing themselves by the department's internal affairs unit. Inspector Phil Tummarello joins the team, then headed by homicide inspector Jim Bergstrom.

► **1995:** Tummarello takes over the case, working in the homicide office.

► **1996:** Police Department accuses Ovanessian and Yawczak of wrongdoing. They are later accused of jeopardizing the safety of a witness, failing to warn potential victims of danger and leaking a sealed request for a search warrant to private investigators. Both investigators have denied wrongdoing. Tummarello is transferred out of Hall of Justice, working alone to prevent leaks about the investigation.

► **JULY 1997:** District attorney's office begins presenting the case to the grand jury.

► **NOVEMBER 1997:** Grand jury indicts eight people on charges ranging from conspiracy to commit murder to fraud, theft and elder financial abuse.

—EXAMINER STAFF

County Jail. No bail was set for Lama, Bufford and Steiner; Danny and Teddy Tene were each being held on \$1 million bail.

Bufford's attorney, Robert Sheridan, said she is innocent.

"The poison murder story is fascinating but it's missing couple of things, like poison and murder," Sheridan said. "The booking sheet says that she is charged with conspiracy to commit murder — not murder. That shows they don't have a case. If they had a case, why didn't they prosecute her four years ago? Three years ago? Two years ago? Last year? Why now? ... This is completely political."

The attorneys for the others could not be reached for comment.

Because copies of the indictments were not made public, the identities of the other three people who were indicted were not known.

Law enforcement officials say all four Tenes are members of the Tene Bimbo clan, which gained notoriety in Peter Maas' best-selling

novel "The Foxglove Plant," in which the clan slowly poisoned using the drug digitalis in a plot to acquire their estates, investigators said. Digitalis, a heart drug that can be fatal in higher doses, is derived from the foxglove plant.

The defendants allegedly won the confidence of their targets, getting access to each man's assets. The defendants decided not to wait for their elderly victims to die of natural causes and instead sped up the process, investigators believe.

The bodies of four men — Philip H. Steiner Jr., 93; Konstantin K. Liotweizen, 92; Nicholas C. Bufford, 87; and Stephen Storvick, 91 — were exhumed in 1994 for autopsies.

An autopsy also was conducted on a fifth man, Harry Glover Hughes, 94, when he died in March 1994. Police have not released the autopsy results.

The five San Francisco men died between 1984 and 1994. Two of the suspected victims were married shortly before they died, one to

members of the clan also shared in the estates of three other elderly men they had befriended, investigators said.

The suspected ring has allegedly acquired more than \$1 million in cash, investments, real estate, jewelry and automobiles, by either befriending or marrying victims, according to private detectives working on behalf of family members of the deceased.

The Foxglove investigation has been very controversial within the Police Department. The original investigators were pulled off the case and later accused of internal misconduct charges for allegedly violating police procedural guidelines. For several years, the Foxglove investigation was referred to as the "Case from Hell" by those who were close to it.

The two original inspectors, Greg Ovanessian and Daniel Yawczak, were taken off the case in 1994 and now face internal police misconduct charges. They are

tority in Peter Maas' best-selling 1974 book "King of the Gypsies," and in a film of the same name.

The allegations of possible poisoning first came to the attention of police in 1993. The men were

ried shortly before they died, one to Mary Tene and the other to her daughter Angela.

Each woman was the principal heir to her husband's estate. Mary and Angela Tene and other mem-

1994 and now face criminal police misconduct charges. They are accused of "engaging in conduct which subverts the good order, efficiency and discipline of the department" in connection with their handling of the early part of the investigation in 1993.

Both inspectors have denied wrongdoing and are fighting the charges.

The investigation has been sharply criticized by family members of the alleged victims, private investigators who worked on parts of the case and others.

George Lama's brother, Jerry Lama, initially cooperated with the investigation. But in recent years he has criticized investigators including Inspector Phil Tummarello, who has been working on the case continuously since 1994. He has maintained that his brother and the Tenes are guilty, but he felt that police botched the case "from day one until today — they are still making mistakes as we speak."

L.A. cop held in bilking of S.F. woman

Officer allegedly
swindled
79-year-old with
Alzheimer's out of
\$70,000 in savings

By Jim Herron Zamora
OF THE EXAMINER STAFF

A Los Angeles police officer has been arrested for allegedly bilking \$70,000 from an 80-year-old San Francisco woman with Alzheimer's disease by promising to invest her money in lucrative securities, investigators said.

After a 15-month investigation, Thomas Wright, 30, of Orange County, was arrested Friday in Irvine at the office where several of his allegedly bogus investment companies are based, said San Francisco police Fraud Inspector Phil Tummarello.

Wright and his partner, Anthony Price, 26, allegedly defrauded Mary Palladino (who has since died) of nearly half her life savings. The scam allegedly took place between December 1993 and last April.

Palladino, a childless widow with Alzheimer's dementia, lived in San Francisco's Ingleside District until her death in October.

"It's disgusting that they were preying on her," said her niece, Denise Meschi, of Fairfield. "The poor thing — they just took advantage of her when she was helpless and confused. These guys make me sick."

Wright and Price are being held in connection with only the Palla-

dino case, but investigators say their work is continuing. Officials from several agencies are reviewing their records taken in a raid Friday in an office park in Irvine.

"It looks like they had contacts with potential investors all over the state," Tummarello said Saturday. "It looks like they were targeting retired people."

The suspects are accused of defrauding people with promises of safe investments with 11% percent returns, Tummarello said. Police said the two men ran three companies: Liberty International Acquisitions, Woodbury Financial and Consolidated Energy — none of which is registered with the state Department of Corporations, Tummarello said.

"Neither is licensed to sell securities in California," Tummarello said. "They acknowledge that she (Palladino) invested \$70,000 with them and Price acknowledged that she has never been paid anything."

Wright served for nearly two years as a reserve or part-time police officer in the LAPD's Rampart station near downtown Los Angeles before he resigned Friday after his arrest, Tummarello said.

It is unclear if he used his police status to further the conspiracy, other than mentioning it to gain Palladino's trust, Tummarello said.

Wright and Price are being held at the Orange County Jail in lieu of \$150,000 bail on charges of elder abuse, grand theft and conspiracy, Tummarello said. Price is on federal probation for mail fraud in Arizona, Tummarello said, and he had been ordered not to sell securities.

Since their arrest, both Wright and Price told police they no longer

[See ARREST, D-8]

from D-1

allegedly F. woman

's money.
admit to me that he
it in a position to
rts of decisions. He
as not surprised she
posed with Alzheimer's
arello said.
led by Tummmarello
as police from Irvine
as well as the state
f Corporations. It
break because of the

victim's poor health and the difficulty of tracking down financial records without tipping off the suspects. But Palladino's plight inspired San Francisco to form a unit dedicated to investigating the swindling of senior citizens.

The investigation began in December 1993, when Wright escorted Palladino to Paine Webber's San Francisco offices and tried to cash out her entire \$140,000 account.

Her broker, Peter Keating, grew suspicious because Palladino, a 20-year client, seemed disoriented and Wright, whom they had never seen

before, was doing the talking, Tummmarello said.

At that meeting, Wright represented himself first as Palladino's investment advisor, then her attorney and then, when Paine Webber employees became suspicious, "He pulled out his LAPD shield and identified himself as an LAPD officer," Tummmarello said. "Then he quickly hustled her into an elevator" and left.

Palladino returned to Paine Webber a few days later again escorted by Wright, Tummmarello said, but Wright waited in the lobby. At that time she withdrew

\$5,000 from her account and then signed it over to Liberty International. She also wrote a check to Liberty for \$25,000 — her entire account — from American Savings Bank, Tummmarello said.

The money was almost immediately withdrawn from Liberty International's account by Wright, Tummmarello said, and hasn't been seen since.

In January of last year, Paine Webber received a letter, signed by Palladino, demanding that her account be immediately closed.

"Paine Webber was suspicious," Tummmarello said, because the let-

ter was postmarked Santa Ana, and their client lives in San Francisco. "It was typed — when she didn't own a typewriter," said Tummmarello.

But until April, Palladino continued to receive calls and visits from Wright and Price. The two took her out to lunch at the Cliff House while winning her trust.

"They found the mother lode and they were up here to drain it," Tummmarello said. "She was totally helpless and these guys got wind of it and took advantage of it like sharks at a feeding frenzy."

Lonely widow bilked of savings

Homeless junkie swindled her out of \$30,000, cops say

By Jim Herron Zamora
OF THE EXAMINER STAFF

An 81-year-old widow, who was tired of crying alone in her studio apartment every holiday, took in a homeless drug user she met on the street to keep her company and ended up being swindled out of her life savings, police said.

"This is a sweet, vulnerable woman who was terribly lonely, and she lost everything to this guy," San Francisco police Inspector Phil Tummarello said Wednesday. After the suspect was jailed in the case, he even called the woman asking for bail money, Tummarello said.

The woman was allegedly cajoled into withdrawing about \$30,000 — virtually her entire life savings — from her bank over an eight-month period and giving it all to Monte Forgue, 43, whom she met while he was panhandling near her home on Van Ness Avenue in February, police said.

"He befriended her, and she appreciated the attention because she is all alone," Tummarello said. "She had only met him once, and she offered him a place to stay.

"She told us she got tired of crying all by herself on all the holidays."

Forgue pleaded not guilty Wednesday in San Francisco Municipal Court to charges of elder abuse, grand theft and burglary.

Forgue, who allegedly spent much of the money to feed a heroin habit, is being held in City Jail in lieu of \$10,000 bail.

"He denies doing anything wrong," Tummarello said. Forgue told police "he was just keeping her company."

Judge Donna Little ordered him not to contact the alleged victim. Forgue, who was arrested Friday, had phoned the woman twice from jail asking her to bail him out, Tummarello said.

She had gone to visit him in jail twice and both times gave him \$20 but declined to bail him out because she could not afford it, Tummarello said.

Police were alerted to the case by tellers at the Wells Fargo Bank branch at 1560 Van Ness Ave. who noticed that the woman, accompanied by Forgue, was withdrawing large amounts of money almost daily.

On Sept. 12, Officer Ed Garcia was at the bank taking a report in a unrelated case, and a teller told him about the woman.

After questioning, "she indicated that she was being intimidated by this man," Tummarello said. "He would ask her to withdraw money almost every day."

The woman also told police that Forgue encouraged her to drink alcoholic beverages, Tummarello said.

"She would ask (him) later what happened to all of the money, and he would say, 'You had a lot to drink, and you must have lost it,'" Tummarello said.

After interviewing her, police arrested Forgue on the sidewalk near her home.

Appendix VI: Estimated Elder Abuse Reports to APS, and APS Investigations and Substantiations in State Fiscal Year 2009

State	Reports of alleged elder abuse received	Elder abuse cases investigated	Elder abuse cases substantiated
Alabama			
Alaska			
Arizona			
Arkansas			
California	76,340	58,338	21,300
Colorado	7,434	4,217	
Connecticut	3,800	3,438	446
Delaware			
Florida		29,434	3,905
Georgia	4,215	4,522 ^a	1,939
Hawaii	1,189	505	81
Idaho			400
Illinois	10,848	9,562	5,809
Indiana			
Iowa			
Kansas			
Kentucky	12,472	9,872	1,973
Louisiana	3,603	3,414	1,953
Maine	2,613	2,312	1,128
Maryland		4,534	
Massachusetts	15,935	11,823	4,738
Michigan	9,590	6,203	1,934
Minnesota	11,852	2,342	320
Mississippi			
Missouri			
Montana		3,865	1,347
Nebraska			
Nevada		3,669	1,167
New Hampshire			
New Jersey	4,500		
New Mexico	6,100	3,600	1,110
New York	22,894	16,523	
North Carolina	11,951	6,394	2,400
North Dakota		383	
Ohio		16,370	

**The Availability and Utility
of Interdisciplinary Data on Elder Abuse:
A White Paper for the
National Center on Elder Abuse**

Erica F. Wood
American Bar Association
Commission on Law and Aging
for the
National Center on Elder Abuse

May 2006

The National Center on Elder Abuse (NCEA) serves as a national resource for elder rights advocates, law enforcement and legal professionals, public policy leaders, researchers, and citizens. It is the mission of the NCEA to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

The NCEA is administered under the auspices of the National Association of State Units on Aging.

National Center on Elder Abuse

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Opinions or points of view expressed do not necessarily reflect the official position or policies of the U.S. Administration on Aging.

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The views expressed herein have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and, accordingly, should not be construed as representing the policy of the American Bar Association.

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Table of Contents

Executive Summary

Chart: Profile of Data Sources Concerning Incidence and Prevalence of Elder Abuse

I. Introduction—Through a Glass Darkly

II. Background and Methodology

III. Findings

A. Health Care Data—Background on Diagnostic Coding

1. Medical Diagnostic Codes

2. Diagnostic Coding on Abuse

a. ICD-9 Coding on Abuse

b. E-Coding on Abuse

c. ICD-10 Coding on Abuse

3. Limitations of Diagnostic Codes for Elder Abuse

B. Health Care Data—Centers for Disease Control (CDC)

Surveys and Databases

1. National Center for Health Statistics (NCHS)—National Health Care Surveys

a. National Hospital Ambulatory Medical Care Survey

b. National Ambulatory Medical Care Survey

c. National Hospital Discharge Survey

d. National Nursing Home Survey

e. National Home and Hospice Survey

2. NCHS Individual Health Care Surveys

a. National Health Interview Survey

b. National Health Examination and Nutrition Survey

3. CDC Injury Data Systems

a. National Violent Death Reporting System

d. National Domestic Violence Hotline

G. Fiduciary Data

1. Social Security Representative Payee System
2. U.S. Department of Veterans Affairs Fiduciary Program
3. Guardianship and Conservatorship Data
 - a. Lack of Guardianship Data
 - b. GAO Report
 - c. NCEA/ABA Data Study
 - d. Guardian Certification Programs

H. Legal Services Data

1. Legal Services Programs
2. Statewide Legal Hotlines for the Elderly

III. Conclusions and Recommendations

Reference List

Appendix A—National Ombudsman Reporting System Data on Elder Abuse

The Availability and Utility of Interdisciplinary Data on Elder Abuse: A White Paper for the National Center on Elder Abuse

Executive Summary

There is wide consensus that currently a clear picture of the incidence and prevalence of elder abuse in the United States is sadly lacking—and that such a picture “is essential if social policy is to be created to impact prevention and treatment” (National Institute on Aging, 2005). While the National Center on Elder Abuse (NCEA) has collected and analyzed state adult protective services data, the penumbra of additional data elements that might be available through health care, long term care, criminal justice, fiduciary, and legal services networks has remained largely unexplored. Therefore, the NCEA sought the development of a white paper examining such data elements, their scope and limitations, and outlining their potential use by the U.S. Administration on Aging (AoA), other federal agencies, and elder abuse professionals and advocates. In response, the American Bar Association Commission on Law and Aging (ABA Commission) conducted exploratory research on a wide range of possible data sources. This white paper presents and evaluates the results.

The seminal work on the state of knowledge about elder abuse and the substantial lack of data is the National Research Council’s *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*, the report of the Panel to Review Risk and Prevalence of Elder Abuse and Neglect. The report served as the starting point for the ABA Commission research. The research methodology focused on Internet and telephone research, including a broad-based Web scan and telephone discussions with 35 key informants.

A blatant difficulty in elder abuse research is widely differing definitions and terminology (National Research Council, 2003). For example, according to the NCEA:

elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. The specificity of laws varies from state to state, but broadly defined, abuse may be: physical abuse, emotional abuse, sexual abuse, exploitation, neglect, abandonment (the NCEA Web site

abuse. It summarizes empirical research and the collection of epidemiological data to date. Following the report, the National Institute on Aging has called for research to “provide the scientific basis for understanding, preventing, and treating elder mistreatment” (National Institute on Aging, 2005). The National Research Council report and its extensive appendices served as the starting point for this paper.

The methodology for the development of the white paper focused on Internet and telephone research. After a baseline discussion with the NCEA partner organizations, the project began with a Web scan of data sources listed in the NCEA Request for Proposals for development of this white paper, including the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the AoA, the Medicaid Fraud Control Units, the U.S. Department of Justice, the National Institutes of Health National Library of Medicine’s *PubMed*, and other leads. In addition, the librarian at the AoA provided results of her preliminary research on possible sources of elder abuse data. The project then sought to examine other sources of data such as the Social Security Administration, the U.S. Department of Veterans Affairs, state probate courts, state quality improvement organizations, legal services programs, and more. Telephone interviews with key informants supplemented on-line Internet research. In total the project interviewed 41 key informants, primarily by telephone, but in some cases by e-mail (see List of Key Contacts)—and also made a number of additional “blind alley” contacts that ultimately did not yield useful information.

The investigation sought both data on the “incidence” and “prevalence” of elder abuse. The incidence rate is the number of new instances of abuse within a specific time period; whereas the prevalence rate tells how frequently abuse occurs at a given point, regardless of the time of onset (National Research Council, 2003). The investigator conceived of the project as a “treasure hunt” for relevant data and kept a detailed research record. Overall, the investigator encountered more “blind alleys” and “dead ends” than “finds,” yet explored several critical areas with varying potential for shedding light on the incidence and prevalence of elder abuse, as summarized throughout the paper (and in the Executive Summary chart).

A blatant difficulty in elder abuse research is the disparity of definitions of “elder abuse” (Lachs & Pillemer, 1995). The National Research Council report’s background paper *Epidemiological Assessment Methodology* (Acierno, 2003) stresses that while various agency records offer possible sources of information, “the definitions for particular forms of elder mistreatment vary widely across social service agency, county, and state.” Similarly, the background paper *Elder Abuse in Residential Long-Term Care Settings* (Hawes, 2003) notes that “agencies use different definitions and have different

A. Health Care Data—Background on Diagnostic Coding

1. Medical Diagnostic Codes

Physicians and hospitals use diagnostic codes for reimbursement purposes and to document the reasons for medical treatments. The World Health Organization develops an *International Classification of Diseases* (ICD) to code and classify mortality data from death certificates, and the National Center for Health Statistics in the CDC in the U.S. Department of Health and Human Services develops a “clinical modification” to code and classify morbidity data from inpatient and outpatient records, physician offices, and National Center for Health Statistics surveys (<http://www.cdc.gov/nchs/icd9.htm>). The ICD and the clinical modifications are revised periodically to reflect changes in the medical field. The version currently in use is ICD-9-CM. The ICD-10-CM has been developed, but is not yet in use. The diagnostic codes generally are known as “ICD codes.” In addition, related “E-codes” under each ICD code classify external causes of injury. The E-codes serve as modifiers that describe the circumstances of an injury or illness.

The ICD coding provides statistical data on the incidence and prevalence of diseases and health conditions in the United States. It serves as a basis for a number of national surveys and databases. The U.S. Public Health Service and CMS require use of the ICD-9-CM for reporting diagnoses and diseases. The National Center for Health Statistics uses ICD-9-CM in its multi-faceted National Health Care Survey (see below). Hospitals use groupings of ICD-9-CM codes called “Diagnostic Related Groups” to describe types of patients and seek reimbursement. The question, then, is to what extent does or can ICD coding include information relevant to the incidence and prevalence of elder abuse.

2. Diagnostic Coding on Abuse

a ICD-9 Coding on Abuse. The ICD codes for child and adult “maltreatment” have existed since 1979 and were expanded in 1996 to include more specification of the types of abuse (Rovi & Johnson, 2003). Today, ICD-9-CM code 995.80 is “adult maltreatment, unspecified,” and additional codes each identify specific kinds of adult abuse, as follows:

995.80 – Adult maltreatment, unspecified

995.81 – Adult physical abuse

995.82 – Adult emotional/psychological abuse

995.83 – Adult sexual abuse

995.85 – Other adult abuse and neglect

Research on these diagnostic codes for abuse suggests they are used very rarely, with one study of inpatient hospital admissions showing only 445 out of over 6.5 million inpatient stays with these codes (Rudman & Davey, 2000). Similarly, a study including both adult and child abuse codes analyzed four years of data from office-based physician visits, as well as visits to hospital emergency and outpatient departments, and found only 93 diagnoses for over 350,000 patient visits, noting that child abuse was diagnosed more often than adult abuse (67 incidences vs. 26 incidences) (Rovi & Johnson, 1999). There are several reasons why such coding is low:

- Reimbursement is low. “Since most reimbursement payment schedules only include the PDX [primary diagnosis] and one secondary code for reimbursement practices (e.g., Medicare and Medicaid), it is not profitable or time efficient for the hospital to include these types of codes . . .” (Rudman & Davey, 2000). Physicians in focus groups on use of the abuse codes confirmed that coding abuse is unlikely to result in insurance reimbursement. One participant noted that: “I’d use the codes if I could get some Medicare reimbursement for it. I mean, there’s no incentive from an individual victim’s perspective or from a system’s perspective for using [the codes], really, there’s no benefit” (Rovi & Johnson, 2003).
- Physicians and coding personnel may be unaware of the abuse codes (Rovi & Johnson, 1999).
- Physicians generally have little training in recognizing and addressing abuse and may feel hesitant in identifying it. They may be troubled by a “gray zone” of uncertainty, especially with older patients, as they bruise easily (Rovi & Johnson, 2002). Moreover, if physicians code a condition as abuse, they may then be required to report it under state law, and may be reluctant to do so. They may fear being asked to testify about the abuse in court, or be concerned that they are making a legal judgment (Rovi & Johnson, 2003).
- Physicians may be concerned that coding abuse could harm or jeopardize the patient. They may believe that coding abuse without patient consent is a breach of patient confidentiality. They may be concerned about insurance company discrimination against victims of abuse, including the question of whether “some HMOs might use the codes [adversely] in their selection of elderly clients” (Rovi & Johnson, 2003).

physical, sexual, and psychological) that are “confirmed”—and identical codes at T76 for specific kinds of adult abuse that are “suspected.” The addition of codes for unconfirmed or suspected abuse was added:

in response to the uncertainty of identifying [abuse or] domestic violence during a specific encounter or the possible unwillingness of the healthcare worker to document suspicions and/or screen more carefully if domestic violence [or abuse] is a possibility. The suspected but unconfirmed . . . codes cannot be used in combination with any perpetrator codes since there is only suspicion, limiting the information we can learn from the data (<http://endabuse.org/programs/display.php3?DocID=173>).

3. Limitations of Diagnostic Codes for Elder Abuse

The most evident barrier in use of the diagnostic codes to identify elder abuse is that the abuse codes are *not age-specific*, lumping domestic violence and other adult abuse along with elder abuse. Thus, ICD data would have to be correlated with a set of data identifying those 60 years of age or older. Second, the ICD-9 codes alone do not indicate the *perpetrator*, but if an E-code showing the cause of the injury is present, the perpetrator may be noted. However, it appears that E-coding is highly variable. One informant from the National Center for Health Statistics explained that the E-codes

are never coded very well because E-codes aim to show the source of the injury. An ambulance might come in [to the hospital] and someone might note what happened, but the physician is really more concerned about what the presenting condition is than what caused it and who did it (R. Pokras, personal communication, August 2005).

Moreover, if a care provider is the source of information, the provider will not be likely to admit to or characterize what happened as abuse. Finally, as described fully above, it would take *extensive education* of physicians and hospital staff to get them to recognize elder abuse and the rationale for using the abuse codes for elderly patients.

All of the deficiencies in medical diagnostic coding for estimating the incidence and prevalence of elder abuse were echoed in an interview with a physician who was a member of the National Research Council’s Panel to Review the Risk and Prevalence of Elder Abuse and Neglect. She stated that she would “doubt if even one doctor ever used the ICD coding to indicate elder abuse. It’s not in the same universe.” She noted that

physicians rarely recognize elder abuse and even if they did, “the medical billing people would not know what to do with it” (L. Mosqueda, personal communication, April 2005).

The ICD-10-CM, which was developed with extensive public input over a number of years, still does not separate elder abuse from adult abuse. It does have a list of perpetrators (called “Y-codes”), which names spouse, siblings, parents, and cousins, but notably does *not* include adult children—which seems to indicate that elder abuse, at least in the family setting, was not considered in the code development. Abuse by “other family members” is Y07.49. Lumping “other family members” into one category will result in the loss of relevant elder abuse data. The list of perpetrators does, however, include abuse by care providers, designating separate codes for “at home adult care providers” and “adult care center providers.” Once ICD-10 is in use, these latter codes may be of use in identifying elder abuse—but would be subject to the same variability as the current E-coding.

The ICD-10 has not yet gone through a rulemaking procedure. Elder abuse professionals and advocates could submit statements during the public comment period after a notice of proposed rulemaking, recommending that elder abuse be a distinct category, as is child abuse. When questioned about the feasibility of this, a National Center for Health Statistics coding expert argued that “child abuse raises distinctly different issues,” whereas elder abuse may not merit a separate category as it is ~~similar~~ enough to other adult abuse (D. Pickett, personal communication, August 2005). Another National Center for Health Statistics expert observed that while it might be a good idea in theory, “just because you have the coding system doesn’t mean there will be data to code” for all of the reasons mentioned above. He advised focusing not so much on the ICD codes on abuse, but instead looking for certain medical patterns that might be flags of abuse in a range of other specific ICD codes—for example, using ICD codes on bruises to identify certain patterns of bruises and contusions for elderly patients over time.

Nonetheless, in response to the NCEA Request for Proposals, this study examined the potential for specific national health care databases to shed light on elder abuse by correlating the ICD diagnostic codes on abuse with age-related data, as detailed below.

B. Health Care Data—CDC Surveys and Databases

The Department of Health and Human Services CDC provides statistical information to assist in policies that improve the health of the American people. The CDC regularly conducts national surveys of health care providers and individual health

burglary, and motor vehicle theft for the population as a whole, as well as for segments of the population, such as women, the elderly, members of various racial groups, city dwellers, or other groups. The NCVS provides the largest national forum for victims to describe the impact of crime and characteristics of violent offenders

(<http://www.ojp.usdoj.gov/bjs/cvict.htm#ncvs>).

The Bureau of Justice Statistics has analyzed data concerning elders from the NCVS and other sources in two publications on *Crimes Against Persons Age 65 or Older*—one for 1992 through 1997, and another from 1993 through 2002 (Klaus, 2000, 2005; Bureau of Justice Statistics, 2005). These publications include extensive statistics on crimes against older persons, including a table on the “Relationship of victim and offender for murder and non-lethal violence, by age of victim,” but nothing specific to elder abuse. The earlier publication includes a special note explaining that the NCVS cannot accurately measure elder abuse, which involves victims who are “injured, neglected, or exploited because of vulnerabilities associated with age, such as impaired physical or mental capacities” (Klaus, 2000). The report cites several limitations on securing elder abuse data:

- Victims may not be able to report the abuse because of cognitive impairment, may be afraid to report it, or may not see it as a crime;
- A victim of financial exploitation may not be aware of it;
- The survey does not include crimes occurring in institutional settings (Klaus, 2000); and
- The survey would not capture the vulnerability of the individual or the trust relationship with the caregiver or family member.

2. FBI Uniform Crime Reports

(Box 3 in figure above)

The FBI system of Uniform Crime Reports (UCR) is a voluntary city, county, state, and federal law enforcement effort based on the submission of crime data by law enforcement agencies throughout the country (<http://www.fbi.gov/ucr/ucr.htm#cius>). UCR Part A collects offense information from police on murder, non-negligent manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny-theft, motor vehicle theft, and arson; and Part B includes more minor crimes. The UCR is not very useful for collecting information on elder abuse because:

event by police departments across the country” (Acierno, 2003). Finally, NIBRS is not yet operational in all states. As of 2001, more than 3,700 agencies across 21 states were submitting NIBRS data (<http://www.ojp.usdoj.gov/bjs/ibr.htm>). Thus, adding elder abuse as an item in NIBRS might have some utility, but it would still be hampered by the very limitations that make elder abuse so difficult to define and measure. For all of these reasons, Bureau of Justice Statistics data represents “preliminary, as opposed to comprehensive, epidemiological data regarding elder mistreatment” (Acierno, 2003; R. Thomas, personal communication, April 2005).

4. Bureau of Justice Statistics—National Survey of Prosecutors (Box 5 in figure above)

In 2001, the Bureau of Justice Statistics surveyed all U.S. prosecutors’ offices that handled felony cases in state courts of general jurisdiction, including over 2,300 offices. The survey found that during the previous year nearly 42 percent of the offices had prosecuted elder abuse cases, with the larger offices more likely to prosecute such cases (97.1 percent) than the small (42.3 percent) or part-time (20.5 percent) offices (Bureau of Justice Statistics, *Prosecutors*, 2002). Thus, the survey asked “Did you prosecute elder abuse?” rather than “How many cases?” providing a very rough measure of prevalence, but shedding no light on the incidence of elder abuse. Elder abuse professionals and advocates could inquire into opportunities for revising the survey to include the number of elder abuse cases.

5. Additional Criminal Justice and Related Information Sources

a. Suspicious Activity Reports. National banks are required to report known or suspected criminal offenses involving transactions over \$5,000 that they suspect may involve money laundering or violate the Bank Secrecy Act. Banks make this report by filing a Suspicious Activity Report (SAR) form with the Financial Crimes Enforcement Network of the U.S. Department of the Treasury (<http://www.occ.treas.gov/sar.htm>). The SAR form has categories of suspicious activity, including embezzlement/theft, check fraud, false or conflicting IDs, use of multiple credit or deposit accounts, and more. However, there is *no indication of age* of any victims on the SAR form. A victim specialist for the FBI who is familiar with SAR reports stated that trying to add information about age would be “too simplistic” as “the whole SAR operation is not geared to things like elder exploitation. That’s too small and falls under the radar for SAR,” which is really targeted toward uncovering large scale drug trafficking and money laundering (D. Deem, personal communication, April 2005).

policymaking purposes—such as data available through the National Health Care Surveys, the National Violent Death Reporting System, or the National Crime Victimization Survey. In both categories, not surprisingly, elder abuse data are extremely difficult to identify, and generally fall below the radar screen because:

- Providers and professionals coding the information lack the training to recognize a fact pattern or medical condition as involving elder abuse. There is no paradigm or “frame” that makes elder abuse indicators evident;
- Elder abuse often is secondary to other conditions or case types that are more likely to be coded;
- There are no incentives for coding or reporting information on elder abuse, and there may be conflicts or disincentives; and
- The largest single driver of data on which elder abuse information might be based is the massive and long-standing ICD coding system widely used throughout the health care and health financing systems. It is the foundation for multiple CDC surveys, for Medicare claims information, and for ARHQ databases. While it does include codes for adult maltreatment, these must be correlated with age to yield information on elder abuse, and even then information on the victim-perpetrator relationship may be missing. Moreover, the existence of coding line items or categories certainly does not guarantee they will be used. It appears that the adult maltreatment codes are used exceedingly rarely for all of the reasons given above. While the development of the next ICD iteration—ICD-10—may offer an opportunity for some change, the barriers are enormous.

This report offers a detailed snapshot of existing sources across multiple agencies and organizations—an alphabet soup array. For each source, the report examines the gaps and limitations, and possible use by AoA, other federal agencies, and elder abuse professionals and advocates, to bolster the statistical basis for elder abuse policy. Indeed AoA is in a key position to partner with the other federal agencies that collect the data described, to strengthen information on the incidence and prevalence of elder abuse. Exploration of approaches could be initiated in collaboration with the Federal Interagency Forum on Aging-Related Statistics, as well as through the Federal Interagency Working Group on Elder Justice, in which AoA already has a leadership role.

hotlines stated the redesign will come up this fall, and invited input on elder abuse.

In addition, an overarching barrier that cuts across many of the data systems is the lack of capacity by professionals—physicians, nurses, hospital staff, coding experts, state health department surveyors, law enforcement officers and legal services attorneys—to recognize a fact pattern as elder abuse and to so code it. Enhanced training and education would help these professionals on the front line to “reframe” the situation so as to more accurately reflect the incidence and prevalence of elder abuse.

While each of the above actions offers some potential to fill in the blanks in the national picture of elder abuse, taken together they are nonetheless insufficient and piecemeal. Indeed the examination of data sources for this white paper supports the need for: (1) the development of scientific research on elder abuse under proposed projects supported by the National Institute on Aging, and (2) a national incidence and prevalence study and other collection of data as recommended by the National Research Council (National Research Council, 2003).


http://www.salon.com/2011/03/03/mickey_rooney_elder_abuse/

THURSDAY, MAR 3, 2011 9:04 PM UTC

Mickey Rooney's heartbreaking elder abuse story

The Hollywood icon draws attention to a problem that will soon affect a generation of baby boomers

BY MARY ELIZABETH WILLIAMS



Entertainer Mickey Rooney testifies on Capitol Hill in Washington, Wednesday, March 2, 2011, about elder abuse, before the Senate Aging Committee. (AP Photo/Alex Brandon) (Credit: AP)

Of the many evil aspects of abuse — whether it's physical, emotional or financial — the shame that too often accompanies it, the way it can make its victims feel complicit in their exploitation, is right up there. But on Wednesday, one prominent survivor spoke to Congress to deliver a message to the world: "You are not alone and you have nothing to be ashamed of."

The message came from 90-year-old screen legend Mickey Rooney. In an emotional testimony before a Senate Special Committee on Aging inquiring on elder

abuse, the actor told how he was kept a "prisoner in his own home." He currently has a restraining order against his 52-year-old stepson Christopher Aber. In court papers, Rooney has accused him of intimidating him, preventing him from leaving his house, and withholding his mail, medication and food. "My money was stolen from me, by someone close," he told the committee. "My money was taken and misused. When I asked for information, I was told that I couldn't have any of my own information. I was literally left powerless."

There are myriad reasons why the elderly are easy targets for abusers, from fragile physical conditions to memory-impairing problems like Alzheimer's to easily manipulated insecurities and misunderstandings about their legal rights or financial options. And the closer an abuser is to the victim, the easier the crime can be to pull off, and the harder it can be to break the silence. It all comes down, as it so frequently does — whether the victim is a child or a woman with no support system or a Hollywood legend who's made over 300 films — to the abuser's hold over someone who may not have the ability to leave.



Astor Case Raises Awareness of Elder Abuse and Need to Fight It

by: Sean Gardiner, from: [AARP Bulletin](#), October 15, 2009

At its heart, the case against Anthony Marshall, the son of renowned New York philanthropist Brooke Astor, is no different from thousands and thousands of other crimes against elders: a trusted caregiver takes advantage of an older person's declining state to enrich himself.

True enough. But that's a little like saying the Queen Mary II and a dinghy are both boats.

In many ways the Astor case, which ended in Manhattan last week with Marshall's conviction on charges that he defrauded his mother, was a once-in-a-lifetime legal saga. It showcased A-list celebrity witnesses like Henry Kissinger and Barbara Walters. It peered voyeuristically into the opulent lifestyle and dysfunction of the grande dame's family. And it laid bare the financial and legal machinations it took to siphon off a \$185 million fortune.

All of that glamour, glitz, gossip and detail through 19 weeks of daily full-press coverage could have overwhelmed the elder abuse issue at the case's core.

But it didn't, elder abuse professionals and experts say. In fact, there are signs that the trial raised the public's awareness and understanding of elder abuse. It's likely that prosecutors will be emboldened to bring more suspected abusers to trial. And the Elder Justice Act, a bill that would authorize millions of dollars to protect older people, but which has languished in Congress since 2002, might have received a boost from the trial's publicity. It was attached as an amendment to the health care reform bill approved by the Senate Finance Committee this week.

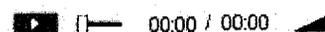
The Astor case also brought to the fore crimes often overlooked as elder abuse: financial exploitation, for example. After deliberating for 12 sometimes contentious days, the jury convicted Anthony Marshall, who turned 85 during the trial, of committing a scheme to defraud, grand larceny and 12 other counts of financial misdeeds. Marshall's lawyer friend and codefendant, Francis X. Morrissey, was also found guilty of forging one of Astor's wills.

"This case raised awareness to a new level on what constitutes elder abuse," says Robert B. Blancato, national coordinator of the Elder Justice Coalition, which includes AARP.

That wasn't expected three years ago when a petition filed by Astor's grandson Philip Marshall to have Anthony Marshall, his father, removed as his grandmother's guardian thrust the case into public light. "The big issue we were concerned about was the psychological abuse, which was prominent," Philip Marshall told the Bulletin. "Undue influence would be a polite way of describing this. But it went far beyond undue influence. This was psychological warfare in an effort to get what they wanted out of her."

Initial stories of Astor's mistreatment at the hands of her only child detailed her abuse by neglect and mistreatment: cutting back on everything from her doctor visits to the brand of makeup she used; dressing her in rags and not allowing nurses to buy her a new outfit for her 104th birthday; locking her beloved dogs, Boysie and Girlsie, away from her because they damaged the antique furniture.

Elder Financial Abuse



Knowing what money normally goes in and out of a loved one's checking account is a good way to spot elder financial abuse. **(Prime Time Focus)**

"Her bedroom is so cold in the winter that my grandmother is forced to sleep in the TV room in torn nightgowns on a filthy couch that smells, probably from dog urine," stated Philip Marshall's guardianship petition.

But between the filing of that petition and Anthony Marshall's criminal trial, the case evolved. The majority of hard evidence available to the lawyers, first in the guardianship case and then in the criminal investigation by the Manhattan District Attorney's Office, centered around financial documents: wills, deed transfers and letters from Anthony Marshall, who had power of attorney for his mother, authorizing a \$1 million retroactive raise for himself for overseeing his mother's finances.

There was a paper trail of financial exploitation, but the neglect and mistreatment allegations were mostly culled from the subjective observations of the Astor staff. When Judge A. Kirke Bartley Jr. barred almost all the testimony about Astor's purported physical abuse and neglect, it ensured that the trial would focus on financial exploitation by a loved one.

Though understanding the testimony at times seemed to require an MBA degree, experts say the trial sent out a strong message. Since the trial began in April, "we have actually seen an uptick in the number of [financial elder abuse] inquiries," says Sharon Merriman-Nai, comanager of the National Center on Elder Abuse. "I can't say with certainty that it's directly related to the Astor trial, but it was a very public case."

And financial elder abuse is a very pervasive problem. A conservative estimate of the annual cost of the crime is \$2.6 billion, according to the study "Broken Trust: Elders, Family, and Finances" released in March by the MetLife Mature Market Institute. As in the Astor case, financial abuse is typically committed by a person the victim trusted. In 55 percent of the financial elder abuse cases, the perpetrator was a family member, friend, neighbor or caregiver. In another 18 percent of the cases, the perpetrator was a financial professional working for the victim. Only 21 percent of the fraud was committed by a scam artist previously unknown to the victims.

Given those statistics, perhaps the most important lesson from the Astor trial, Merriman-Nai says, is that if financial abuse can happen to a rich and famous woman like Astor, it can happen to anybody. "There are many, many people out there being taken advantage of in much smaller ways," she says. "It may be smaller dollar amounts than in the Astor case, but it can be just as devastating in their lives. The point [the trial made was] this occurs everywhere."

The impact of the Astor case on the national elder abuse debate would have been drastically different, some experts say, had the jury come back with a different verdict. An acquittal or even a mistrial might have had a "chilling effect" on prosecutors' offices across the nation, says Thomas Hafemeister, a University of Virginia law professor studying the prosecution of elder abuse crimes. "It would have been very demoralizing for prosecutors in general and the numerous offices across the country that are establishing special elder abuse/fraud units in particular if the defendants had been found not guilty," he says.

But "in part driven by the attention given to this case" and because of the "greater numbers, greater wealth and greater political mobilization" of the nation's elderly population, Hafemeister says, "societal attention to financial abuse of the elderly is likely to increase."

Publicity from the Astor case may finally help usher into law the Elder Justice Act, which has been introduced but has died in every Congress since 2002. It was added to the Senate Finance Committee's health care reform bill five days after the jury delivered a verdict in the Astor trial. The trial "helped raise the visibility of elder abuse and the need to pass the Elder Justice Act," says Rhonda Richards, AARP's senior legislative representative.

The act would provide funds to the notoriously underfunded state agencies that provide adult protective services. Those monies would be used to improve or bolster reporting mechanisms, investigations, prosecutions and training focused on detecting and recognizing elder abuse.

"That's basically the missing link, people's inability to know what elder abuse is and report it," says Blancato of the Elder Justice Coalition.

Though Philip Marshall couldn't fathom that his guardianship petition would become the jumping off point on the financial elder abuse debate, he says he is hopeful that this issue will define the legacy of his grandmother even more than the \$200 million she gave away to charity or any of the causes she championed while living.

"I think it has started a national conversation on the problem of elder abuse," says Philip Marshall, who is a professor of historic preservation at Roger Williams University in Rhode Island. "It continues and it will continue. While my grandmother didn't choose this, this may be her lasting legacy in a good way over even the other philanthropic work she has done in New York City. The importance of this issue exceeds the gravitational force of New York. This is nationwide."

Sean Gardiner is a veteran journalist who most recently covered the criminal justice system for the Village Voice.

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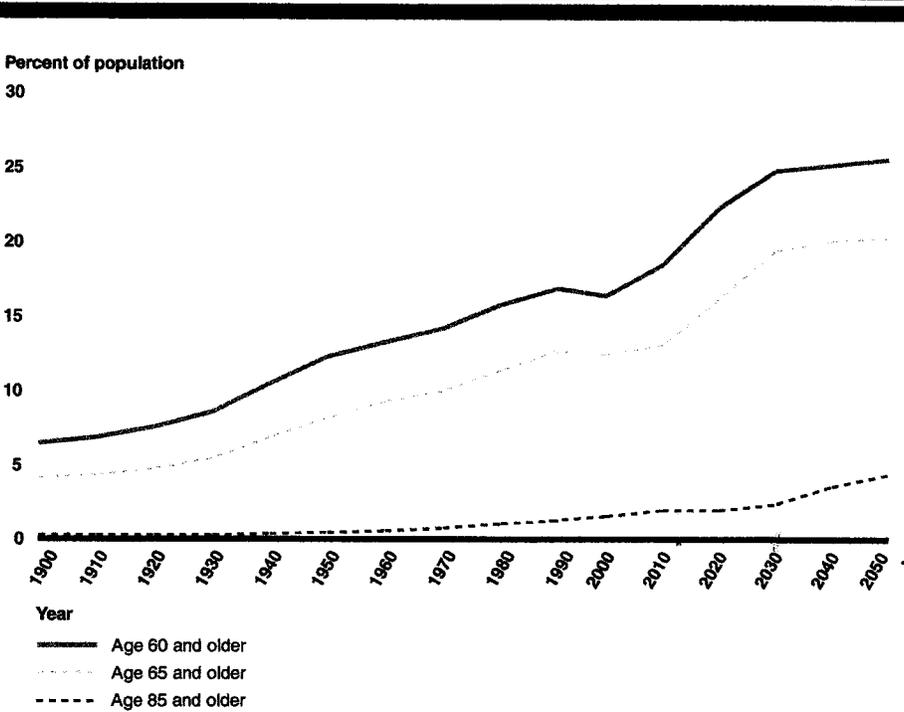
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Appendix I: Growth in Percentage of U.S. Elderly Population, 1900-2050



Source: GAO analysis of U.S. Census Bureau data by the Administration on Aging.

Mortality by underlying cause, ages 18+: US/State, 2001-2009 (Source: NVSS)

Other: Measure (Rate per 100000), Year (2007-2009), Sex (All), Race/Ethnicity (All races), State (Montana)

Age	All ages (age-adjusted)	All ages (crude)	18+ (age-adjusted)	18+ (crude)	18-44	18-24	25-44	45-64	45-54	55-64
Cause of Death										
Asthma	0.7	0.8	1.0	1.0	*	*	*	*	*	*
Pneumonitis due to solids and liquids	5.5	6.7	7.4	8.7	*	*	*	*	*	*
Peptic ulcer	1.0	1.2	1.4	1.6	*	*	*	*	*	*
Chronic liver disease and cirrhosis	12.6	14.2	17.0	18.4	6.2	*	8.7	28.3	27.4	29.5
Kidney diseases	11.3	13.4	15.0	17.3	*	*	*	4.0	*	*
Birth defects	3.9	3.9	1.7	1.8	*	*	*	*	*	*
Unintentional injuries	59.9	62.9	75.7	77.2	65.1	69.5	63.3	60.0	64.4	54.7
Homicide	3.5	3.4	4.2	3.9	5.6	*	5.4	3.4	5.3	*
Suicide	20.5	21.3	26.5	26.6	26.2	25.5	26.4	28.3	28.5	28.1

85+

39.8

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PAPERS

Role of media reports in completed and prevented suicide: Werther v. Papageno effects

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Declaration of interest

None.

Abstract

Background

Media reporting of suicide has repeatedly been shown to trigger suicidal behaviour. Few studies have investigated the associations between specific media content and suicide rates. Even less is known about the possible preventive effects of suicide-related media content.

Aims

To test the hypotheses that certain media content is associated with an increase in suicide, suggesting a so-called Werther effect, and that other content is associated with a decrease in suicide, conceptualised as a Papageno effect. Further, to identify classes of media articles with similar reporting profiles and to test for associations between these classes and suicide.

Method

Content analysis and latent class analysis (LCA) of 497 suicide-related print media reports published in Austria between 1 January and 30 June 2005. Ecological study to identify associations between media item content and short-term changes in suicide rates.

Results

Repetitive reporting of the same suicide and the reporting of suicide myths were positively associated with suicide rates. Coverage of individual suicidal ideation not accompanied by suicidal behaviour was negatively associated with suicide rates. The LCA yielded four classes of media reports, of which the mastery of crisis class (articles on individuals who adopted coping strategies other than suicidal behaviour in adverse circumstances) was negatively associated with suicide, whereas the expert opinion class and the epidemiological facts class were positively associated with suicide.

Conclusions

The impact of suicide reporting may not be restricted to harmful effects; rather, coverage of positive coping in adverse circumstances, as covered in media items about suicidal ideation, may have protective effects.

Articles citing this article

Changes in suicide rates following media reports on celebrity suicide: a meta-analysis

J. Epidemiol. Community Health November 1, 2012 66:1037-1042

[Abstract](#) [Full text](#) [PDF](#)

Suicide rates in the national and expatriate population in Dubai, United Arab Emirates

Int J Soc Psychiatry November 1, 2012 58:652-656

[Abstract](#) [PDF](#)

From the Editor's desk

Br. J. Psychiatry April 1, 2011 198:332

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Murder-Suicides in Elderly Rise

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Husbands commit most murder-suicides -- without wives' consent.

WebMD Feature One Sunday morning, Charlie Woods returned home from church to find two police officers waiting at his door. First the officers asked if he had any health problems. Then they told him both his parents were dead. His father had killed his mother, firing six bullets through the bedroom door of their Tallahassee home. Then the 59-year-old man turned the gun on himself.

Since 1988, when Woods' parents died, the homicide-suicide rate among couples 55 and older in Florida has increased about tenfold, according to Donna Cohen, a professor of psychiatry and behavioral sciences at the University of South Florida's department of aging and [mental health](#).

Though statistics for the entire nation are not available, Cohen believes the Florida numbers are representative of the rest of the country. She estimates that nearly 20 older Americans die each week in homicide-suicides.

These are not couples who, in the sunset of their years, romantically choose oblivion together. Cohen has found that the typical homicide-suicide case involves a depressed, controlling husband who shoots his ill wife. "These are acts of [depression](#) and desperation," she says. "The wife does not want to die and is often shot in her [sleep](#). If she was awake at the time, there are usually signs that she tried to defend herself."

"There's nothing loving about murdering another person," adds Woods, whose 53-year-old mother was not ill and did not want to die.

Undiagnosed and Untreated Depression

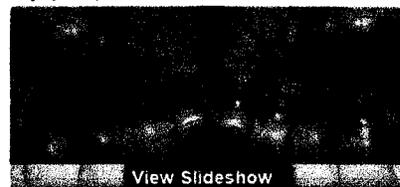
It's not clear why more and more elderly men -- the murderers are almost all men -- are depressed enough to kill themselves and their wives. One reason may be loneliness, says Patrick Arbore, Director of the Center for Elderly Suicide Prevention at the Goldman Institute on Aging. He points out that more and more seniors live isolated from their friends and families.

In one study of an area in Florida, Cohen found that two-thirds of the men who killed their wives and themselves had visited their doctors within three weeks before committing the deadly act. None, however, were being treated for depression.

But a doctor is unlikely to diagnose a condition like depression in a six-minute office visit, partly for lack of time and partly because older people tend to put up a good front in the doctor's office.

"We can't really pass the buck to the physician here. It's important for adult children and members of the community to pay attention and to listen -- to really listen -- to what these older people are saying," says Arbore. "Sometimes comments like 'I'm going to kill myself' are so provocative that we can't believe it and let it go by."

Psoriasis Symptoms, Causes and Treatment



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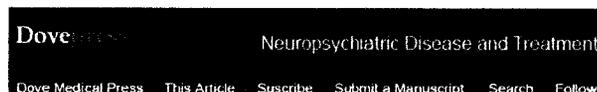
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Neuropsychiatr Dis Treat. 2006 September; 2(3): 359-363.

PMCID: PMC2671820

Suicidal attempts by prescription drug overdose in the elderly: a study of 44 cases

Gerasimos Gavielatos,¹ Nikolaos Komitopoulos,¹ Petros Kanellos,² Efstratios Varsamis,¹ and John Kogeorgos²

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Abstract

Go to:

A series of 44 consecutive elderly, admitted to a busy general hospital following deliberate self-poisoning, is reviewed for associated medical and psychosocial factors. In all but 3 cases the act involved an overdose of drugs prescribed for the treatment of a chronic medical and/or psychiatric disorder. Women outnumbered men by 2.7 to 1. There was high proportion of chronic psychiatric (80%, mostly depressive) and medical (60%) conditions. Chronic stress from the physical illness, social isolation, or tacit family conflict were common and seemed instrumental in the self-poisoning act. Most attempts were carried out around the weekend and during winter. One man succumbed to complications of the overdose but the rest of the patients recovered. Psychosocial (especially depressive) and medical vulnerability, plus availability of prescribed drugs, were the most important determinants of suicidal behavior among these elderly attempters.

Keywords: drug overdose, elderly, suicidal attempts, self-poisoning

Introduction

Go to:

Attempted suicide remains a serious clinical and public health issue, which appears to be rising in parallel with or exceeding suicide rates (Diekstra 1996; McLoone and Crombie 1996; McEvedy 1997). Further, attempted suicide and attendant risk of death are of special importance in the elderly due to a combination of particular factors in old age, including failing physical and mental health and reduced income and social supports. Deliberate drug overdose is the preferred means and commonest method of suicide in the elderly (Cattel and Jolley 1995; Tadros and Salih 2000; Harwood et al 2000), conceivably facilitated by their greater physical vulnerability, further compromised by frequent medical comorbidities and polypharmacy. Despite such high risks and related severity of suicidal behavior in the elderly, relatively few studies have focused on this problem (Hawton and Fagg 1990; De Leo 1997).

The aim of the present investigation was to explore the relevant factors associated with deliberate self-poisoning of 44 elderly subjects, admitted to a busy general hospital, following their gesture, over a period of 3.5 years.

Patients and methods

Go to:

All elderly subjects (aged 65 or over) admitted to the 2nd Internal Medicine Department of Aghia Olga's Hospital following a suicidal attempt by drug overdose over the period were reviewed through their systematically recorded case notes. Their demographic, clinical, and psychosocial characteristics, medical and drug history, the particular circumstances surrounding their action, and their mental and medical status as routinely and meticulously recorded on admission, including their state of consciousness, were all noted on specially designed clinical forms. Particular care was taken to establish the presence or not of a psychiatric and/or personality disorder and to ensure that the drug overdose was not accidental but an intended suicidal act. Information from medical and psychiatric examinations was complemented with interviews with relatives or other key persons, and relevant social work reports. Relevant psychosocial conflicts or other stresses preceding the overdose were also recorded, including apparent psychodynamics related or leading to the final act of the attempt. These assessments and coordinated actions were carried out alternately by two experienced psychiatric registrars based at the psychiatric department of the hospital and in charge of the consultation-liaison service provision to Aghia Olga's casualty and medical wards. These psychiatrists also decided on each patient's required management and whether a patient should be treated on the medical ward or transferred to psychiatric in-patient care, for more specialized observation and treatment. Psychiatric assessments and initial management of these elderly attempters were carried out in the medical setting, over a period of a few days, in parallel with these patients' medical investigative and treatment procedures and complemented by further out-patient follow-up supervision and support.

Results

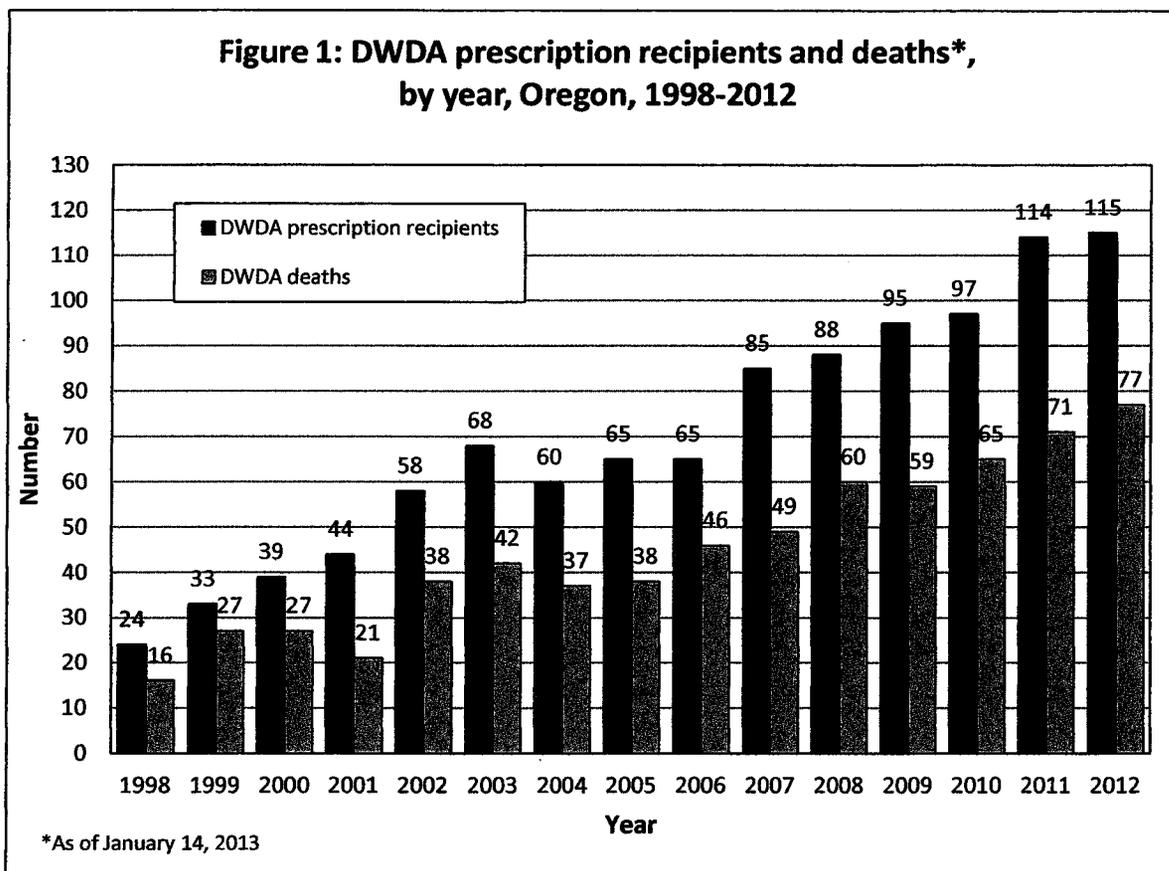
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A total of 44 elderly patients were studied, representing 6.3% of all patients admitted to the clinic over the same period following a deliberate drug overdose. Of these, 13 were males and 31 females (age range 65-91 years; mean 73 years; median 71 years). About half the patients (48%) were married, the remainder being widowed (30%), divorced (8%), or never married (14%). Of the second two categories, fewer than half were living alone at the time of their admission.

About 60% (27) of the patients had been suffering from one or more chronic medical illnesses (mostly pulmonary or cardiovascular conditions, notably hypertension, diabetes mellitus, arthritis) and receiving related medications. About 80% (35) of the patients had a history of a chronic depressive disorder but less than one third (14) of the patients had a history of psychiatric consultation for depression - in 2 cases following a previous attempt - and only 4 patients were receiving antidepressant treatment at the time of their attempt. Several patients were already known to some social agencies. In 31 (70%) of the patients the final act of self-poisoning could be linked to a specific domestic stress. This most often was related to health or financial issues, or due to tacit conflict with other family members, leading to disproportionate guilt feelings or a fully fledged depressive reaction. In the remainder, the attempt could be related to a sense of impasse caused by the stress of chronic medical illness and medication. It is telling that in several of these patients the drug overdose took place during a lengthy period of low grade stress from chronic symptoms or exacerbations of these, commonly pain or impaired mobility.

Oregon's Death with Dignity Act--2012

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2012 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of January 14, 2013. For more detail, please view the figures and tables on our web site: <http://www.healthoregon.org/dwd>.



- As of January 14, 2013, prescriptions for lethal medications were written for 115 people during 2012 under the provisions of the DWDA, compared to 114 during 2011 (Figure 1). At the time of this report, there were 77 known DWDA deaths during 2012. This corresponds to 23.5 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2011 (32,731), the most recent year for which final death data is available.

Table 1. Characteristics and end-of-life care of 673 DWDA patients who have died from ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Sex			
	N (%) ¹	N (%) ¹	N (%) ¹
Male (%)	39 (50.6)	308 (51.7)	347 (51.6)
Female (%)	38 (49.4)	288 (48.3)	326 (48.4)
Age			
18-34 (%)	0 (0.0)	6 (1.0)	6 (0.9)
35-44 (%)	1 (1.3)	14 (2.3)	15 (2.2)
45-54 (%)	8 (10.4)	44 (7.4)	52 (7.7)
55-64 (%)	16 (20.8)	123 (20.6)	139 (20.7)
65-74 (%)	23 (29.9)	170 (28.5)	193 (28.7)
75-84 (%)	18 (23.4)	168 (28.2)	186 (27.6)
85+ (%)	11 (14.3)	71 (11.9)	82 (12.2)
Median years (range)	69 (42-96)	71 (25-96)	71 (25-96)
Race			
White (%)	75 (97.4)	579 (97.6)	654 (97.6)
African American (%)	0 (0.0)	1 (0.2)	1 (0.1)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.1)
Asian (%)	1 (1.3)	7 (1.2)	8 (1.2)
Pacific Islander (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Two or more races (%)	0 (0.0)	0 (0.0)	0 (0.0)
Hispanic (%)	1 (1.3)	4 (0.7)	5 (0.7)
Unknown	0	3	3
Marital Status			
Married (%) ²	33 (42.9)	271 (45.7)	304 (45.4)
Widowed (%)	23 (29.9)	134 (22.6)	157 (23.4)
Never married (%)	6 (7.8)	49 (8.3)	55 (8.2)
Divorced (%)	15 (19.5)	139 (23.4)	154 (23.0)
Unknown	0	3	3
Education			
Less than high school (%)	2 (2.6)	40 (6.8)	42 (6.3)
High school graduate (%)	13 (16.9)	139 (23.5)	152 (22.8)
Some college (%)	29 (37.7)	148 (25.0)	177 (26.5)
Baccalaureate or higher (%)	33 (42.9)	264 (44.7)	297 (44.5)
Unknown	0	5	5
Residence			
Metro counties (%) ³	34 (44.2)	253 (42.7)	287 (42.8)
Coastal counties (%)	4 (5.2)	47 (7.9)	51 (7.6)
Other western counties (%)	37 (48.1)	250 (42.2)	287 (42.8)
East of the Cascades (%)	2 (2.6)	43 (7.3)	45 (6.7)
Unknown	0	3	3
End of life care			
Hospice			
Enrolled (%) ⁴	64 (97.0)	522 (89.7)	586 (90.4)
Not enrolled (%)	2 (3.0)	60 (10.3)	62 (9.6)
Unknown	11	14	25
Insurance			
Private (%) ⁵	36 (51.4)	382 (66.2)	418 (64.6)
Medicare, Medicaid or Other Governmental (%)	34 (48.6)	185 (32.1)	219 (33.8)
None (%)	0 (0.0)	10 (1.7)	10 (1.5)
Unknown	7	19	26

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Underlying illness			
Malignant neoplasms (%)	58 (75.3)	480 (80.9)	538 (80.3)
Lung and bronchus (%)	14 (18.2)	112 (18.9)	126 (18.8)
Breast (%)	4 (5.2)	52 (8.8)	56 (8.4)
Colon (%)	7 (9.1)	36 (6.1)	43 (6.4)
Pancreas (%)	2 (2.6)	42 (7.1)	44 (6.6)
Prostate (%)	5 (6.5)	26 (4.4)	31 (4.6)
Ovary (%)	2 (2.6)	25 (4.2)	27 (4.0)
Other (%)	24 (31.2)	187 (31.5)	211 (31.5)
Amyotrophic lateral sclerosis (%)	5 (6.5)	44 (7.4)	49 (7.3)
Chronic lower respiratory disease (%)	2 (2.6)	25 (4.2)	27 (4.0)
Heart Disease (%)	2 (2.6)	10 (1.7)	12 (1.8)
HIV/AIDS (%)	1 (1.3)	8 (1.3)	9 (1.3)
Other illnesses (%)⁶	9 (11.7)	26 (4.4)	35 (5.2)
Unknown	0	3	3
DWDA process			
Referred for psychiatric evaluation (%)	2 (2.6)	40 (6.7)	42 (6.2)
Patient informed family of decision (%) ⁷	71 (92.2)	493 (94.4)	564 (94.2)
Patient died at			
Home (patient, family or friend) (%)	75 (97.4)	562 (94.8)	637 (95.1)
Long term care, assisted living or foster care facility (%)	2 (2.6)	25 (4.2)	27 (4.0)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	5 (0.8)	5 (0.7)
Unknown	0	3	3
Lethal medication			
Secobarbital (%)	20 (26.0)	374 (62.8)	394 (58.5)
Pentobarbital (%)	57 (74.0)	215 (36.1)	272 (40.4)
Other (%) ⁸	0 (0.0)	7 (1.2)	7 (1.0)
End of life concerns⁹			
	(N=77)	(N=592)	(N=669)
Losing autonomy (%)	72 (93.5)	538 (90.9)	610 (91.2)
Less able to engage in activities making life enjoyable (%)	71 (92.2)	523 (88.3)	594 (88.8)
Loss of dignity (%) ¹⁰	60 (77.9)	386 (82.7)	446 (82.0)
Losing control of bodily functions (%)	27 (35.1)	318 (53.7)	345 (51.6)
Burden on family, friends/caregivers (%)	44 (57.1)	214 (36.1)	258 (38.6)
Inadequate pain control or concern about it (%)	23 (29.9)	134 (22.6)	157 (23.5)
Financial implications of treatment (%)	3 (3.9)	15 (2.5)	18 (2.7)
Health care provider present¹¹			
	(N=77)	(N=526)	(N=603)
When medication was ingested ¹²			
Prescribing physician	8	100	108
Other provider, prescribing physician not present	4	231	235
No provider	1	72	73
Unknown	64	123	187
At time of death			
Prescribing physician (%)	7 (9.1)	89 (17.3)	96 (16.2)
Other provider, prescribing physician not present (%)	4 (5.2)	254 (49.4)	258 (43.7)
No provider (%)	66 (85.7)	171 (33.3)	237 (40.1)
Unknown	0	12	12
Complications¹²			
	(N=77)	(N=596)	(N=673)
Regurgitated	0	22	22
Seizures	0	0	0
None	11	463	474
Unknown	66	111	177
Other outcomes			
Regained consciousness after ingesting DWDA medications ¹³	1	5	6

The Dangers of Assisted Suicide

No Longer Theoretical

By Mary E. Harned
Staff Counsel, Americans United for Life

Euthanasia advocates in the United States argue that they support “aid in dying” rather than suicide. However, “aid in dying”—which Kathryn L. Tucker, the Director of Legal Affairs for Compassion & Choices defines as “the practice of a physician prescribing medication that a mentally competent, terminally-ill patient can ingest to bring about a peaceful death if the dying process becomes unbearable”¹—is simply physician-assisted suicide by a misleading name. The terms “aid in dying,” “death with dignity,” and “patient-directed dying” are merely euphemisms for the practice. In fact, these terms are not recognized by the medical community and are simply used by suicide advocates to mask what they advocate.

Nonetheless, proponents continue to cloak physician-assisted suicide in these compassionate-sounding terms as they promote it in state legislatures across the country. Today, two states—Oregon and Washington—statutorily authorize physician-assisted suicide by the name of “death with dignity.” Further, at least six other states have considered legalizing physician-assisted suicide in recent years.

Euthanasia advocates turn to the courts to achieve what they cannot accomplish democratically through legislatures. While the United States Supreme Court held in 1997 that there is no federal constitutional right to assisted suicide under the Due Process or Equal Protec-

tion Clauses of the Fourteenth Amendment,² courts have considered whether a “right” to assisted suicide exists under state constitutions. In December 2008, a Montana trial court created such a right in the Montana Constitution.³ Upon review, the Montana Supreme Court did not reach the issue of whether there is a “right” to physician-assisted suicide; however, the court ruled that existing state laws and policies did not preclude it. Physicians who assist in suicides can raise a “consent” defense if later prosecuted.⁴

Recently, however, states have rejected the efforts of euthanasia advocates. In 2011, the people of Idaho responded to pressure from advocates to “find” legal recognition of physician-assisted suicide within their law by enacting a *new* law prohibiting it. In 2010, a Connecticut court held in *Blick v. Connecticut* that the state’s manslaughter statute “does not include any exception from prosecution for physicians who assist another individual to commit suicide.” Further, the court held that “the legislature intended the statute to apply to physicians who assist a suicide, and intended the term ‘suicide’ to include self-killing by those who are suffering from unbearable terminal illness.” Therefore, prosecutors were within their authority to prosecute physicians for providing “aid in dying.” In a discussion of *Blick*, a publication of the American Medical Association (AMA) characterized the plaintiff’s argument that “aid in dying”⁵ was not prohibited



as “assisted suicide” as a “novel approach.”⁶ Further, in Montana efforts to codify the state supreme court’s aforementioned opinion have thus far failed.

Unquestionably, euthanasia advocates have had some success in embedding their distorted view of end of life issues in the minds of the American people. The so-called “right to die” is now a phrase of common household knowledge, as are the euphemisms for physician-assisted suicide. While most states explicitly or implicitly prohibit assisted suicide, educational and legislative efforts must continue in order to prevent the acceptance and legalization of suicide—by any name—as appropriate “medical treatment” and a legitimate “choice.”

ISSUES

While euthanasia advocates market physician-assisted suicide as an option for “mentally competent, terminally ill patients” facing unbearable suffering, implementation of the practice looks quite different. Rather than “empowering” individuals facing terminal illness to make their own decisions, the mere availability of physician-assisted suicide can pressure sick, depressed, elderly, or disabled patients to end their lives.

In fact, in court filings, euthanasia advocates define the phrase “terminally ill” so broadly that virtually all persons could claim some sort of need for or “right” to physician-assisted suicide. In the Montana case *Baxter v. State*, suicide advocates, led by Compassion & Choices, defined “terminally ill adult patient” as a per-

son 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time.⁷

This definition is not at all limited to “terminal illnesses” or any specific set of illnesses, conditions, or diseases. Therefore, it could be used in any number of “incurable” or “irreversible” medical situations, including diabetes or asthma. For example, an 18-year-old college student with controlled diabetes, but who relies on medical treatments in order to maintain such control over the disease, falls under this definition of a “terminally ill adult.” Furthermore, there is no specific timeline for suspected death under this definition.

As discussed below, the dangers inherent in the legalization of physician-assisted suicide range from untreated depression to elder abuse to the slippery slope of outright euthanasia. In order to avert these dangers and affirm that the lives of all Americans are valuable, states must reject efforts to extend the legalization of physician-assisted suicide to more states.

The Dangers of Assisted Suicide

Depression

Most if not all terminally ill patients who express a wish to die meet diagnostic criteria for major depression or other mental conditions.⁸ Depression is frequently underdiagnosed and



undertreated, especially in elderly individuals and patients with chronic or terminal medical conditions.⁹ In one study, treatment for depression resulted in the cessation of suicidal ideation for 90 percent of the patients.¹⁰

Despite these statistics, “safeguards” in Washington and Oregon, where physician-assisted suicide is legal, are failing to protect patients, as there are no requirements that patients receive psychological evaluation or treatment prior to receiving lethal drugs. In 2010, only 1 out of 65 patients in Oregon who died as a result of physician-assisted suicide was referred for psychiatric or psychological counseling.¹¹ In Washington, the Department of Health received a psychiatric/psychological consulting form for only 3 of 87 patients. No information is available regarding whether they were treated for any mental complications.¹²

Further, most patients who request physician-assisted suicide do not have longstanding relationships with the physicians who provide the lethal drugs. In Oregon, some physicians prescribe lethal drugs for patients whom they have known as little as one week or less.¹³ In Washington in 2010, half of the patients had a “relationship” with their physician of only 3 to 24 weeks.¹⁴ This lack of a long-term relationship between doctor and patient precludes a doctor from truly understanding a patient’s psychological condition, and encourages physician shopping.

Pain

Euthanasia advocates wrongfully claim that assisted suicide is “needed” for those terminally ill patients who face, or fear, great pain. But most experts in pain management believe that 95 to 98 percent of such pain can be relieved.¹⁵ In most cases, patients who request assisted suicide on the basis of pain will withdraw the request after pain management, depression, and other concerns are addressed.¹⁶

Studies have revealed that when offered personal support and palliative care, most patients adapt and continue life in ways they might not have anticipated.

Very few of these individuals ultimately choose suicide.¹⁷ Given that our healthcare system often fails to diagnose and treat depression or provide adequate palliative care, the legalization of physician-assisted suicide is profoundly dangerous for individuals who are ill and vulnerable or “whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.”¹⁸

Critically, the availability of assisted suicide may lead to a decrease in or failure to increase the availability of pain management and palliative care. In fact, proper palliative care is languishing in Oregon. In 2004, Oregon nurses reported that the inadequacy of meeting patients’ needs had increased “up to 50 percent” and that “[m]ost of the small hospitals



in the state do not have pain consultation teams at all.”¹⁹

Further, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of life. The AMA states that

“allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.” The AMA advocates that multidisciplinary interventions be sought, including specialty consultation, hospice care, pastoral support, family counseling, emotional support, comfort care, and pain control.²⁰

Coercion

Many patients who request physician-assisted suicide are coerced or pressured by family members. Some patients believe they will be a “burden” on their families. There have been documented accounts of individuals committing suicide under pressure and/or duress from family members, friends, and/or suicide advocates present at the ingestion of lethal drugs.²¹ In 2010, over one-fourth (1/4) of patients who died after ingesting a lethal dose of medicine in Oregon and Washington did so because, at least in part, they did not want to be a “burden” on family members, raising the concern that patients were pushed into suicide.²²



The Death with Dignity Act in Oregon provides an example of how this coercion is embedded in the state law. While the Act requires two witnesses at the time of request for physician-assisted suicide, one of those witnesses can be a relative who stands to inherit

from the patient, and the second witness can simply be a friend of the relative. The witness requirement, therefore, does not adequately protect against coercion.²³

Terminally ill patients also face a form of coercion from health insurance companies and other healthcare payers who provide coverage for suicide assistance, but not for treatment of disease or palliative care. This poses a significant threat to vulnerable persons who may not have adequate access to medical care. A lack of options may effectively pressure patients into assisted suicide.

For example, in 2008, patient Barbara Wagner was denied coverage under her Oregon state health plan for medication that would treat her cancer and extend her life; instead, the state health plan offered to pay for the cost-effective option of ending her life by physician-assisted suicide.²⁴

Elderly Americans

Physician-assisted suicide can be the ultimate manifestation of elder abuse. The National Center on Elder Abuse estimates that one to two million Americans aged 65 or older “have been injured, exploited, or otherwise mistreat-



ed by someone on whom they depended for care or protection.²⁵ Too often, the physicians and family members to whom a terminally-ill patient looks to for support and protection are the same ones counseling that suicide may be the best option for the patient. Facing deteriorating health and increasing age, the elderly are at a greater risk of suicide than any other age group.²⁶

Physician-assisted suicide greatly increases the risk of elder abuse and suicide among the elderly by creating yet another path of abuse against older individuals—abuse which is often subtle and extremely difficult to detect. In fact, legalized physician-assisted suicide may hide abuse of elderly and disabled Americans by providing complete liability protection for doctors and promoting secrecy.

For example, in Oregon physicians providing physician-assisted suicide are self-reporting, death certificates are required to report a “natural” death (as opposed to a suicide), and there are no requirements that witnesses be present at the time of death. Further, Oregon collects information about the time and circumstances of patients’ deaths only when the physician or another healthcare provider is present at the time of death. Yet in 2010, physicians were present in only 25 of the deaths²⁷ —meaning that information on over 60 percent of the patients’ deaths is unknown. This creates unacceptable gaps in Oregon’s data. Further, a publication of the AMA has reported that the Oregon Department of Human Services “has no regulatory authority or resources to ensure compliance with the law.”²⁸

The Disabled and Other Vulnerable Americans

Additionally, none of the reasons frequently cited by patients requesting physician-assisted suicide—a fear of a perceived (not necessarily actual) loss of autonomy, loss of dignity, and decreasing ability to participate in activities that make life enjoyable²⁹—are unique to terminally ill patients. For example, a person left paralyzed after an accident or illness could also use these reasons to claim a “need,” or a “right,” to physician-assisted suicide.

Therefore, it will be difficult, if not impossible, to limit physician-assisted suicide to “competent, terminally ill patients.” Individuals who are not competent, who are not terminally ill (but potentially in more pain than a terminally ill patient), or who cannot self-administer lethal drugs will also seek the option of physician-assisted suicide, and no principled basis will exist to deny them this “right.” For instance, an Oregon Deputy Attorney General has opined that the Americans with Disabilities Act (ADA) would likely require the state to offer “reasonable accommodation” to “enable the disabled to avail themselves” of the Death with Dignity Act.³⁰

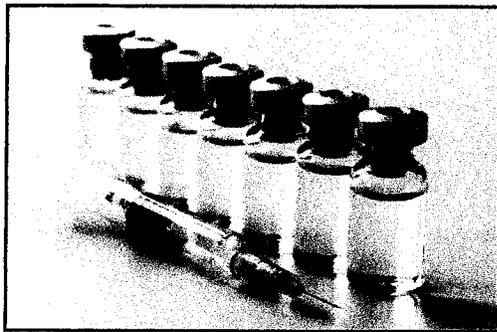
Assisted Suicide in Other Countries – The Slippery Slope Becomes a Reality

Physician-assisted suicide and euthanasia have been legal in the Netherlands and Belgium for years. Yet instead of strengthening autonomy at the end of life, the legalization of physician-assisted suicide and euthanasia has proven to degrade and dehumanize the lives of patients, resulting in physicians routinely performing euthanasia without the consent of their patients. As the New York State Task Force on



Life and the Law concluded, “[A]ssisted suicide and euthanasia are closely linked; as experience in the Netherlands has shown, once assisted suicide is embraced, euthanasia will seem only a neater and simpler option to doctors and their patients.”³¹

A report commissioned by the Dutch government demonstrated that more than half of euthanasia and assisted-suicide-related deaths were involuntary in the year studied.³² At least half of Dutch physicians actively suggest euthanasia to their patients.³³ Studies in 1997 and 2005 revealed that eight (8) percent of infants who died in the Netherlands were euthanized by doctors.³⁴



The slippery slope is also manifest in Belgium. A recent study published in the *Canadian Medical Association Journal*³⁵ showed that out of 1,265 nurses questioned, 120 of them (almost 10 percent) reported that their last patient was involuntarily euthanized. Only four (4) percent of nurses involved in *involuntary* euthanasia reported that the patient had ever expressed his or her wishes about euthanasia. Most of the patients euthanized without consent were over 80 years old, reaffirming the fact that assisted suicide and euthanasia quickly lead to elder abuse. The researchers acknowledged that nurses are likely reluctant to report illegal acts (here, euthanizing a patient without physician involvement)—thus, it is possible that the number of nurses killing their patients without physician involvement is much higher than revealed by

the study. The researchers concluded that “[i]t seems the current law... and a control system do not prevent nurses from administering life-ending drugs.” In other words, the “safeguards” purported by suicide advocates simply do not work.

Refusal or Withdrawal of Life-Sustaining Treatment is not Physician-Assisted Suicide

Despite the claims of euthanasia advocates otherwise, there is a medically- and court-recognized difference between the withdrawal of life-sustaining treatment, which allows death, and the use of lethal drugs or other means to directly cause death.

For instance, while the AMA opposes physician-assisted suicide, it finds it ethically acceptable to withdraw or withhold life-sustaining treatment at the request of a patient who possesses decision-making capacity.³⁶ The New York State Task Force on Life and the Law also distinguished between assisted suicide and the withdrawal or refusal of life-sustaining treatment, concluding that the State’s interest in protecting patients and criminalizing physician-assisted suicide outweighed any claims of individual autonomy.³⁷ In contrast, the Task Force found that the “constitutional balancing of individual and state interests yields an entirely different result for decisions to forgo life-sustaining treatment . . . [state] interests are best served by permitting the refusal of treatment in accord with appropriate guide



lines, and [] individual decision making about treatment will ultimately promote the public good.”³⁸

Further, in *Vacco v. Quill*, the United States Supreme Court affirmed the distinction between assisting suicide and the withdrawal of life-sustaining treatment, stating it is a “distinction widely recognized and endorsed in the medical profession and in our legal traditions” and that it is important, logical, and rational.³⁹

KEY TERMS

- **Assisted suicide** is the act of suicide with the help of another party. **Physician-assisted suicide** specifically involves the help of a physician in performing the act of suicide. Such assistance usually entails the prescribing or dispensing of controlled substances in lethal quantities that hasten death.

- **Euthanasia** involves the killing of one person by or with the physical assistance of another. **Voluntary euthanasia** is the ending of one life by another at the patient’s request. **Non-voluntary euthanasia** describes “a physician’s ending the life of a patient incapable of giving or refusing consent.”⁴⁰ **Involuntary euthanasia** describes the termination of a competent patient’s life without his or her consent.⁴¹

MYTHS & FACTS

Myth: Allowing assisted suicide will not encourage the slide toward euthanasia. Safeguards can be put into place to ensure that physician-assisted suicide is only available for competent, terminally ill patients.

Fact: The tragic example of the Netherlands refutes this claim. Further, if physician-assist-

ed suicide⁴² is accepted for the terminally ill without intractable pain, then those Americans with severe chronic pain who, unlike the terminally ill, must live with such severe pain for many years to come, would also seem to have a legitimate claim to physician-assisted suicide. Thus, it is reasonable to expect physician-assisted suicide to be made available to severe chronic pain sufferers, then to non-severe chronic pain sufferers, and then to those suffering from psychological pain or distress, as in the Netherlands. Both the British House of Lords and the New York State Task Force on Life and the Law have concluded that it would not be possible to secure limits on physician-assisted suicide.⁴³ Arguably, allowing one group of patients to use physician-assisted suicide but denying it to another could be considered unconstitutional.⁴⁴

Myth: Physician-assisted suicide allows terminally ill patients a choice and preserves autonomy and dignity.

Fact: Physician-assisted suicide “will ultimately weaken the autonomy of patients at the end of life.”⁴⁵ Not only is human dignity found in more than a healthy body and autonomous lifestyle, but “the dignity of human life itself precludes policies that would allow it to be disposed of so easily.”⁴⁶ Additionally, many physician-assisted suicide patients are coerced into suicide because of familial pressures and a desire not to be a burden.⁴⁷ They often feel a need to justify their decisions to stay alive.⁴⁸ This is not the essence of choice, autonomy, or human dignity.

Myth: To say that “the so-called right to die all too easily becomes a duty to die”⁴⁹ is mere rhetoric.

Fact: It was after examining end of life issues



for almost 10 years that the non-partisan New York State Task Force on Life and the Law reached the conclusion that “the so-called right to die all too easily becomes a duty to die.” The 25-member task force, comprised of prominent physicians, nurses, lawyers, academics, and representatives of numerous religious communities, held differing views on physician-assisted suicide and euthanasia. However, the group unanimously concluded that the dangers of physician-assisted suicide vastly exceed any possible benefits.⁵⁰

Moreover, the “duty to die” is demonstrated in Oregon, where the state actively promotes assisted suicide over medical care. In just one month in 2008, at least two different terminally-ill patients were denied medical treatment under the state health insurance plan, and instead were told that the state would pay for the patients’ suicides. The message was clear: “We won’t treat you, but we will help you die.” The duty to die cannot be much clearer.

Myth: The availability of physician-assisted suicide will not inhibit the availability of palliative care.

Fact: Palliative care actually “languishes as a consequence” of the easy availability of physician-assisted suicide and euthanasia.⁵¹ Physicians are likely to grant requests for physician-assisted suicide before all avenues of palliative care have been explored.⁵² In addition, physicians are not pushed to better educate themselves on palliative care, and researchers spend less time looking for better palliative medications and techniques.⁵³

Endnotes

¹ K.L. Tucker & C. Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, THE ADVOCATE, August 2010, at 42.

² *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*,

521 U.S. 793 (1997).

³ *Baxter v. State*, 2008 Mont. Dist. LEXIS 482 (First Jud. Dist. Ct. Mont. Dec. 5, 2008).

⁴ *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

⁵ *Blick v. Connecticut*, 2010 Conn. Super. LEXIS 1412, at *39-40 (Conn. Super. Ct. June 1, 2010).

⁶ K.B. O’Reilly, *Assisted-Suicide Statute Challenged by 2 Connecticut Doctors*, AMER. MED. NEWS (Oct. 19, 2009), available at <http://www.ama-assn.org/amednews/2009/10/19/prsd1019.htm> (last visited Aug. 31, 2011).

⁷ Plaintiffs’ Answers to State’s Interrogatories, *Baxter v. State* (Mont. 1st Jud. Dist. Ct. 2008) (on file with Americans United for Life).

⁸ See, e.g., New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 13 (1994) [hereinafter “Task Force”].

⁹ *Id.* at 32.

¹⁰ *Id.* at 26.

¹¹ See *Oregon Death with Dignity Act Annual Report for Year 13*, available at <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx> (last visited Aug. 31, 2011).

¹² *Washington State Department of Health 2010 Death with Dignity Act Report*, available at <http://www.doh.wa.gov/dwda/forms/DWDA2010.pdf> (last visited Aug. 31, 2011).

¹³ *Oregon Death with Dignity Act Annual Report for Year 13*, *supra*.

¹⁴ *Washington State Department of Health 2010 Death with Dignity Act Report*, *supra*.

¹⁵ See, e.g., T.E. Quill & C.K. Cassel, *Professional Organizations’ Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, ANNALS OF INTERNAL MED. 138(3):208 (2003), available at <http://www.annals.org/cgi/reprint/138/3/208.pdf> (last visited Aug. 31, 2011). See also Project on Death in America/Open Society Institute, Brief of *Amicus Curiae* for Reversal of the Judgments Below at Part II.A.1, *Vacco v. Quill*, 521 U.S. 793 (1997) (stating that pain can be alleviated in 98 percent of cases); Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 166 (1996) (stating that knowledgeable physicians and researchers claim that pain can be alleviated in 98 percent of cases).

¹⁶ Task Force, *supra*, at 108 n.113.

¹⁷ *Id.* at 178.

¹⁸ *Glucksberg*, 521 U.S. at 732 (quoting New York State Task Force on Life and the Law, *supra*, at 120).

¹⁹ See Brief *Amicus Curiae* of International Task Force et al., filed in *Baxter v. Montana*, available at <http://www.internationaltaskforce.org/montana.htm> (last visited Aug. 31, 2011) (citing House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Testimony of Sue Davidson of the Oregon Nurses Ass’n*, response to question 1098).

²⁰ American Medical Association, *Code of Medical Ethics, Opinion 2.211 – Physician-Assisted Suicide*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> (last visited Aug. 31, 2011).



- ²¹ See, e.g., Herman Hendin, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE* 50-56, 61, 128-32, 142 (1998).
- ²² *Oregon Death with Dignity Act Annual Report for Year 13, supra*; Washington State Department of Health 2010 *Death with Dignity Act Report, supra*.
- ²³ See Oregon Health Authority: *Death with Dignity Act, Frequently Asked Questions about the Death with Dignity Act*, available at <http://public.health.oregon.gov/PROVIDERPARTNER-RESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx> (last visited Aug. 31, 2011).
- ²⁴ See, e.g., S. Ertelt, *Woman Victimized by Oregon Assisted Suicide Law Urges Washington to Vote No* (October 28, 2008), available at <http://www.lifenews.com/2008/10/28/bio-2608/> (last visited Aug. 31, 2011).
- ²⁵ National Center on *Elder Abuse Fact Sheet, Elder Abuse Prevalence and Incidence*, available at http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/FinalStatistics050331.pdf (last visited Aug. 31, 2011).
- ²⁶ Task Force, *supra*, at 30.
- ²⁷ *Oregon Death with Dignity Act Annual Report for Year 13, supra*.
- ²⁸ L. Prager, *Details emerge on Oregon's first assisted suicides*, AMER. MED. NEWS (Sept. 7, 1998).
- ²⁹ See *Oregon Death with Dignity Act Annual Report for Year 13, supra*.
- ³⁰ See Correspondence of Deputy Attorney General David Schuman to state Senator Neil Bryant (Mar. 15, 1999).
- ³¹ Task Force, *supra*, at 145.
- ³² See W.J. Smith, *FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER* 118-19 (2003) (citing the Dutch government's *Rommelink Report*).
- ³³ See *id.* at 119 (citing R. Fenigsen, *Report of the Dutch Government Committee on Euthanasia*, 7 ISSUES LAW & MED. 239 (Nov. 1991); Special Report from the Netherlands, N.E.J.M. 1699-711 (1996)).
- ³⁴ See *id.* at 129-30 (citing A. van der Heide et al., *Medical End of life Decisions Made for Neonates and Infants in the Netherlands*, LANCET 350:251 (July 26, 1997)); A.M. Vrakking et al., *Medical End of life Decisions Made for Neonates and Infants in the Netherlands*, 1995-2001, LANCET 365:1329 (Apr. 9, 2005).
- ³⁵ E. Inghelbrecht et al., *The role of nurses in physician-assisted deaths in Belgium*, CAN. MED. ASS'N J. (June 15, 2010).
- ³⁶ See American Medical Association, *Opinion 2.211 - Physician-Assisted Suicide*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> (last visited Aug. 31, 2011); American Medical Association, *Opinion 2.20 - Withholding or Withdrawing Life-Sustaining Medical Treatment*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.shtml> (last visited Aug. 31, 2011).
- ³⁷ Task Force, *supra*, at 73.
- ³⁸ *Id.* at 74-75.
- ³⁹ *Vacco*, 521 U.S. at 800-01, 808.
- ⁴⁰ Task Force, *supra*, at 13 (emphasis added).
- ⁴¹ *Id.* at 92.
- ⁴² See, e.g., the story of "Netty Boomsma" in Hendin, *supra*, at 76-83. Few advocates of PAS argue that the right to physician-assisted suicide should be limited to the terminally-ill. Task Force, *supra*, at 74 n.113.
- ⁴³ *Report from the Select Committee on Medical Ethics*, House of Lords Session 1993-94, § 238; Task Force, *supra*, at 145. On May 12, 2006, the House of Lords again rejected proposed laws to allow physician-assisted suicide.
- ⁴⁴ E. Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337, 348 (1996) ("If autonomy is the guiding principle and the determination of pain and suffering is so subjective, then any competent person... has the right to choose euthanasia.") Hendin, *supra*, at 122. The New York State Task Force concluded that "it will be difficult, if not impossible, to contain the option to such a limited group.... [N]o principled basis will exist to deny [other patients] this right." New York State Task Force on Life and the Law, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 5 (Supp. 1997) [hereinafter "Task Force Supp."]. The Task Force explains that if the right to refuse medical treatment is not limited to the terminally-ill, then physician-assisted suicide will not be limitable, either. *Id.* at 12-13.
- ⁴⁵ *Id.* at 18; see also Task Force, *supra*, at 134 (stating that while the "autonomy" of some patients may be extended, the autonomy of many others would be compromised with the legalization of physician-assisted suicide).
- ⁴⁶ Task Force, *supra*, at 138.
- ⁴⁷ See, e.g., Hendin, *supra*, at 50-56, 61, 128-32, 142.
- ⁴⁸ Task Force, *supra*, at 95.
- ⁴⁹ *Id.* at 99.
- ⁵⁰ *Id.* at ix, 120.
- ⁵¹ Hendin, *supra*, at 244.
- ⁵² Task Force Supp., *supra*, at 4.
- ⁵³ See, e.g., Hendin, *supra*, at 15.



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theguardian

NHS accused over deaths of disabled patients

Mencap inquiry finds institutional discrimination against people with learning disabilities led to at least 74 deaths

*Anna Bawden and Denis Campbell
The Guardian, Monday 2 January 2012 16.18 EST*



Kyle Flack, 20, suffocated to death at Basildon hospital in 2006 when his head became wedged in the bars of his bed. Photograph: PA

The NHS is accused of causing or contributing to the deaths of at least 74 patients with a learning disability because of poor care that reveals enduring "institutional discrimination" among doctors and nurses.

The 74 vulnerable patients' deaths over the past decade were either caused or complicated by mistakes in hospitals and decisions by staff who failed to treat them properly and displayed ignorance or indifference to their

plight, according to the charity Mencap and families of some of those who died.

Inquiries by Mencap into the deaths raise searching questions for the NHS, which has been criticised in a series of recent reports for providing poor care, especially to older patients. The parliamentary and health service ombudsman, Ann Abraham, has already ruled that four of the cases highlighted were avoidable deaths and found serious failings in eight others. Inquest verdicts also confirm failings occurred in several cases.

"These cases are a damning indictment of NHS care for people with a learning disability," said David Congdon, Mencap's head of campaigns and policy. "They confirm that too many parts of the health service still do not understand how to treat people with a learning disability and they are an appalling catalogue of neglect and indignity. As a result of institutional discrimination in the NHS, people with a learning disability are dying when their lives could be saved."

While the NHS had taken a lot of positive steps since the charity's *Death by Indifference* report in 2007, "we are still hearing of many patients with a learning disability receiving poor treatment", he said. "Sadly, we believe that the cases in this report represent the tip of the iceberg," he added.

The 74 cases show that advice from the families of people with a learning disability has gone ignored, staff have failed to diagnose serious illness in them, patients have been denied basic nursing care and been left in excruciating pain after being denied medication, while some staff have assumed that some learning disabled patients' quality of life is so low that they are not worth saving, according to Mencap.

Ministers endorsed the charity's concerns on Monday and promised changes to improve staff's care of these patients. Paul Burstow, the care services minister at the Department of Health (DH), said: "This government is committed to improving the health of people with learning disabilities. We share Mencap's concerns that some people with learning disabilities are not receiving the high quality health care that they should expect."



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Elderly Abuse Statistics

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Statistic Verification
Source: National Center on Elder Abuse, Bureau of Justice Statistics
Research Date: 9.12.2012

Elderly Abuse Statistics	Data
Number of elderly abuse cases in 2010	5,961,568
Percent of elderly population abused in 2010	9.5 %
Demographics of Elderly Abuse Victims	Percent
Percent of female elder abuse victims	67.3 %
Median age of elder abuse victims	77.9
Percent of white victims	66.4 %
Percent of black victims	18.7 %
Percent of hispanic victims	10.4 %
Breakdown of Reported Elder Abuse Cases	
Neglect	58.5 %
Physical Abuse	15.7 %
Financial Exploitation	12.3 %
Emotional Abuse	7.3 %
Sexual Abuse	0.04 %
All other types	5.1 %
Unknown	0.06 %
Family Perpetrated Elderly Abuse	
Percent of Adult Protective Service cases that involve elderly abuse	68 %
Percent of elderly abuse perpetrated by adult children or spouses	66 %
Percent of murder victims over 60 who were killed by their own offspring	42 %
Percent of murder victims over 60 who were killed by their spouses	24 %
Nursing Home Abuse	
Percent of nursing homes that lack adequate staff to properly care for patients	91 %
Percent of nursing homes that have been in violation of elderly abuse laws	36 %
Elderly defined as 60 years of age and older	

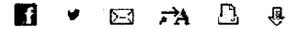
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Aging Statistics

The older population--persons 65 years or older--numbered 39.6 million in 2009 (the latest year for which data is available). They represented 12.9% of the U.S. population, about one in every eight Americans. By 2030, there will be about 72.1 million older persons, more than twice their number in 2000. People 65+ represented 12.4% of the population in the year 2000 but are expected to grow to be 19% of the population by 2030. The information in this section of the AoA website brings together a wide variety of statistical information about this growing population.

Please select from the topics below to learn more:

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Oregon Public Health Division

- Since the law was passed in 1997, a total of 1,050 people have had DWDA prescriptions written and 673 patients have died from ingesting medications prescribed under the DWDA.
- Of the 115 patients for whom DWDA prescriptions were written during 2012, 67 (58.3%) ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.
- Eleven (11) patients with prescriptions written during the previous year (2011) died after ingesting the medication during 2012.
- Twenty-three (23) of the 115 patients who received DWDA prescriptions during 2012 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 25 patients who were prescribed DWDA medications in 2012. Fourteen (14) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 11 patients, both death and ingestion status are pending (Figure 2).
- Of the 77 DWDA deaths during 2012, most (67.5%) were aged 65 years or older; the median age was 69 years. As in previous years, most were white (97.4%), well-educated (42.9% had a least a baccalaureate degree), and had cancer (75.3%).
- Most (97.4%) patients died at home; and most (97.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (51.4%) was lower in 2012 than in previous years (66.2%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (48.6% compared to 32.1%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.5%), decreasing ability to participate in activities that made life enjoyable (92.2%), and loss of dignity (77.9%).
- Two of the 77 DWDA patients who died during 2012 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for seven patients (9.1%) during 2012 compared to 17.3% in previous years.
- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 77 DWDA deaths during 2012. Among those 11 patients, time from ingestion until death ranged from 10 minutes to 3.5 hours.


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STATE OF DESPAIR

HIGH-COUNTRY CRISIS

Montana's suicide rate leads the nation

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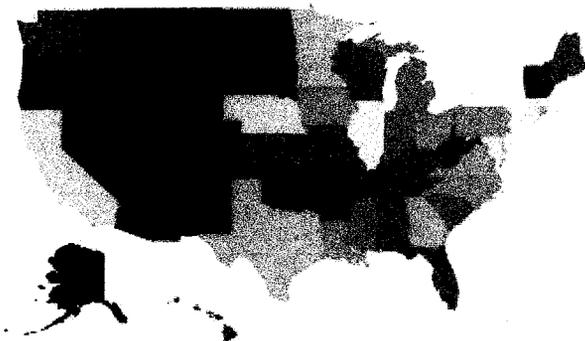
Source: Montana Department of Public Health and Human Services, Montana Strategic Suicide Prevention Plan

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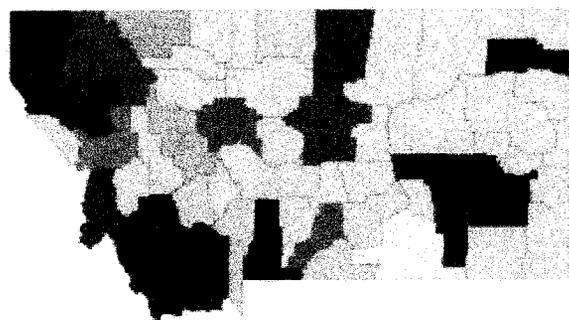


Special section: State of despair

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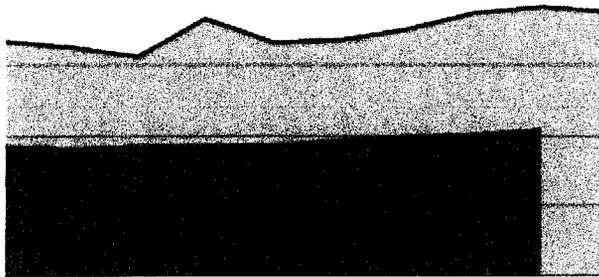


Frequency of U.S. suicides, 2010



Frequency of Montana suicides by county, 1997-2011

Montana Suicide Rates, 2002-2011



Montana and U.S. suicide statistics

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Depression and suicide assessment

There's a romance to Montana that beguiles. Ask anyone to define the state and they'll mention the mountains, the wide-open spaces, the stoic, hardworking cowboy culture.

Like all great places, though, it comes with trade-offs.

Those distances, that stoicism, the frontier pockets of the state where jobs are scarce can be overwhelming.

And it may be why the state that residents regard as the "last, best place" has ~~been near the top in~~ the nation in the rate of suicide for 35 years.

"Montana's suicide epidemic is a public health crisis," said Matt Kuntz, ~~executive director of the~~ Montana chapter of the National Alliance on Mental Illness.

During 2010, at least 227 Montanans killed themselves. In 2011, the number was closer to 225. That's about 22 people per 100,000 residents, nearly twice the national average.

The victims are military veterans, American Indians, senior citizens and teenagers. Often, they are depressed and hundreds of miles from the nearest mental health professional. Even where they can get help, they tend to "cowboy up," afraid their illness will be seen as weakness.

Not only has Montana's suicide rate hovered in the top five nationally for decades, in the past few years it has gone up. That spike is reflected across the nation.

In the past five years, the state's suicide rate has crept from 20.1 per 100,000 people to 22.5. Nationally five years ago, the rate was 10 people per 100,000. Today, it's closer to 12 people per 100,000.

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And those are the ones who succeed. A recent federal study suggests that 8.3 million Americans — 3.7 percent of all adults — have serious thoughts of suicide each year; 2.3 million make a plan, and 1.1 million attempt suicide.

The result is an estimated 37,000 suicide deaths annually, and the Rocky Mountain region shoulders the bulk of the deaths.

In Montana, every one of the 452 Montanans who killed themselves last year had a face, be they a troubled father, a confused teenager, or a lonely, elderly widow.

The majority who took their lives — 77 percent, or 350 — were males. The victims came from all age groups, although most of them — 91 people — were 55 to 64. Another 88 were 45 to 54, and 75 of the victims were between the ages of 24 and 34.

Another 5,600 Montanans — an average of about 15 per day — attempted to kill themselves last year.

"We've got a lot of hurting people," said Jim Hajny, executive director of the Montana Peer Network, a nonprofit organization of individuals who are in recovery from mental illness, substance abuse or both. "We have to get at this."

Suicide figures vary from community to community, with the bulk of them occurring in Western Montana and pockets on the eastern edge of the state.

The highest rate of suicide in the state is among American Indians, 27.2 per 100,000; followed by Caucasians at 22.2 per 100,000. For 2010-2011, there were 38 American Indian suicides, compared to 410 Caucasian suicides. American Indians make up 7 percent of the Montana population.

There are specific risk factors for American Indian communities that contribute to their higher suicide rate, including high unemployment rates, substance abuse, alienation, and varying cultural views on suicide. A major issue among the American Indian communities is the separation taking place between generations, said Karl Rosston, Montana's suicide-prevention coordinator. Traditionally, the youth have looked toward the tribal elders for guidance and identity.

"However, in recent generations, there has been a breakdown in this guidance," Rosston said. "Subsequently, American Indian youth appear more hopeless and unsure of their place in their culture. This may contribute to the high number of suicides among American Indian youth."

The underpinnings of Montana's problem are considered universal among many, though not all, health experts on the local, state and national level.

Many of the self-imposed death sentences stem from a Western independence, where acknowledging personal problems may be viewed as contrary to the cowboy way, said Drew Schoening, a psychologist at the Montana State Hospital in Warm Springs.

"So, they go untreated and we know untreated mental illness results in higher rates of premature death, accidental death and suicide death," Schoening said.

The prevalence of guns in the state compounds the problem, not only because they're handy, but also because they're generally fatal. Victims are less likely to survive an attempt and then seek help. Most of the state's victims last year — 291 — used a gun.

The second and third most common methods were suffocation/hanging and poisoning/overdose. Other methods included drowning, cutting and piercing, jumping from heights, burning, and motor vehicles.

Montana ranks third in the nation for per capita gun possession, according to an analysis by the news website The Daily Beast of the FBI's National Instant Background Check System.

Kentucky is first, followed by Utah at second, with Wyoming in fourth and Alaska fifth.

People who live in areas with high concentrations of guns are more likely to die by suicide, according to a 2007 study by researchers at the Harvard School of Public Health. The study looked at the 15 states with the highest firearm ownership and found that twice as many people were successful in committing suicide in those states compared to the six states with the lowest firearm ownership.

Another leading cause is considered to be the social isolation that comes with living in Montana. The state has 6.7 people per square mile, according to the 2010 Census. The national average is 88.7 people per square mile. Neighbors are often few and far between, reducing the possibility for social contact or communication. The isolation can contribute to many emotional, behavioral and physical disorders including anxiety, panic attacks, eating disorders, addictions, substance abuse, depression and violence.

"That may be because when somebody gets into a difficulty, they don't have friends and family to go to (who can) help them with that," said Dr. Alex Crosby, a medical epidemiologist with the Atlanta-based Centers for Disease Control and Prevention. "Those who have a stronger network of social support have a lower incidence of suicide."

Use of drugs in Montana, especially alcohol, is also widespread. That is significant because nationally about 33 percent of the people who die by suicide have alcohol in their system, Rosston said.

Montana counties with the highest suicide rates also have high unemployment and high rates of poverty. Twenty percent of Montana's youth live 100 percent to 200 percent below the poverty line.

The shortage of mental health professionals and mental health treatment facilities in the state is also well-known and widely reported.

As of Nov. 1, there were 146 licensed psychiatrists in Montana. Patients can wait anywhere from two weeks to three months or longer to see a psychiatrist. In some areas of the state, there is one psychiatrist serving a vast, multicounty area.

There are about 50,000 psychiatrists in the United States-- too few to serve all the patients who need help, especially in rural areas, according to the American Psychiatric Association. About half of currently practicing psychiatrists are over the age of 55, and many will soon retire.

"How do you provide service if you're trying to cover 1,000 square miles?" asked John Glueckert, administrator of the Montana State Hospital in Warm Springs. "It's very difficult."

In the absence of psychiatrists, patients sometimes are referred to lesser-trained therapists.

"They can assess the gravity of the situation," said Dr. Bruce Swamy, a psychiatrist at Glendive Medical Center. "Is it the ideal set-up? I don't know, but it's the best we can do."

NAMI's Kuntz said it is unrealistic to think every Montana town will ever have its own psychiatrist. Still, he believes there is an opportunity to infuse communities with the help they need.

"If we had psychiatrists or psychiatric nurses everywhere that Wal-Mart thinks there's enough people to set up a store, we'd be a little closer," Kuntz said. "If you're in a little, tiny Montana town and you drive to Miles City to go to Wal-Mart to get cheap groceries, then that's the town you would go to for your mental health treatment."

Most residents in the far corners of the state don't have access to mental health professionals, forcing them to travel hundreds of miles to seek help. In one extreme case, a person traveled more than 400 miles one way, much of it on secondary roads, to receive mental health services in Bozeman.

"The stigma for reaching out in their own community was so extreme, it wasn't an option," Hajny said.

Despite all the well-reasoned explanations for the runaway number of suicides, there is no one-size-fits-all reason.

"Every person I talk to would probably have a different, unique reason for wanting to take their life," Schoening said. "That's why we have such a struggle at trying to help people through this. ... I think the true scientists are still trying to figure it all out."

Kuntz said the reasons for suicide go beyond the idea of the state having a "cowboy culture."

"It's not that easy," Kuntz said. "Personally, I think we need to be comfortable with the fact that no one really knows."

Crosby concurs. "Most researchers that look into the area of suicide believe it is not the result of just one factor."

Suicide is so common that some see it as the solution to divorce, family dysfunction, custody disputes and financial woes. It is considered acceptable when an individual's burdens mount, said Crosby, the medical epidemiologist with the Centers for Disease Control and Prevention.

Though it's difficult to place a dollar figure on the impact of suicide, the fact remains that the economic burden of suicide falls on everyone in the state. The total lifetime medical and work loss costs of suicide in Montana was at least \$279.4 million during 2010, according to data available from the CDC.

The price tag includes expenses associated with suicide and its aftermath, including cost for the medical examiner/coroner investigations, emergency department treatments, hospitalizations, and nursing home care. It also includes costs associated with future productivity losses (i.e. lost wages, fringe benefits and lost household work) due to premature mortality. Not included in this figure is the cost associated with property damage, pain/suffering, loss of quality of life, litigation, and the impact, emotional and otherwise, of each suicide on surviving family members, friends, and other loved ones.

So dire is the problem that in 2007 the Montana Legislature passed Senate Bill 468, which created the statewide suicide prevention coordinator position to spearhead the Department of Public Health and Human Services suicide prevention activities. The program's annual budget is \$400,000 with \$200,000 going to the state suicide prevention hotline.

Rosston said that to reduce the suicide numbers it is going to take a cultural shift in thinking.

"We need to begin to challenge our traditional perceptions of how we view depression as a weakness or that we are a burden to our families if we are depressed," Rosston said. "We need to make it OK to talk about depression and make it OK to ask for help. This is not a quick fix. If it is a generational problem, it is going to take generations to fix."

It is not an impossible mission, he said.

"I wouldn't be in the job if I didn't think something could be done. I think it's just going to take time."

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