



December 13, 2019

Cabinet Workgroup on Aging
Attn: Secretary Mark Ghaly, MD
California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, California 95814

Subject: Recommendations for a Senior and Disability Victimization Component of the Master Plan for Aging

Dear Members of the Cabinet Workgroup on Aging:

We wish to thank Governor Newsom, the Legislature, the members of the Master Plan for Aging Stakeholder Advisory Committee, Department of Aging Acting Director Kim McCoy Wade, and each of you for your commitment to developing a plan to accommodate and welcome the rapidly growing population of older Californians and of adults and children with disabilities.

We note that “increase prevention of elder abuse - both physical and financial” is the highest-ranked goal that California voters selected for the Master Plan for Aging. (*California Statewide Voter Survey - Report on Results*, Wallin Opinion Research, July 17, 2019).

Wide Extent of the Problem Nationally

What state law (Penal Code Section 368.6, enacted by SB 338 (Hueso) of 2019), now calls senior and disability victimization, including but going beyond elder and “dependent” adult abuse, is already an urgent and appalling problem. It includes these crimes committed against either older adults or people with disabilities: child abuse, sexual assault, domestic violence, human trafficking, hate crimes motivated by bias against people with disabilities including disabilities caused by aging, and homicide. The obstacles to justice include lack of reporting of these crimes to law enforcement agencies and the law enforcement agencies’ frequently inadequate response to the reports they do receive. Without timely and forceful action throughout the state, it can only get worse as the population of likely victims increases.

Several recent national studies found these shocking results:

Abuse of People with Disabilities: Victims and Their Families Speak Out (Nora Baladerian, Thomas F. Coleman and Jim Stream, Spectrum Institute Disability and Abuse Project, 2013) surveyed victims with disabilities, including disabilities caused by aging, and their families. Of the cases where victims reported the abuse to authorities, 52.9 percent said that nothing happened. According to the victims and family members surveyed, the number of alleged perpetrators arrested was 7.8 percent.

- *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (Office of the Inspector General, U.S. Department of Health and Human Services, June 2019) focused on abuse of nursing home residents who end up in emergency rooms. It looked at claims sent to Medicare in 2016 for treatment of head injuries, body bruises, bed sores and other diagnoses that might indicate physical abuse, sexual abuse or severe neglect. It found that nursing homes failed to report nearly one in five of these cases. Separately, it found that in five states where nursing home inspectors did investigate and substantiate cases of abuse, 97 percent were never reported to law enforcement as required by law.
- *CMS Could Use HHS Medicare Data to Identify Instances of Potential Abuse or Neglect* (Office of the Inspector General, U.S. Department of Health and Human Services, June 2019), looked at Medicare claims for the treatment of potential abuse or neglect of older adults, regardless of where it took place. The report projected that, of more than 30,000 potential cases, health care providers failed to report nearly a third of the incidents to law enforcement.
- *Criminal Victimization, 2017* (U.S. Bureau of Justice Statistics, December 2018) reported that persons with disabilities had a much higher rate of violent victimization (40.4 per 1,000 persons age 12 or older) than persons without disabilities (17.7 per 1,000). Persons with cognitive disabilities such as dementia, intellectual disabilities or mental illness experienced 76 violent victimizations per 1,000 persons age 12 or older, the highest rate among persons with any disability.

More broadly, a very large body of research stretching back for many years indicates that, throughout the country, persons with disabilities including disabilities caused by aging are victimized by violent crime at much higher rates than the general population and that the large majority of these crimes go unreported. (“Crimes Against Persons with Disabilities,” *Protecting Californians From Hate Crimes: A Progress Report*, Gregory deGiere, California Senate Office of Research, August 2004.)

Wide Extent of the Problem in California

The above national research reports are consistent with research and our experience here in California.

An evaluation of part of California's Crime Victims with Disabilities Initiative (*Crime Victims with Disabilities Specialists Program: A Report Prepared for the California Department of Mental Health*, Valerie Jenness, University of California Irvine, and Nancy Naples, University of Connecticut, November 2003) stated the problem starkly:

“Across a variety of studies, the officially reported violence against persons with disabilities is simply alarming (Petersilia 2001). Moreover, the evidence suggests that officially reported violence against people with disabilities and criminal victimization of people with disabilities more generally is merely the tip of the iceberg as most violence against people with disabilities goes unreported. Lack of reporting occurs for a variety of reasons, including that the criminal justice system cannot-- or will not--serve those with disabilities. Therefore, it is entirely appropriate to refer to people with disabilities who are victimized as ‘invisible victims’ (Sorenson 1997). As such, they have historically and in the present day been systematically denied access to justice via the criminal justice system (Petersilia 2003; Tysla 1998).”

The same California report found “numerous challenges” including:

- “Quite often there is a failure to pursue cases perceived to lack a credible victim (i.e., a victim with certain kinds of disabilities).”
- “Cases are dropped due to mistakes that occur during the investigation process.”
- “Cases are not investigated due to concerns over jurisdictional issues.”
- “Care facilities often deal with these types of crimes internally and may not create a safer environment for the victims who are often revictimized by other clients.”

Our experience since this 2003 study is that these problems persist.

In San Francisco in June 2019, the Department of Public Health reported that 23 patients of the Laguna Honda Hospital and Rehabilitation Center, ranging in age from 30 to around 100, suffered systematic verbal, physical and sexual abuse from 2016 to January 2019 at the hands of six employees who video recorded the abuse and exchanged the videos and photos by text messages. The estimate of victimized patients later was raised to 130. The San Francisco public health director pointed to what he called “a culture of silence” at the facility, where staff turn a blind eye to abuse. To date, no criminal charges of abuse or mandated reporters’ failure to report have been filed.

Our experience over many years indicates that such cultures of silence are common in some care facilities, particularly those serving residents with mental disabilities such as dementia, mental illness or intellectual disabilities, and that these cultures of silence often originate at the supervisory or management level.

Most recently, *“The Rats Sensed She Was Going to Pass Away”*: *Elderly Often Face Neglect in California Care Homes that Exploit Workers* (Jennifer Gollan, Reveal, Center for Investigative Reporting, September 18, 2019) found that some operators of senior board-and-care homes that violate labor laws and steal workers’ wages often also endanger or neglect their residents, sometimes with dire consequences.

Recommendations

We strongly recommend that the following 28 items be included in the Master Plan:

Upgrade enforcement by local law enforcement agencies

AB 2623 (Pan) of 2014 amended Penal Code Section 13515 to require all local law enforcement agencies to train their officers on the legal rights and remedies available to elder and “dependent” adult abuse victims. It also requires to the Commission on Peace Officer Standards and Training (POST) to update its relevant training materials.

Virtually all law enforcement agencies adopt formal policies guiding their officers on enforcement of a wide variety of laws. In the past, most California law enforcement agencies’ elder and “dependent” adult abuse policies omitted any reference to Penal Code Sections 368 and 368.5, the relevant criminal statutes. As a result, many agencies viewed this abuse as a purely civil rather than criminal problem. SB 1181 (Hueso) of 2018 amended Penal Code Section 368.5 to require every local law enforcement agency to revise its policies to include the content of these sections making it clear that abuse is a criminal and not just a civil problem. We know of no accounting of whether all agencies have complied.

SB 338 (Hueso) of 2019 enacted Penal Code Section 368.6, the Senior and Disability Justice Act. The act includes a detailed though not comprehensive listing of items that every local law enforcement agency is required to adopt if it adopts or amends an elder and “dependent” adult abuse policy or a broader senior and disability victimization policy, including extensive required training, required investigation of every report of senior or disability victimization, detailed protocols for handling these crimes, and outreach to the older adult and disability communities to encourage reporting and cooperation with law enforcement.

- (1) The Attorney General should notify law enforcement agencies of the requirements of PC 368.5 and PC 13515 and, after giving them adequate time to comply with these sections as amended, should survey them to determine whether they now comply.
- (2) POST should review all its relevant training materials to ensure that they comply with PC 368.5 and PC 13515.
- (3) POST should develop a model law enforcement agency policy including but not limited to the items listed in the Senior and Disability Justice Act, as Penal Code Section 368.6(c)(21) envisions.
- (4) The Governor and Legislature should mandate that every local law enforcement agency adopt a senior and disability victimization policy as spelled out in the Senior and Disability Justice Act, including items added by POST. In legislating this mandate, the Legislature should review Section 368.6 and make whatever corrections and additions

experience indicates would be prudent. Because of its far-reaching effect, this is our highest priority recommendation for legislation.

- (5) The Governor and Legislature should mandate that every county develop an interagency, interdisciplinary plan for attacking all aspects and senior and disability victimization, similar to but going beyond the San Diego County Elder and “Dependent” Adult Abuse Blueprint.

Upgrade enforcement by the Department of Justice

Abuse by licensed professionals, financial institutions and organized crime is often beyond the ability of local law enforcement agencies to police.

- (6) The Governor and Legislature should make the Department of Justice the lead agency for combatting senior and disability victimization, including by authorizing DOJ to require local agencies to submit such information as the department may require concerning these crimes, such as copies of their formal policies and information on their officer training and outreach to the older adult and disability communities.
- (7) The Attorney General should create, and the Governor and Legislature should fund, a senior and disability victimization unit in the Law Enforcement Division of the Department of Justice, incorporating the Bureau of MediCal Fraud and Elder Abuse. The new office should cooperate closely with state licensing agencies and with federal and other states’ law enforcement agencies.
- (8) The Attorney General should revive and expand, and the Governor and Legislature should fund, Attorney General Lockyer’s “Face It, It’s a Crime” program for public information about and reporting of these crimes, both in and out of care facilities.

The statewide reporting portion of the program should include reporting by telephone, text, and Internet.

It should be explicit that anonymous reports are accepted and there should be a way for anonymous reporters to obtain report numbers to demonstrate that they made anonymous reports. While this should not relieve any mandated reporter of the duty to report fully, law enforcement, prosecutors and the courts should weigh any seriously mitigating facts including documented anonymous reports when they make decisions concerning arresting, prosecuting and sentencing mandated reporters who fail to fully report due to interference or well-founded fear of retaliation but instead make anonymous reports that result in stopping the abuse.

Local or state law enforcement agencies, in cooperation with adult protective services, local long term care ombudsman programs and other cooperating agencies where appropriate, should investigate every report, absent documented, unusual, compelling circumstances.

Upgrade prosecution by district attorneys

Cases involving victims or witnesses with cognitive or communications disabilities can be hard to prosecute and often require specially trained prosecutors, investigators and victim advocates.

District attorney's offices without such specialists are at a disadvantage in prosecutions, including in providing victims with the services they need to recover from their victimization and be effective witnesses.

Abused and Betrayed (Joseph Shapiro, National Public Radio, January 8, 9, 16, 18 and 20 and June 25, 2018) reported that adults with intellectual disabilities are sexually assaulted at a rate seven times higher than those without disabilities. According to that report, there is reason to believe that predators target people with intellectual disabilities because they know they are seen as easily manipulated and will have difficulty testifying later. (This confirmed earlier California reports cited in "Crime Victims with Disabilities" (above), including one of a sexual predator overheard telling another to get a job in a developmental disability care facility where victims are "easy pickings.") As a result, these crimes often go unrecognized, unprosecuted and unpunished.

AB 640 (Frazier) of 2019 amended Penal Code Section 13836 to cover sexual assault of people with developmental disabilities in the prosecutor training program developed by an Office of Emergency Services (OES) advisory committee.

- (9) The Governor and Legislature should mandate and fund district attorney's offices' elder and disability victimization "vertical prosecution" units, staffed by trained attorneys, investigators and victim advocates. The mission of these units should be broad, and include: providing emergency assistance to victims including financial aid to stabilize finance abuse victims, adequate shelter for those at risk of homelessness due to their victimization, transportation to let them participate in the prosecution of their cases, and navigation to other available services; coordination with agencies and organizations that often learn of cases that would not otherwise reach the DAs, such as older adult and disability groups and service agencies, adult and child protective services, local long term care ombudsman programs, sexual assault and domestic violence agencies, and civil legal assistance services; ensuring prosecution of mandated reporters who fail to report and those who interfere or retaliate against mandated reporters, taking account of our Recommendation 8; and assistance with restorative justice sentencing.
- (10) The Governor and Legislature should expand the prosecutors' sexual assault training program created by PC 13836 to cover sexual assault of all persons with cognitive disabilities, including disabilities caused by aging, and to expand the membership of the OES advisory committee to include subject-matter experts selected by older adult and disability groups.

Combat financial abuse of older adults and adults with disabilities

Academic studies confirm the common-sense observations that aging affects human decision-making ability and that older adults as a result are more likely to fall prey to financial abuse of all sorts, including deceptive advertising, telemarketing and information technology victimization, and in-person con artists. For example:

- Approximately 35-40 percent of older adults studied were poor decision makers, displaying defective autonomic responses reminiscent of patients with traumatic brain injury. (*The Orbitofrontal Cortex, Real-World Decision Making, and Normal Aging*, Natalie L. Denberg et al, University of Iowa Hospitals and Clinics, 2008).

- Financial literacy scores decline by 1 percent per year after age 60. Yet large declines in cognition and financial literacy have little effect on older adults' confidence in their financial knowledge and almost no effect on their confidence in managing their finances. (*How Does Aging Affect Financial Decision Making?*, Keith Jacks Gamble, Patricia A. Boyle, Lei Yu and David A. Bennett, Center for Retirement Research at Boston College, 2015.)

The True Link Report on Elder Financial Abuse (True Link Financial Advisors, 2015) surveyed older Americans' family caregivers. It extrapolated that financial abuse costs seniors more than \$36 billion a year, 12 times earlier estimates. Even more shockingly, this report totally omits billions more lost to abuse by unscrupulous licensed professionals, financial institutions (particularly though reverse mortgage abuse), and organized crime (particularly financial abuse rings).

Here in California, hundreds of thousands of older adults and adults with disabilities are victimized by financial abusers every year. The losses to the individuals range from a few hundred dollars to millions. This abuse also puts a strain on the family members who have to use their assets for loved ones' survival. Tragically, the instance of death goes up three-fold for those who are financially abused. Financial abuse is growing faster than any other type of abuse. Statewide, it has risen 176 percent since 2006. (*People Are Ripping Off LA Seniors At Alarming Rate - and It's Making Them Sick*, Michelle Faust Raghavan, LAist, June 18, 2019, citing *SOC 242 - Adult Protective Services and County Block Grant Monthly Statistical Report*, California Department of Social Services, June 2019).

Too often, law enforcement tells a victim that their matter is "a civil case," when, in fact, yes, it is a civil case, but also a criminal case that needs to be prosecuted. Because of difficulty in representing elders and people with disabilities who may be reluctant or incapable of aggressively pursuing civil cases, and the lack of clarity in some of the statutes, few civil litigators pursue financial abuse cases.

Existing elder and "dependent" adult abuse criminal law (Penal Code Section 368) prohibits "theft, embezzlement, forgery, fraud, and identity theft" but includes no explicit prohibition of undue influence.

In cases of civil elder or "dependent" adult financial abuse, there is confusion as to what constitutes assisting a perpetrator.

Financial predators take full advantage of these omissions and unclarity to exploit older adults and adults with dementia or diminished capacity. This can leave no recourse for families who want to protect their loved ones' property but who cannot find attorneys who will take their cases, cannot afford the few attorneys who are willing to try to litigate these cases, or are advised to that it is pointless to pursue legal action because their estates, after being partially or fully drained by scam artists, are no longer worth as much as their potential attorneys' fees. These cases often involve sophisticated, organized schemes, including taking vulnerable adults across state lines to isolate them from their families and avoid legal process.

- (11) The Governor and Legislature should amend Penal Code Section 368 to prohibit undue influence, which should be defined as "a person's use of the person's role, relationship or power to exploit or knowingly assist or cause another to exploit the trust, dependency, or fear of an elder or dependent adult, or uses the person's role, relationship, or power to gain control deceptively over the decision making of the elder or dependent adult so that the free will of the elder/dependent adult has been removed. Such exploitation can be accomplished through deceiving, persuading, intimidating, threatening, isolation, fraudulent affection, or otherwise inducing the elder/dependent adult to act or fail to

act, in a manner detrimental to the elder's or dependent adult's interests resulting in inequity.”

- (12) The Governor and Legislature should include in the finding in Welfare and Institutions Code Section 15600 that elders and “dependent” adults have a civil right to be free of the abuse, which California Elder Abuse and “Dependent” Adult Civil Protection Act (EADACPA, WIC Section 15600 et seq) prohibits, and that “abuse of an elder or dependent adult” as defined in WIC §15610.07 constitutes a violation of the victim's civil rights.
- (13) The Governor and Legislature should amend EADACPA to clarify that a person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use, or to have assisted such conduct, if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property, or assists such conduct, and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or “dependent” adult. They should also clarify that a person is deemed an assistor of financial abuse if that person knows or should know that their conduct is likely to be harmful, which is the standard used for the person who does the actual taking.
- (14) The Attorney General should develop, and the Governor and the Legislature should fund, a comprehensive plan to combat financial abuse and other financial exploitation of older adults and adults with disabilities. The plan should include provisions to encourage supported decision-making, neither leaving those with limited capacity unprotected nor stripping them of their right to make their own decisions with whatever assistance they need.

Combat anti-disability hate crimes

Crimes committed in whole or in part because of victims' actual or perceived disabilities, including disabilities caused by aging, are hate crimes under both California and federal laws. In practice, however, law enforcement officers rarely recognize these hate crimes.

A national survey of victims (*Hate Crime Victimization, 2004-2015*, U.S. Bureau of Justice Statistics, 2017) estimated 40,000 anti-disability hate crimes per year. (This figure is certainly an under-estimate. The survey omitted people with disabilities in hospices, nursing homes, group homes, hospitals, and other institutions.) Yet law enforcement agencies reported just 177 anti-disability hate crimes (*2018 Hate Crime Statistics*, Federal Bureau of Investigation, 2019), less than 0.5 percent of the estimated number based on the earlier victim survey. In California in 2018, law enforcement agencies reported just seven anti-disability hate crimes.

SB 1234 (Kuehl) of 2004 added disability as a protected characteristic under the hate crime law (PC 422.56(c)), required all state and local agencies to use the statutory definition of “hate crime” exclusively (PC 422.9), and required POST to develop a model hate crimes policy, which local law enforcement agencies are encouraged to adopt and state law enforcement agencies are required to adopt (PC 13519.6(c)).

PC 13023 mandates law enforcement agencies to submit to the Department of Justice such information on hate crimes as the Attorney General directs, including copies of their hate crime policies, if any, and their hate crime pamphlets mandated by PC 422.92. The last known time when DOJ surveyed law enforcement agencies and required submission of hate crime policies (though not pamphlets) was 2010. Of the 464 agencies surveyed, 44 did not respond, 76 reported they had no hate crime policies, and 39 submitted policies that did not comply with the requirement to use the statutory definition of “hate crime,” so just 65.7 percent submitted legally compliant policies. (*Hate Crime Survey Project*, Spring Robbins, Division of Law Enforcement, Department of Justice, October 12, 2010; and review of submitted policies, Jo Michael, Equality California, 2016).

A 2018 audit (*Hate Crimes in California: Law Enforcement Has Not Adequately Identified, Reported or Responded to Hate Crimes*, California State Auditor, May 2018) found that some law enforcement agencies failed to adequately carry out their responsibilities.

AB 1985 (Ting) of 2018 enacted Penal Code Section 422.87, including spelling out provisions for inclusion in law enforcement agencies' hate crimes policies guiding officers on recognizing anti-disability hate crimes. POST this year updated its model policy to be consistent with the new law. We know of no evaluation of how many law enforcement agencies have adopted the updated POST model. The Department of Justice this week issued a bulletin to all California law enforcement agencies informing them of the requirements of AB 1985 (Information Bulletin No. 2019-DLE-08, December 9, 2019).

- (15) The Attorney General should inform law enforcement agencies of the all provisions of the statutes listed above, not just those in AB 1985. After giving them adequate time to comply, the AG should survey the agencies pursuant to PC 13023 and require them to submit their hate crime policies, hate crime pamphlets, and information on officer hate crimes training. The Attorney General, in consultation with subject-matter experts including older adult, disability and civil rights groups, should determine the adequacy of the policies, pamphlets and training, including compliance with the statutes listed above and the audit recommendations.
- (16) If the policies are inadequate or simply nonexistent, the Governor and Legislature should mandate all law enforcement agencies to adopt hate crime policies that include, but are not limited to, the statutory provisions, the audit recommendations, and any additional items determined by POST or the Legislature.

Improve victim services

AB 2877 (Thomson) of 2000 authorized the Crime Victims with Disabilities Initiative, administered by the Department of Mental Health. The bill allowed the department to use the Restitution Fund, generated from criminal fines, to address the problem of unequal protection for, and unequal services to, crime victims with disabilities, including disabilities caused by advanced age.

The program included grants in six counties for specialists on crime victims with disabilities. The specialists assisted victims and service providers in identifying and reporting crimes, and assisted the criminal justice system during investigations, prosecutions and trials.

The *Crime Victims with Disabilities Specialists Program* evaluation (cited above) found:

“When crimes against people with disabilities are reported, often there are limited community supports for them. For example, when a woman with a disability is a victim of domestic violence, there are no shelters available that will serve her if she is unable to perform chores and other duties associated with residency in a shelter.”

The same study evaluated the Crime Victims with Disabilities Specialists Program favorably:

“Overall the [program] was successful in increasing awareness of the needs of crime victims with disabilities, increasing the number of reports of crimes against people with disabilities, and increasing the number of prosecutions and convictions involving crime victims with disabilities.”

The university researchers who authored the evaluation recommended:

“Fund crime-victim specialists across the state in a way that recognizes training, time and emotional work involved in this unique form of service and advocacy.”

Unfortunately, though too typically, Governor Davis and the Legislature defunded the program and repealed the statutory authorization in the 2003 budget crisis -- before receiving the university researchers' evaluation.

- (17) The Governor and the Legislature should reauthorize and expand the Crime Victims with Disabilities Initiative, providing for specialists in every county. In reauthorizing and funding the program, the Governor and Legislature should take account of the evaluation's recommendations.
- (18) The Attorney General should determine whether victims services including domestic violence shelters are accessible to victims with disabilities including disabilities caused by aging. If they are not, the Governor and Legislature should mandate and fund them.

Remedy mandated reporters' failure to report

According to reports we have received for many years, California mandated reporters often fail to meet their legal responsibilities to report, often because of factors such as: their employers' interference in reporting, sometimes even with formal policies instructing them to report to managers instead of the required authorities; fear of retaliation by their employers, coworkers or others; well-founded beliefs that police will not take their reports seriously; and equally well-founded beliefs that police will not arrest them for failure to report, even if the police find out about the abuse from other sources.

The elder and "dependent" adult abuse mandated reporting statutes and child abuse reporting statutes prohibit supervisors or administrators from interfering in mandated reports. There is no such criminal statute covering coworkers or other persons and no known prohibition of retaliation for filing mandated reports.

The elder and "dependent" adult abuse reporting statutes and the child abuse reporting statutes are complicated and, in some cases, inconsistent with each other. The confusion may lead some mandated reporters to fail to report and law enforcement agencies to fail to enforce the reporting laws.

The *Crime Victims with Disabilities Specialists Program* report recommended:

"Develop and implement training programs for health care workers, educators, social workers, and bank personnel to improve the reporting and investigation of these crimes."

- (19) The Governor and Legislature should amend the elder and "dependent" adult abuse reporting statutes and the child abuse reporting statutes to prohibit interference or retaliation by any person.
- (20) The Attorney General should evaluate the abuse reporting statutes. If necessary following that evaluation, the Governor and the Legislature should clarify and simplify them and make them consistent to the maximum extent possible.
- (21) The Attorney General should develop, and the Governor and Legislature should mandate and fund, training for all mandated reporters. The training should include the anonymous reporting mechanism, penalties for nonreporting, and seriously mitigating facts we suggest in Recommendation 8.

Require criminal background checks of caretakers

Crime Victims with Disabilities Specialists Program also found:

“People with disabilities are victims of physical, sexual, and emotional abuse and neglect by their caretakers. However, [some] agencies serving them such as [Supported Living Services] are not required by law to conduct background investigations or fingerprinting of caregivers or other employees.”

- (22) The Governor and the Legislature should mandate California Department of Justice criminal background checks for all caretakers of persons with disabilities including disabilities caused by aging, and all supervisors, managers, and other employees of service provider agencies, both licensed and unlicensed and both paid and unpaid, except for caretakers who are the person’s parent or who the person or the person’s parent selects, supervises, and has the legal authority and actual ability to remove. However, in cases of service provider agencies carrying out the state’s Lanterman Act responsibilities -- agencies that are constantly in danger of closing due to state under-funding -- the Governor and Legislature must fund the Department of Justice to cover the full costs of the background checks, not impose unfunded mandates on an already fragile system.

Improve end-of-life hospice care

Nationally between 2012 and 2016, over 80% of hospices serving dying patients had at least one deficiency; 20% had a serious deficiency, The problems included poor care planning, mismanagement of services and inadequate assessment of patients. (*Deficiencies Pose Risks to Medicare Beneficiaries*, U.S. Department of Health and Human Services Office of Inspector General Hospice, July 2019.) In a separate report from the same federal agency, a dozen examples of harm to patients were presented in gruesome detail. In one case, the hospice didn’t treat ulcers on a patient’s heels, and an amputation was required after gangrene set in. For another patient, “the hospice allowed maggots to develop around a beneficiary’s feeding tube.” (*Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm*, U.S. Department of Health and Human Services Office of Inspector General, July 2019.)

Here in California, some hospice residents also face serious problems in the last days of their lives, including: layers of fraud; poor staffing; broken care promises; avoidable suffering by hospice patients; lack of oversight and no accountability. Families seeking hospice care for their parents often encounter aggressive marketing, pressure by hospital staff, lack of comparative information to distinguish good hospice agencies from bad ones. (Steve Lopez, Los Angeles Times, January 19, February 16, February 24 and August 10, 2019).

- (23) The Governor and Legislature should order a comprehensive evaluation of hospice care, taking account of the findings and recommendations of the two federal reports and leading to corrective legislation.

Ensure access

Lack of physical accessibility and necessary interpreters in effect means lacks access to justice for some older adults and people with disabilities.

- (24) The Governor and Legislature should review all relevant statutes and amend them as necessary to ensure that all law enforcement agencies and other agencies serving older adults and people with disabilities are accessible to all victims and witnesses, and that everyone who needs access accommodations and interpreters (including sign language interpreters for deaf people) has them.

Require data collection and evaluation

Crime Victims with Disabilities Specialists Program found:

“There is a lack of systematic data collection efforts and systems that reveal the extent of the need for special services to crime victims with disabilities.”

Our own, generally unsuccessful efforts to find good data on senior and disability victimization indicate that, 16 years later, this has not changed.

The report recommended:

“Require law-enforcement agencies and district attorney’s offices to gather data on the number of crime victims with disabilities and the disposition of their cases, and reward agencies that dedicate adequate resources to pursuing these crimes.”

- (25) The Governor and the Legislature should mandate that law enforcement agencies report full, valid and reliable data on senior and disability victimization to the Department of Justice. This should include data on reports, arrests, disposition of cases, and demographics of victims by characteristics including age, disability, race and ethnicity.
- (26) The Governor and Legislature should provide for evaluation and periodic reevaluation of the effectiveness of measures adopted in response to, at a minimum, the Master Plan’s senior and disability victimization component.

Clarify terminology

The multiple definitions of the terms “dependent” in the “dependent adult” and “dependent person” statutes are, for most practical purposes, virtually identical to the Penal Code definition of “disability” (PC 422.56(b)). However, the misleading word “dependent” has led many law enforcement officers, service providers and even abuse victims and their families to believe that the many people with disabilities who live independently are not protected by the elder and “dependent” adult or “dependent” person abuse laws.

The term “elder and dependent adult abuse,” too, is cumbersome, often leading to use of shorthand terms such as the misleadingly narrow “elder abuse” and the misleadingly broad “adult abuse.”

Finally, the term “dependent” demeans and insults the many people with disabilities who live independently.

- (27) The Governor and Legislature should amend all relevant statutes to drop the term “dependent,” instead referring to “elder and disability abuse.” In amending the statutes,

the Governor and Legislature should make it explicit in the codes that the current legal definitions remain unchanged, merely changing the term defined, unless they determine that a change of any specific definition is needed.

Ensure policy and budget transparency

During budget crises, Governors and Legislatures often don't just suspend some programs but also repeal their statutory authorization -- or suspend the programs' authorizations in obscure sections of the budget bills that future Governors and Legislatures give little or no attention to reviewing, thus leaving the programs in the codes but having the same practical effect as outright repeal. Unfortunately, programs serving older adults and people with disabilities often have been the victims of these midnight, stealth repeals.

(28) For any parts of the Master Plan on Aging that the Governor and Legislature enact, future Governors and Legislatures should honor those enactments and not repeal them without full consideration not only of any temporary budget issues but also of longer-range policy and its effect on California's older adults and people with disabilities. If they believe that a budget crisis requires them to suspend programs, they should amend those suspensions into the statutory authorization code sections and include sunset dates of no more than two years for the suspension. Such boilerplate language to be added to existing code sections might say:

"This section is suspended as of the effective date of the act that enacts this subdivision in the [years] session of the Legislature. This suspension shall end, and the section shall become effective, on [date] unless a later enacted statute extends that date."

Thank you for your consideration of our recommendations.

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