ELDER ABUSE

June 15, 2006 Adelaide
National Elder Abuse Day
Elder abuse: a medical view

- The rise and rise of awareness
- Definitional issues
- Epidemiology (Aust and beyond)
- Role of medical profession
- Clinical issues in tackling abuse
- Questions
there I met an old man who wouldn't say his prayers left leg and threw him down the stairs
Policy Statements

Delirium
Residential Care
Driving and dementia
Nutrition
Elder abuse
Restraints
Fractured neck of femur
Fall prevention
Etc
Sources of information

  • www.elderabusecenter.org
  • www.preventelderabuse.org
  • www.inpea.net
  • www.elderabuse.org.uk
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Australian epidemiology

• ACAT referrals, retrospective study: 1.2% (Kurrle et al 1997)
• Referrals to hospital aged care and rehab service. Med records review: 4.6% (Kurrle et al 1993)
• Consent issues are not addressed in such broad brush surveys
The extent of the problem

- Population based random sample surveys of older people (age > 65)
  - US (1988) 4% victims of abuse
  - Canada (1989) 4.8% victims of abuse
  - South Australia (2000) 2.7%
  - WHO report (2002) up to 6%

- Aged care services population (1992), community dwelling older people (2001)
  - NSW (1992) 4.6%
  - NSW (2001) 5.4%
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The role of the medical profession

• older people are major users of health services - over 90% see their GP at least once a year
• GP best placed to assess risk with family insights
• impairment and disability play a significant part in the occurrence of abuse and referral to support can improve the situation
Wider opportunities for the MD

• As GP - prevention and identification
• As geriatrician
• As aged care psychiatrist (both experts in competency assessment)
• As emergency room physician
• As member of an interdisciplinary team where information often emerges
Identification of abuse

• one of the major problems in dealing with abuse is the difficulty in recognising it
• symptoms and signs are often subtle and easily attributed to other causes
• older people can be reluctant to admit that they are being abused by a family member or caregiver on whom they rely for their basic needs (NB Dementia does NOT always mean a loss of capacity to decide)
Risk factors

• Frailty appears an indirect risk factor through carer stress
• Cognitive impairment of victim
• Shared living arrangement with abuser
• Psychopathology/mental illness in carer
• Financial hardship: dependence on victim
• Carer history of past violence (marital and outside home)
Lack of involvement of the medical profession? reasons

• lack of knowledge of elder abuse
• ageism…lack of interest in advocacy
• lack of clear guidelines and management strategies
• feeling of discomfort at dealing with abuse
• fear of being enmeshed in legal action
• changing pattern of General Practice
The Abuser

80% to 90% are close family members, spouse, adult child or grandchild, or other close relative.

Although poverty and lack of resources play a role in the occurrence of elder abuse, it occurs in both urban and rural settings, and in all socioeconomic and religious groups.
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Alerts

- Delay between injury or illness and seeking attention
- Disparity in history of older person and carer
- Implausible history by either party
- Frequent ER visits
- Presentation of impaired older person without their carer
Physical abuse: suspect

- Poorly explained accidents or injuries
- Attendances at several or hospitals
- No regular GP
- “Accident prone” older person
- Under and over concern by carer
Physical abuse: recognition

- head - bald patches, bruising, poor dentition
- arms - bruising, grip marks, bite marks, burns,
- trunk - bruises, burns, old rib fractures (on Xray)
- genital area – urine scalds,
- lower limbs - bruising, lacerations, past or present fractures
- Poor foot care
Neglect: clues

- malnourishment, weight loss, wasting
- faecal impaction
- inappropriate use of medication
- lack of necessary aids
- poor hygiene
- inappropriate clothing
- pressure areas (home and residential care)
Assessment and management of elder abuse

- a non-judgemental approach - often a victim-victim situation
- observation of ethical principles (patient autonomy)
- assessment of mental competence is essential,
- involvement of victims in decision making
- Strive for confidentiality
Dementia referrals

- Setting: Rural, N Ireland
- 49 referrals, 38 agreed to interview on abuse issue.
- Abuse elicited in 14 (37%)….verbal 13, physical 4, no neglect
- Issues: poor premorbid personality of victim, problem behaviours in victim, carer anxiety, perception of not getting help
- Degree of dementia, or physical dependence not associated with abuse risk

Ref: Int J Geriatric Psychiatry 1998;12;632
If suspicion of abuse

- Interview older person and carer separately and alone
- Check care giver understanding of patients illness and care needs.
- Is there unexpected anxiety or depression
- Is victim competent to decide?
Clinical practice and abuse

• American Medical Association says ask all the elderly if abused
• Know the cognitive ability of older person
• No standardised evaluation tool exists
• Home visiting is ideal platform for detection (doctors rarely seen…need to rely on others)
• Collateral history from other sources when suspicions aroused.
Management of abuse

- Ensure the older person’s safety
- Take pressure off carer/family
- Respect autonomy...does the older person have capacity to decide in this area?
- Who is the endorsed Guardian and/ or EPOA
- Follow up if a competent older person agrees to return to a risk situation
- Consider involving agencies eg ARAS, Guardianship Board
Tacking abuse

• Address underlying medical problems
• crisis care/alternative accommodation admission
• Provide support services, including respite care
• counselling and advocacy for the victim
• Treatment of the abuser
• legal interventions
Interventions available

- Referral to specialised health services
- Aged Rights Advocacy Services
- mainstream legal services e.g. to establish or revoke a Power of Attorney, or Power of Guardianship, to evict an unwelcome abuser person from the home, to provide legal advice
- Specialist practitioner to establish competency of older person
- restraining order via Courts
- Police involvement
- Guardianship Board... to revoke past EPOG, EPOA
Some personal views

• In recent decades, I suspect that Elder abuse has been less prevalent in Australia due to our aged care support services and Residential care standards
• We now properly prevent progression to elder abuse rather than detect cases
• Elder abuse is likely to increase with demand for support services exceeding supply, and stress on family availability
• Changes in GP practice (cultural profile, minimal home visiting, polydoctor clinics) demand increased vigilance by all health care personnel
QUESTIONS?
Case 1

- 78 year old woman with early dementia
- daughter moved in with her 4 months ago
- loud voices heard, bruising noted on face and forearms by neighbours
- admitted to hospital as considered at high risk of further abuse
- diagnosis of thrombocytopenia and deafness, not abuse
Case 2

- man in his early eighties admitted with haematemesis
- endoscopy NAD, thought to be related to NSAIDS
- admitted with massive melaena, INR > 6
- not prescribed warfarin but warfarin noted in urine drug screen
- son is bankrupt solicitor with father’s POA, his wife had access to warfarin
Case 3

- man in his late 70’s, significant dementia, attends day centre, always drowsy
- wife insisting on N/H placement
- admitted to hospital, wife always present in am, feeds husband toast and jam
- benzodiazepines in urine drug screen
- wife has diazepam prescribed for her
Case 4

- man in his early 70’s, lives with wife
- severe Parkinsons Disease requiring 4th hourly L-dopa, given by wife
- admitted with pressure areas, poor mobility, and falls, responds well to regular medication and mobilisation
- follow-up home visit - immobile in chair, incontinent
- wife withholding medication
EPIDEMIOLOGY

- Boston USA 3.2% community living elderly had experienced some form of maltreatment since 65 years of age. Types: physical 2.2%, habitual verbal aggression 1.1% and neglect 0.4%  
  *(Gerontologist 1988)*

- Institutional rates uncertain. Untrained staff admit to abuse (10% physical, 40% psychological abuse)  
  *(Gerontologist 1989)*
The Queensland approach

• 1997 Elder Abuse Prevention Unit funded
  – provides 1300 statewide telephone helpline
    • Monday to Friday business hours
    • crisis counselling for victims, professional service providers, community
  – provides education and information
  – provides peer support network
  – has full time project officer, and part time workers in regional areas
Physical abuse

The infliction of physical pain or injury, or physical coercion.

Examples include any form of assault such as hitting, kicking, beating, biting, burning. It includes sexual assault and physical restraint.
Psychological abuse

The infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and feelings of shame and powerlessness.

Examples include verbal intimidation, humiliation and harassment, threats of physical harm or institutionalisation, and withholding of affection.
Psychological abuse

• huddled when sitting, nervous with abuser nearby
• insomnia, loss of appetite, anorexia
• fearfulness, helplessness, hopelessness, apathy, resignation, withdrawal, paranoid behaviour, anxiety
• reluctance to talk openly and avoidance of eye contact
Financial abuse

The illegal or improper use of an older person’s property or finances.

This would include misappropriation of money, valuables or property, forced changes to a will or other legal document, and denial of the right of access to, or control over personal funds.
Financial abuse...alerts

- loss of money - from small amounts of cash to large cheques, unexplained withdrawals of money
- sudden inability to pay for food or services
- “loss” of bank books, credit cards, cheque books
- loss of jewellery, paintings, furniture
- unprecedented transfer of money
- improper use of POA
- making of a new will
Neglect

The failure of a caregiver to provide the necessities of life to an older person i.e. adequate food, shelter, clothing, medical care or dental care.

*Neglect may involve the refusal to permit others to provide appropriate care. Examples include abandonment, non-provision of food or clothing, inappropriate use of medication, and poor hygiene or personal care.*