Factors contributing to Elder Abuse and to the failure of organisations and individuals to respond to it.

Missing in Action

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This de-identified presentation attempts to examine the factors which contribute to elder abuse in this case scenario.

It aims to explore and shed light onto the forces which collude to conceal and maintain Elder Abuse as well as those which act as barriers to detection and intervention. It demonstrates once again that Elder Abuse is often associated with complexity.
He’s 85, has dementia and is very deaf. Each day in his Southern suburban home, he endures an abusive and derogatory tirade as he is pushed and pulled, dragged and dropped in a routine of daily care. With anger and apparent resentment he is forcibly ambulated, each step driven cruelly by knees driven up into his hamstrings, thighs and buttocks. Steered from behind without the reassurance of guiding hands, his face betrays his terror, and the faltering-resistant steps and searching hands, his futile indignation. The intolerable circumstance could be made more unbearable if he were aware that the abuse was at the hands of his daughter and apparently sanctioned by his unprotesting wife.
85 and lives in the family home in outer southern suburbs with a spouse who is herself disabled by chronic movement disorder.

Youngest daughter is carer. Oldest daughter is estranged.

Carer has ‘difficult’, rigid and angry personality.

Client and spouse have previously expressed desire to ‘not be put in a home’. There is a strong family belief about the horror of ‘being dumped in an old folks home’.

Client sent home from hosp ‘to die’ 12 months ago. He has responded well to common aspects of ADL care (feeding, bathing, ambulation) and now looks physically well, is putting on weight etc
• An invited visiting Nurse notes unnecessarily rough physical treatment and abusive language.
• Reported internally and Specialist nurse asked to explore.
• Specialist also experiences rough and abusive physical treatment of the client and unreasonable and uncalled-for, coarse, derogatory and abusive language.
• Carer/daughter advised of the unacceptability of her care behaviours but unable to accept recommendation.
• Behaviours justified by improved physical health outcomes, by examples of service failure and/or service withdrawal.
• Carer soon cancels services (later ..all services)
• Decision made to contact Police and to explore further with view to intervene to cease abuse.
• Discussed concerns with GP.
• Discussed with and sought clarification from ARAS.
• All service organisations in contact with family over previous 2 years plus estranged family.
• History of service and professional concern with ‘rough’ treatment and frustration in their inability to garner medical support for legal intervention.
• Some reports of health professionals carrying anxiety, frustration and feeling ‘traumatised’ over a year following their family contact.
• At least one professional fearful to visit alone and reluctant to send in staff.
Service organisations withdraw or are dismissed one by one as their workers fail to alter unacceptable carer behaviour and refuse to collude in behaviours which leave some of them feeling frustrated and traumatised.

Care Coordinators feel powerless and unable to attract the medical support they believe is necessary to achieve the client’s safety. Without this support they feel that they have little choice but to distance their staff and their organisations from the situation.
The **Number of Services**
Involved with health care of the client and his wife over the previous two years

10
The **Number of Health Professionals** who personally recognised unreasonably rough or abusive language or behaviour towards the aged client

**15+**
The **Number of Non-medical Professional Staff** who **personally** comprehensively assessed and evaluated allegations or reports of rough, abusive or unreasonable language and/or behaviour to the client
The **Number of Doctors** who received reports of rough, abusive or unreasonable language and/or behaviour from more than one person

4
The **Number of Doctors** who **personally** comprehensively assessed and evaluated allegations or reports of rough, abusive or unreasonable language and/or behaviour towards the client: 0
The **Number of Times** the General Practitioner allegedly received reports by a family or community services or health staff member of rough, abusive or unreasonable language and/or behaviour towards the client

4+
The **Number of People** who contacted the Police to report the abusive behaviour

1
The Number of People who contacted ARAS about concerns of rough, abusive or unreasonable language and/or behaviour towards the client 3
If we **SEE** it why don’t we act on it?

If we **HEAR** about it why don’t we act on it?

**Barriers to Action**
Quotes

– “There’s no reporting body!”
– “There’s no-one to get help from!”
– “There’s no-one whose qualified to stop it”
– “No-one will take responsibility”
– “There are no specific guidelines”
– “We need a national review of care of the elderly by their carers”
– “There’s no body chartered with responsibility!”
– “We need someone with the authority & power to assess care”
Barriers- System

- No-one has the responsibility to report
  *(There is no legal imperative therefore no-one ‘has to’)*

- Beliefs about the dependency on Medical support to generate action

- Perceived risk to an individual or organisation if ‘wrong’ *(the ‘A Current Affair ‘ effect)*
Barriers – Human, Psychological

- Empathy or identification with family or carer Pathology. *(there by the grace of God…)*
- Self Doubt in the face of other’s inaction *(I’m probably missing something)*
- Fear of objection to challenge *(They might become angry/aggressive/violent if I tell them what I think)*
- Fear of rejection *(They may not like me or want me anymore –or my service $)*
• Threat of loss of the ‘good nurse’ image (they fail to see me as good, caring, kind)

• Perception of limits of a professional role and responsibility (I’m only here for respite)

• Rejection (We don’t like it, or agree with it but can’t make it stop so we withdraw to demonstrate our disapproval)

• Sensitivity to foreseeable potential cascade of effects on others (consequences (to client/others) if I decide to report which are not intended?)
• Rescuing of ‘Abuser’ who has made naive pledge. “I promise I’ll never put you in a home” etc. (Forgetting the Abused)

• Guilt and remorse about consequences of anticipated action (What have I done to these poor people?) (Forgetting the Abused)

• Discounting & Rationalising (from Child Abuse; I suppose that it’s not ‘that’ bad and the carer is under a lot of stress!” (forgetting the abused)

• Projection of personal feelings and values ‘the family home’ V’s property’ & ‘Family responsibility’
• Critical judgement of one’s own motives and right to take action (and losing sight of the victim) *(Who am I to be taking the high ground on this matter?)*
Barriers - Deficits

- Ignorance about what constitutes abuse *(what abuse looks like behaviourally)*
- Confusion about advocacy roll *(client’s interest V’s Client’s wishes)*
- No physical or psychological evidence of abuse *(nothing showing on body or mind)*
- Poorly defined ‘concerns’ about the mental health of the carer
- Imbalance in concern for Civil Rights
• Commonly sought evidence does not support the nature of the allegation
• Conflicting beliefs and judgements about what is ‘Right’ for the client (client knowledge and Vs system knowledge)
Barriers-Client-related

- Client’s previously expressed wish (whether or not circumstances have changed)
- Client’s current expressed wish (whether or not evidence exists which suggests that capacity to decide is diminished)
- Family belief systems about consequences (‘Dumped in an old folks home’)
- Mental Health of the Carer
- Low carer and family understanding of elder needs
A Common Current Reporting Pathway

W=Witness, S=Supervisor, I=Investigation, C=Communication, R=Report,
A Common Current Reporting Pathway

W=Witness, S=Supervisor, I=Investigation, C=Communication, R=Report,
SO What!
Recommendations

- **Education & training** for staff at **EVERY** staff level on identifying and describing client and care-related behaviours.

- Promotion of behaviours which may reflect abuse at **EVERY** staff level. Everyone must be clear about what is & isn’t EA.

- Clear **Policy & Guidelines** directing staff to report & discuss ‘suspect’ and possibly abusive behaviours with supervisors and to ‘capture’ these events as ‘Incidents’ in their Incident reporting process.
• Development of **skills in supervisors** to be open to hear from staff about ‘tricky’ aspects of working with a client. ‘*Hi, tell me about you more difficult clients*’

• Development of **knowledge in supervisors** about how to support clients and staff when EA is suspected/evident

• Development of **management guidelines** for dealing with EA when concerns or allegations are about the behaviour of our own staff
• Assignation of ‘Champion’ roles & responsibilities at a potent level for Elder Abuse education and reduction strategies

• Funding imperatives to collaborate in investigation of any overt or suspected EA

• Lobby for Requirement for Medical Officers to investigate allegations and expressed concerns about EA

• Lobby to have Police agencies release guidelines for intending reporters
• Promotion of accessible resourced **advocacy services** for vulnerable individuals

• Capacity for planned & funded **rotational placements with advocacy services** for supervisory staff to enhance their capacity to manage EA appropriately

• **Implement** (at the very least) **ALL** of the recommendations in the 2007 ‘Our Actions to Prevent the abuse of older South Australians’.
More Recommendations

Development of a Reporting Pathway

W=Witness, S=Supervisor, I=Investigation, C=Communication, R=Report,
Thank you

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