

Elder Mistreatment

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Dr. Cole earned her medical degree from the University of South Florida in Tampa and completed her residency and fellowship training at Florida Hospital in Orlando. As part of her role as director of the Geriatric Fellowship, she supervises medical students, residents, and geriatric fellows in the care of elderly patients in the hospital, outpatient clinics, nursing homes, and home visits. Within the Centre for Aging and Wellness, she oversees a Comprehensive Geriatric Assessment Clinic where elderly patients and their caregivers meet with an interdisciplinary team to evaluate their medical, functional, and psychosocial status. Dr. Cole is a member of the AAFP, the American Geriatrics Society (AGS), and the American Medical Directors Association (AMDA). She is board certified in family medicine and geriatric medicine and is a Certified Medical Director (CMD).

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Learning Objectives

1. Identify types of elder mistreatment.
2. Screen for elderly mistreatment in accordance to evidence-based recommendations.
3. Differentiate disease processes or normal signs of aging from signs of injuries.
4. Interview patients and caregivers separately when screening for elder mistreatment.
5. Establish management and intervention plans when elder abuse is suspected.

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Audience Engagement System



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Definition of Elder Abuse

- Numerous definitions exist
- Intentional or neglectful acts by a caregiver or trusted individual that lead to, or may lead to, harm of a vulnerable elder
- Most abuse is reported by family members, social workers, and friends and neighbors

Locations

- Community
- Institutional



Elder Mistreatment: A Failure of Justice

- Both an individual and societal/cultural problem
- Surveillance and prosecution is not the only solution
- Elders are not only vulnerable dependent victims-elders are valuable members of a community
- Solutions typically focus on individuals, but society needs to embrace changes
- Reducing the social isolation of elders will help prevent and lead to quicker recognition of abuse

Poll Question 1

- The US Dept of Justice and the Dept of Health and Human Services estimate that what percent of people over age 60 have experienced elder abuse or neglect?
 - A. 5%
 - B. 10%
 - C. 20%
 - D. 30%

Risk factors – older adults

- Cognitive impairment
- Disruptive behaviors
- Functional impairment/dependency
- Female gender
- Shared living situations
- Incontinence
- Isolation from family and friends/limited social support
- Low income



Risk factors - caregivers

- Caregiver dependency on the older person (usually financial)
- Elderly caregiver, often with health problems
- Adult child caregiver caring for children as well, or feels elder was abusive/not nurturing parent
- Alcohol, other drug misuse
- Mental illness
- Low income/unemployment

Prevalence

- Estimates are 1 in 10 older adults experience abuse or neglect by a caregiver each year
- The most common relationships of victims to alleged perpetrators were adult child (32.6%) and other family member (21.5%).
- Abuse/neglect victims have a 3X greater risk of mortality

Screening

- USPSTF found insufficient evidence to assess balance of harms and benefits of screening older adults for abuse/neglect
- Elder Abuse Suspicion Index
 - 6 questions, yes/no
 - Sensitivity of 0.47, specificity of 0.75
 - Validated in primary care settings for cognitively intact patients

Elder Abuse Suspicion Index

Example Questions

- Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
- Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- Has anyone tried to force you to sign papers or to use your money against your will?

Poll Question 2

- What percent of reports of elder abuse/neglect to US Adult Protective Services come from physicians?
 - A. 2%
 - B. 5%
 - C. 10%
 - D. 16%

Types of elder abuse

- Physical
- Sexual
- Psychological/Emotional
- Financial
- Neglect



Physical abuse

- Hitting, slapping, pushing
- Restraining
- Excess/improper medication
- Withholding medication or other treatment
- Withholding food/water or needed assistance (such as changing depends)
- In institution: most abuse is caused by other residents



Mrs. G



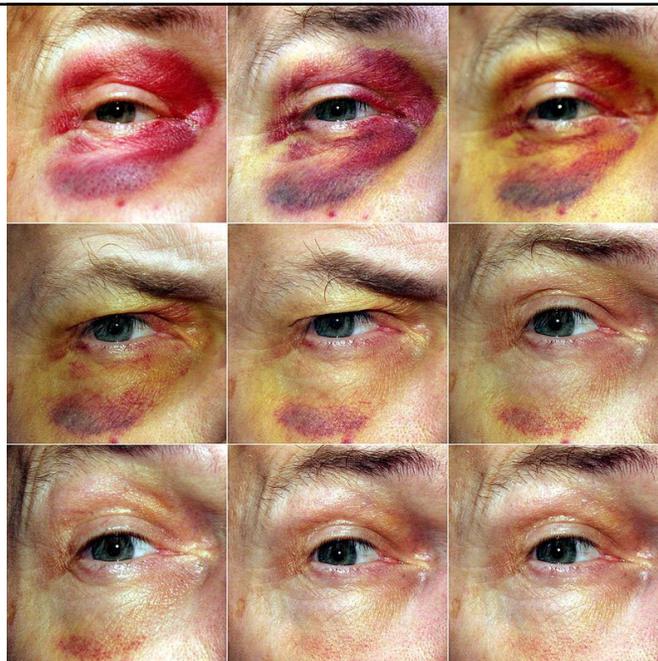
- 78 y/o widow, no children
 - DM2, HTN, hypothyroidism
 - Chronic lymphedema, LE ulcers
- Lives with nephew and his partner
- Bruise on dorsal hand, pt reported intentionally caused by nephew's partner

Physical signs of abuse

- Patterned injuries: hand slap or bite marks, ligature marks at wrists or ankles
- Traumatic alopecia with scalp swelling
- Multiple burns or in unusual patterns or locations
- Bruises on abdomen, neck, posterior legs, medial arms
- Unusual or unexplained fractures
 - Spiral long bone fractures, first rib fractures
- **Is the explanation provided consistent with the findings?**

Further signs of abuse

- Bruising around genitals
- Malnutrition
- Missing medications
- Unusual delay in seeking medical attention for injuries
- Dirty clothing, poor hygiene



Medical conditions that can mimic abuse

- Constipation, weight loss
- Poor wound healing
- Bruising/fractures caused by falls, osteoporosis
- Fragile, photo-aged skin with senile purpura
- Weight loss due to pulmonary/cardiac cachexia or end of life

Sexual Abuse

- Forcing participation in any sexual act or conversation
- Includes patients lacking ability to consent

Consent and Sexual Expression

- Disinhibition common in dementia
- Common challenge in SNF setting, often more upsetting to family and staff
 - AMDA has a white paper “CAPACITY FOR SEXUAL CONSENT IN DEMENTIA IN LONG-TERM CARE”

ABA/APA Assessment of Capacity to Consent to Sexual Contact

- 1. Patient’s awareness of the relationship:
 - a. Is the patient aware of who is initiating sexual contact?
 - b. Does the patient believe that the other person is a spouse and, thus, acquiesces out of a delusional belief, or [is he/she] cognizant of the other’s identity and intent?
 - c. Can the patient state what level of sexual intimacy [he/she] would be comfortable with?
- 2. Patient’s ability to avoid exploitation:
 - a. Is the behavior consistent with formerly held beliefs/values?
 - b. Does the patient have the capacity to say no to uninvited sexual contact?
- 3. Patient’s awareness of potential risks:
 - a. Does the patient realize that this relationship may be time limited (placement on unit is temporary)?
 - b. Can the patient describe how [he/she] will react when the relationship ends?

Henry Rayhons, 78, Iowa state Senator

- Arrested, tried, acquitted of sexual abuse of wife Donna, severe Alzheimers, in nursing home, 2015
- Pt unable to consent to sex, husband informed
- No allegation that Mrs. Rayhons resisted or showed signs of abuse

Psychological/Emotional Abuse

- Infliction of mental anguish
- Humiliation, name calling, yelling
- Nonverbal forms include ignoring, silence, shunning, or withdrawing affection

Financial Abuse

- Misappropriation of financial resources
- Exploitation of resources such as housing, food, etc.
- Likely the most common, most underreported

Mrs. C



- 81 y/o woman, significant functional impairment due to HFrEF, OA
- 35 y/o grandson, who she raised, lives with her, helps with shopping and transportation
- Some verbal and possibly financial abuse
- Mrs. C has called police on him multiple times over years during conflicts but refuses to ask him to leave

Phone/email scams

- Sweepstakes winner, need to pay taxes on winnings to receive
- Impersonating family members, asking to wire funds

Neglect

- Self neglect is the most common type of abuse reported to APS
- Caregiver neglect is the second most common
- Self-neglect
 - Failure to access food, clothing, shelter, or medical care

Mr. L



- 89 y/o widower, wife deceased 6 yrs ago
- Comes to office smelling of urine/feces
- Acknowledges difficulty keeping up with cleaning home, caring for dogs, getting groceries and cooking for himself
- APS called, arranged for meals-on-wheels, motivated patient to hire house cleaner

Capacity and Neglect

- Adults have the right to self-neglect
 - Avoid medical care
 - Risky behaviors
- That right dissipates in dementia

Mrs. P

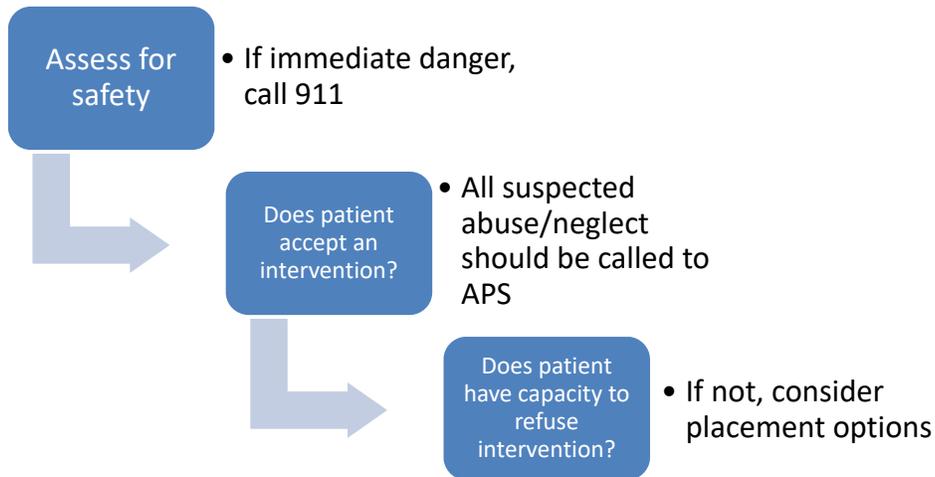


- 85 y/o woman with well established moderate Alzheimer's, cared for by husband
- Husband had CV disease, hospitalized in VA system 2-3 times/yr, inquired about respite SNF placement
- Husband died, no other family, neighbor brought her to office visit
- APS evaluated, initially recommended home healthcare
 - after multiple calls and letter stating incapacity, APS arranged for guardian and ALF placement

When a patient shows signs of abuse/neglect

- Interview patient and caregiver separately
 - Fear of retaliation, shame, dependency may hinder disclosure
- “Can you tell me what happened?”
- Functional assessment (ADLs, IADLs)
- Home environment, perception of safety

Suspect Abuse or Neglect



Safety Plan

- Individualized, written plan
- Safe places to go, such as family or friend's home, shelter
- Checklist of essential items to keep together in a safe place
- Telephone number of family, friends, community resources
- Special considerations like transportation needs
- Follow-up plan

How do I report?

- <http://www.napsa-now.org/get-help/help-in-your-area/>
- Call APS
- Consider other resources
 - Family or friends
 - Social workers



What happens after I report?

- APS will determine whether the report meets criteria
- If criteria met, APS will investigate and determine if abuse/neglect has occurred
- An elder with capacity to consent may opt out of services/interventions

Poll Question 3

Which of the following characterizes elder abuse?

- A. Physicians and other medical providers are mandated to report suspected abuse in all 50 states
- B. Abuse is easily distinguished from signs of medical illness
- C. The victim commonly reports the abuse
- D. The perpetrator can be identified by typical characteristics

Barriers to reporting

- Victim denial
- Uncertainty about reporting process
- Uncertainty about reporting laws and resources
- Only subtle signs of abuse

- A doctor visit may be an elder's only source of interaction outside the home!

“In most cases, the greatest dilemma is how to balance the older person’s right to self-determination with the need to take action to end the abuse.”

– [World Report on Violence and Health](#), World Health Organization, 2002

False Accusations

- Paranoia, delusions, accusations of stealing are a common symptoms of dementia
- In the community setting, use judgement
- In the institutional setting, regulations require reporting of all alleged abuse

Prevention

- Listen to older adults and their caregivers to understand their challenges and provide support.
- Check in often on older adults who may have few friends and family members.

Prevention

- Provide caregivers with emotional and instrumental supports such as local caregiver support groups, adult day care programs, counselling, or outlets intended to promote emotional well-being.
- Encourage and assist persons (either caregivers or older adults) having problems with drug or alcohol abuse in getting help.

Practice Recommendations

- Know your local resources for individuals suffering abuse
- Interview patients and caregivers separately
- Be prepared to make a safety plan with an abused elder in your practice setting
- Report known or suspected abuse, neglect, or exploitation to your state APS

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Questions



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