

This slide lecture presentation is designed for California-based physicians in training and health care providers seeking continuing education. The length can range from 40 to 55 minutes according to the audience and its interests.

# ACKNOWLEDGEMENTS

This slide lecture presentation was created by the Center of Excellence in Elder Abuse & Neglect at the University of California, Irvine, School of Medicine Program in Geriatrics.



Center of Excellence  
in Elder Abuse and Neglect

This slide lecture presentation was prepared by members of the University of California Irvine Center of Excellence in Elder Abuse and Neglect. One of the contributors, Ronald Chez MD, incorporated some of the content he co-authored in learning modules produced by the American College of Obstetricians and Gynecologists.

The information contained in this teaching module is designed to aid providers in making decisions about appropriate care of older adults. The content is intended to be an introduction to the subject of elder abuse. Any guidelines should not be construed as dictating an exclusive course of treatment of procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the type of practice or institution.

## LEARNING OBJECTIVES

- To place knowledge on the definition and categories of elder abuse into clinical context.
- To encourage the clinician's routine inquiry about elder abuse in the office, clinic and hospital.
- To identify the spectrum of presenting signs and symptoms of elder abuse through history taking and physical examination.
- To define the clinician's role in documenting and reporting suspected elder abuse.



There are four learning objectives for this lecture. They speak to the fact that elder abuse cuts across all of the categories and disciplines of medicine and nursing. It can present with diverse signs and symptoms. Too often the victims are invisible to others in their community and to the health professionals who provide their care. Our responsibility is to support and where necessary improve the quality and the dignity of aging population.



## OVERVIEW

Family violence is an umbrella term that encompasses these main categories of abuse through the life cycle. The term includes child abuse, child-parent abuse, sibling-sibling abuse, partner abuse, sexual assault and elder abuse.

Family violence is a crime that has now reached epidemic proportions in our country. However, if the clinician does not ask and the patient does not speak of it, the abuse will not be recognized. Unrecognized abuse is untreated abuse. As a result, the patient remains at risk and denied access to safe alternatives.

## ELDER ABUSE DEFINITIONS

- Elder: any person residing in California who is 65 years of age or older.
- Elder abuse: acts of omission or commission by a person who stands in a trust relationship that result in harm or threatened harm to the health and or welfare of an older adult.
- Caregiver: any person who has the care, custody or control of, or stands in a position of trust with, an elder or dependent adult.



A care custodian or formal caregiver is a paid employee or volunteer connected to the health care or social service system. The term informal caregiver refers to family members and friends who provide care.

A trust relationship is defined as a caregiver relationship or other familial, social or professional relationship where a person bears or has assumed responsibility for protecting the interest of the older person or where expectations of care or protection arise by law or social convention.

## PREVALENCE OF ELDER ABUSE

- Current:
  - 3-5% of elders in home/residential facility
- Victim-perpetrator:
  - no typical victim
  - 90% of abusers known to victim
- Future:
  - growing proportion of seniors in society
  - increasing number of abused/at risk elders



Elder abuse can occur in the patient's home, the home of the caregiver or in a residential facility in which the patient is residing.

It is estimated that 3-5% of elders in our country are abused.

There is no typical victim. Elder abuse occurs in all racial, social, educational, economic and cultural levels. Perpetrators of elder abuse are known to the victim 90% of the time. Approximately two-thirds of abusers are adult children or partners.

We can anticipate an increasing number of abused and at risk elders as awareness of the problem increases, elderly people live longer with the associated increased potential for being frail and vulnerable and the baby boomer generation enters old age thereby growing the proportion of seniors who need formal and informal care in our population.

# ELDER ABUSE

Only 1 out of 6 cases are reported!!

Unaware + Unspoken = Unrecognized

**UNTREATED**



It is estimated that five out of six cases of elder abuse go unreported. In Orange County California, Adult Protective Services receives 500 reports of suspected elder abuse each month. This translates to 3000 cases of potential elder abuse a month.

## CATEGORIES OF ELDER ABUSE

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect
- Abandonment
- Abduction
- Financial exploitation
- Self-neglect



There are eight categories of elder abuse. They are physical abuse, sexual abuse, emotional abuse, financial and material exploitation, neglect, abandonment, abduction and self-neglect.

## PHYSICAL ABUSE

- Use of physical force that causes or may cause non-accidental physical pain, harm or bodily injury.
  - ◆ beating
  - ◆ shaking
  - ◆ kicking
  - ◆ throwing objects
  - ◆ force feeding
  - ◆ assault with deadly weapons
  - ◆ pinching
  - ◆ burning
  - ◆ choking
  - ◆ unreasonable restraint
  - ◆ misuse of medication



Physical abuse is the intentional use of physical force that causes or may cause non-accidental physical pain, harm or bodily injury. It includes, but is not limited to beating, slapping, kicking, shoving, pinching, shaking, choking, throwing objects, burning, unreasonable physical or chemical restraining, force feeding, inappropriate use of medication and assault with a deadly weapon.

## EMOTIONAL ABUSE

- The infliction of mental anguish, pain or distress upon another person.
  - ◆ threatening
  - ◆ criticizing
  - ◆ debasing
  - ◆ ridiculing
  - ◆ ignoring
  - ◆ debasing
  - ◆ yelling
  - ◆ humiliating
  - ◆ intimidating
  - ◆ social isolating



Emotional abuse is the infliction of mental anguish, pain or distress upon another person. Verbal with words or nonverbal with actions, it includes threatening, debasing and indicting values, yelling, criticizing, humiliating, ridiculing, intimidating, ignoring and socially isolating the victim. It also may take the form of the destruction of property, killing pets and reckless behavior on the part of the abuser.

## SEXUAL ABUSE

- Any form of sexual contact or exposure without consent.
  - ◆ unwanted touching and fondling
  - ◆ sexual name calling
  - ◆ forced and coerced sexual acts
  - ◆ purposefully hurtful sex
  - ◆ sodomy
  - ◆ rape



Sexual abuse is any form of sexual contact or exposure without consent or when the person is incapable of giving consent. Behaviors include lewd and lascivious acts such as unwanted touching and fondling, sexual name calling, forced and unwanted sexual acts, use of pornography, purposefully hurtful sex, oral copulation, sodomy and rape. Abusers can be spouses/partners, adult children, family members, caregivers, strangers or someone in a position of power.

## NEGLECT

- Denial of care:
  - food, water, shelter
  - personal hygiene, clothing, bedding
  - medical care, medicines, assistive devices
- Isolation:
  - control of time, activities, contacts
  - disinformation tactics
  - false imprisonment



Neglect occurs when the caregiver refuses [active] or fails [passive] to fulfill the degree of care or custody that a reasonable person in a like situation would exercise. This includes denial of food including a prescribed diet, water, shelter, personal hygiene, clothing and bedding, medication and assistive devices, failing to access necessary medical care and protection from safety hazards and unsafe conditions.

Isolation is another manifestation. The elder's time, activities and contacts are controlled including preventing receiving visitors, telephone calls and mail.

Disinformation tactics with false representation of the elder's illnesses or wishes to not make contact with others may occur. False imprisonment including denying access to outside the home and physical restraint are other examples.

## ABANDONMENT

- Willful unattended care or custody by an identified caregiver who has assumed responsibility when a reasonable person in a like situation would not do so:
  - home
  - public place



This occurs when the caregiver or the person who has assumed responsibility for the care or custody of the elder deserts them. Leaving the elder unattended at home or a public place when a reasonable person in a like situation would continue to provide care and custody is an example.

## FINANCIAL ABUSE

- Exploitation of property, resources and assets:
  - denying access
  - stealing, hiding
  - purposeful mismanagement, deception
  - fraud, extortion, forging
  - improper use of legal documents



This is the illegal or wrongful exploitation of funds or other material assets including denying access to the person's own assets, transferring assets, stealing, hiding and purposeful mismanagement of money or property belonging to the victim.

Committing fraud or extortion through deception, scams, forging and falsifying records, inappropriate influence, threats and intimidation related to material assets and improper use of Power of Attorney and other legal documents are other examples.

## ABDUCTION

- The removal of a person from California or restraining a person from returning to California who does not have the capacity to consent to this action.



This category is a specific category of elder abuse in California law. It is defined as removal of a person from California or restraining the person from returning to California who does not have the capacity to consent to this action.

## SELF-NEGLECT

- Basic activities of daily living are neglected, threatening personal health and safety:
  - hygiene
  - food, water
  - clothing and bedding
  - shelter and surroundings
  - finances
  - health care
  - hoarding



This is the one category of elder abuse that does not include a person other than the patient. It is defined as an elder who lacks capacity secondary to physical, mental, disease, substance abuse and/or cognitive reasons to manage the basic activities of daily living of a reasonable person in a like situation. These activities include personal needs in the areas of hygiene, food and water, clothing, shelter and surroundings, finances and health care. Hoarding is considered a form of self-neglect. As a result of these behaviors, there is a threat to the person's personal health and safety.

## RISK FACTORS FOR ELDER ABUSE

- Isolation of caregiver-elder dyad
- History of abuse in either
- Abuser dependent on elder
- Mental illness in either
- Substance abuse in either
- Elder's vulnerability and frailty
- Caregiver's perceived distress



Some red flags that increase the vulnerability for or probability of abuse include caregiver-elder dyad isolation from others, a history of abuse in either, the abuser dependent on the victim for shelter and money, the abuser's perception of distress, a caregiver or elder who has a mental illness or substance abuse problem and the victim's vulnerability to or inability to defend self secondary to poor health, cognitive impairment and/or functional impairment

## CONSEQUENCES OF ELDER ABUSE

- Hostage in unsafe environment:
  - ? access to medical care
  - ? chronic disease complications
  - ? malnutrition and dehydration
  - ? physical and psychological harm
-  3x premature death



The various categories of abuse, particularly neglect and self-neglect, can have adverse medical consequences on the victim. As a function of living as a hostage in an unsafe environment, the patient may have unmet health needs secondary to inadequate access to medical care and treatment. This in turn contributes to the morbidity listed on the slide. There are published clinical research data showing an increased incidence of premature death in abused elders.

## ASSESSMENT:DEMEANOR

- Flat affect, listless, apathetic
- Hesitant, evasive
- Fearful, anxious
- Hostile, aggressive
- Uncooperative, suspicious
- Abrupt change in a known patient

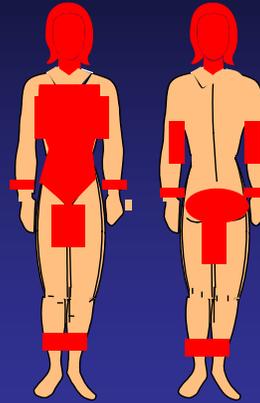


### CLINICAL ASSESSMENT

The patient's demeanor can range from flat affect, listless, apathetic, hesitant, fearful, evasive, anxious and withdrawn to hostile, aggressive, uncooperative and suspicious. An abrupt change in behavior, personality and/or communication of a patient known to the clinician can be an important clue to abuse.

## ASSESSMENT: INJURIES

- Location and shape
- Multiple injuries
- Various healing stages
- Suspicious explanation
- Delay seeking care



Injuries on the outer aspect of the extremities may be a result of the elder's usual everyday activities or the result of battering. Injuries on the head, neck, central part of the body, wrists, ankles and inner aspects of the extremities are most suspicious of being caused by abuse. Thus, the location and shape of bruising and injuries such as abrasions, avulsions, burns and cuts is relevant.

When asked about what caused the injury, some patients will say: "I've been beaten", but some will not. Other clues to abuse are a vague, inconsistent or implausible explanation of the cause of the injury, multiple injuries in different stages of healing, delay in seeking care and unusual patterns of alopecia.

## ASSESSMENT: SEXUAL ABUSE

- Fear of being touched
- Inappropriate modesty on examination
- Inner thigh bruising, tenderness
- Perineal bruising, tenderness, blood
- Breast bruises
- Unexplained STDs including HIV



Signs that sexual abuse has occurred include bruising on the inner thighs, tenderness, bruising and/or blood in the perineal area, bruised breasts in women, evidencing fear of being touched, unexplained sexually transmitted disease, genital parasite infestations and inappropriate modesty on examination.

## ASSESSMENT: EMOTIONAL ABUSE

- Depression:
  - sleep and appetite disturbances
  - decreased social contact
  - loss of interest in self
  - apathy and suicidal ideation
- Evasiveness, anxiety, hostility



Depression evidenced by sleep disturbances, changes in appetite, decreased social contact, loss of interest in self, apathy and suicidal ideation can be present in elders. It also is both a risk factor for and a sign that emotional abuse may be present. Other signs can include anxiety, hostility toward the provider and evasiveness.

## ASSESSMENT: NEGLECT

- Indicators:
  - inadequate, dirty or inappropriate clothing
  - malnutrition, dehydration
  - odor and poor hygiene
  - pressure sores
  - misuse/disregard/absence of:
    - medicines
    - medical assistive devices
    - medical regimens



Indicators of neglect include malnutrition, dehydration, excessive odor and poor hygiene, pressure sores, inadequate or inappropriate clothing, absence of the person's necessary medical assistive devices such as eyeglasses, dentures, hearing aides, misuse of medicines and disregard of medical treatment regimens and proscriptions.

## ASSESSMENT: FINANCIAL ABUSE

- Fear, vague answer, anxiety when asked about personal finances
- Disparity between assets and appearance and general condition
- Failure to purchase medicines, medical assistive devices, seek medical care or follow medical regimens



Patients may not seek medical care, purchase or refill medicines, purchase medical assistive devices or follow a prescribed medical regimen because they are prevented access to their personal funds by the abuser. It may also be secondary to the caregiver depleting the available funds for their own use without permission. When asked about their finances, the victim may manifest fear and anxiety and respond with a vague answer. The elder also may refuse to spend money without the abuser's agreement.

## ASSESSMENT: SELF-NEGLECT

- Indicators:
  - inadequate or dirty clothing
  - malnutrition, dehydration
  - odor and poor personal hygiene
  - misuse/disregard/absence of medicines, health services, medical regimens
- ? Eccentric or idiosyncratic behavior
  - self-imposed isolation
  - marked indifference



Many of the indicators of caregiver neglect are also present with self-neglect in the absence of an abuser. These include poor personal hygiene, inadequate or dirty clothing, evidence of malnutrition and dehydration, misuse and inconsistencies in the use of medicines and medical devices and refusal of help in general including health care services.

At times, the challenge can be to distinguish between idiosyncrasy and eccentric behaviors reflecting the individual's lifestyle, or the role of poverty or serious health threatening actions and thoughts secondary to mental or physical illness.

## ASSESSMENT: CHART DESCRIPTORS

- “accident prone”
- “noncompliant of medical care”
- “diffuse anxiety disorder”
- “depression”
- “help-rejecting behaviors”
- impaired patient presenting alone
- ER visits: injuries, exacerbations of chronic illness under treatment
- caregiver hostility, anger, distress



Indirect clues in the medical chart that can suggest an abusive relationship include diagnoses or labels of accident prone, noncompliant of medical care, diffuse anxiety disorder, depression, help-rejecting behaviors, an impaired patient presenting for care unaccompanied by a caregiver and frequent visits to the emergency room for injuries and exacerbations of chronic illnesses currently being treated under a prescribed medical regimen

## ASSESSMENT: CAREGIVERS

- Majority: adult children, partners
- Clues on observation:
  - speech, tone, touch interactions
  - stands watch, monitors interactions
  - overly protective or lacking concern
  - answers questions directed to patient
  - continually tests limits of the visit
  - refuses to leave room when asked
- Hostile and surly to staff



The majority of informal caregivers are adult children, spouses and partners. Thus, they are well known to the patient. It is important to observe the speech, tone and touch interaction between the dyad as it can reflect caring, tension, disrespect, blaming, confronting, arguing and correcting.

Indirect clues that can suggest an abusive relationship include the caregiver who appears to lack concern about or in interest in the medical visit, closely monitors the interaction between victim and provider, is overly protective or solicitous to the patient, infantilizes the patient, answers questions directed to the patient, provides answers disparate to those from the patient, refuses to leave the room when asked and is hostile and surly to staff.

## CONFIRMING THE DIAGNOSIS

- Ubiquity statements:
  - “I don’t know if this is a problem for you, but because so many patients I see are dealing with abusive relationships, I have started asking about it routinely.”
  - “Because there is help available for my patients who are being abused, I now ask everyone about the possibility if it is occurring to them.”



Some patients will talk about abuse if they feel safe and supported. Integrating questions about elder abuse into the Present Illness or Review of Systems portions of the workup will provide that opportunity.

It can be helpful to make a statement of fact about elder abuse before asking a patient a direct question. The use of ubiquity statements that inform the patient that every patient is asked prior to asking the direct question will help the patient understand s/he is not being singled out and this is a routine part of the visit.

Effective screening includes asking the questions when alone with the patient, the use of clear and simple language and open-ended questions. Being attentive, facing the patient, making eye contact when possible and allowing silence with sufficient time for responses is important.

## CONFIRMING THE DIAGNOSIS

- Direct question examples:
  - “Does anyone threaten, hurt or abuse you?”
  - “Do you feel safe where you live?”
  - “Do you feel put down, made fun or ridiculed by your caregiver?”
  - “Are you afraid of anyone?”
  - “Do you feel your caregiver keeps you from doing what you want?”
  - “Are you made to stay in your room or left alone a lot?”



These are examples of direct questions that follow the ubiquity statements. For valid and useful information, this must be done when the provider is alone with the patient.

## CONFIRMING THE DIAGNOSIS

- Direct question examples:
  - “Do you call or get out with your friends and family?”
  - “Who does the shopping or prepares your meals?”
  - “Have you been forced to sign documents when you did not understand them?”
  - “Who handles your checkbook?”
  - “Does anyone steal money or take things from you?”
  - “Has your caregiver ever refused to help take care of you when you asked for help?”



These are additional examples of direct questions that follow the ubiquity statements.

## CONFIRMING THE DIAGNOSIS

- Direct questions: Sexual abuse:
  - “Have you been forced to do something sexually that you don’t want to do?”
  - “Does anyone force you to have sex or make you do things related to sex that make you feel uncomfortable?”



These are two examples of direct questions about sexual abuse.

## CONFIRMING THE DIAGNOSIS

- Direct questions: Lethality potential
  - “Has your caregiver ever threatened to kill you or himself?”
  - “Are there weapons in the house?”
  - “Does your caregiver hurt your pets?”
  - “Has the abuse increased in frequency or severity recently?”



Dr J Campbell of Johns Hopkins University has found these direct questions related to the risk of the abused person being killed useful to assess the potential for lethality.

## FOLLOW UP OF A **YES** ANSWER

- ☑ Give permission
  - ◆ validate the experiences and name it
  - ◆ identify abuse as a problem
  - ◆ affirm elder's right to safety
- ☑ Provide information
  - ◆ educate about dynamics of abuse
  - ◆ identify and refer to community resources
- ☑ Establish a follow up process



### **INTERVENTION**

The first priority is patient safety. The major roles of the provider are to offer support, encourage the patient with capacity to make change, document the abuse, provide appropriate referrals for protection and safety and report to the proper authorities. This is particularly essential for the patient who lacks capacity.

## FOLLOW UP OF A **YES** ANSWER

### ❖ Examples of responses:

- ◆ “I am concerned about your safety and well being.”
- ◆ “You are not alone.”
- ◆ “The abuse is not your fault; only your abuser can stop the abusive behavior.”
- ◆ “No one deserves to be abused; there is no excuse for abuse.”
- ◆ “There are options and resources available.”



These are some comments that can be made to assure and support the abused elder's right to safety and change. The primary message for the patient is that the abuser is responsible for the abuse and not the patient. That no one has the right to abuse the patient. That the abuse is not a transient or temporary occurrence, and that it will get worse over time. That there are safe options and that help is available.

## SAFETY PLANNING

- Respect patient's autonomy
- Respect patient's confidentiality
- Referrals: team approach
  - Adult Protective Services
  - Long-term care ombudsman
  - Law enforcement agencies
  - Emergency planning



Safety planning involves providing information about community resources and viable alternatives. As it is essential to respect the autonomy of a competent adult to make decisions, this is done in the context of inquiry about and then responding to the patient's wishes relative to intervention.

Referrals reflect the importance of a team approach to elder abuse. The phone numbers and hot lines of community resources should be provided. The relevant agencies can include Adult Protective Services, Long-term care ombudsman and the local law enforcement agencies. Organizations such as the Caregiver Alliance can provide guidelines to minimize burden and stress when there are non-abusing family caregivers who will benefit from a clear plan defining their role and division of responsibilities of care.

Emergency planning has to be instituted if lethality is a possibility. This can include hospitalization of the patient who is not competent, and notification of the local law enforcement agency of the potential risk.

## ADULT PROTECTIVE SERVICES

- Authorized and budgeted by California
- Integral part of safety planning
- Integral part of care plan
- Benefits:
  - prompt response and investigation
  - comprehensive psycho-social assessment of elder's needs
  - coordinate direct links to resources
  - advocacy and individual care plan



Reporting abuse to Adult Protective Services [APS] is an integral part of the care plan and of safety planning when elder abuse is suspected. California has authorized protective services for elders and for dependent adults [those with disabilities ages 18-64 years] who are victims of abuse. The latter are defined as those who have physical or mental limitations that restrict the ability to carry out normal activities or to protect their rights including providing for or protecting themselves. Emotional abuse is not listed as a specific requirement for reporting in California.

Major benefits of reporting abuse are that the victim will be given an advocate and options to keep safe from harm. In addition to promptly responding to and investigating directly a report, APS also can provide a comprehensive assessment of the elder's needs and then coordinate an individualized link to appropriate community resources. These include preventive and remedial supportive social, counseling and mental health, health care and legal services. When appropriate, the individualized care plan can be extended to the victim's family members and friends. There are no income or asset requirements or tests for these services to be provided.

## ADULT PROTECTIVE SERVICES

- Reporting:
  - Health practitioners are mandated reporters
    - legal protection of reporter
    - name not disclosed to victim, family, abuser
  - Requirements when abuse suspected:
    - abuse does NOT need to be confirmed
    - telephone when practically possible
    - formal written report [SOC 341], mail or fax within 2 working days



California health practitioners are mandated reporters. They are required to telephone as soon as practicably possible, and mail/fax a formal written report [SOC 341] within two working days when a competent elder or dependent adult ages 18-64 years directly reports abuse or when abuse is suspected. It is not required that the abuse be confirmed by the reporter. Legal protection of reporters acting in good faith from reasonable suspicion is provided. The name of the reporting party is confidential and is not disclosed to the victim, family or alleged abuser.

Failure to report is a misdemeanor punishable by jail, fine or both.

## ADULT PROTECTIVE SERVICES

- Reporting:
  - Failure to report: jail, fine or both!
  - If report is unsubstantiated: no penalty if report was made in good faith



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## OTHER COMMUNITY SERVICES

- Law enforcement agencies:
  - County Sheriff
  - Local police department
- Long-Term Care Ombudsman



If the abuse is occurring in a licensed care facility such as a nursing home or board and care facility, California has a Long-Term Care Ombudsman program. Its mission as mandated by California law is to empower residents and to act on their behalf through advocacy, mediation, complaint-investigation and resolution.

The local law enforcement agency should be immediately contacted in an emergency situation. This also applies when there is a risk of lethality.

## BACKGROUND OF A **NO** ANSWER

- ❖ Patient:
  - acceptance of blame
  - feeling of shame and embarrassment
  - fear of loss of independence
  - fear of reprisal and escalation
  - believes no viable alternatives exist
  - unaware of community resources
  - cultural and family structure issues
- ❖ **Practitioner: report still must be made!**



There are victims who will answer “no” in the presence of overt abuse. The reasons for doing so include lack of privacy and confidentiality, acceptance of blame, a feeling of shame and embarrassment, fear of reprisal and escalation, fear of loss of independence and particularly institutionalization, abandonment or conservatorship, fear of getting a family member in trouble, cultural issues related to family structure and personal values, belief that the provider cannot help, that no viable alternatives exist and lack of awareness of community resources.

A competent abused elder has the overriding right to choose a plan of life and action believed to be most viable. The provider has to avoid imposing upon the competent victim’s autonomy and decision making, and thus has to respect the no answer. However, information giving about safety and community resources and permission giving in the form of having the right to safety can be offered in a nonjudgmental and courteous manner.

Particularly important, the practitioner is still required to make the telephone call and written report to APS.

## BACKGROUND OF A **NO** ANSWER

- ❖ Practitioner:
  - trust relationship not yet established
  - inappropriate setting
  - lack of privacy and confidentiality
  - inappropriate history taking
  - inappropriate format



Every patient is a potential victim of abuse. Abuse is a health risk and thus well within the scope of normative health care practices that encompass identification of and intervention for illness and disease. All of the reasons listed above are readily remedial by a practitioner committed to the welfare of his or her patients.

## DOCUMENTATION

### ❖ Patient's Medical Record:

- ☑ date, time
- ☑ patient identifying information
- ☑ patient's statements
- ☑ findings on physical examination
- ☑ medical opinion/diagnosis
- ☑ treatment required
- ☑ follow-up and referral plans
- ☑ reporting requirements fulfilled



The medical chart should include all verbatim reports of abuse and answers to relevant questions by the victim, findings on physical examination including statements about the patient's appearance, emotional status and cognitive function, physical signs of abuse and neglect with a body map or photography [with consent] when appropriate, medical opinions, a follow-up plan, what referrals were provided and that legal reporting requirements were met with a phone call made when practically possible and the submission of the required written form [SOC 341].

## VARIABLE: CAPACITY

- Ability to care for oneself and make informed decisions:
  - normal mild declines with aging:
    - cognitive capacity
    - functional capacity
  - causes of impairment:
    - malnutrition, dehydration
    - manifestations of chronic illness
    - misuse or lack of use of medication, devices
    - *EMOTIONAL ABUSE*



### **BARRIERS**

The capacity to make informed decisions and the ability to care for oneself are functions of competency. With aging, there can be normal, mild declines in cognitive and functional capacity in areas such as memory, comprehension and concentration. Apparent cognitive impairment can result from malnutrition, dehydration, reversal facets of chronic illnesses [such as thyroid disease, vitamin deficiencies, depression] and misuse or lack of use of medications or access to medical assistive devices.

The appearance of impairment also can be secondary to emotional abuse.

## VARIABLE: CAPACITY

- Evaluation and assessment:
  - clinical manifestations:
    - variable loss of memory
    - variable loss of function
    - variable loss of one cognitive domain
  - office tools:
    - Mini-Mental State Exam, Mini-Cog, Six-item screen, MoCA
- Clinician's role: observe, provide opinion, not make a specific diagnosis



Cognitive dysfunction can influence whether the abused elder recognizes the abuse, is believed when reporting it or can decide on options for intervention. Impairment is characterized by variable loss of memory, loss of function and the loss of at least one cognitive domain [language, spatial relations, judgment]. Clues to its presence include appearing befuddled, repetitive speech, difficulty in comprehending speech, confabulation and distraction techniques.

Office tools that a provider can use to screen for cognitive status related to short term memory, language, orientation and concentration include the Folstein Mini-Mental State Exam, the Mini-Cog, the Montreal Cognitive Assessment and the Six-item Screener.

The clinician's responsibility is to make observations and provide an opinion. The actual diagnosis of the type and cause of impairment requires a detailed assessment usually performed by professionals knowledgeable and skilled in this area.

## VARIABLE: FAILURE TO SCREEN

- Lack of knowledge
- Legal concerns
- Discomfort in showing ignorance
- Sense of powerlessness
- Fear of offending patient or the abuser
- Minimization and denial
- Reluctance to become involved
- Time constraints



Potential reasons for reluctance to screen include lack of knowledge on how to proceed if abuse is suspected, unfounded legal concerns including the mandatory reporting requirements, reluctance to become involved, a sense of powerlessness in the belief change is not possible, fear of offending, minimization and denial, fear of the abuser and concern about time constraints secondary to an increased workload.

Ignoring the problem will not only place the patient in continued jeopardy, but will result in more time spent with the patient in repeated health visits, multiple workups and the treatment of the adverse impact of the abuse.

# TRUISM

“I don’t have enough time.”

**EQUALS**

“I don’t want to get involved.”

Reality testing. Willful ignorance and the ignoring of elder abuse are unethical and immoral.

## VARIABLE: CAREGIVER STRESS?

- Unintentional harm:
  - lack of necessary knowledge, training, skills
  - response to patient's aggressive behavior
- Intentional abuse:
  - characteristics of caregiver
  - exercise power and control
- Etiology for elder abuse ?:
  - blames the victim
  - discourages reporting suspected abuse



It is true that caregiving can be stressful, time consuming, overwhelming and hard work. It is also true that well-intended caregivers may hurt the person they are trying to help because they lack the necessary knowledge, training and skills or secondary to responding to aggressive behavior of the patient. This is unintentional.

Intentional abuse appears to be a function more of the underlying personality and characteristics of the caregiver who then responds to stress with abuse. The dynamics appear to be a purposeful exercise of power and control rather than loss of control per se.

Indicting caregiver stress as the etiology of abuse blames the victim as the cause and discourages reporting the suspected abuse. It denies the fact that intentional abuse is the problem, and that a crime is being committed. And it ignores the fact that the motivation for the intentional abuse can be domination and control by creating an imbalance between victim and abuser. To achieve this state, the abuser inflicts the various forms of abuse recurrently and chronically.

## VARIABLE: SYSTEM BARRIERS

- Lack of institutional support
- Disinterest of colleagues
- Lack of reimbursement for time and effort spent
- Overt and covert Ageism



The reality is that elder abuse is a complex issue and health care providers are only one of the links in obtaining safe alternatives. It is true that the health care provider cannot per se stop the abuse. And it is true that the provider cannot make choices for competent adults.

There can be lack of institutional support when a victim is identified, there may be disinterest on the part of colleagues and team members to recognize that the problem exists and there may be covert or even overt ageism. In our current health care system, there also can be lack of reimbursement for the time and effort spent.

## ASSESSMENT: CAREGIVER

- Direct question examples:
  - “What does X need help with every day?”
  - “How do you and X handle disagreements?”
  - “What expectations does X have of you?”
  - “Is caring for X different than you thought it would be?”
  - “Have you ever felt out of control when caring for X? What did you do?”
  - “What do you do or who do you tell when you are feeling stressed?”



These are some additional examples of direct questions.

## ASSESSMENT: CAREGIVER

- Ubiquity statements:
  - “Some people find it difficult to care for a parent with your mother’s condition. Do you?”
  - “Are you able to meet your personal and family needs?”
  - “Sometimes providing care for a family member is challenging. Do you ever feel like you will lose control?”



There is little value in the practitioner confronting a suspected abuser. It is doubtful that new information will be forthcoming, and it can place the patient at risk for additional abuse from retaliation. These three statements and questions are non-judgmental ways to start a discussion that can provide insight into what informational needs and advice may modulate caregiver behaviors and actions.

## ASSESSMENT: CAREGIVER

- Direct question examples:
  - “Now that you are caring for X, have your feelings become negative?”
  - “Is X physically or verbally abusive toward you?”
  - “Are you overwhelmed, confused, fearful, or angry as a result of being a caregiver?”
  - “Are problems from your family’s past resurfacing?”
  - “Are you neglecting your own health?”
  - “I am worried about the bruises on X, do you know how X got them?”
  - “Is there a reason for waiting this long to seek medical care for X?”



In this slide, X equals the senior’s name. Some clinicians will have caregivers as primary patients. According to the caregiver-patient’s responses to the ubiquity statement, these are examples of direct questions for further exploration.

## REFUSAL OF CARE

- **California Welfare and Institutions Code 15636:**
  - (a) Any victim of elder or dependent adult abuse may refuse or withdraw consent at any time to an investigation or the provision of protective services by an adult protective services agency or long-term care ombudsman program. The adult protective services agency shall act only with the consent of the victim unless a violation of the Penal Code has been alleged. A local long-term care ombudsman shall act only with the consent of the victim and shall disclose confidential information only after consent to disclose is given by the victim or pursuant to court order.



Competent adults, that is adults with capacity, in the absence of being a victim of an alleged criminal action, have the right to self-determination. This means that they can refuse help from or withdraw consent at any time to APS and other agencies. The right of the individual to autonomy applies in this instance. Legally competent victims retain all of their civil rights.

However, section (b) states: If the elder or dependent adult abuse victim is so incapacitated that he or she cannot legally give or deny consent to protective services, a petition for temporary conservatorship or guardianship may be initiated in accordance with Section 2250 of the Probate Code.



- Mission:
  - Identify and promote legal remedies for elder abuse through collaborative evaluation, consultation, education and research.
- Participating agencies:
  - UCI Program in Geriatrics
  - Adult Protective Services
  - Law enforcement agencies
  - District Attorney
  - Victim Assistance Program
  - Long-Term Care Ombudsman
  - Older Adult Mental Health Services
  - Human Options DV Services



The UCI Program in Geriatrics' Center of Excellence in Elder Abuse and Neglect created the Orange County Elder Abuse Forensic Center in 2003. Its mission is to identify and promote the appropriate legal remedies for elder abuse through collaborative evaluation, consultation, education and research. It accomplishes this through formal weekly team review of cases brought to it by one of its member agencies, in home evaluations to determine the presence of abuse and assess cognitive function, medical record review and serving as expert witnesses.

The agencies include UCI geriatric medicine via its Vulnerable Adult Specialist Team [VAST], adult protective services, local law enforcement agencies, office of the district attorney, public guardian and public administrator, geropsychologists, older adult mental health services, domestic violence assistance program, the human options domestic violence shelter and long term care ombudsman.

## SUMMARY: FACTS

- Elder abuse:
  - a reality in our society
  - increasing prevalence
  - present in all demographics
  - most is unrecognized by clinician
  - **can be addressed effectively through collaborative, coordinated community resources**



### SUMMARY

Elder abuse is a fact in our society and in our patients. Elder abuse is increasing and will continue to do so. Elder abuse cuts across all demographics. Most elder abuse is unrecognized.

The problem of elder abuse is complex with multiple ethno-cultural, social and economic facets. However, it can be addressed effectively through collaborative, coordinated community resources.

## SUMMARY: AGENTS OF CHANGE

### ❖ Practitioners can:

**R**outinely integrate questions

**A**sk ubiquity and direct questions

**D**ocument findings

**A**ssure patient safety

**R**efer to community resources



Health providers have the opportunity and the ability to identify and help a victim of abuse. This is done by being familiar with the signs, symptoms and impact of abuse on the patient, by routinely asking direct questions related to abuse, by documenting the findings, by identifying and encouraging the abused elder and their significant non-abusing others to access safe alternatives and by reporting and referring to appropriate community resources.

Anne Flitcraft MD at the University of Connecticut devised this helpful mnemonic.

## GOALS

Elder Abuse must become a  
**CULTURAL TABOO**

**ZERO** tolerance of Elder Abuse

Goals for our society.

## RESOURCES: NATIONAL

- AARP: [www.aarp.org](http://www.aarp.org)
- UCI Center of Excellence in Elder Abuse and Neglect: [www.centeronelderabuse.org](http://www.centeronelderabuse.org)
- Administration on Aging: [www.aoa.gov](http://www.aoa.gov)
- National Center on Elder Abuse: [www.ncea.aoa.gov](http://www.ncea.aoa.gov);
- American Bar Association Commission on Law and Aging: [www.abanet.org/aging](http://www.abanet.org/aging)
- American Society on Aging: [www.asaging.org](http://www.asaging.org); [Generationsjournal.org](http://Generationsjournal.org)
- Family Caregiver Alliance: [www.caregiver.org](http://www.caregiver.org)
- Clearinghouse on Abuse and Neglect of the Elderly: <http://db.rdms.udel.edu:8080/CANE/>



Some national resources for various aspects of elder abuse and caregiving.

## RESOURCES: NATIONAL

- Eldercare Locator: [www.eldercare.org](http://www.eldercare.org)
- Lesbian and Gay Aging Issues Network:  
[www.asaging.org/Networks](http://www.asaging.org/Networks)
- National Clearinghouse on Abuse in Later Life:  
[www.ncall.us](http://www.ncall.us)
- National Committee for the Prevention of Elder Abuse:  
[www.preventelderabuse.org](http://www.preventelderabuse.org)
- National Council on the Aging: [www.ncoa.org](http://www.ncoa.org)
- Nursing Home Database:  
[www.medicare.gov/Nursing/Overview](http://www.medicare.gov/Nursing/Overview)



An additional selection of national resources.

## RESOURCES: ORANGE COUNTY

- UCI Center of Excellence on Elder Abuse and Neglect  
[www.centeronelderabuse.org](http://www.centeronelderabuse.org)
- Adult Protective Services 800 451 5155
- Sheriff: 714 834 3636
- Long-Term Care Ombudsman 800 300 6222
- Office on Aging 800 510 2020
- Forensic Center Coordinator 714 825 3087

**Download form SOC 341 [www.aging.ca.gov](http://www.aging.ca.gov)**



Each county has similar local resources.

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Insert additional resource information pertaining to your audience

Thanks to Ron Chez, MD for his work on this presentation.

