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## Abuse of the Older Person: Is this the case you missed last shift?

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The Australian Network for the Prevention of Elder Abuse specifies that elder abuse is “*any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect.*”<sup>1</sup> Elder abuse can occur in any setting where an older person is targeted based on age or disability.<sup>2-4</sup> Different types of elder abuse commonly occur together.

A New South Wales (NSW) Parliamentary Standing Committee held a review on elder abuse in 2016<sup>5</sup>, identifying that Emergency Department (ED) staff are at the front line of identification of elder abuse. Furthermore, an Australian Law Reform Commission inquiry will report in 2017<sup>6</sup>, with the aim of optimising legal frameworks to safeguard older Australians. Community awareness is key in elder abuse, as it is with other forms of violence. It reflects social norm and the lens through which we as emergency physicians assess, diagnose and manage abuse.<sup>7</sup> In an Australian study, Helmes describes our society as having less value for older people, where doctors may be reluctant to report elder abuse when they having competing demands and where the consequences of reporting may leave victims more isolated particularly where perpetrators are “caregivers”.<sup>7</sup>

Elder abuse is associated with as much as a three-fold higher mortality,<sup>8–12</sup> as well as higher rates of ED visits, unplanned hospitalisation, depression and nursing home placement.<sup>3,11,13–15</sup> Australian research is limited but suggests a prevalence of approximately 6%<sup>8</sup> in older women. Table 1 outlines the definitions and assessment findings of different types of abuse.<sup>3,16–19,20–23</sup>

Victims of abuse often live in social and medical isolation, only receiving healthcare or access to non-abusers when they present to the ED.<sup>24</sup> With only about 5% of cases identified and reported in the US,<sup>13,14</sup> it is critical that ED clinicians are able to identify and respond appropriately to potential elder abuse.<sup>7</sup> Documented risks include female gender; poor physical health; cognitive impairment, particularly with disruptive behaviours; poor future planning; and a dysfunctional family setting.<sup>3,11</sup> 50% of perpetrators<sup>16</sup> are a victim's child and 14% are their spouse. Risk factors for perpetrators include drug and alcohol dependence; mental illness; financial dependence on the victim; and carer stress.<sup>3,8,11,25</sup> (Figure 1)

### Scenario 1: Is it a “fall”?

Fred, a 92-year-old male with moderate dementia lives with his 71-year-old son. He presents with hip pain after a fall 12-hours earlier while walking to the bathroom before bed. Although forgetful and a difficult historian, he reports that the injury occurred when he tripped over a rug. He had to awaken his son by crying out because he couldn't get back up. Fred is unkempt with soiled clothes and appears cachectic. Examination reveals a grade-2 sacral pressure injury. His son is unable to be contacted and when he later arrives he gives unclear answers.

In Fred's case, was his fall accidental or could his injuries represent elder abuse? Injuries of elder abuse victims are often falsely reported to have occurred due to a fall.<sup>13,26</sup> Given the ED commonly sees older people with falls, some will inevitably be hidden cases of elder abuse. A high index of suspicion is required by ED clinicians.

Fred's delayed presentation and appearance are other indicators to prompt further enquiry. Neglect is one of the commonest forms of elder abuse.<sup>17,23</sup> This is the failure of a caregiver to provide the necessities of life to an older person, including adequate food, accommodation, clothing and access to medical care and medications.<sup>18,27,28</sup>

ED management should include:

- Carefully considering whether the injuries are consistent with the reported mechanism
- Collateral history from other members of his family, his medical record and General Practitioner (GP).
- Time and thoughtfulness spent with his son, to better understand his reluctance to talk. Is he exhausted with limited supports in caring for Fred? Is he worried Fred may need placement? Does he have medical problems of his own? Has he become isolated from family and friends?

- Referral to social workers and / or advanced practice nurses with an understanding of elder abuse and the community resources, such as elder abuse helplines,<sup>29</sup> that may be available to support Fred and his son will greatly assist the time- or knowledge-poor ED physician.
- Admission to hospital may be required to allow confirmatory evidence to be collated and a safe disposition arranged.

## **Scenario 2: Patient Transferred from Residential Aged Care Facility (RACF) with Agitation**

Connie, an 87-year old woman, is transferred to the ED from her RACF. Connie is moaning and calling out but otherwise unable to provide any history. Scratches are noted on Connie's forearms, with bruising and tenderness on the ulnar aspect of her right forearm. Right forearm x-ray reveals a new ulnar fracture, consistent with a defensive injury. Family members are contacted and explain that they and the RACF staff have noted Connie to be more confused than usual. It was thought that this coincided with her roommate, who also has dementia, becoming more disruptive towards Connie, frequently yelling at her.

270,559 people lived in Australian RACFs at some point during 2013–4, representing 7.8% of the population aged over 65 years.<sup>30</sup> As at least 30 transfers from RACF to the ED occur per 100 RACF beds annually,<sup>31–33</sup> aged care residents represent a substantial fraction of older adult ED presentations.<sup>34</sup> These are the most vulnerable older adults in society<sup>32,35</sup> and may become victims of mistreatment.<sup>36–39</sup> While staff mistreatment in RACF environments still occurs, likely contributed to by poor wages, low staff-to-patient ratio, high staff turnover, and inadequate training or supervision,<sup>40,41</sup> resident-to-resident elder mistreatment is likely much more common.<sup>38,42,43</sup> Dementia and associated aggressive behaviors in RACF residents is high<sup>30,41</sup> predisposing to verbal, physical, and even sexual mistreatment between residents. A recent US study found that more than 20% of RACF residents had been victimized by another resident during the previous month.<sup>42</sup> This can cause severe physical and psychological injury and even death.<sup>42</sup>

Collateral history and a thorough examination will aid detection. For patients able to report, questions about safety and experience of mistreatment should be asked in the ED. Research findings suggest that physical elder abuse victims are likely to have injuries on their maxillofacial area, head, and upper extremities. Injuries to neck or ulnar forearm are particularly concerning for abuse.<sup>27,28</sup>

## **Scenario 3: Financial abuse, fraud is a major crime**

Lorena is a 93-year-old woman with no family who had previously lived alone. She has been admitted to your hospital four times this year. During one admission she was befriended by a man and woman she had never previously met. On discharge from hospital, Lorena moved into the couple's home ostensibly for care as she wanted to avoid RACF placement. The couple brought Lorena back to the ED today with breathlessness. During the history taking, Lorena volunteers that she has not been taking her prescribed medication from her recent

discharge because the couple have told her they cannot afford all her pills, despite the fact that Lorena has periodically transferred large sums from her life savings into accounts controlled by the couple. Further questioning reveals Lorena has put her house on the market, as she “no longer needs it”.

Financial abuse tends to co-occur with psychological abuse, with the victim fearful of their “carers”.<sup>5</sup> As well as being frightened for their safety, victims are typically embarrassed by their situation and may be reluctant to divulge details. If they are dependent on the perpetrator for access to care, food, clothing and accommodation, intervention may risk their living situation.<sup>3</sup> Financial abuse often involves the victim’s children rather than strangers,<sup>44</sup> a phenomenon known as “inheritance impatience”.<sup>16</sup>

Such scenarios may require specialist geriatrician or psycho-geriatrician assessment of capacity as perpetrators have been known to misrepresent an older adult’s capacity for financial gain. In general, capacity is task specific and depends on the complexity of decisions to be made.<sup>45</sup> Ultimately, financial guardianship can be sought from authorised bodies if the individual does not have decision-making capacity and their designated Power of Attorney appears to be financially exploiting the situation. Facilitated family discussions and elder mediation have a role to play.<sup>46</sup>

Emergency physicians will only infrequently identify financial exploitation. It may not have immediate health consequences, though it may lead to neglect, as in this case. Remember, all cases of abuse, including financial abuse are associated with increased mortality.<sup>10</sup> We should take seriously a report by an older adult of financial exploitation, even if the patient has a dementing illness. If you are not sure, it is just as important to refer cases of possible financial abuse to social workers, state-based elder abuse services or police, for further assessment.

## Conclusions

Elder abuse is common, under-recognised, and simultaneously serious and complex.<sup>47</sup> Many victims suffer from multiple types of abuse. It often requires cooperation from multiple government and non-government agencies. EDs should have guidelines in place for the management of elder abuse.<sup>48,49</sup> As part of our health advocacy role, emergency physicians should have a proactive approach to identifying and supporting victims. Where appropriate, referral to a social worker and facilitating admission for victim safety are common first line responses. Police and (in Australia) state based elder abuse services can be contacted for further support in investigation and management.<sup>29</sup>

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## Identifying Elder Abuse

### What to look for (signs of abuse)

- Carer hovers around older person
- Unkempt appearance
- Ill-fitting clothes or underweight
- Not dressed for weather
- Poor hygiene or unsanitary conditions
- No food in the house, unpaid bills
- Overly paranoid or excessive fear
- Limited access to money/bank account.

### Elder abuse can take many forms

**Financial:** Misuse of money, bank accounts or powers of attorney.

**Psychological:** Verbal abuse, belittling or name calling, isolating older person from others.

**Neglect:** Failure to provide for basic needs eg. food, heating or healthcare.

**Physical:** Assault, shoving or rough handling, physical or chemical restraint.

**Sexual:** Any unwelcome sexual behaviour or act, can include inappropriate washing or handling.



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## Responding to Elder Abuse

### **Talk/Listen to the older person**

Ask the person if they feel safe to talk and arrange for privacy if necessary.

### **Do not just rely on information from family or carers**

Exclude if needed.

### **Respect the right of the older person to decide for themselves**

(eg. Finances, who lives with them etc.)

### **If you suspect abuse, take action**

- Call an ambulance, a social admission to hospital can prevent further abuse.
- Consult the DO, DVLO or CPO.
- Record all details on COPS.
- Contact myagedcare for service assessment.
- Call EAHRU for advice.



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**Figure 1.**

**Table 1**

Types of elder mistreatment and guidance for assessment in the ED

Types of mistreatment and its definition	Estimated Prevalence <sup>17</sup>	Evaluation questions	Observation
<b>Financial exploitation</b> <ul style="list-style-type: none"> <li>• Unauthorised or improper use of property or finances.</li> <li>• Misappropriation of money, valuables or property</li> <li>• Forced changes to a will or other legal document</li> <li>• Denial of the right of access to, or control over, personal funds.</li> </ul>	<ul style="list-style-type: none"> <li>• 1–9%</li> </ul>	<ul style="list-style-type: none"> <li>• Is your money used without your permission or stolen?</li> <li>• Have you been forced to sign any legal document or documents that you didn't understand against your will?</li> <li>• Does your caregiver depend on you for shelter or money?</li> </ul>	
<b>Neglect</b> <ul style="list-style-type: none"> <li>• Failure of a caregiver to provide the necessities of life to an older person</li> <li>• Not providing adequate food, shelter, clothing, medical care, or dental care</li> <li>• Refusal to permit other people to provide appropriate care.</li> <li>• Underuse of medication; and poor hygiene or personal care.</li> </ul>	<ul style="list-style-type: none"> <li>• 0–6%</li> </ul>	<ul style="list-style-type: none"> <li>• Is your home safe?</li> <li>• Has anyone not helped you when you needed it?</li> </ul>	<ul style="list-style-type: none"> <li>• Poor hygiene</li> <li>• Cachexia</li> <li>• Pressure injuries particularly those with no evidence of active management</li> </ul>
<b>Psychological abuse</b> <ul style="list-style-type: none"> <li>• Threatening or coercive</li> <li>• Actions that cause fear of violence, isolation or deprivation</li> <li>• Controlling behaviour including access to transport, telephone, money</li> <li>• Humiliation, harassment</li> <li>• Threats of physical harm or institutionalisation</li> </ul>	<ul style="list-style-type: none"> <li>• 1–6%</li> </ul>	<ul style="list-style-type: none"> <li>• Are you sad or lonely often?</li> <li>• Do the people who care for you threaten you with punishment or being put in an institution?</li> <li>• Are medications or foods ever forced on you?</li> <li>• What happens if you and your caregiver disagree?</li> </ul>	<ul style="list-style-type: none"> <li>• Caregiver who insults, threatens or infantilises the patient</li> </ul>
<b>Physical abuse</b> <ul style="list-style-type: none"> <li>• Injured, assaulted or threatened</li> <li>• Hitting, pushing, burning</li> <li>• Physical restraint and overmedication.</li> </ul>	<ul style="list-style-type: none"> <li>• 0–5%</li> </ul>	<ul style="list-style-type: none"> <li>• Do you trust most of the people in your family?</li> <li>• Are you afraid of anyone at home?</li> <li>• Do you feel safe at home?</li> <li>• Has anyone close to you tried to hurt or harm you recently?</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple injuries at varied stages of healing;</li> <li>• Traumatic alopecia</li> <li>• Broken teeth</li> <li>• Patterns of bruises inflicted by object with characteristic shape / clustering of bruises</li> </ul>

Types of mistreatment and its definition	Estimated Prevalence <sup>17</sup>	Evaluation questions	Observation
		<ul style="list-style-type: none"> <li>Have you been locked in a room or tied down?</li> </ul>	<ul style="list-style-type: none"> <li>Bilateral arm bruises; burns (ropes, cigarettes, iron, hot water)</li> </ul>
<b>Sexual abuse</b> <ul style="list-style-type: none"> <li>Sexual contact against the older person's will</li> <li>Unable to understand the act or communicate</li> <li>Indecent assault, sexual harassment, violent rape.</li> </ul>	<ul style="list-style-type: none"> <li>0–1%</li> </ul>	<ul style="list-style-type: none"> <li>Has anyone touched you sexually without your permission?</li> </ul>	<ul style="list-style-type: none"> <li>Bleeding, discharge or lacerations in rectum or vagina</li> </ul>

Evaluation questions and observations adapted from various resources<sup>20–23</sup> Estimated prevalence from WHO for high and middle-income countries<sup>17</sup>