Elder Abuse and Self-Neglect: Assessment & Intervention

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Case Example: Ms. P

- 92 year-old woman, admitted to hospital
- Chief complaint: Fall, back pain
- History:
  - Gathering trash in house
  - Misstep, tripped, fell. No LOC.
  - “Wedged” between couch and wall
  - Stuck overnight until neighbor arrived

Medical Hx:
- HTN
- Stable CAD
- On very few meds
- Well nourished
- Physical exam unremarkable

Social/Functional Hx:
- Lives alone
- Divorced, 2 kids closeby
- Ambulates with cane
- Independent with ADLs and IADLs

Hospital Course:
- Cognition appeared normal, no delirium
- Workup negative for fracture, ICH, acute coronary syndrome, infection
- Lab abnormalities:
  - Mild hypokalemia, low B12 (183)
- PT evaluation:
  - Independent with ambulation (with cane)

Ready for discharge...

Email received from patient’s son to social worker, expressing concerns...

My response:
Ms. P’s response:

I’m going home.

(Period.)

Clinical Questions

• Is this elder abuse?
  • Does hoarding = self-neglect?

• Is it safe for her to return home?

• Does she have the capacity for self-care?

Objectives

• Definition of elder abuse and scope of problem
• Assessment, screening
• Review of decision-making capacity
• Management and intervention
• Role of primary care provider

Definitions

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Use of physical force that may result in bodily injury, pain, or impairment</th>
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<tbody>
<tr>
<td>Psychological/Verbal Abuse</td>
<td>Infliction of anguish, pain, or distress through verbal or non-verbal acts</td>
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<tr>
<td>Sexual Abuse</td>
<td>Non-consensual sexual contact of any kind with an elderly person</td>
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<tr>
<td>Financial Exploitation</td>
<td>Illegal or improper use of an elder’s funds, property or assets</td>
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<tr>
<td>Neglect</td>
<td>Refusal, or failure, to fulfill any part of a person’s obligations or duties to an elder</td>
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American Psychological Association, 2010

Prevalence – Community Dwellers

• Survey of >4,000 older adults in NY state: Rate of elder abuse: 14.1%¹
• Survey of >3000 U.S. older adults: 9% (verbal abuse)²
• Phone survey of >5000 U.S. older adults: 10%³

General prevalence: 10%

• Higher in dementia:
  • In person survey of patients and caregivers: 47.3% (n=129)⁴

**Prevalence: Long Term Care**

- Study of 2000 nursing home residents\(^1\):
  - 44% reported they had been abused
  - 95% of residents reported seeing another resident being abused

- Study of 24 nursing facilities\(^2\):
  - 50% of staff admitting to mistreating patients within the prior year (physical violence, psychological abuse)

\(^1\) Broyles, K. Atlanta Long-Term Care Ombudsman Program, 2000.

- 5% of the 78 million baby boomers will reside in a nursing home at any given time. (3.9 million people)

**Risk Factors for Elder Abuse**

- Cognitive impairment
- Ethnic minorities
- Functional impairment/poor physical health
- Adult child being dependent on older adult
- Living in isolation
- Hx domestic violence in the home

**Who are the perpetrators?**

- Adult children
- Spouses
- More often male
- Hx past or current substance abuse
- Mental or physical health problems
- Unemployed, financial/job stress
- Hx criminal record

**PCPs tend to NOT report**

- <2% of reports of elder abuse/neglect to APS come from physicians\(^3\)
- Survey of ~400 family physicians/internists:
  - 80% could not recall any med school or residency training on elder abuse\(^2\)
  - 96% wanted more training\(^2\)

\(^2\) Kennedy RD. Fam Med. 2005.

**PCPs tend to NOT report – why?**

- Signs are subtle, victims are in denial
- Lack of knowledge about reporting procedures
- Concern about losing doctor-patient rapport
- Concern about retaliation
- Fear of liability
- TIME limitation
Suspected Elder Abuse: Clinical Evaluation

Should we formally screen everyone?
- USPSTF is not sure.
  “The current evidence is insufficient to assess the balance of benefits and harms of screening all elderly/vulnerable adults for abuse and neglect”
- Inadequate evidence on accuracy or that early detection reduces exposure
- Screening tools difficult in dementia
- PCPs are not trained to intervene
  Dong, X. JAGS, 2015

Assessment – General Tips
- Interview patient alone
- Address caregiver burden
- Adopt a sympathetic, nonjudgmental approach
- Use “I” statements, give examples/choices
- Can start with open-ended, indirect questions, move to direct
- The interview of suspected abuser is best left to APS
  • Aggressive accusations/confrontation may escalate abuse

Assessment – General Tips
Conduct standardized assessments of depression, anxiety, cognition
- Geriatric depression scale
- MOCA, MMSE
- Mini-cog (clock draw)

Indicators of Physical Abuse
- Abrasions, bruises
- Lacerations, burns
- Fractures
- Use of restraints
- Pain with no other explanation
- Depression/anxiety
- Delirium with no other explanation

Physical Abuse: Tips and Caveats
- Ask directly how injuries were sustained
  • Note findings that are discordant with mechanism reported
- Remember older adults may bruise spontaneously
- Falls typically result in fx to orbital and nasal bones
  • Not jaw/zygomatic fx
- Long bone fx’s can occur spontaneously in absence of physical abuse in bedbound pts
**Indicators of Verbal/Psychological Abuse**

- Direct observation of verbal abuse
- Subtle signs of intimidation
  - Deferring questions to a caregiver or potential abuser
  - Also common in dementia/depression
- Evidence of isolation of victim from previously trusted friends/family members
- Depression, anxiety

**Verbal/Psychological Abuse: Tips and Caveats**

- “Does your son or daughter ever yell or curse at you?”
- “Have you been threatened with being sent to a nursing home?”
- “Are you prevented from seeing friends/family members whom you wish to see?”
- Assess size/quality of patient’s social network
  - “How may people to you see/speak to on the telephone each day?”
  - “Who would assist you in the event of an accident/emergency?”

**Indicators of Sexual Abuse**

- Bruising, abrasions, lacerations in anogenital area or abdomen
- Newly acquired STI
- (Similar to manifestations of sexual violence in younger adults)

**Sexual Abuse: Tips/Caveats**

- Inquire directly about sexual assault or coercion in any sexual activity
- ED referral if indicated (pelvic/forensic exam)
- May involve hypersexual behaviors in dementia, especially in long term care
  - Raises fundamental issues about capacity in older persons with dementia to consent to sexual activity

**Indicators of Financial Abuse**

- Inability to pay for food, rent, medical care, etc.
- Nonadherence, failure to renew rx’s or keep appts
  - Red flag behaviors with controlled meds
- Malnutrition, weight loss without obvious medical cause
- Evidence of poor financial decision making
- Firing of home care or other services by abuser
- Unpaid utility bills, eviction
Financial Abuse: Tips/Caveats

• “Who makes decisions regarding your finances?”
• “Has money or property been taken from you without consent?”
• “Have people called your home to try to get you to send/wire money to them?”
• “At the end of the month, do you have enough money for food, rent, utilities...?”

Red flags:
  • Abrupt changes in long time banking, spending patterns
  • Older person inaccurately designated as lacking financial capacity

Signs of Neglect

• Decubitus ulcers
• Malnutrition
• Dehydration
• Poor hygiene
• Nonadherence to medication regimen
• Delirium without any other explanation

Neglect: Tips/Caveats

• Thorough clinical exam to assess status of chronic illnesses, nutrition, cognition
• Interview primary caregiver about understanding of patient’s care needs
• Neglect may be unintentional due to:
  • Frailty, cognitive impairment, mental illness in the caregiver
  • Limited health literacy of caregiver

Indicators of Self-Neglect

• Poor hygiene, unclean living quarters
• Insect/rodent infestation
• Lack of food/utilities
• Failure to pay bills, loss of benefits/services
• Extended time between PCP appointments, poor adherence to medications
• Compulsive hoarding
  Look for a CHANGE in behavior/new onset of signs

Compulsive Hoarding

• Diogenes Syndrome: Behavioral disorder characterized by domestic squalor, extreme self-neglect, hoarding, and lack of shame regarding one’s living condition
  • Variant of self-neglect
  • Can be associated with mental illness/dementia
  • Stress reaction to emotional trauma, personality disorders (obsessive-compulsive)
  • Patients often average to above-average intelligence
  • 46% five-year mortality

Approach to Self-Neglect

• Evaluate patient’s decision-making capacity
• Evaluate their willingness to accept services
  It must be presumed that an older adult has decision-making capacity until determined otherwise
Review of Decision-Making Capacity

Capacity:
- Medical decisions
- Depends on decision
- Loss of capacity may be transient
- Consent vs. assent
- Anyone can assess

Competency:
- Legal term, judge's ruling
- Factors involved:
  - Medical diagnosis
  - Age, education
  - Personal eccentricity

Elements of Decision-Making Capacity

- Understanding
  - Comprehension of appropriately communicated info
  - Retention
  - Perception of relationship between intervention and outcome

- Appreciation
  - Relationship of information with circumstances
  - Insight

Elements of Decision-Making Capacity

- Reasoning
  - Ability to compare between different alternatives
  - Describe consequences associated with options

- Expressing a choice
  - Articulation of a clear choice with regard to a specific decision
  - Why this choice is superior

Is decision-making capacity impaired?

- Refer to psychiatrist/neuropsych for eval
- May refer to APS

- Report to APS
- Follow-up frequently
- Home health referral
- House call by clinician

- Can it be restored?
  - Yes
    - Medication review
    - Treat illnesses that may impair cognition
  - No
    - Report to APS

Adapted from Mosqueda L & Dong X, JAMA, 2011

Reporting and Intervention

- Adult Protective Services: Receives mandatory reports of suspected abuse in most states
- LTC Ombudsman: Handles concerns regarding the rights of residents receiving long-term care
- Home Health, Medical providers: Important for detection of abuse
- Community non-governmental/non-profit services: Can help mitigate abuse (senior centers, home visits, programs, care managers)
- Police: Should be notified first if there is immediate danger
- Housing authority: Issues such as eviction, squatting, misuse of housing
- Legal services: Handle living wills, guardianship
### Mandatory Reporting in Pennsylvania

Employee or Administrator of a facility who has reason to suspect abuse or neglect

- Assisted living facility/personal care home
- Nursing facilities
- Home Health Agency
- “An organization or group of people who uses public funds and is paid, in part, to provide care and support to adults in a licensed or unlicensed setting”

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### Mandatory Reporting in Pennsylvania

- Written report must follow within 48 hours of oral report
- An Administrator or Employee of a facility who has reason to suspect sexual abuse, serious bodily injury, or death that is suspicious will immediately make a report to law enforcement officials
- Reporters may remain anonymous and have legal protection from retaliation, discrimination, civil/criminal prosecution
- Failure to report is a crime

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### General Tips: Reporting/Documentation

- Compassionately explain to patient/caregiver that a report will be made
- Except where there is concern about escalating violence
- Info to have ready: demographics, level of physical/mental capacity, details of situation
- Documentation:
  - Physical signs/sxs, emotional state, direct quotes, effort made to assist the patient
  - Date case was referred to APS, who made report, with whom you spoke

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### What Happens after an APS Report

- APS will investigate the allegations within 72 hrs
  - Determine if substantiated
  - Physician/provider may be asked to provide evidence from the physical exam/history regarding capacity
- Provide services to adults who voluntarily consent
  - Decision-making capacity is assumed until proven otherwise
- Provide guardianship if needed
- Cooperatively develop a plan for services
  - Goal is to provide services in the least restrictive environment

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### Patients who decline services

- Align with the patient, build trust
  - “I agree that it’s really important to keep you in your home – let’s talk about what we can do”
  - “Can you tell me what concerns you have about letting someone come in your home to help you?”
- Make a home visit if able
- Help the patient create a plan for worst-case scenario
  - “What if you fell, broke your hip, and needed 24-hour care? How would you want your care to proceed?”
  - If the goal is to remain at home, consider hospice as an appropriate intervention

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### Take-Home Points

- Elder abuse is prevalent — you will see this in clinical practice if you are aware of the signs
- Suspected abuse should be reported to APS
- Remember the 4 elements of decision-making capacity
  - Understanding, appreciation, reasoning, expressing a choice
- Intervention requires a multidisciplinary team
Outcome of Case: Mrs. P.

- Electrolytes, B12 repleted
- Discharged to home, transportation arranged
- Physically unable to get into the house
- Returned to hospital for placement in a nursing facility

OPEN DISCUSSION:
Other examples? Challenging cases?

Who to Call

- Reports to APS (24 hr):
  - 412-350-6905 or 1-800-490-8505
- Questions for APS: 717-736-7116
- Area Agency on Aging Senior Line:
  - 412-350-5460
- ReSOLVE Crisis Network: 1-888-796-8226

Web Resources

- Pennsylvania Adult Protective Services: http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/#.VvhboNrlZ4
- Area Agency on Aging: http://www.alleghenycounty.us/Human-Services/About/Offices/Area-Agency-on-Aging.aspx
- National Center on Elder Abuse: http://www.ncea.aoa.gov/index.aspx