SPECIAL CONSIDERATIONS
WHEN ASSESSING ELDER ABUSE AND NEGLECT
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Presentation Objectives

Participants will be able to:
- Describe elder abuse and neglect
- Select and utilize key questions to use during a diagnostic interview to identify the presence of elder abuse or neglect
- Discuss use of assessment tools to identify elder abuse or neglect
- Discuss specific ethical issues when working with older adults and reporting elder abuse or neglect
- List and critique PA specific mandated reporting law

Myth or Truth

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<th>Myth or Truth</th>
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<tr>
<td>Most incidents of elder abuse/neglect occur in a nursing home or residential setting.</td>
<td>It is easy to make the distinction between normal interpersonal stress and abuse.</td>
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<td>Only older adults who have poor physical health or cognitive impairments are vulnerable to abuse/neglect.</td>
<td>Most victims of elder abuse/neglect are victims of physical abuse.</td>
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Defining Elder Abuse

Elder abuse is the infliction of physical, emotional/psychological, sexual, or financial harm on an older adult.

Elder abuse can also take the form of intentional or unintentional neglect of an older adult by the caregiver.

Physical Abuse

Physical abuse can range from slapping or shoving to severe beatings and restraining with ropes or chains. Physical abuse can include hitting, beating, pushing, shoving, kicking, pinching, burning, or biting. It also includes the inappropriate use of medications and physical restraints and physical punishment of any kind. When a perpetrator uses enough force to cause unnecessary pain or injury, the behavior can be regarded as abusive.

Verbal, Emotional, or Psychological Abuse

Verbal, emotional, or psychological abuse can range from name calling or giving the “silent treatment” to intimidating and threatening the individual. When a perpetrator behaves in a way that causes fear, mental anguish, or emotional pain or distress, the behavior can be regarded as abusive. Verbal and emotional abuse can include yelling, swearing, and making insulting or disrespectful comments. Psychological abuse involves any type of coercive or threatening behavior that sets up a power differential between the older adult and the perpetrator. It can also include treating the older person like a child and isolating the person from family, friends, and regular activities—through force, threats, or manipulative behavior.
Sexual Abuse

Sexual abuse can range from sexual exhibition to rape. Sexual abuse can include inappropriate touching, photographing the person in suggestive poses, forcing the person to look at pornography, forcing sexual contact with a third party, or any unwanted sexualized behavior. It also includes rape, sodomy, or coerced nudity. Sexual abuse is the least reported type of elder abuse.

Financial Abuse

Financial abuse and exploitation can range from misuse of an older person’s funds to embezzlement. Financial exploitation includes fraud, taking money under false pretenses, forgery, forced property transfers, purchasing expensive items with the older person’s money without that person’s knowledge or permission, or denying the older person access to his or her own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships. It also includes a variety of Internet, telephone, and face-to-face scams perpetrated by sales people—or even by so-called friends—for health-related services, home repair services, mortgage companies, and financial services.

Neglect

Caregiver neglect can range from withholding appropriate attention from the older adult to intentionally failing to meet the physical, social, or emotional needs of that person. Neglect can include failure to provide food, water, clothing, medications, and assistance with activities of daily living or help with personal hygiene. If the caregiver is responsible for paying bills for the older person, neglect can also include failure to pay the bills or to manage the older person’s money responsibly. Caregivers may inadvertently neglect their older relatives because of their own lack of knowledge, resources, or maturity.

Signs & Symptoms of Elder Abuse

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<tr>
<th>Physical</th>
<th>Psychological</th>
<th>Sexual</th>
<th>Financial</th>
<th>Neglect</th>
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<td>Bruises/</td>
<td>Uncommunicative</td>
<td>Unexplained vaginal or anal bleeding</td>
<td>Inconsistency between life circumstances and financial assets</td>
<td>Lack of hygiene care, food, water, or clothing</td>
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<tr>
<td>rope marks</td>
<td>and unresponsive</td>
<td>Unexplained vaginal or anal bleeding</td>
<td>Inconsistency between life circumstances and financial assets</td>
<td>Lack of medical aids, missing medications, delay in seeking care</td>
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<td>or welts</td>
<td>Fearfulness or suspiciousness without reason</td>
<td>Unexplained injuries</td>
<td>Lack of medical aids, missing medications, delay in seeking care</td>
<td>Unexplained TBI, bone fractures</td>
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<td>on wrists</td>
<td>Torn/bloody underwear</td>
<td>Sunken eyes or medically unexplained weight loss</td>
<td>Lack of social interest/contact</td>
<td>Untreated pressure sores; decubitus ulcers</td>
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<td>or ankles</td>
<td>Large withdrawal, accounts switched, unusual ATM activity</td>
<td>Untreated TBI, bone fractures</td>
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<td>Dirty clothing</td>
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Mandated Reporting

Act 79 - Older Adult Protective Service Act (OAPSA) effective July 1, 1988

Amended in 1996 (Act 169) to add criminal background checks

Amended in 1997 (Act 13) to add mandated reporting requirements

PA Reporting Laws – Act 13

Definitions:
- Who has to report?
- Employees of a facility providing care
- Contract employee who has direct contact with residents of a facility
- Students completing internships or clinical rotations
Those identified as a care taker
an individual or institution that has assumed the responsibility for the provision of care needed to maintain the physical or mental health of an older adult. This responsibility may arise voluntarily, by contract, by receipt of payment, as a result of family relationship or by court order.

Who is in need of protective service?
Older adult = anyone over age 60
Adult who is unable to perform or obtain services that are necessary to maintain physical and mental health for which there is no responsible caregiver and who is in imminent risk of danger to his/her person or property.

General Requirements
If there is a reasonable cause to suspect that a recipient is a victim of abuse
Immediately make an oral report to the agency

Which agency?
Agency for Adult Protective Services
PA Department of Aging
1-800-490-8505
Can also call local Adult Protective Services office (varies by county)

If in a facility, notify the administrator immediately
Employees of a facility may request Administrator make report (many facilities may prefer this)

For some serious abuses:
sexual abuse
serious physical injury – causes severe pain or impairs physical functioning
serious bodily injury – risk of death, serious permanent disfigurement, protracted loss of function
suspicious death

Must be reported to Protective Services AND Police
PA Reporting Laws – Act 13

Important note:

Reporter has legal protection from retaliation, discrimination, civil or criminal prosecution if they acted in good faith.

Criticisms of OAPSA

Not crystal clear who a mandated reporter is – act is broad

Vague parameters – if you suspect, report

Limited funding for Adult Protective Services

Criticisms of OAPSA

Positions are often entry level, with entry level experience and pay – but making serious decisions about people’s safety

Elderly population as a whole is growing – will need additional staff in the future

Many adult protective services programs also cover persons age 18-59 who have a disability

Criticisms of OAPSA

Large case loads, low pay, high stress = high turn over rates of staff

Lack of emergency placements

There are consequences only when criminal charges are filed

Interview Assessment

Important to review confidentiality and mandated reported status when reviewing consent for treatment/assessment.

Part of initial contact is assessing patient orientation, and ability to give a reliable history.

Calm, non hurried presentation is helpful.

Being able to build rapport quickly is also helpful.

Key Questions: Interview

How are things going at home? with your spouse, children?

Do you have a power of attorney? How did you decide who it should be?

Who helps you with your money? Do you feel they are doing a good job?
Key Questions:

Has anyone yelled at you?
   Hit you?
Are you afraid of anyone?
Have you been threatened in any way?
Has anyone touched you in a way you are not comfortable with?

Key Questions:

Who helps you cook or get food?
   What do you eat?
Is there anything you need at home (food, heat, clothing)?
When have you last been to the Doctor? Why did you go?
   What do you do in the community (or for fun)?

Key Questions:

Has anyone asked you to sign papers that you didn’t understand?

Questions for family:
   Have they given away money? (including mail donations)
   Have they had work done to the house that you weren’t expecting?

Formal Assessment Measures

- Direct questioning or self-reports
  - H-S/EAST
  - VASS
  - Self-Disclosure Tool
  - EASI
  - CASE

Formal Assessment Measures

- Signs of Abuse Tools
  - EAI
  - Signs of Abuse Inventory

Formal Assessment Measures

- Risk of abuse indicators
  - IOA screen
  - E-IOA screen
Formal Assessment Measure

- Two measures have attempted to integrate the three categories into one assessment tool
  - Ohio Elder Abuse tool
  - Domestic Violence in Late Life screening tool
- Tool designed to assess for abuse/neglect in dementia populations
- Tool designed to assess “conflict”

Pros/Cons of using Assessment Tools

**Pros:**
- For new clinician, tools provide structure, may reduce bias
- Trigger to think and ask about each type of abuse
- Easy to document with (checklist, with some additional written information)

**Cons:**
- May feel “in your face” if not done as a natural extension of interview (chance of less accurate information, could impede establishment of rapport)
- False positive results may be obtained secondary to family conflict, feelings of anger
- Cultural considerations

Ethical Issues

- Autonomy – capacity is important. Can the elder understand what is being considered, can they appreciate the consequences?
- Beneficence/Justice/Respect – we have to separate our own values, and ideas of how things should go
- Nonmalefeasance – Do No Harm, also relates to not making a report if there are concerns
- Fidelity/Integrity – explain the role of mandated reporter during the beginning of treatment or assessment

Vignette#1

80 year old female patient comes in for dementia evaluation. She is accompanied by spouse to appointment, and daughter (POA). She does not feel she is having any problems.

Spouse reports he is frustrated with her behavior and at times yells. During evaluation, she does not appear afraid of him, and denies she is afraid or being harmed when asked directly.
Vignette #1

Patient performance and functional reports is impaired, and a diagnosis of dementia is given.

At the session to review results, both spouse and daughter are present. The spouse asks for education regarding dementia, and tips on behavioral management.

Basic education is provided, as well as a few tips, with a referral to the Alzheimer's Association support group in town, and referral to the AA contact person, and contact information for the evaluating psychologist's office to discuss further if he desires. A six month follow up is scheduled with the patient to monitor situation. He is encouraged to seek counseling support to help him cope with these changes.

Vignette #1

Any concerns so far? What type of abuse might we be concerned about?

Has enough been done? What else could/should be done?

Vignette #1

A month later, the patient’s spouse calls and asks if patient had reported being afraid. Psychologist says no, and asks why?

Spouse reports she told daughter she was afraid, daughter moved her out and will not allow contact between patient and spouse.

Vignette #1

Spouse requests a copy of evaluation.

Should you give it to him?

What do you advise him to do?

Vignette #2

Information you have from the chart: 68 year old female patient referred for a dementia evaluation.

Behavioral observations of the patient and her presumed partner in the waiting room as you approach them: sitting close to each other, holding hands, and laughing together about something you didn’t hear. You call her name and she introduces herself and her husband.

During the interview it seems hard to engage the patient and get her to answer your questions. She answers many questions with “I don’t know,” and the majority of your information you obtain from her husband. He explains they have three estranged adult children, with whom they have not had any contact for approximately 15 years. He reports that she has been exhibiting significant behavioral, emotional, and cognitive changes. She does not outwardly react to these statements.

Vignette #2

When you inquire about history of conflict in the home the husband readily admits that in his early adulthood he was violent and that he and his wife had had a tumultuous relationship. He also admits that they have a history of arrest related to domestic violence episodes and that she had taken out and canceled multiple PFAs against him (all during the first 7 years of their marriage). He quickly volunteers that he has been very involved in a local anger management group for the past 25 years and had been in individual therapy for two years to work on his issues (terminated 23 years ago). Spouse reports that there is no current conflict in the home. The patient remains quiet.

What are your thoughts so far? What additional information might you want?
Vignette #2

The examiner proceeds to introduce the couple to the post-doctoral fellow who will be completing the testing portion of the evaluation. The material is administered and scored by a post-doctoral fellow. When she brings you the scored material she states that at the end of the testing session without any prompting, the patient started to cry and stated that her husband has been screaming at her lately, accusing her of promiscuous behavior and calling her names. She stated that she believed that she could handle that but he has also started acting out violently against her. She said that just last night he threw her into the door and that she hit her head and back hard. And that she doesn’t feel safe to go home with him today. You review the findings and conclude the patient’s performance pattern and functional reports suggest impairment consistent with a diagnosis of frontotemporal dementia.

What are your thoughts now? What do you believe should be done?

Vignette #2

You invite the patient and her husband back for a same day feedback session. The results of the evaluation are reviewed with both the patient and her spouse. The diagnosis is given and psychoeducation about it and its typical progression is provided, as well as your recommendations for compensatory cognitive strategies and behavioral management. You ask the patient how she is feeling and she states she understands what I am saying, but doesn’t believe the tests have accurately captured her abilities. You explain the reasons you are confident in this diagnosis and she becomes quiet. Then, you explain that the fellow had informed you about the concerns the patient raised during the evaluation. You explain to the patient and her husband that as a mandated reporter you have a responsibility to report this to Adult Protective Services and that you would like to make the oral report with them.

Vignette #2

The husband looks extremely upset and denies that everything she said is untrue and asks how I could believe her given the diagnosis. The patient screams “I never said any of that. I am not afraid for my safety and I want to leave NOW.” I state “I understand this is a very difficult and complex set of circumstances. But, it is outside of my scope of practice to investigate this report. I understand that this may not be an accurate portrayal of your current relationship, but because this report was shared with me I am obligated to call and report this. That being said, I want you both to be involved in this phone call and provide your perspectives to them as well in order to present as complete a report as possible.”

How do you believe the situation was handled? Would you have acted differently?

Vignette #4

You are asked to complete a bedside consult on a 78 year old male to evaluate capacity for decision making. He had been living with his 24 year old grandson, and was brought to the hospital after neighbors found him wandering in the neighborhood late at night. The social worker of the hospital informs you the grandson works third shift and was not home.

Vignette #4

The patient was described in the medical chart as “filthy”, with fecal matter under his fingernails, and soiled clothing that had been worn for some time. He had irritation of the skin, which had not yet been identified. He was very thin, gaunt even.

He was quite confused, disoriented, and unable to provide much meaningful history. Nursing staff revealed he refused to eat lunch because he thought the staff were trying to poison him.
Vignette#4

What are your questions so far?

Upon further consultation with the patient, he scored very low on the SLUMS, was unable to demonstrate much safety awareness or insight, could not give an accurate medical history and you have decided he does not hold capacity to make decisions.

Vignette#4

Do you talk to the grandson?

As the grandson is present, you attempt to gain some history from him. He reports that his grandfather has been refusing his medications and food for some time, although he tries to get him to eat every day. Grandfather has also been refusing to bathe or change his clothing.

He reported Grandfather has been forgetful, but is unaware if he has been previously diagnosed with dementia. He denied any history of mental health issues.

Vignette#4

Grandson reported his mother had lived with them until her death 6 months ago and he has been trying to work nights and take care of his Grandfather during the day. He did not have any responsibility for his Grandfather before his mother’s death, which was sudden and unexpected.

He reported he makes a little over minimum wage and has worked at his job for 1 year. Grandfather gets social security each month which pays the rent, and grandson pays for everything else. Usually grandfather was sleeping when he left. He always locked the door when he left at night so grandfather was safe.

Vignette#4

Do you feel Grandfather is safe at home?

Is this an abusive situation?

What do you do?

In this setting – the hospital social worker was already involved and had placed a call to Protective Services. The hospital social worker met with the grandson to provide education and the grandfather was discharged to a skilled facility.

Was the neglect in this case purposeful?