Screening for identification of older people at risk of abuse by their caregivers

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Topics of the presentation
- Introduction
- Definitions, context, explanations, types
- Prevalence
- Consequences
- Identification facts
- Screening for abuse
- The three level screening model
- Building and assessment of the three dimensional screening tool
- Description of the short screening tool
- Conclusions

The problem of elder abuse has intensified parallel to the increasing rate of older persons in the general population, the lengthening of the life span, and the resulting rise in the number of demented and dependent older persons.

The World Health Organization’s definition of elder abuse

Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

Elder abuse covers a range of actions, from criminal to subtle abuse.

- It may be: intentional or unintentional planned or unplanned ongoing or a single act.

- In most cases it occurs in the context of a relationship between the abused person and the abuser.

Most often the perpetrators are:
- Partners
  (often a pattern of lifelong violence in the family)
- Children, grandchildren, children—in-law
- Neighbors
- Paid caregivers

Only in minority of the cases abuse is performed by strangers.
Why does it occur?

- Dependency
- Cycle of family violence
- Caregiving stress
- Lack of knowledge and understanding of the aging process
- Isolation
- Lack of community responses/supports
- Cultural and/or language barriers

Types of abuse

Physical abuse

Use of physical force that may result in bodily injury, physical pain, or impairment

- Multiple bruising, not consistent with falls
- Black eyes, slap marks, kick marks, finger tip bruising, other bruises
- Burns, such as cigarette burns, hands/feet being immersed in boiling hot water.
- Fractures not consistent with falls

Neglect

- Refusal, or failure to fulfill any part of a person’s obligations or duties to an elderly person.
- Passive Neglect: Unintentional failure of a caregiver to fulfill their caregiving responsibilities.
- Self Neglect: The older person does not provide for his/her own essential needs

- Malnourishment or dehydration
- Medical abnormalities
- Inappropriate/Dirty clothing
- Unkempt appearance
- Signs of infrequent bathing
- Stench of urine or feces
- Pressure sores
Psychological abuse
Infliction of anguish, pain, or distress through verbal or non-verbal acts.
- Humiliation
- Intimidation
- Ridicule
- Causing fear/mental anguish/anxiety
- Threats/threatening behavior
- Bullying
- Verbal abuse (e.g., shouting, swearing)
- Harassment
- Isolation/withholding social contacts
- Denial of basic rights (e.g., choice, opinion, privacy).

Financial/material exploitation
Illegal or improper use of an elder’s funds, property, or assets. Theft or misappropriation of an elder person’s money, property or assets
- Misuse of a power of attorney
- Forged signatures on checks
- Requesting money or assets by threatening deprivation of familial context and help
- Persuasion to transfer money, bank accounts, property, assets, or management of finances to another person
- Not allowing paid care or admission to residential care by a relative who expects to inherit money/property when the older person dies

Sexual abuse
Non-consensual sexual contact of any kind with an elderly person.
- Inappropriate touching
- Fondling
- Inappropriate kissing
- Oral contact
- Genital contact
- Rape
- Initiating unwelcomed talk about sex
- Proposing unwelcomed sexual contact

Prevalence of elder abuse in the community
In the USA every year an estimated 2.1 million older people are victims of physical, psychological, or other forms of abuse and neglect.
Based on case reports or surveys in various countries, the estimates of the frequency of elder abuse in the community range from two to ten percent.
Data on the elder abuse in domestic settings suggest that only 1 in 14 incidents, excluding incidents of self-neglect, comes to the attention of the authorities.

Current estimates in the US put the overall reporting of financial exploitation at only 1 in 25 cases, suggesting that there may be at least 5 million financial abuse victims each year.
Persons aged 80 and older are abused and neglected two to three times more than all the other elder persons (US Bureau of Justice Statistics, 2010).
When a thorough identification of abuse methods was used, 20% to 30% of elderly persons were found to suffer at least one type of abuse (Eizikovitz et al., 2005, Cohen et al., 2007, Reis & Nahmiash, 1998).

In nursing homes
A study in nursing homes and sheltered homes in Sweden: 11% of the nursing aides had observed incidents of abuse; 2% admitted committing abusive behaviors (Saveman et al. 1999)
A study in Germany: 79% of the staff in a nursing home observed incidents of physical abuse, verbal abuse or neglect in the previous year (Goergen, 2001)
A Norwegian study: 91% of the nursing staff had observed at least one act of inadequate care 87% had committed at least one act of inadequate care (Malmedal, Ingebrigtsen and Saveman 2008)
In the USA:

- 36% of 577 randomly selected nurses and nursing-aides reported observing physical abuse.
- 10% reported committing physical abuse during the previous year.
- 81% had observed and 40% had committed psychologically abusive acts over this period. (Pillemer and Moore 1989).

A recent study in Israel:

31% of patients reported experience of maltreatment or abusive behavior during the previous year:

- 11.3%: a very low level of maltreatment / abuse (1-4)
- 8.4%: mild maltreatment / abuse (score 5-11)
- 9.9%: moderate maltreatment / abuse (score 11-20)
- 1.4% (one participant): severe abuse (score of 51).

Possible range 0-72

(Cohen et al., Ageing and Society, 2010)

Types of abuse reported by the nursing home residents

<table>
<thead>
<tr>
<th>Types</th>
<th>Percentage of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>No abuse</td>
<td></td>
</tr>
<tr>
<td>Very low</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>Neglect of basic needs</td>
<td>45.8%</td>
</tr>
<tr>
<td>Disrespectful attitudes</td>
<td>20.6%</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>19.8%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>34.4%</td>
</tr>
</tbody>
</table>

Actual signs of abuse

14 (19.8%) were identified for neglect, physical abuse or exploitation:

- 6 (8.5%) - very low
- 6 (8.5%) - low
- 2 (2.8%) - moderate

No case of severe abuse

Severe forms of abuse are rare. A wide range of mistreatment, including disrespectful behavior and humiliation, are prevalent.

Consequences of elder abuse

Elders who have been abused tend to experience:

- Higher morbidity and disability
- Higher mortality rate
- Depression, anxiety
- Accelerated cognitive deterioration
- Seriously impaired quality of life

Why do victims fail to report?

- Non-recognition, denial or disbelief that the incident has occurred
- Fear of reprisal, abandonment, isolation or institutionalization
- Victim is under complete control of the abuser for food, shelter, clothing
- Shame, embarrassment, guilt, confusion
- Victims do not know their rights
- Lack of awareness of community resources and support
- Distrust of the police or social service
- Attempt of the abuser and of the abused to hide the “family secret”
Identification of abuse by social and health professionals

How many cases of suspected abuse have you identified during the previous month? During the previous year?

In contrast to what might be expected, rates of abuse identification in hospitals and social agencies are low.

Studies revealed that doctors and nurses were unaware of the problem of elder abuse among their clients.

They could not identify abuse in patients in their care.

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Why do professionals fail to identify elder abuse?

• Lack of alertness among the professional workers
• Difficulty in distinguishing symptoms of abuse and neglect from symptoms related to physical diseases or medical treatments
• Many professionals hesitate to penetrate the private family sphere
• Tools for identifying elders at risk are few
• Lack of knowledge of professional means for helping the abuse person
• Uncertainty in identifying abuse

Why do professionals fail to identify elder abuse?

Mrs. A., age 85, widow, cognitively sound, dependent in IADL. She has a daughter, age 47, youngest of 3 children and the only one living in the same city.

She takes care of her mother’s affairs, doctors’ appointments, shopping, etc.

When shopping, she also shops for her family with her mother’s credit card.

She has never told her mother about this.

Is this financial exploitation?

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Is this financial exploitation?

A nursing aid in a nursing home makes long-distance calls on residents’ private phones while they are out of their rooms.

She is a very caring and warm person, loved by the residents.

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She is a very caring and warm person, loved by the residents.

Is this financial exploitation?

Mr. D. is 88, lives independently in his home. He refuses to take a cleaning lady or other paid help.

His son, worried about him, often raises his voice during discussion of these topics.

When visiting his physician, he asks (in a routine screening) if Mr. D. experiences instances of mistreatment.

He reports that his son shouts at him.

Is this psychological abuse?
Important points:

- Signs of abuse are often mild, hidden or ambiguous
- Mild cases of abuse tend to accelerate over time
- Most victims will not report
- Abuse can happen anywhere
- It is common in all socio-economic strata and in all cultural and ethnic settings
- It is wrong to stereotype the typical victim and typical abuser – it can happen to anyone
- Most of the existing tools focus on identification of signs of abuse

Any encounter with a social worker, physician, nurse or other professional may create an opportunity for detection of abuse otherwise not identified:

- A thorough, multi-professional examination is performed
- Trust relationships develop
- An opportunity to observe caregiver’s attitudes and behaviors is given

• Screening for abuse should be performed in every encounter of professionals with an older person

• Since actual signs of abuse are mostly undetectable and most older persons will not report being abused, screening should focus on indicators of risk of abuse

Risk of abuse indicators

- Reis and Nahmiash (1998) developed the Indicators of Abuse (IOA) list.

- The IOA consists of 27 items indicating mental and psychosocial characteristics of the elderly and of family caregivers.

Older persons’ risk indicators

- Lack of support
- Social isolation
- Emotional dependence

Older persons’ Caregivers’ indicators

- Behavior problems
- Mental or emotional difficulties
- Marital or family problems
- Economic dependence

Caregivers’ risk indicators

- Lack of understanding of medical condition
- Caregiver’s reluctance to give care
- Caregiver’s inexperience
• The advantage of the IOA tool is the thorough identification of risk of abuse indicators.
• The disadvantage of the IOA is that it supplies indicators only, and is based on an open clinical interview in which the interviewers may differ widely in skills and in methods of psychosocial evaluation.

Developing screening instrument for identification of abuse

Our aims were:
1. To improve strategies for identifying and locating older persons at risk of abuse, and as a result, to provide professional interventions for stopping or preventing the abuse or neglect.
2. To develop a diagnosing tool for screening for abuse in health settings.

Study 1: Developing and validating an identification instrument

• Building a semi-structured interview based on the risk indicators (Reis & Nahmiash, 1998).
• Assessment of the instrument with 20 known abused and 20 non-abused elder persons (blind to the interviewer).
• Screening of a sample of 108 elder patients hospitalized in internal medicine department.

Cohen et al., Aging and Health, 2006; 18: 660-685

• High reliability (inter-rater reliability and internal consistency)
• High validity (content, criterion, discriminant validity and construct validity).

Study 2: Assessing the three-level identification instrument

The three-level screening procedure

1. Direct questioning of the elder person
2. Signs of abuse
3. Risk of abuse indicators

Participants

- 730 participants being treated at two major hospitals in Israel.
- Consequently selected from hospitalized older persons.

Assessments

Direct questions for disclosure of abuse:
10 items probing whether and how often during the previous year the patient suffered from abusive behaviors:

Physical violence, verbal violence, being coerced or forbidden to do activities, being forced to hand over property, being forced to give financial support against his or her will.

The Expanded Indicators for Abuse Questionnaire (E-IOA)

- Evident signs of abuse: physical, psychological, sexual abuse, neglect and financial exploitation
- Bio-markers and health: albumin and creatinine in blood, incontinence and multi-diseases, number of hospitalizations

Sensitivity and specificity of the indicators of abuse screen- against the criterion of the existing signs of abuse

- Sensitivity 92%
- Specificity 88%
- Overall exact identification 97.7%

Comparison of disclosure of abusive behavior, identified abuse, and high risk of abuse

- 74.4% (n=32) of respondents who disclosed abuse were also proved to be at high risk of abuse
- 70% of the respondents identified for evident abuse, were also found at high risk of abuse

Risk scores for identified vs. disclosed abuse

An escalation exists across the four categories; lowest risk scores were obtained for respondents not disclosing abuse and not identified for it, next came those who disclosed only, followed by those identified for evident abuse; those who both disclosed abuse and were identified for it obtained the highest scores
Mean risk scores, based on patients’ and caregivers’ risk indicators, predicted neglect among participants.

Cohen, Internal Medicine Journal 2008; 38: 704-707

Bio-markers of risk

Albumin is the main protein of plasma. Low level of protein may be caused by different diseases, and by malnutrition.

Level of albumin in plasma was found to be a significant predictor of neglect and of overall abuse.

Study 3:
Assessment of a short tool for screening for abuse in health and social services

Responding to the need for a short screening tool

Participants

- 1317 participants
- Emergency units, social welfare agencies and day care centers
- Country based representative sample (39 communities)
- Jewish and Arab cities and villages
- Interviews were conducted in Hebrew, Arabic and Russian

Rates of abuse and neglect

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>94</td>
<td>4.2</td>
</tr>
<tr>
<td>Neglect</td>
<td>129</td>
<td>9.7</td>
</tr>
<tr>
<td>Financial abuse</td>
<td>131</td>
<td>11.4</td>
</tr>
<tr>
<td>Psychological abuse (N=672)</td>
<td>63</td>
<td>9.4</td>
</tr>
<tr>
<td>Overall cases of abuse</td>
<td>184</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Severity of abuse

Mild, Moderate, Severe
Self-report of abuse: Distribution of severity scores

Indicators of risk of abuse

<table>
<thead>
<tr>
<th></th>
<th>Non-Abused</th>
<th>Abused</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Care receiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior problems</td>
<td>1.0</td>
<td>1.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Poor emotional state</td>
<td>2.6</td>
<td>3.5</td>
<td>12.6</td>
</tr>
<tr>
<td>Financial dependence</td>
<td>0.1</td>
<td>0.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Family members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family problems</td>
<td>0.6</td>
<td>1.4</td>
<td>3.2</td>
</tr>
<tr>
<td>Psychiatric disorders</td>
<td>1.1</td>
<td>1.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Financial dependence</td>
<td>0.3</td>
<td>0.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Alcohol/drug problems</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01, ***p<.001

Level 1: Direct questions
(For patients without cognitive deterioration)

It is feasible to ask direct questions and even welcomed by the older persons!!

Scores 0-4

- Has anyone in your family, or other people that you know, made you afraid of him?
- Has anyone hurt you (hit, shaken, pushed)?
- Has anyone you know insulted you, yelled at you or talked to you in a way that made you feel bad, shamed or threatened?
- Has anyone forced you to do things against your will (e.g., to stay in bed)?
- Has anyone denied you basic things (such as food, taking a bath, watching TV)?
- Has anyone taken from you goods, possessions, money, or forced you to sign papers against your will?
- Have family members refused to give you help you need?
- Do you lack essentials, such as food, medications?
- Has anyone tried to force you to sign papers, or to use your money, against your will?
- Has anyone touched you in ways that you did not want, or forced you to perform sexual acts?

One item scored 3 or higher or two items scored 1 or higher

Suspect abuse

Level 2: Signs of actual abuse
Signs of physical abuse (Scores 0-4)

1. Unexplained injuries or unsatisfactory explanations for them
2. Unexplained injuries/internal hemorrhage
3. Unexplained new and old scars
4. Scars on upper parts of both arms
5. Burns on parts of the body not usually subject to burns
6. Unusual burn or shape of burn (matching certain objects such as cigarette or flat iron), or dipping burns
7. Disclosure of episodes of physical abuse

Suspect abuse, if: a score of 3 or higher on items 1-3, or 1 or higher on items 4-7

Material/financial abuse (For patients without cognitive deterioration)

1. Unaware, or partially aware, or confused about his/her financial situation
2. Sudden inability to pay bills, purchase food or other commodities
3. There is a difference between patient's income and living style
4. Fear and anxiety are aroused whenever financial matters are discussed
5. Exaggerated interest by a family member in the older person's financial situation
6. Refusal, by the older person or a family member, of any treatment or assistance involving financial expense

Suspect abuse, if: a score of 3 or higher on items 1-3, or 1 or higher on items 4-7

Neglect (0-4)

1. Dehydration
2. Poor nutrition
3. Hypothermia
4. Unsuitable clothing
5. Lack of teeth, spectacles, hearing aid
6. Skin sores
7. Sudden and unexplained decline in health situation
8. Pressure sores
9. Exaggerated/lacking or unsuitable use of medicine

Suspect neglect, if any item scored 2 or higher

Signs of sexual abuse

- Torn or stained underwear
- Difficulties walking or sitting
- Sexual organ – pain/bleeding/burns
- Disclosure of sexual abuse

Psychological abuse (0-4)

Caregiver is seen to maltreat, shout at, insult, disregard needs or requests of the older person.

Suspect abuse if any item scores 2 or higher
### Level 3: Identification of risk of abuse

1. Behavior problems
2. Poor emotional state
3. Financial dependence
4. Poor social network / isolation
5. Cognitive difficulties / Dementia
6. Multiplicity of serious diseases

#### Indicators of abuse screen – the care receiver

<table>
<thead>
<tr>
<th>Indicators of abuse screen – the care receiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drug or alcohol use</td>
</tr>
<tr>
<td>2. Psychiatric disorders (personality disorders, schizophrenia), or mental retardation</td>
</tr>
<tr>
<td>3. Financial dependence</td>
</tr>
<tr>
<td>4. Family conflicts</td>
</tr>
<tr>
<td>5. Poor social network</td>
</tr>
<tr>
<td>6. Lack of understanding of the condition of the elderly person</td>
</tr>
</tbody>
</table>

The subject will be considered at risk of abuse if:

1) At least 7 of all categories above were marked 1, 2 or 3

2) At least one of the factors in grey received a score of 2 or 3.

#### Behavior problems

<table>
<thead>
<tr>
<th>Behavior problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has outbursts</td>
</tr>
<tr>
<td>Committed to his/her obligations</td>
</tr>
<tr>
<td>Engages in conflicts with family, friends/neighbours</td>
</tr>
<tr>
<td>Has poor personal functioning</td>
</tr>
<tr>
<td>Has poor family functioning</td>
</tr>
<tr>
<td>Blames external forces for his/her situation</td>
</tr>
<tr>
<td>Angry and bitter towards his/her environment</td>
</tr>
</tbody>
</table>

#### Lack of social support

<table>
<thead>
<tr>
<th>Lack of social support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few friends/associates or family members</td>
</tr>
<tr>
<td>Friends/associates do not extend help</td>
</tr>
<tr>
<td>Friends/associates do not show interest in his/her condition</td>
</tr>
</tbody>
</table>
Emotional/cognitive difficulties

<table>
<thead>
<tr>
<th>Emotion/Cognitive Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritable or nervous</td>
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<tr>
<td>Paranoid ideations (thinks that people harass him/her, plot</td>
</tr>
<tr>
<td>against him/her, or are unfair)</td>
</tr>
<tr>
<td>Exaggerated, inappropriate, or fluctuating emotional reactions</td>
</tr>
<tr>
<td>Distorted perception (exaggerated or not reality-based) of self,</td>
</tr>
<tr>
<td>other people, and events</td>
</tr>
<tr>
<td>Depressed (moody, lack of motivation and of interest, low self-</td>
</tr>
<tr>
<td>esteem, low energy, sleep disturbance, or poor appetite or</td>
</tr>
<tr>
<td>overeating)</td>
</tr>
<tr>
<td>Anxious (fears, vigilance, automatic hyperactivity, motor</td>
</tr>
<tr>
<td>tension, restlessness)</td>
</tr>
<tr>
<td>Is confused or disoriented</td>
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</table>

Concluding remarks

- A routine screening is recommended
- Level and depth of screening should be adapted to the circumstances of the encounter
- Workshops for professionals for learning the use of the tool and gaining confidence in its use

On-going studies

- Case-controlled study of blood measures as biomarkers of abuse
- Evaluation of the effect of workshops on sense on knowledge and skills of identification of abuse and on actual rates of abuse in multi-professional teams in hospitals.
- Assessment of a screening tool for older persons with Dementia

The research team:
- Gideon Friedman, MD, Geriatric Unit, Hadassah Medical Center, Jerusalem
- Sara Halevy-Levin, MSW, Geriatric Unit, Hadassah Medical Center, Jerusalem
- Roni Gagin, MSW, Social Work Department, Rambam Medical Center, Haifa

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Thank You!