Elder Abuse and Neglect

INTRODUCTION

- Elder abuse is a growing problem costing Americans billions of dollars annually through health care, social service, investigative and legal fees, as well as lost income/assets.
- The National Center on Elder Abuse categorizes elder abuse and neglect into abandonment, emotional or psychological abuse, financial or material exploitation, neglect, physical abuse, sexual abuse, self-neglect and resident-to-resident aggression.
- Abused elderly tend to die earlier than other elderly, even those without chronic illness.

EPIDEMIOLOGY

- Up to 11% of U.S. elders experienced some type of neglect each year.
- Most common abusers (89%) are family members, usually an adult child or a spouse. Risk is increased if they abuse alcohol or drugs, or have a history of violence or mental illness.
- Poor health and cognitive impairment increase the risk of maltreatment by reducing one's ability to report the abuse or capacity for self-defense.

LEGAL IMPLICATIONS

- Medical care providers do not need definitive proof that abuse or neglect has occurred to file a report, just a legitimate concern. Most states with mandatory-reporting laws grant immunity to providers who report their suspicions in good faith.
- The appropriate authorities, generally adult protective services, then investigate the claim.
- State specific information on reporting requirements is available on the National Center for Elder Abuse website at: http://www.ncea.aoa.gov/
- An investigation that does not reveal intentional abuse or neglect, can still be helpful to identify resources that they were previously unaware of such as visiting nurses and adult daycare options.
- Hospital admission may be necessary to sort out social situations; assessment of patient's decision-making capacity may be required if they wish to leave AMA.

RECOGNITION

- Red flags include lack of medical aids (medications, walker, cane, glasses), poor hygiene, untreated medical issues (pressure sores, colostomy, dehydration), inadequately explained injuries, delay in seeking medical attention after an injury, incongruity between accounts given by the patient and caregiver or presentation of a mentally impaired patient without a care provider.

Elder Abuse Suspicion Index (EASI)

#1-5 are answered by the patient, #6 by the physician.

1. Have you ever relied on people for any of the following: bathing, dressing, shopping, banking or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you feel afraid, touched you in ways that you did not want, or hurt you physically?
6. Doctor: Asks physician if any abuse findings (poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises inappropriate clothing or medication compliance issues) are noticed upon patient visit or within prior 12 months.

A response of "yes" to one or more of the questions from #2-6 should prompt concern for acute or neglect.

SUMMARY

- Elder abuse and neglect are unrecognized and underreported. Joint Commission requires EDs to screen all patients. Physicians can make a difference by becoming familiar with screening tools, the reporting requirements and available assistance resources.

ABSTRACTED FROM

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COMMENTARY by Ginny H. Lee, MD, Alison Southern MD (Summa Health System)

The prevalence of elder abuse and neglect will increase with the rapidly increasing elderly population.[1] This article showed that there are simple questions in place to supplement clinical gestalt and to help guide patient dispositions from the ED when suspicion is present.[2] In reality, many factors unfortunately prevent these crucial questions from being asked, from time constraints of a busy ED, to the presence of the patient's family in the room, to uncertainty of patient's cognitive status. Consistent systems must be in place to screen every elderly patient, enabling us to protect this vulnerable population.

1. Sooryanarayana R, Choo WY, Hairi NN: **A review on the prevalence and measurement of elder abuse in the community**. *Trauma Violence Abuse* 2013, **14**(4):316-325.
2. Johannesen M, LoGiudice D: **Elder abuse: a systematic review of risk factors in community-dwelling elders**. *Age Ageing* 2013, **42**(3):292-298.