Why Elder Abuse Continues to Elude the Health Care System

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Abstract

Elderly men and women of all socioeconomic and ethnic backgrounds are vulnerable to mistreatment, and most often it goes undetected. For many elderly victims of abuse, the hospital is the only potential site for outside contact and support. An elder abuse program has been created at The Mount Sinai Hospital in New York City, and funding was granted to assist victims with compensation claims; provide counsel and advocacy for victims; and provide support via ongoing telephone contact and referrals to community agencies. Simultaneously, hospital-wide educational seminars and rounds have provided the staff and students with information concerning detection of abuse and neglect.

Over a 2-year period, 182 cases were identified and assessed. More than 50% of these cases involved patients with a diagnosis of memory impairment. Five percent of the cases involved a long history of domestic violence. In most cases a family member was identified as the abuser, and in a majority of instances the victim either denied the suspected abuse or tried to rationalize the behavior of the abuser. Patients were afraid of reporting abuse or changing their situation, despite being informed of possible resources.

To combat this escalating problem in our growing elderly population, interdisciplinary collaboration between physicians and social workers is often crucial. Communication via the medical record can be key to monitoring patients in the community. There also needs to be ongoing education of all hospital staff in an effort to continually heighten awareness of this problem.

Key Words: Elder abuse, elder neglect, elder mistreatment, detection of abuse.

As the aging population grows, the problem of elder mistreatment is escalating. It is well known that elderly men and women of all socioeconomic and ethnic backgrounds are vulnerable to mistreatment, most of which goes undetected. Currently, elder abuse affects from one to ten percent of the population in the United States (1). According to an executive summary of a National Elder Abuse Incidence Study, conducted in 1996, a total of 449,924 elderly persons, aged sixty and over, experienced abuse and/or neglect in the community. However, 84% of the cases are not reported to any adult protective services agency (2).

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For many elderly abuse victims, the hospital setting is the only potential source of outside contact and support. Health care professionals, therefore, may be the only people in a victim's life who have the opportunity to recognize the abuse and offer help. Despite this, it is felt that medical staff are not adequately trained in detecting elder mistreatment or making appropriate referrals to social workers and protective service agencies. Interestingly, a study done in Michigan showed that, between 1989 and 1993, some of the highest physician-reporting rates were found in counties with low physician-to-population ratios. These data suggest that rural primary care physicians are more apt than specialists to detect and report elder mistreatment (3). Indeed, few specialty training programs specifically educate their house staff about family violence. Continuing medical education programs rarely address this issue in any systematic way (4).

The Mount Sinai Hospital Elder Abuse Program

In October of 1998, the Department of Social Work Services at The Mount Sinai Hospi-

tal, a voluntary teaching hospital located in New York City, was awarded a grant by the New York State Crime Victims Board to provide direct services to elderly abuse and neglect victims at The Mount Sinai Hospital, which has a sizable elder patient population. This funding has supported the creation of the Mount Sinai Hospital Elder Abuse Program. It is coordinated by a social worker with a master's degree, who assists with compensation claims, counsels victims, maintains follow-up telephone contacts, accompanies victims to legal offices, provides information and referral services, and advocates for the needs of the victims. The Elder Abuse Program social worker collaborates with a geriatrician who is an expert in the field of elder abuse.

Not surprisingly, there have been many obstacles to identifying cases within the hospital setting, and it was felt that staff education was essential to raise awareness of the problem of elder abuse and neglect. Prior to acting as advocates for elder abuse patients, the staff needed to be educated about elder abuse/neglect and the process of identifying and referring possible victims to the program. Various teaching tools have been used to increase awareness, including: the distribution of printed brochures about the Elder Abuse Program; presentations at medical grand rounds and social work rounds; and informal discussions with medical staff, nurses, patient representatives and other staff. In these presentations, definitions of elder abuse and neglect (Table 1) (5), assessment tools and intervention strategies are discussed. A pocket-sized laminated card (6), listing helpful questions in eliciting information from patients, was developed and is distributed widely (Table 2). Through these efforts, medical and social work students are becoming aware of this growing problem early in their careers.

TABLE 1
Definitions of Elder Abuse

Physical Abuse — The infliction of physical pain or injury such as slapping, pushing, sexually molesting, etc.

Psychological Abuse — The infliction of mental or emotional distress such as threats, intimidation, verbal attacks, etc.

Financial Abuse — The illegal or improper use of funds or other resources.

Active Neglect — A conscious and intentional attempt to inflict physical or emotional distress by refusing or failing to fulfill a caregiving responsibility, such as withholding food or medication.

Passive Neglect — An unintentional failure to fulfill a caregiving responsibility, such as not providing food or health-related services because of inadequate knowledge or caregiver's own infirmity.

Case Example

Mr. R. was a ninety-eight-year-old widowed Hispanic man, living with his son. They resided in a home privately owned by Mr. R. in New York City. Mr. R. was a retired presser, supported by Social Security and a pension. He had medical insurance through a managed care Medicare provider.

Mr. R. was initially seen at The Mount Sinai Hospital Coffey Geriatrics Practice in December 1997 for routine medical care. His medical problems included dementia, emphysema, vitamin B12 deficiency, visual and hearing impairments, a gait disorder and degenerative joint disease. His medical history was significant for pneumonia, a tibial fibula fracture and alcohol abuse. His subsequent visits were sporadic; however, in May 1999 his son brought him to the Coffey Geriatrics Practice because of swelling and redness of his right hand. Mr. R.'s personal hygiene was poor and he appeared rather thin. He was evaluated by the nurse practitioner and referred to the Elder Abuse Program social worker for further assessment. The social worker, along with a Spanish-speaking

TABLE 2
Elder Abuse / Neglect Screening Assessment Tool

1. Has anyone ever hurt you?
2. Does anyone ever talk or yell at you in a way that makes you feel bad about yourself?
3. Has anyone ever taken anything from you or used your money without permission?
4. Are you afraid of anyone or has anyone ever threatened you?
5. Has anyone ever refused to help you?
6. Do you feel that your food, clothing, and medications are available to you at all times?
7. Are you able to go out of your house when you wish to do so?
8. Do you get to see other relatives and friends?
9. Do you have ready access to a telephone?
10. Do you live with anyone or have any close family members who abuse drugs and alcohol or have a psychiatric or emotional illness?

Adapted from: Elder mistreatment guidelines for health care professionals: detection, assessment and intervention. New York: Mount Sinai/Victim Services Agency Elder Abuse Project; 1988 (6).

medical office assistant, interviewed Mr. R. without the son being present in the room. Mr. R. was somewhat tangential and repetitive, but was able to provide information. He reported being dependent on his son for assistance with most activities of daily living and financial management, for which his son had power of attorney. He was quite isolated, with almost no social or family contact apart from his son. He admitted that his son was verbally abusive, neglectful and threatening, specifically stating that his son would lock him out of his own home. Mr. R. was evasive about episodes of physical abuse, stating, "I'm not here to answer questions."

Based on Mr. R.'s injury, his general appearance, and concerns about elder abuse, the social worker, in collaboration with the medical team, decided to admit him for further evaluation. Over time, Mr. R. revealed, usually to Spanish-speaking staff, that his son had been physically abusive to him. Although Mr. R. was amenable to a short-term rehabilitation program in a nursing facility, his managed care plan would not cover this, because he had no medical needs. Despite several meetings with Mr. R. advising him of safety risks in his home, he chose to return home to the care of his son, stating "Family is family."

Discharge plans by the team included:

1. A referral to Protective Services for Adults for evaluation of Mr. R.'s safety in the home, with oversight by the Mount Sinai Hospital Elder Abuse Program.

2. A referral to the Visiting Nurse Service for nurse and social work assessments in the home.

3. Frequent follow-up appointments and monitoring by the Elder Abuse Program and staff at the Coffey Geriatrics Practice.

Mr. R. was brought by his son to the Coffey Geriatrics Practice for his initial follow-up appointment after his discharge from the hospital. The son was quite angry and somewhat threatening to staff because a Protective Services for Adults caseworker had visited their home earlier in the day. Although Mr. R. appeared anxious about his son's anger, he repeatedly stated that he wanted to go home with him. The staff allowed the son to verbalize his anger while discussing concerns about the patient's safety. They reinforced the need for regular follow-up care. The medical staff agreed that Mr. R. had no current signs of physical abuse and had not had any further weight loss. He was therefore sent back home to the care of his son. The Protective Services for Adults caseworker was contacted after Mr. R.'s initial follow-up visit. He reported that Mr. R.'s home was clean and that the son was cooperative during his visit. He therefore closed the case, even though he was concerned about the son's evasiveness with respect to Mr. R.'s finances. The Elder Abuse Program social worker also spoke with the visiting nurse, who initially had difficulty arranging a home visit with Mr. R. and his son, but had finally been able to gain entry to the home. He did not detect any significant problems, but felt that Mr. R.'s son had a limited understanding of his father's deficits. The visiting nurse saw Mr. R. twice and was allowed one more visit by Mr. R.'s managed Medicare program; however, phone calls made to arrange a follow-up visit were never returned by the son.

Approximately two months later, Mr. R. was brought to the Coffey Geriatrics Practice by his son for a routine follow-up appointment. The social worker greeted them in the waiting area. Mr. R. immediately began telling the social worker that he was frequently left alone at home ("I can only see other people by looking out the window"). Despite attempts to calm Mr. R. and reassure him that this would be discussed in a private area, his anger escalated. His son became irate and they both left the appointment without further evaluation. Follow-up telephone messages were left for the son to bring Mr. R. back, but they went unanswered.

An attempt was made by the Elder Abuse Program social worker to re-refer the case to Protective Services for Adults; however, they did not feel that Mr. R.'s situation had changed from their initial assessment. The Protective Services for Adults director and intake supervisor were contacted, since the medical team felt strongly that a reevaluation was advisable. The intake supervisor reported that telephone contact had been made with the son, who indicated that the home situation was stable, with Mr. R. receiving food from Meals-on-Wheels. The son also claimed that he took his father outdoors several times a week. Additionally, the assistant director of Protective Services for Adults spoke with the son, via telephone, about follow-up medical care for Mr. R. The son indicated that Mr. R. was resistant to returning to the Coffey Geriatrics Practice, and that they would be seeking alternate medical care. Despite these coordinated efforts by the Elder Abuse Program

social worker and the staff at Protective Services for Adults, the case was lost to follow-up.

Epilogue

In October 2001, the Elder Abuse Program social worker was consulted by the inpatient geriatrics unit medical team on a one-hundred-year-old Hispanic man brought in after sustaining a fall at home. Staff was concerned about physical abuse and neglect, as the patient was bruised and had poor personal hygiene. The Elder Abuse Program social worker immediately recognized Mr. R., noting that he was more cachectic, less alert, and more cognitively impaired than he had been two years previously. Mr. R. was unable to provide any information (even with Spanish-speaking staff), given his weakened state and poor mental status.

The medical staff and the Elder Abuse Program social worker met with the son, who appeared to minimize the extent of his father's physical and cognitive deficits. The son related that, despite Mr. R.'s visual deficits and poor physical condition, he was able to ambulate independently in their home. He stated that Mr. R. had episodes of falling, but medical care was not sought, as Mr. R. would not have wanted to be brought to a hospital. Mr. R.'s son called 911 after this fall because Mr. R. had seemed "dazed."

Discharge options were discussed. Mr. R.'s son was amenable to short-term geriatric rehabilitation if Mr. R.'s insurance covered it, but would not agree to permanent nursing home placement, given the high costs of this option.

Unfortunately, Mr. R. aspirated and died a few days later in the hospital.

Results of Elder Abuse Program Initiatives

1. Between January 1999 and November 2001, one hundred and eighty-two (182) cases were identified and assessed.

2. The majority of referrals have been from social workers in the emergency room, the inpatient geriatrics unit, and physicians and nurse practitioners in the Home Visiting Doctors program.

3. In approximately 50% of referred cases, there was a diagnosis of memory impairment.

4. Referrals primarily involved suspicion of verbal abuse, neglect and financial exploitation. Very few referrals for cases of physical or sexual abuse were received.

5. Nine cases (5%) of accepted cases involved a long history of domestic violence.

6. A family member was usually the abuser, although there were approximately 15 cases in which home attendants were suspected of abuse.

7. In many cases, victims either denied the suspected abuse was taking place or tried to rationalize the behavior of the abuser, especially if this was a family member.

8. Patients were fearful of reporting abuse or changing their situation, despite being informed of possible resources.

Based on the needs of the identified cases, the following interventions were made by the Elder Abuse Program:

1. Referrals of victims for follow-up medical care, since some of these individuals had not had medical care for years.

2. Ongoing social work involvement for continued counseling.

3. Reassurance telephone calls to monitor victims' safety in the community.

4. Home visits to victims who were too frail to come to the Coffey Geriatrics Practice.

5. Referrals of victims to community agencies for more intensive case management and additional services, with oversight by the Elder Abuse Program.

6. Involvement of Protective Services for Adults for guardianship proceedings, in collaboration with the Elder Abuse Program.

7. Placement of victims in assisted-living facilities or nursing homes.

Discussion

Although there have been multiple initiatives to educate medical and other hospital staff

about the signs and symptoms of elder abuse and neglect, it is likely that some patients experiencing mistreatment are still not being referred to the program. Feelings of shame, guilt and fear may be responsible, or partially responsible, especially if a family member is the abuser (7). One should take into account the perspectives of both the patients and the health care providers in considering the reasons for this. Additionally, it is well known that domestic violence victims as well as elder abuse victims are reluctant to change their situations for fear of being alone or placing the abuser at risk (e.g., homelessness, incarceration). While some victims may be willing to discuss their abusive situations with a health care provider, victims tend to minimize the seriousness of the abuse and display tremendous loyalty to their abusers. Victims are generally not willing to take legal action against a family member. Many victims prefer tolerating the abuse to losing close personal ties to family members. Often, the abuser is the only person the patient can rely on for assistance with the activities of daily living. As such, the victim may fear that institutionalization, such as nursing home placement, is the only alternative solution.

In the same vein and as pointed out in the literature (8), many health care professionals are either unaware of the prevalence of abuse or are reluctant to ask their patients about domestic violence. This applies to elder mistreatment as well. Talking about family violence with patients has been characterized as "opening a Pandora's box" (9). Practitioners may feel helpless about their inability to "fix" the situation or influence a patient's decision. Feelings of anger and blame are natural reactions to reports about abuse, especially when the practitioner feels powerless to change them. These responses may be even more pronounced for health care professionals who believe they are supposed to "treat" the problem. Additionally, the pressures and time constraints of medical practices leave little time to delve into the complex issue of family violence.

Another significant factor impacting medical staff is concerns and doubts about patients' safety if they are discharged to abusive environments. From the hospital's standpoint, given economic considerations, it may be difficult to admit these patients, as insurance companies will not reimburse for so-called "social admissions." We need to be aware of the possibility of retaliation on the part of the abuser and must have safety measures in place, should the victim be punished by the abuser for exposing the mistreatment. The health care provider should ensure that a victim has access to a telephone and can call for emergency assistance. It is necessary to explore with the victim whether there may be a safe place to stay or if there are other social supports available, even on a temporary basis. Alternative housing options can also be discussed with the victim. The concern of staff for its own safety may be another factor hindering willingness to uncover abuse. A health care provider may feel frightened or even threatened by an abuser, which may make it difficult to question a victim. Safety measures need to be considered, to decrease possible harm to both health care providers and patients. In the case of Mr. R., his son was loud and threatening. Those staff members who were not in direct contact with Mr. R. and his son were alerted to the tension and were available to contact the security department, if it became necessary.

Often, patients themselves will choose to return to environments deemed unsafe. In these situations, staff members struggle to determine whether victims are exercising poor judgment or have crossed over the fine line to decisional incapacity. A patient's ability to report or describe abuse may be affected by language or cognitive deficits. In these cases it is important to observe behavioral changes in determining the patient's risk and ability to make a decision (10).

A patient's right to self-determination is the underlying factor in states where there is no requirement for mandatory reporting of abuse to government agencies. In these states, it is argued that victims with mild cognitive and memory impairments can still make their own decisions about remaining in abusive situations. Health care providers may feel uncomfortable with a patient's decision to remain with the suspected abuser, but may need to accept this and continue to help the victim strive to improve the situation through ongoing counseling.

The isolation of elderly victims is an additional barrier to the reporting and detection of mistreatment. Often, medical visits are the only times victims leave their homes or are allowed out by the abuser. Abusers tend to isolate victims by denying them access to friends and telephone. In one particular study comparing elder abuse victims with a control group, it was found that abused elders did appear more isolated (11). They tended to have fewer overall contacts and to feel negatively about their social situations. The abuser often prevents or inhibits

contact with outsiders through threatening behavior or by creating conflict in order to make visitors feel uncomfortable. Friends or other family members who may be able to intervene in the situation are driven away, allowing the abuser's behavior to escalate. This, in turn, leads to further isolation and makes it even more difficult for the victim to discuss the mistreatment.

Mr. R. was confined to his home because of his functional limitations, but also by his son, who rarely took him out. He was unable to go out independently because of the risk of his falling and his poor eyesight. He had previously participated in a local senior center, but was no longer able to go there on his own. A wheelchair was available to the patient, but he depended on his son to transport him, which was infrequent. Medical appointments were sporadic and Mr. R. was generally brought to the hospital only for emergency purposes. Mr. R. himself complained that the only people he saw were those "out of [his] window." His son clearly isolated him and was insensitive to the negative impact this was having on him.

Cultural diversity among patients provides unique challenges to social service and health care providers. Among various cultural groups, elders have held the traditional position of respect and esteem. If they expect to be cared for by the family that is no longer willing or able, they may become vulnerable to abuse. Family members may become or resentful of their obligations, which can lead to abusive situations (12). Elderly victims may feel embarrassed to divulge information about abuse to a representative of their own community, and even more so to one not of their cultural background. Understanding the risk factors for elder abuse in specific cultures is critical for practitioners working with immigrant families. A victim's inability to speak English and fear of abandonment are factors contributing to an elder's reluctance to talk about the abuse that is being experienced. A common belief among various cultural groups is that outsiders should not know about their affairs. Elder abuse victims, over their lifetime, may have internalized this belief and, additionally, may view American social welfare institutions as alien, thereby making it difficult for practitioners to detect any problems (13). If abuse is detected, the victim may deny it or reject interventions unless offers to help are framed in a culturally sensitive manner. In our efforts to provide services to these patients, we may need to expand our educational efforts and refer cases to practitioners who are from a similar cultural background and speak the same language. The use of interpreters is important and can be a source of support for the victims; however, we need to ensure that accurate information, through the translation process, is obtained. The case of Mr. R. brings to light cultural factors impacting on our interactions with him. Mr. R. was more forthcoming about abuse with Spanish-speaking staff. It was felt that his frequent refrain of "family is family" represented the Hispanic belief that family members should remain together. For non-Hispanic staff working with Mr. R., it was important to learn of the concept of *la familia*, in which the needs of the family unit are greater than the needs of the individual. Pride in the Hispanic family leads to practices of privacy and nonacceptance of outsiders to deal with family problems. The values of loyalty, interdependence and privacy are inherent in this culture, making it difficult for an abuse victim to reveal mistreatment or allow family to be confronted (12).

An additional factor not to be overlooked when working with elderly abuse victims is their own "ageist attitudes" or feelings of self-blame. Often, victims believe that they are responsible for the abuse or that they pose a burden on their caregivers. These feelings frequently lead to diminished self-esteem, with the elderly person feeling that, in a sense, the mistreatment is deserved. In the case of Mr. R., he pointedly stated, "I am a burden to my son."

Health care professionals struggle with their own ageist feelings about the elderly and their caregivers. This can present obstacles to viewing certain actions as abusive in the face of behaviorally challenging patients. Are we as staff sufficiently trained or able to predict which overwhelmed caregiver may be at risk of becoming abusive? Are we sometimes biased in our decisions, given our interactions with the abuser or potential abuser? Staff needs to be proactive in providing counseling and resources to caregivers, in an attempt to avoid any future abuse.

Recommendations

Cases of elder mistreatment can be highly complex, and the development of a "high-risk team" for interdisciplinary collaboration can be helpful to practitioners and elderly patients. Members of the team can bring distinct exper-

tise in detecting problems. Physicians may be able to uncover abuse during physical examinations, when patients may not openly admit to the problem. Victims would also gain comfort in knowing that various members of the health team are aware of their problem and are willing to help. Health care settings should develop ways of identifying those cases considered to be at risk (e.g., "flagging a chart"). Emergency room staff should have a list of patients known to be victims of abuse, as the ER is often the patient's first contact in the hospital. The availability of a 24-hour-a-day social worker or volunteer trained in elder abuse is also important, so that cases can be handled effectively when a patient presents to the hospital.

While victims' services hotlines are available in many states, perhaps hotlines developed specifically for elder abuse could be made available for victims over the age of 60. Counselors would be able to determine if victims are at immediate risk or could be referred for more intensive case management services. In states where mandatory reporting is not required, perhaps a "registry" would be beneficial, whereby victims' names could be registered. Given concerns about confidentiality, this would need to be done with the client's consent. If the current situation destabilizes, the practitioner could then make a formal referral to a protective services agency. Victims themselves could call the "registry" if they feel their safety is at risk.

Managed care providers may be limited in the services that they can provide; however, the severity and escalation of the problem of elder abuse needs to be brought to their attention, so that patients receive appropriate services and counseling. Case management services should be available through the provider, in order for a patient's safety to be monitored in the community.

Of utmost importance is the ongoing education of health care and social service staff. We need to continually heighten the awareness of everyone within the hospital community to the abuse of elders. For example, housekeeping staff have contact with patients and need to recognize inappropriate behaviors and know how to report their observations. Medical students must be made aware early in their careers of the problems associated with abuse of the elderly. Continuing education efforts through grand rounds, seminars and training sessions should be developed to maintain the focus on this growing problem.

Conclusion

Elder abuse is an escalating problem in our society, but one that often eludes us. To protect our elders, health care professionals need to heighten their awareness of this problem and expand their "comfort level" in questioning patients about family violence. The general community also needs to be informed about this problem, so that appropriate services can be developed and provided. The media could play an important part in calling attention to this often undetected social problem.

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