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AHC Media

Identification of Elder Abuse in the Emergency Department

Elder abuse and neglect do occur; the challenge is how to identify and report amidst the complexities of assessing and caring for these often challenging patients and situations. Universal screening, while called for by accrediting agencies, does not appear effective. So what are we to do? To use a much maligned term, profiling is a more useful approach. Being aware of and looking for factors associated with elder abuse, as described in this issue, yields greater return for the effort.

—J. Stephan Stapczynski, MD, FACEP, Editor

Introduction and Overview

Modern reports of elder abuse in the medical literature date from 1975 when the *British Medical Journal* published a report of "granny battering."[1,2] In the United States, reports of abuse and neglect in nursing homes in the 1970s led to a systematic study of elder mistreatment by the United States Senate Special Committee on Aging.[3] Since that time, under the auspices of the Department of Health and Human Services, the National Institute on Elder Abuse was created. The first federal government measures to address elder abuse came in Title XX of the Social Security Act of 1974, which gave individual states authorization to use Social Service Block Grant funds to protect elderly persons as well as children.[4] The World Health Organization recognizes elder abuse and neglect as global health problems.[5]

Initially treated as a social problem within society, elder abuse has recently become both a criminalized act and a growing public health concern.[6,7] This transition is due in large part to the growing elderly population. Based on the 2010 census data, there are 40.3 million, or 13% of the total population aged 65 years and older.[2,7] It is estimated that by 2050, people aged 65 and older will make up 20% of the population.[2] Those older than 85 years represent the fastest growing segment of the elderly population; it is estimated that the number of persons older than 85 years in 2050 will be 19 million, which is seven times higher than it was in 1980.[2,8] As the elderly population grows, the problems associated with abuse, neglect, and exploitation become more apparent.[9] While

EXECUTIVE SUMMARY

- Providers should be aware of the possibility of elder abuse, even in the absence of signs of physical injury.
- Caregivers and family members may need to leave the room in order to obtain an accurate history of events and of the true risk to the elderly patient.
- Elder abuse is associated with adverse health outcomes: accelerating dementia, depression, and death. Alteration in an elder's mental status may be a result of abuse.
- In all 50 states, physicians are required to report cases of known or suspected elder abuse for investigation. Elder abuse is likely widely under-reported.
- Conducting an interview with a caregiver should be nonjudgmental and nuanced. The discussion should be non-threatening. The primary goal of the investigation is not to punish the caregiver, but to end the abuse.
- For many elders, it is more frightening to be institutionalized, rather than to remain in an abusive situation. Home care assistance and respite care with other in-home resources may be preferable to removal from the home.
- The emergency physician may have to hospitalize the elderly patient who is in immediate physical danger.

there are many misconceptions about elder abuse, research has shed new light on the issue. It was once thought that most incidents of abuse occurred in nursing homes, but research has shown that most cases of abuse occur in the home.[9] Literature suggests that the abusers most frequently appear to be family members and caretakers of the elderly.[10] One study showed that the abuser was a household member in 89.7% of cases and a paid caregiver in only 4% of cases.[9] It is also now known that abuse does not follow a single pattern and can develop in a number of different situations. The abuse may also be the continuation of lifelong abuse that prior to age 65 was considered domestic abuse. Elderly people who are ill, frail, demented, depressed, or disabled are more commonly abused; however, those without these risk factors can also be victims.[9]

It has been estimated that between 1 million and 2 million elderly Americans experience some form of mistreatment annually.[11] Other sources cite as many as 2-2.5 million cases of elder abuse each year.[12,13] Reports of abuse have certainly increased with time, with 117,000 reports of elder abuse in 1986, 293,000 in 1996, and 450,000 in 2012.[9,14] Older men and women have similar per capita abuse rates, estimated at a prevalence rate of more than 1 in 10 people older than the age of 65.[7] These statistics, however, are likely gross underestimates, as it has been estimated that only 1 in 14 cases of elder abuse or neglect comes to the attention of authorities.[15] Factors leading to misdiagnosis and underreporting include denial by both victim and perpetrator, clinicians' reluctance to report victims, disbelief by medical providers, and clinicians' lack of awareness of warning signs.[16]

Elder abuse in family settings has increased in recent years for a number of reasons: the increasing proportion of older adults in the total population, the increase in chronic disabling diseases, progressive dependency, and the increasing involvement of families in caregiving relationships with elders. These trends are likely to continue into the foreseeable future.[17]

It has been shown that elder neglect may be more readily detected in the emergency department by screening protocols, and several screening protocols have been created and tested.[18] Many emergency departments, however, lack protocols for elder abuse, and many physicians are not even aware of it as an entity, according to one report.[19] The gross lack of detection by physicians has been demonstrated in several studies. In one study, only 2% of all cases reported in the state of Michigan were made by physicians.[20] Another study found that less than 2% of reports of elder abuse to state APS agencies come from physicians.[21] It is unclear, however, if this is due to others reporting abuse on behalf of the physician. One survey of emergency physicians indicated that 79% reported that they had treated a case of elder abuse in the preceding year, yet only 50% reported the abuse. Hospital protocols have been recommended by the American Medical Association and the American College of Emergency Physicians to aid in the detection and management of elder abuse.[22,23] These protocols, as well as generalized knowledge and training in elder abuse, become increasingly important when considering the impact of elder abuse. The risk of death for elder abuse and neglect victims is three times higher than for elderly non-victims.[24]

Definitions

Elder abuse and neglect refers to an act or omission resulting in harm, including death, or threatened harm to the health or welfare of an elderly person. It often is referred to globally as elder mistreatment (EM). The 1985 Elder Abuse Prevention, Identification and Treatment Act defines abuse as the "willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness."[25]

The American Medical Association in 1987 proposed this definition: "Abuse shall mean an act or omission which results in harm or threatened harm to the health or welfare of elderly person. Abuse includes the intentional infliction of physical or mental injury, sexual abuse, or withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person by one having the care, custody, or responsibility of an elderly person."[26] Other types of EM include violation of rights, denial of privacy, and denial of participation in decision-making.[27] EM may entail more subtle practices, which make it fall under the concept of "undue influence." Undue influence is the substitution of one person's will for the true desires of another. Such influence often

Table 1. Types of Elder Abuse

Type of Abuse	Definition	Examples
Physical abuse	Use of physical force that can result in injury, pain, or impairment to an elderly person	Hitting, biting, slapping, shoving, burning, pushing, kicking, medication misuse, use of physical or chemical restraint, force feedings
Sexual abuse	Nonconsensual sexual contact of any kind with an elderly person	Rape, forced fondling, forced nudity, indecent exposure, indecent speech, humiliating forced nude pictures
Financial or material exploitation	Illegal or improper use of an elderly person's funds, property, or assets	Taking of possessions, coerced signing over of property, funds, goods, coerced changing of wills, forging elderly person's signature, failure to pay bills despite adequate funds
Self-neglect	Elderly person's refusal or failure to provide adequate food, water, clothing, shelter, personal hygiene, medications, or safe living conditions	Elderly people who are malnourished, dehydrated, have poor hygiene, are living in places with no heat or running water, home insect infestations, not getting needed glasses, dentures, or medical needs, homelessness, living in unsafe housing
Caregiver neglect	Failure or refusal to fulfill any duties or obligations to an elderly person	Not providing care or necessary resources such as food, water, clothing, unclean living conditions, not getting appropriate care for elderly person's health problems or getting medications for health problems, allowing elderly people to get bed sores and not treating them
Abandonment	Desertion of an elderly person by an individual who has responsibility to provide care or by someone with custody of the elderly person	Desertion of elderly person at hospital, shopping center, or public location
Emotional or psychological abuse	Infliction of pain, anguish, or distress to an elderly person through verbal or nonverbal acts	Humiliation, intimidation, threats of abandonment, ridicule, purposely causing fear or anxiety, harassment, verbal abuse, isolation and withholding social interaction, giving an older person the "silent treatment"
Resident-to-resident aggression	Negative physical, sexual, or verbal interactions between residents of a long-term care facility	Physical, sexual, or verbal abuse between residents that has a negative impact, including fighting or physical assault, forced sexual assault, arguments, or verbal insults

entails fraud, duress, threats, or other pressures. Undue influence occurs when one person uses his or her role and power to exploit the trust, dependency, or fear of another to gain psychological control over the weaker person's decision-making, often for financial gain. While dependent and impaired people are especially susceptible, this can happen to people who would be considered otherwise competent.[28]

Domestic elder abuse is any type of mistreatment that is committed by a person with special relationship to that elder, including spouse, child, sibling, friend, or caregiver.[29] Institutional abuse is any type of mistreatment that occurs in residential facilities, including nursing homes, assisted living facilities, foster homes, and group homes, where there is a legal or contractual obligation to provide some component of care.[29]

Elder abuse has been classified into the following broad categories by the National Center on Elder Abuse.[9,29,30] (*See Table 1.*)

Specific Categories of Elder Abuse

Physical Abuse. The most recognizable form of abuse is the use of physical force that might result in bodily injury, physical pain, or impairment. It may comprise a wide range of behaviors, including slapping, shaking, hitting, kicking, pinching, pulling hair, force feeding, choking, burning, pushing, or striking with objects, any of which are carried out with the intention of causing suffering, pain, or other physical impairment.[9,29,31] It can also include more subtle forms such as forced isolation, not allowing use of restroom or bathing, or the use of chemical or physical restraints.[9] Signs of abuse may not always be apparent depending on the nature of the abuse.[9] It can also be extremely difficult to differentiate injuries sustained from abuse from those sustained by accidents such as falls.[9] Some common signs of physical abuse are bruises, welts, burns, cuts, and wounds — especially those in various stages of healing — black eyes, restraint marks, and broken bones.[29,31] Because elderly patients bruise more easily, and osteoporosis leads to a higher incidence of fractures, clinical judgment must be used to determine whether or not injuries signal abuse.[32] Dehydration, malnutrition, bed sores, inappropriate clothing, and improper administration of medicines may also be less obvious indicators.[33,34]

The patient's general appearance should be noted for hygiene or dirty clothing. The skin and mucosa should be examined for dehydration, bruises, decubitus ulcers, lacerations healing by secondary intention, or multiple lesions in various stages of healing. The oral cavity may indicate ecchymosis from forced oral sex, lesions from venereal disease, tooth fractures, or cigarette burns. The oral mucosa may exhibit signs of dehydration. There may be clustering of bruises or characteristic shape, as from injuries inflicted with a belt or iron. Examination of the head may reveal traumatic alopecia, vitreous hemorrhage, orbital fractures, or retinal detachment.

Table 2. Risk Factors for Elder Abuse

Patient

- Dementia or cognitive impairment
- Female
- Decreased physical health
- Requirement for more assistance with daily living activities
- Social isolation
- Increased age
- Behavior problems
- Psychiatric illness
- History of past abuse
- Low income or wealth

Caregiver

- Caregiver mental health
- Caregiver substance abuse
- Elevated levels of stress of caregiver
- Poor or conflictual relationship with elder
- Dependence on the elder for finances or resources
- Legal or financial difficulties

Environmental

- Shared living conditions
- Low social support and social isolation

Evidence for occult fracture, immersion burns, or cigarette/cigar burns may be present.[32] Rope or restraint marks on the wrists or ankles may be present.[35] Another important clue to physical abuse may be an abrupt change in the behavior of the elderly person, especially signs of fear of the caregiver.[29] The American Medical Association has recommended that all health care providers routinely ask their elderly patients about abuse.[36] This may have to occur after the caregiver has left the room — and if a translator is needed, someone other than the caregiver or family member should be used. A caregiver's refusal to allow physician history or exam with the elder alone, as well as caregiver's refusal of allowing visitors with the elder alone, can also indicate abuse.[29]

Sexual Abuse. This is broadly defined as nonconsensual sexual contact of any kind with an elderly person.[9,29,37] This includes any sexual contact with an individual unable to give consent.[29] This type of abuse is thought to be the least common and the most understudied form of abuse, with one study estimating that 1% of the elderly population in the United States are sexually abused.[9] This, however, could be due to underdetection, as elders are often very reluctant to admit to sexual abuse.[9] The spectrum of sexual abuse ranges from unwanted touching, indecent exposure, sexually explicit photography, or unwanted innuendo, to fondling with a non-consenting competent or incompetent person, to rape itself. The patient may complain of genital or anal pain, itching, bruising, or bleeding, or he or she may have venereal disease. Any case of venereal disease in a person whom the medical care provider believes cannot consent to relations should be considered a case of sexual abuse and should be reported appropriately.[9] The provider does not need to accuse or confront potential abusers, but does have an obligation to report the incident.[9] The patient's underwear may be stained or bloody, as there is a greater likelihood of genital injury in elderly victims than in younger victims.[35] Studies in 2001 found that the older the victim, the less likely that the offender would be convicted, despite the fact that this population is the least able to defend themselves and more likely to be abused.[9]

Sexual offenders may exhibit certain characteristic tendencies. Specifically, they have been proposed to be domineering or bullying, with a feeling that they are entitled to exert power and authority. They may show narcissistic tendencies and feel that the victim deserved maltreatment.[35]

Financial or Material Exploitation. This occurs when family members, caregivers, or friends take control of the elderly person's resources, including funds, property, or assets.[9,29,37] This can include coercion or outright theft, with or without the awareness of the victim. Some examples are cashing an elder person's check without permission, forging an elder person's signature, misusing or stealing an elder person's money or possessions, coercing or deceiving an elder into signing any documents such as wills or contracts, and improper use of wills, power of attorney, guardianship, or conservatorship.[29] This type of abuse can affect individuals from all socioeconomic classes. The estimated incidence of financial exploitation is approximately 30%.[9]

Self-Neglect. This category encompasses behaviors of an elderly person that threaten his or her own health or safety.[29] By definition, self-neglect excludes situations in which a mentally competent older person who understands the consequences of his or her decisions makes a conscious decision to engage in acts that threaten his or her own health or safety.[29,35,38] It is the result of an adult's ability due to diminished capacity to perform essential self-care tasks, including the provision of essential food, clothing, shelter, personal hygiene, safety precautions, and medical care, as well as the management of financial affairs.[9,29] Signs and symptoms of self-neglect are dehydration, untreated medical conditions, malnutrition, poor personal hygiene, hazardous and unsafe living conditions, unsanitary or unclean living environments, inappropriate or inadequate clothing, lack of medical aids such as eyeglasses, dentures, or hearing aids, or inadequate housing or homelessness.[29,37] Many elders with neglect often have underlying mental disorders including dementia, depression, psychosis, or substance abuse that prevent them from understanding and recognizing when they need to request assistance.[9] One study indicated that self-neglect contributed to increased mortality. In that report of elderly patients, 40% of those in the self-neglect cohort, vs. 17% in the non-investigated cohort, died during a 13-year period.[39] It has also been found to be associated with increased rates of hospitalization.[9] Elder self-neglect is the most common type of abuse reported to social services.[9]

Caregiver Neglect. The term "abuse" refers to acts of commission, while "neglect" refers to acts of omission. It is the refusal to fulfill any part of a person's obligations or duties to a vulnerable elderly person.[9,29,37] Neglect may entail failure to meet nutritional and hygienic needs, or lead as far as manslaughter or suicide.[40] The refusal or failure to fulfill his or her obligations or duties to an elderly person may include deprivation

of food, clothing, hygiene, medical care, shelter, proper heat, sanitary living conditions, or supervision that a prudent person would consider essential for the well-being of another.[29,41] Poor nutrition, poor hygiene, poor skin integrity, contractures, dehydration, fecal impaction, excoriations, and untreated medical problems all may constitute physical evidence of neglect.[29,42] Psychological neglect includes failure to provide social stimulation, forced isolation, or restriction of social interactions.[9] Unfortunately, neglect is very common, but is often the hardest type of abuse to prove.[9] There are also many cases of neglect that are not intentional but occur as a result of lack of resources or knowledge about obtaining assistance when it is needed.[9] Elders are also very reluctant to report cases of neglect for fear they will upset or lose companionship of family members or caregivers or fear of being placed in a nursing home.[9]

Abandonment. This is the desertion of an elderly person by an individual who had responsibility for providing care or with physical custody.[9,29] Some examples of this type of abuse are desertion of an elderly person at a hospital, nursing facility, or institution, or at a shopping center or public location.[29] This also includes an elderly person's report that he or she has been abandoned. The deserter can be a family member, friend, caregiver, or institutional facility employee.[37]

Emotional and Psychological Abuse. This is defined as the infliction of mental anguish, pain, or distress by verbal or nonverbal acts.[9,29] This may encompass a variety of actions intended to inflict emotional pain or injury, ranging from verbal threats to threats of institutionalization or belittling and humiliating statements.[9,29] It also includes treating the person like an infant, isolating the elderly person from family or friends, or forced social isolation.[29] While this is the second most common form of abuse, it is often harder to prove than other forms of abuse.[9] Patients may present with behavior problems, including self-neglect and psychotic behavior. Depression, suicidal thoughts or actions, or other self-destructive behaviors such as rocking in place or biting may also be presentations, and would constitute reasons for hospitalization.[43]

Resident-to-Resident Aggression. This type of abuse occurs when a negative physical, sexual, or verbal interaction occurs between long-term care residents in a community setting that causes physical or psychological distress to the recipient.[9]

Risk Factors

As elder abuse becomes further studied, more risk factors for abuse can be identified. (*See Table 2.*) The lack of knowledge of risk factors is thought to contribute to the low detection of abuse.[44] Dependency, either on the part of the victim or of the perpetrator, and caregiver stress are common denominators in abusive situations. Functional impairment leads to dependency and vulnerability of elderly persons, especially those who cannot perform activities of daily living. Institutionalization is recognized as a risk factor for neglect and abuse.[16] On the other hand, elder abuse occurs most commonly in residential rather than institutional settings.[21,45] Older persons most commonly are abused by the people with whom they live, most often an adult child or spouse.[44] Frail, very old (older than 75 years) adults who have a diagnosis of depression or dementia are more likely to be mistreated than are other elderly people. Physical or cognitive impairment, alcohol abuse, female sex, and a history of domestic violence also are risk factors for elder mistreatment.[33,46] Older adults who require assistance with activities of daily living or have poor social networks have been found to be at higher risk as well.[33] Victims of caregiver neglect are more likely to be widowed, very old, cognitively impaired, and socially isolated. Developmental disabilities, special medical or psychiatric needs, and lack of experience managing finances all place a person at risk, as do patient aggression, verbal outbursts, or embarrassing actions.[14] A recent systematic review of the literature found that there were certain risk factors that were reproducible across the range of 49 studies, suggesting they are common components of abuse. (*See Table 2.*) Those risk factors with the highest association were related to relationships and environment, highlighting the role of socio-cultural factors of abuse.[44]

The risk to the victim may be related more to characteristics of the perpetrator than to those of the victim. There may be a family history of violence or substance abuse. Abusers most often are the primary caregivers. Males abuse more than females.[26] The risk is greater if the caregiver has a financial or emotional dependence on the victim,[36] and may be exacerbated by alcohol or drug abuse, legal or financial difficulties, or psychiatric disease on the part of the caregiver.[14,20] Caregivers may be well-intentioned, but simply overwhelmed by the amount of care required. They themselves may be impaired by mental or physical problems, which serve as barriers to the provision of adequate care. A domineering, violent, or bullying category of provider has been described, who is prone to financial abuse and neglect as well as possibly sexual abuse.[47]

Identification of Elder Abuse

Part of the growing problem with elder abuse is the large number of cases that are not identified and therefore not reported. In order to decrease this number, medical care providers must become more proficient in the identification of elder abuse. Emergency medical care providers are in a vital position for identifying cases of abuse, as the elderly use emergency medical services at twice the rate of the general population.[48] One study found that 80% of elderly abused victims had at least one emergency department visit within the past year.[52] Another study found that elder abuse victims who suffered two or more types of abuse had an even significantly higher rate of emergency department use.[49]

Physical abuse is most easily recognized, although neglect is more common.[33] Psychological and financial abuse may be missed more easily. Difficulty arises when an elderly patient's caregiver seems indifferent or angry toward that person and is unwilling to cooperate with health care providers.

The history should entail direct and simple questions. Examples of these may include general queries about who handles the patient's finances, who cooks for him or her, under what

circumstances medical care is sought, and whether the patient feels safe where he or she lives.[32] Specific questions may be posed as to whether the patient has been slapped, struck, kicked, or tied down. The patient, the suspected abuser, and other family members should be interviewed separately without other family members or caregivers in the room. The rationale for this is clear: Confidentiality is necessary if the interviewer is to ascertain whether the patient has been touched without consent, has had items taken without permission, or is afraid of anyone at home. This also may help the elder person feel safe and comfortable and more willing to disclose the abuse. A thorough physical exam should be conducted on all patients, looking for any signs of abuse such as wounds, bruising, ligature marks, marks from restraints, or signs of sexual abuse. Emergency department clinical presentations of the abused elder may include dehydration, apathy, or depression. The most common complaints for patients older than age 75 are falls, dehydration, and failure of self-care.[50] Each major category of abuse and things to look for were previously discussed.

Red flags for abuse include: reluctance of the caregiver to leave the patient alone with the health care provider; lack of caregiver knowledge of the patient's medical conditions; delay in seeking needed medical care; and missed doctor appointments.[51,52] (*See Table 2.*) Caregivers who abuse are often likely to interrupt the patient and answer questions for him or her. Other red flags include unexplained changes in behavior such as agitation, new depression, withdrawal, altered mental status, or isolation.[9] There are also certain patterns of injury such as ligature marks; multiple burns, especially in a stocking and glove pattern; and bruises on the abdomen, neck, posterior legs, or medial arms, which do not normally occur as result of accidental trauma or falls.[21] There are also certain fracture patterns that can suggest abuse, such as spiral long bone fractures and first rib fractures.[21]

Another important component to the identification of abuse and neglect includes the proposed screening tools. Screening is not intended to be diagnostic but to highlight the need for further review. Numerous screening tools have been developed to be used along with the standard history and physical exam in the evaluation of elderly adults. Several of these screening tools have shown promise in improving identification of abuse. The Elder Abuse Suspicion Index (EASI) is a screening tool that can be easily implemented in health care settings such as the emergency department. EASI is composed of six questions (five asked of the patient, one question answered by the physician) which takes only a few minutes to complete. An answer of "yes" to any question should raise suspicion or further evaluation for abuse or neglect.[53,54] Studies of the EASI have demonstrated a sensitivity and specificity of 0.47 and 0.75.

Another screening tool was developed by the American Medical Association and consists of nine questions, with any answer of "yes" prompting a more in-depth evaluation.[9] There are also several other screening tools, some of which are not realistic due to time constraints (Indicators of Abuse screen takes 2-3 hours to fully complete), while others focus only on one type of abuse, and others have failed to show benefit.[55]

Currently there is no definite evidence that screening and early detection of abuse and neglect reduce exposure to abuse or harm from abuse.[55] The U.S. Services Task Force has not found adequate data to assess the harms versus benefits of screening all older adults. Data have not shown if these screening tools decrease the incidence or impact of abuse more than simply having a heightened suspicion for abuse.[55] Several medical associations as well as the National Center on Elder Abuse do recommend routine inquiry about abuse.[55] In U.S. hospitals with emergency departments accredited by The Joint Commission, it is required to screen all patients to ensure they are not victims of abuse or neglect.[9] In most cases, however, this is usually a simple question of asking if they feel safe at home or simply asking if they are abused.

Obstacles to Detection of Elder Abuse

A large part of the under-reporting of elder abuse is due to the obstacles to detection. These obstacles may be related to the victim as well as to the medical care provider. Elderly people may not report abuse because they do not recognize it or they may normalize the actions within the context of their culture, family, or lifestyle.[55] Victims often have low self-esteem, may blame themselves for the abuse, and do not want to betray their families. They may feel that they are a burden and rationalize the abuse as justified due to the stress they cause caregivers.[55] They may not want to admit their vulnerabilities, or may feel ashamed for having raised a child who would betray him or her in any way.[14,56] They especially may be ashamed to acknowledge their own dependency on the abuser or may be loyal to that abuser and unwilling to press charges against a family member. An abused older adult may be uninformed or misinformed regarding services available.[56] He or she may harbor a fear of being removed from the home and placed in a nursing institution. This fear, in fact, may be warranted. In a Connecticut study, 78% of abused and neglected victims admitted for short-term care remained institutionalized permanently.[57] The victim may worry about further abuse from a caregiver in retaliation for having divulged information. He or she also may worry about not being believed because the alleged abuser may act differently in public and the victim is unable to prove the abuse.[55] Many elderly people are isolated and seldom leave the house, resulting in less opportunity for detection of abuse by others. The abuser may control access to others and may stay present during encounters with outsiders to ensure that secrecy is maintained.[58] The victim also may lack the capacity to give a history due to dementia or inability to communicate.[55]

There may be differing definitions of abuse by victims from differing cultural backgrounds based on the perception of the intent of the abuser. One example cited is that of a woman who sedated her elderly mother when company came to prevent embarrassment from her mother's senile dementia. That report listed Korean Americans in particular as unwilling to reveal "family shame" to others or to

create conflict among their relatives.[59]

Healthcare visits may be an elderly person's only contact with the outside world. Physicians infrequently report elder abuse for a variety of reasons. Perhaps the most significant is that physicians lack training and experience on the assessment, identification, and reporting of elderly abuse.[21] A study of ACEP members in 1997 found that 76% stated that they could not accurately diagnose elder abuse, and only 25% of emergency medicine residency trained emergency physicians recalled any educational training on elder abuse.[48] Physicians may not be familiar with reporting laws. They may fear offending patients or their abusers or are concerned with time limitations in the emergency department. Time limitations may be a pervasive and driving fear in other medical specialties as well. There may be a feeling that requiring physicians to report cases may be patronizing to victims, who may be perceived as unable to make decisions for themselves, especially if they are competent.[14] Emergency physicians may believe that they do not possess appropriate evaluation skills. A hospital may have no protocols for identifying or addressing elder abuse. Physicians may be reluctant to ask questions about potential abuse because of fear of litigation and of possible court appearances.[37,56] For whatever reasons, it is reported that physicians notify the appropriate authorities in only one of every 14 cases of suspected elder abuse they identify.[7]

Further confounding factors may relate to any underlying medical disorder that the patient may have. Advanced neurologic disease such as multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease may lead to immobilization and severe disability. These individuals are at risk for pressure ulcers, pneumonia, or venous thromboembolism, even with adequate care.[35]

Abuse in Long-Term Care Facilities

Abuse in long-term care facilities is also becoming a growing concern as more of the population resides in such facilities. In 2008, 3.2 million Americans resided in nursing homes and more than 900,000 people lived in assisted living settings.[60] In 1987 Congress enacted legislation that required nursing homes participating in the Medicare and Medicaid programs to comply with certain quality of care requirements. This legislation was included in the Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act.[61] Every state has a nursing home ombudsman program that responds to reports of neglect or abuse in the nursing home elderly. Physicians may report suspicions of abuse to the state ombudsman or to Adult Protective Services.[31,32]

Abuse in institutional settings may manifest in similar ways to those in residential settings: theft of money or personal property, unsanitary conditions, poor personal hygiene, sexual assault, physical abuse or unexplained injury, bed sores, physical or chemical restraint, or malnutrition and dehydration.[32,61,62]

Elder abuse in nursing homes is well documented. One study found that 50% of nursing home staff admitted to mistreating older patients within the prior year. This included physical violence, mental abuse, or neglect.[60] Another study in 2000 found that of 2,000 nursing home residents studied, 44% admitted to being abused and 95% believed they had been neglected or witnessed neglect of other residents.[2] Abuse may be related to burnout or personal stress among staff, or to attitudes that residents are childlike and in need of discipline. Primary abusers of nursing home residents were nurses' aides and orderlies with no stress training. The coalition of Advocates for the Rights of the Infirm Elderly (CARIE) has developed an eight-hour program for caregivers working in long-term care facilities. The program focuses on recognizing abuse and possible triggers for abuse.[63] There still seems to be a large number of abuse cases that are not identified or reported. The U.S. General Accountability Office conducted a study in 2008 and found that state surveys grossly underestimated cases in facilities, with 70% of state surveys showing at least one deficiency in care; 15% missed cases of actual harm to a nursing home resident.[2]

Legal Considerations

State laws against elder abuse date from 1973.[33,41] Currently, all 50 states and the District of Columbia have passed legislation to establish adult protective service (APS) programs. State APS statutes authorize agencies to receive cases of abuse, investigate cases of elder mistreatment, and offer a number of services to reduce or eliminate cases of abuse or neglect.[7,62] These laws in general were based upon laws addressing child abuse. Since the latter concerned physical abuse primarily — and children had no money to exploit — earlier laws tended to be weak in the area of financial exploitation. The legal remedies offered for various forms of elder abuse tend to emphasize removal of the abused person form the setting in which the abuse is occurring.[31,61]

The federal government drafted the first laws regarding elder abuse in 1981 in the U.S. House Select Committee on Aging. Federal definitions of elder abuse were standardized in 1985 with the Elder Abuse Prevention, Identification, and Treatment Act (HR 1854), and addressed further in the 1987 Amendments to the Older Americans Act.[31,33] In 2010 the Elder Justice Act was passed, which authorized federal funds to address elder abuse, exploitation, and neglect.[5]

Other resources that address the issue of elder abuse include: Criminal Justice Services; National Association of State Units on Aging; National Center on Elder Abuse; National Organization for Victim Assistance; and the National Coalition Against Violence. (*See Table 3.*)

Laws for reporting elder abuse vary from state to state, with 43 states that currently have mandatory reporting laws; physicians should understand existing law in their own state.[48] These mandatory reporting laws mean that failure to report is a criminal act with penalties including charges of misdemeanor, financial penalties, imprisonment, civil liability for damages, community service, and notification to state licensing boards.[37] A study of penalties given to violators of mandatory reporting laws found that fines were the most common penalty, with 60% of the offenders being fined.[6] In this same

study they found that jail and community service were infrequently applied but are still a possibility, and probation was used in one-third of the cases.[6] Generally, physicians and other reporters are granted immunity when the reporting is done in good faith.[45] Health care providers need not actually prove the abuse, just show suspicion for abuse. They are to report it with the expectation that appropriate authorities will investigate the report. Documentation should be clear and legible, as it may become evidence in a court of law.

Management and Intervention

The emergency physician should maintain a high index of suspicion for abuse when treating elderly patients. This is easier to detect when complaints are specific to sexual or physical abuse. Screening programs may be initiated. A detailed history should include functional capacity, who the patient lives with, where the patient lives, and whether he or she feels safe. Laboratory and radiographic analysis should be conducted as indicated by history and physical findings. Photo documentation of injuries, sores, and general patient condition are helpful.

If the physician believes the patient is in immediate danger, the patient should be hospitalized, transferred to the care of a friend or reliable family member, or placed in emergency shelters. Suspected abuse should be reported to the appropriate state agency, which can provide a more thorough long-term assessment. Local resources may vary, but may include social work, possible home nursing assistance, safe homes for older battered persons, and calls to the local Adult Protective Services (APS) agency.[40] In cases of physical or sexual abuse, police should be called in accordance with state law. Patient disposition depends on the medical condition of the patient and the results of APS investigation. The patient may need to be admitted to the hospital for his or her protection until an alternative living situation is found or legal guardianship is established. Admission for specific medical problems, such as decubitus ulcers or dehydration, may be more acceptable to the patient and the family or caregiver. This may be especially true if the home situation is not easily remedied, as in the case of the abuser with substance abuse or mental illness.

If the patient is not competent to decide for himself or herself, contact with APS should be initiated.[64] APS is the official state entity charged with promoting advocacy and protecting victims of elder abuse and neglect. APS agencies broadly provide access to services that address the social, housing, medical, and legal needs of elderly persons.[65] APS agencies were established by state statutes and may provide immediate evaluation, counseling, and relocation in cases of suspected elder mistreatment. In smaller jurisdictions they are under local law enforcement. They can establish a court-ordered guardianship or conservatorship to arrange shelter, finances, and care. Once a report has been filed to APS, a social worker is assigned to the case and makes a home visit. After conducting an interview and screening the case, the social worker may suggest solutions. In general, the patient and the caregiver should be interviewed separately. The patient's decision-making capacity must be assessed. If an adult is suffering from mental illness or cognitive impairment and represents an immediate risk for hurting himself or herself, emergency removal orders may need to be pursued authorizing temporary involuntary

Table 3. Resources on Elder Abuse

Resource	Services Provided	Web Site/Phone Number
Administration on Aging: U.S. Health & Human Services	Administration of grants and funding, listing of community resource centers and foundations, information on legislation	www.aoa.gov
National Center on Elder Abuse	An Administration on Aging-funded resources that provides research, training, news, and resources on elder abuse. Provides FAQs, training, fact sheets, and lists of resources	www.ncea.aoa.gov
Adult Protective Services	Receive reports of abuse/neglect and investigate these reports, assess victim's risk, assessing victim's capacity to make decisions and understand, arrange for emergency shelter, care, support services, or legal assistance, service monitoring and evaluation	
Eldercare Locator	Provides information and referrals to older Americans and their caregivers to services in their area. Provides links, fact sheets, information on long-term care planning and advanced care planning, and benefits Check website to help find benefit programs to help older Americans afford their needs	1-800-677-1116 www.eldercare.gov/Eldercare.NET/Public/Index.aspx
National Clearinghouse on Abuse in Later Life	Training resources and links to other resources for health care providers	www.ncall.us
National Organization for Victim Assistance	Referrals and resources in every state	1-800-TRY-NOVA or 703-535-NOVA www.trynova.org
National Coalition Against Domestic Violence	Training and education on domestic violence, publications and programs	303-839-1852 www.ncadv.org
Clearinghouse on Abuse and Neglect of the Elderly (CANE) Department of Consumer Studies and Research. University of Delaware	Archive of published research, training resources, government documents	www.cane.udel.edu

hospital admission. Legal guardianship, also called conservatorship, signifies the permanent removal of a person's right to make his or her own decisions. This requires judicial oversight and due process for wards and conservatees.[49]

In non-emergency cases, APS workers usually have between 30 and 78 days to complete an investigation and determine the validity of an allegation.

In most states, mandatory reporting applies to the professional whose role brings them into contact with the patient. Failure to report is a punishable offense in 43 states, and good faith reporters are immune from civil and criminal lawsuits.[54] Protective services must keep the identity of the reporter confidential.

Two studies found that, by being referred to APS, elderly persons were more likely to be institutionalized.[60,66] With increasing demand for APS, there may be pressure to solve difficult problems through nursing home placement,[67] although the irony of using a system intended to protect the health and independence of the vulnerable elderly population by institutionalizing them has not been lost on at least one author.[56]

On occasion, medical case management teams are convened to provide consultation and support to hospital staff, to assist in the multidisciplinary evaluation of suspected abuse, and to develop treatment plans. Team members generally are composed of a physician, nurses, and social workers.[67] They may make house calls. Services provided may include physical and occupational therapy, nutritional improvement, or treatment of disease states. Legal intervention teams have been utilized as well.

Their purpose may be to address financial management, probate and guardianships, or other legal and housing issues. Civil courts can issue protective orders, create guardianships, order assets to be frozen, adjudicate lawsuits, and issue emergency removal orders.[48] In extreme cases, Fatality Review Teams have been convened to review deaths of older persons. These teams require participation by the medical examiner.[64] A variety of agencies exist which offer information, research services, and advice regarding abuse and neglect of the elderly.[48,52,68] (*See Table 3.*)

In some cases of unintentional neglect, education of the caregiver may be the only intervention necessary. Options for support to decrease the stress and anxiety that preceded the abuse may include home health aides, respite services, day programs, or accessible transportation to unburden the caregiver.[14] Ultimately, the goal of treatment is not to punish the victim or the abuser, but to stop the abuse. When mistreatment results from the caregiver being overburdened, intervention may be welcomed by all parties. Options for the caregiver in less acute situations include periodic respite care, support groups, home health services, adult day care, and church activities or pastoral visitations.[45]

Conclusions

Elder abuse is becoming a growing problem and concern, and many of those patients have substantial interactions with emergency departments. Geriatric abuse as a health care issue is a relatively recent phenomenon and still is evolving. Millions of elderly persons experience progressive dependency, social isolation, poorly rated self-health, and psychological decline, making them more susceptible to abuse and neglect. Physicians and other health care workers are well situated for detecting and reporting suspected cases, although many barriers exist on the individual level. Due to these barriers, abuse cases are frequently missed and certainly underreported. With increased awareness about abuse and neglect, as well as continued research and education, providers can help to break down the barriers to identifying abuse and neglect which can have substantial effects in the lives of elderly patients and within the healthcare system.

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CME Questions

1. Which of the following constitute(s) risk factors for elder abuse on part of the victim?
   A. female sex
   B. very old age (age older than 75)
   C. cognitive impairment
   D. dependency on the part of the victim
   E. all of the above
2. Obstacles to detection of elder abuse include:
   A. differing definitions of abuse by people of varying cultural backgrounds
   B. victims' unwillingness to betray their family or caregivers
   C. fear of victim that they will be placed in a nursing home
   D. social isolation of the victim
   E. all of the above
3. Abrupt changes in will, changes in bank practices, lack of appropriate food and clothing despite the person having adequate funds for such things are examples of which type of abuse?
   A. sexual abuse
   B. financial exploitation
   C. abandonment
   D. psychological or emotional abuse
4. When assessing a patient and screening for abuse, it is important to do all of the following *except*:
   A. conduct a full physical exam looking for any signs of possible abuse
   B. ask open-ended questions about any injuries or signs of abuse
   C. ask the patient who they live with and if they feel safe
   D. always interview the patient when the caregiver is present so the patient can feel more comfortable
5. Which of the following regarding elderly abuse is *false*?
   A. Most cases of elderly abuse occur in nursing homes.
   B. Abusers are most commonly household members.
   C. Elder abuse has serious financial impacts on our healthcare system.
   D. Physician reporting accounts for only a very small number of the total reported cases.
6. An elderly woman who you believe does not have capacity to make decisions and provide consent for herself is found to have new lesions suggestive of a sexually transmitted infection. As the treating physician, you should:
   A. Ask the patient if she was abused; if she says no, then no further intervention.
   B. Accuse the caregiver who is present with the patient of sexually abusing the patient before obtaining any more information.
   C. Report the case of suspected abuse to proper authorities, as you believe she has been sexually abused.
   D. No further intervention, as you cannot prove sexual abuse just based on the exam.
7. Which of the following are "red flags" for elder abuse?
   A. delays in seeking necessary medical care
   B. a caregiver who is unwilling to leave the patient alone with the healthcare provider
   C. poor knowledge of the patient's medical conditions by the caregiver
   D. none of the above
   E. all of the above
8. Which of the following regarding self-neglect is *false*?
   A. It includes situations in which a mentally competent older person makes a conscious decision to engage in acts that threaten his or her own safety.
   B. It affects mortality.
   C. The elderly person lacks capacity to perform essential self-care tasks.
   D. Most victims have underlying mental disorders.
9. Which of the following regarding reporting elder abuse is true?
   A. Providers are granted immunity when reporting in good faith.
   B. A provider does not need to prove abuse in order to report it.
   C. Most states have mandatory reporting laws.
   D. Failure to report can lead to fines, community service, or even jail time.
   E. All of the above are true.
10. Which of the following exam findings is *not* suggestive of neglect?
    A. weight gain
    B. decubitus ulcers
    C. soiled clothing with urine or feces
    D. failure to have necessary medications
    E. signs of bug infestation

CME Objectives

Upon completion of this educational activity, participants should be able to:

- recognize specific conditions in patients presenting to the emergency department;
- apply state-of-the-art diagnostic and therapeutic techniques to patients with the particular medical problems discussed in the publication;
- discuss the differential diagnosis of the particular medical problems discussed in the publication;
- explain both the likely and rare complications that may be associated with the particular medical problems discussed in the publication.

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EMERGENCY MEDICINE **REPORTS**

Identification of Elder Abuse in the Emergency Department

Types of Elder Abuse

Type of Abuse	Definition	Examples
Physical abuse	Use of physical force that can result in injury, pain, or impairment to an elderly person	Hitting, biting, slapping, shoving, burning, pushing, kicking, medication misuse, use of physical or chemical restraint, force feedings
Sexual abuse	Nonconsensual sexual contact of any kind with an elderly person	Rape, forced fondling, forced nudity, indecent exposure, indecent speech, humiliating forced nude pictures
Financial or material exploitation	Illegal or improper use of an elderly person's funds, property, or assets	Taking of possessions, coerced signing over of property, funds, goods, coerced changing of wills, forging elderly person's signature, failure to pay bills despite adequate funds
Self-neglect	Elderly person's refusal or failure to provide adequate food, water, clothing, shelter, personal hygiene, medications, or safe living conditions	Elderly people who are malnourished, dehydrated, have poor hygiene, are living in places with no heat or running water, home insect infestations, not getting needed glasses, dentures, or medical needs, homelessness, living in unsafe housing
Caregiver neglect	Failure or refusal to fulfill any duties or obligations to an elderly person	Not providing care or necessary resources such as food, water, clothing, unclean living conditions, not getting appropriate care for elderly person's health problems or getting medications for health problems, allowing elderly people to get bed sores and not treating them
Abandonment	Desertion of an elderly person by an individual who has responsibility to provide care or by someone with custody of the elderly person	Desertion of elderly person at hospital, shopping center, or public location
Emotional or psychological abuse	Infliction of pain, anguish, or distress to an elderly person through verbal or nonverbal acts	Humiliation, intimidation, threats of abandonment, ridicule, purposely causing fear or anxiety, harassment, verbal abuse, isolation and withholding social interaction, giving an older person the "silent treatment"
Resident-to-resident aggression	Negative physical, sexual, or verbal interactions between residents of a long-term care facility	Physical, sexual, or verbal abuse between residents that has a negative impact, including fighting or physical assault, forced sexual assault, arguments, or verbal insults

Risk Factors for Elder Abuse

Patient

- Dementia or cognitive impairment
- Female
- Decreased physical health
- Requirement for more assistance with daily living activities
- Social isolation
- Increased age
- Behavior problems
- Psychiatric illness
- History of past abuse
- Low income or wealth

Caregiver

- Caregiver mental health
- Caregiver substance abuse
- Elevated levels of stress of caregiver
- Poor or conflictual relationship with elder
- Dependence on the elder for finances or resources
- Legal or financial difficulties

Environmental

- Shared living conditions
- Low social support and social isolation

Resources on Elder Abuse

Resource	Services Provided	Web Site/Phone Number
Administration on Aging: U.S. Health & Human Services	Administration of grants and funding, listing of community resource centers and foundations, information on legislation	www.aoa.gov
National Center on Elder Abuse	An Administration on Aging-funded resources that provides research, training, news, and resources on elder abuse. Provides FAQs, training, fact sheets, and lists of resources	www.ncea.aoa.gov
Adult Protective Services	Receive reports of abuse/neglect and investigate these reports, assess victim's risk, assessing victim's capacity to make decisions and understand, arrange for emergency shelter, care, support services, or legal assistance, service monitoring and evaluation	
Eldercare Locator	Provides information and referrals to older Americans and their caregivers to services in their area. Provides links, fact sheets, information on long-term care planning and advanced care planning, and benefits Check website to help find benefit programs to help older Americans afford their needs	1-800-677-1116 www.eldercare.gov/Eldercare.NET/Public/Index.aspx
National Clearinghouse on Abuse in Later Life	Training resources and links to other resources for health care providers	www.ncall.us
National Organization for Victim Assistance	Referrals and resources in every state	1-800-TRY-NOVA or 703-535-NOVA www.trynova.org
National Coalition Against Domestic Violence	Training and education on domestic violence, publications and programs	303-839-1852 www.ncadv.org
Clearinghouse on Abuse and Neglect of the Elderly (CANE) Department of Consumer Studies and Research. University of Delaware	Archive of published research, training resources, government documents	www.cane.udel.edu

Supplement to *Emergency Medicine Reports*, June 28, 2015: "Identification of Elder Abuse in the Emergency Department." Authors: Jonathan Glauser, MD, FACEP, Associate Professor, Emergency Medicine, Case Western Reserve University, Faculty, Emergency Medicine Residency, MetroHealth Medical Center/Cleveland Clinic, Cleveland, OH; and Sarah Pfeiffer, MD, Emergency Medicine Residency, MetroHealth Medical Center, Cleveland, OH.