AMERICAN HEALTH CONSULTANTS®

Primary Care Reports

The Practical, Peer-Reviewed Journal for Primary Ca

NEWSLETTER & ELECTRONIC PUBLISHERS FOUNDATION EDITORIAL EXCELLENCE AWARD WINNER

Volume 7, Number 18 **September 3, 2001**

Editor's Note—*Part I of Elder Mistreatment: Primary Care Assessment and Management covered an introduction and history of elder abuse along with etiology, incidence/prevalence data, cultural considerations, definitions, and case studies. In this issue, a detailed review of patient presentation, assessment and diagnosis (including physical exam and laboratory evidence), mandated reporting, advocacy, and prevention will be covered. Numerous resources for the health care provider, patient, and caregiver are also offered.*

Elder Mistreatment—Part II: Primary Care Assessment and Management

Authors: **Scott S. Meit, PsyD**, Associate Professor of Family Medicine, West Virginia University School of Medicine; and **Vincent DeLaGarza, MD**, Associate Professor of Family Medicine, West Virginia University School of Medicine, Morgantown, WV.

Presentation

The signs of elder abuse are protean in presentation. They may include bruises, burns, lacerations, fractures, behavioral changes, monetary difficulties, or evidence of poor hygiene. However, abuse in older people as compared to that of children may be more subtle in presentation.

The physical signs of elder abuse may include bruises, belt and restraint marks, broken bones, or lacerations. In this respect, the signs are similar to those found in children and nonelderly adults. Another physical finding of abuse is that of venereal disease (condyloma, herpetic vesicals) in an adult with compromised cognitive ability. This finding is always significant, similar to its implication with children. Oral soft tissue damage (and clearly oral manifestations of STD) can also evidence sexual abuse.[1]

Dental examination may also reveal physical signs of abuse and neglect. Findings may include lip trauma, bruising of the edentulous ridges or facial tissues, fractured subluxated or avulsed teeth, fractures of the zygomaticomaxillary complex, maxilla, or mandible, as well as ocular injuries.[1] A dental evaluation may prove useful toward assessing the probability of injury being accidental as opposed to abuse. Further, poor dental hygiene or missing dentures may suggest neglect or self-neglect—especially in the patient with dementia.

The clinician should strongly consider the possibility of abuse when conditions usually associated with immobility occur in an otherwise ambulatory patient. For example, the development of decubitus ulcers in a normally active person may imply the use of restraints to control an older person's actions or behavior. In addition, malnutrition and dehydration in a person able to feed themselves but not able to prepare or obtain food (perhaps secondary to dementia or osteoarthritis) may suggest neglect. State surveyors for nursing homes are particularly alert to the development of dehydration, stool impaction, weight loss, and decubitus ulcers in nursing home residents. In fact, these conditions are often referred to as "quality indicators," and their occurrence in a low-risk patient will initiate an inspection of the nursing home. Since nursing homes are required to electronically transmit patient data (the minimum data set) to the state and the Health Care Financing Administration on a regular basis, software programs can trigger these indicators. However, it must be strongly emphasized that the development of these

conditions do not represent conclusive evidence of neglect or abuse as a significant illness can leave as sequelae all of the above findings.

Signs of neglect may be subtle. An elder who has a chronic illness in poor control or requires frequent hospitalizations to treat exacerbations of chronic illness may not be getting prescribed medication from caregivers. Recurrent candidiasis or perineal dermatitis because of stool or urinary incontinence may suggest an inability of the caregiver to adequately manage a dependant older person and, thus, be a form of neglect—especially if the caregiver has insight into the mechanism of the development of the rash. Unexpected deterioration of functional ability in an elder may suggest enforced immobility. In clinical practice, it is useful to obtain a baseline of activities of daily living (ADL) to enable a referenced tracking of future functioning (*see Table 1*).

Psychological signs of elder mistreatment may include insomnia, anxiety, dysphoria, anhedonia, suspiciousness, fearfulness, or apathy. A recent study noted clinical depression to be more prevalent in patients identified as neglected.[2] Disturbed behavior in patients with dementia can also be related to neglect if it is due to recognized but ignored painful conditions, constipation, sensory deprivation, or itching. A frequent situation uncovered in our health sciences geriatric clinic is the use of over-the-counter or prescribed medication to render older persons more manageable and to lessen the required effort to care for them. For example, surreptitious use of medication (ie, antihistamines) given during the day to encourage sleeping will make a caregiver's job easier, but it may precipitate delirium, disturbed behaviors, or nighttime insomnia. In turn, the onset of disturbed behavior may initiate a request by the family for psychotropic or hypnotic medication. Such prescriptions may worsen further the quality of life for the elder. This type of abuse, as perpetrated by babysitters, has been exposed in multiple newspaper articles,[3-5] but incidence rates involving both children and elders are unknown. Tacit encouragement by the caregiver of an elderly person to sleep during the day, rather than providing stimulating activities, may also be common, but again the frequency of this type of neglect remains unclear.

Financial exploitation may be difficult to detect in the office. A comment from an older person that they cannot afford medication may be legitimate, but it may also suggest that another person is in control of and withholding finances. In our clinic, the most common form of financial exploitation occurs when an adult child, grandchild, or niece or nephew resides in an older person's residence—receiving free room and board plus an "allowance" (which may be appropriated by persistent unwelcome pleading or implied threats). The older person often feels they cannot ask the younger person to leave, given concerns and compassion for their financial and/or social status. Our experience is consistent with reports that children, grandchildren, and other relatives make up almost 80% of the perpetrators of such abuse.[6] Financial abuse also frequently coexists with other types of abuse.[7] Despite reports that financial exploitation may account for up to half of all instances of elder abuse, the medical literature is notably anemic in terms of studying and addressing the issue; Tueth provides a timely review of this often subtle but devastating form of abuse.[8]

Older persons, especially those with dementia or those who smoke, are at increased risk for burns. Neglect by a caregiver may worsen that risk, and it is notable that the elderly comprise a significant percent of a burns unit admissions. In one study, 8-12% of patients admitted to a burns unit were older than 60; many patients suffered burns, which could have had a relationship to neglect.[9]

Diagnosis

A determination of elder abuse must be made only after careful and deliberate analysis of the evidence. Overlooking the diagnosis may lead to increased morbidity for the patient since abuse appears to be a recurring problem.[10] In addition, abused elders have a higher mortality.[11] There is also evidence that elder abuse is a risk factor for suicide (above and beyond the well-established age cohort risk for suicide).[12] Erroneous diagnoses of abuse and/or neglect, on the other hand, may lead to unnecessary nursing home placement, family conflict, and/or stigmatization. Cases of suspected abuse reported to Adult Protective Services (APS) are substantiated only 40-60% of the time.[6] This should serve as a reminder that while some situations are vague and/or do not provide sufficient evidence to conclude mistreatment, other investigations definitively clear those alleged to be committing such abuses.

As with all medical decision making, establishing the diagnosis begins with a good history. A caveat must be kept in mind, however. Reports in the literature (consistent with our own experience) demonstrate that older people are often reluc-

Primary Care Reports™, ISSN 1040-2497, is published biweekly by American Health Consultants, 3525 Piedmont Rd., NE, Bldg. 6, Suite 400, Atlanta, GA 30305.

VICE PRESIDENT/GROUP PUBLISHER: Donald R. Johnston.
EDITORIAL GROUP HEAD: Glen Harris.
MANAGING EDITOR: Robin Mason.
ASSOCIATE MANAGING EDITOR: Neill Larmore.
SENIOR COPY EDITOR: Robert Kimball.
MARKETING PRODUCT MANAGER: Schandale Kornegay.
GST Registration Number: R128870672.
POSTMASTER: Send address changes to ***Primary Care Reports™***, P.O. Box 740059, Atlanta, GA 30374.

Periodical rate postage paid at Atlanta, GA.
Back issues: $23. Missing issues will be fulfilled by Customer Service free of charge when contacted within one month of the missing issue's date.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Subscriber Information

Customer Service: 1-800-688-2421.

E-Mail Address: customerservice@ahcpub.com
Editorial E-Mail Address: robin.mason@ahcpub.com
World-Wide Web: http://www.ahcpub.com

Subscription Prices

United States
$299 per year (Student/Resident rate: $150).

Multiple Copies
1-9 additional copies: $269 each; 10 or more copies: $239 each.

Canada
Add GST and $30 shipping

Elsewhere
Add $30 shipping

For 50 AMA/AAFP Category 1/Prescribed hours, add $100.

Accreditation

American Health Consultants (AHC) designates this continuing medical education (CME) activity for up to 50 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

AHC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians.

This CME activity was planned and produced in accordance with the ACCME Essentials.

This program has been approved by the American Academy of Family Physicians as having educational content acceptable for Prescribed credit hours. Term of approval covers issues published within one year from the beginning distribution date of Jan. 1, 2001. This volume has been approved for up to 50 Prescribed credit hours. Credit may be claimed for one year from the date of this issue.

Questions & Comments

Please call **Robin Mason,** Managing Editor, at (404) 262-5517 or e-mail: robin.mason@ahcpub.com between 8:30 a.m. and 4:30 p.m. ET, Monday-Friday.

Statement of Financial Disclosure

In order to reveal any potential bias in this publication, we disclose that Dr. DeLaGarza (author) serves on the speaker's bureau and is a stockholder of Pfizer and Novartis. Dr. Meit (author) reports no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

tant to disclose abuse.[13] The NCEA study on elder abuse showed that only 18% of victims reported emotional abuse.[6] More frequent reporting by victims may not occur because of a tacit acceptance of the circumstance by the elder and family for varying reasons.[14] This "acceptance" may include cultural variations for tolerating such conditions.[15-17] Also, the victim commonly fears that disclosure of abuse will lead to nursing home placement—often a threat directly issued by the abuser. Given these realities, the history must be interpreted carefully with respect for cultural diversity, individual circumstances, and relevant contexts.

Reliably reported victim and perpetrator risk factors should also be taken into account in considering patient presentations (*see Table 2*). Victims of elder abuse and/or neglect commonly suffer from cognitive impairment, isolation, depression, chronic medical illnesses, and poor general health; they are often caused by reduced ADL skills/functional status.[2,18-20] Recent research findings also identify unresolved grief as a risk factor associated with abuse.[21] This is particularly cogent given the multitude of losses associated with advanced aging (ie, personal loss of function, deteriorating health status, reduced quality of life, as well as loss of friends and family). It should be noted, however, that gender itself has not been found to be a reliable risk factor for becoming a victim of elder abuse and/or neglect. Numerous studies have demonstrated males and females to be equally likely to suffer from such mistreatment.[19] Perpetrators of abuse and/or neglect are commonly caregivers under stress; they are often the adult child or spouse of the victim. Many times suffering from psychiatric and/or cognitive disturbance themselves, they may abuse alcohol and/or illicit drugs, and are often financially dependent upon the elder victim.[2,18-20]

One of the first steps when presented with possible abuse or seeing a high-risk patient or family is to document the patient's capacity to make decisions. Assessment of the patient's decision-making capacity is critical toward determining the degree to which the patient can participate in planning should abuse and/or neglect be identified. We strongly believe that leaving an older person, who has decision-making capacity, out of the decision-making process is a form of prejudice (ie, ageism). Decision-making capacity means that the patient understands the treatment plan, its consequences, as well as alternatives to the plan and their consequences. The patient must be able to express a preference and give rational reasons for choosing a specific plan or alternative. Lo presents a well-balanced review of the intricacies often encountered when assessing decision-making capacity.[22]

Beyond decision-making capacity, the patient's cognitive status must be determined. It is important to understand that patients with dementia may still retain decision-making capacity. There are several instruments in use to screen for dementia. The most common one in use is the Mini Mental State Exam (MMSE).[23] This exam is public domain and can be found online at: http://www.medafile.com/mmes.htm. A low score on this screener (23 or less, out of 30) implicates compromised cognitive functioning and may indicate the presence of dementia. The MMSE, however, is not a diagnostic test; a poor score does not indicate which of a large number of potential causes may be responsible for the impairment.[28] Further, as MMSE performance is correlated

Table 1. Activities of Daily Living (ADL) Assessment

	Receives No Assistance	Performs with Help	Unable to Perform
Activity	❑	❑	❑
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Toileting	❑	❑	❑
Getting from bed to chair	❑	❑	❑
Controlling urination	❑	❑	❑
Controlling bowel movements	❑	❑	❑
Eating	❑	❑	❑
Using the telephone	❑	❑	❑
Traveling beyond walking distance	❑	❑	❑
Grocery shopping	❑	❑	❑
Doing housework	❑	❑	❑
Cooking	❑	❑	❑
Doing handyman work	❑	❑	❑
Doing laundry	❑	❑	❑
Taking medicines	❑	❑	❑
Climbing stairs	❑	❑	❑
Managing money	❑	❑	❑
Driving	❑	❑	❑

Table 2. Abuse and Neglect Risk Factors

Victim	Perpetrator
Dementia	Financial dependency upon elder
Depression	Caregiver stress
Frail, chronically ill	Cognitive impairment in caregiver
Isolation (for self-neglect)	Alcoholism/substance abuse
Poor ADL skills	Psychiatric illness
Prolonged grief	Adult child or spouse of elder

with years of education, established cutoff scores are of doubtful use for those with less than a ninth grade education.[25] Where cognitive status remains unclear, the primary care physician (PCP) should consider referral for more sophisticated psychometric and diagnostic evaluation. It should also be noted that, while the presence of dementia is itself a risk factor for abuse, it may also bring into question the history obtained from an affected elder. Persecutory and financial delusions, for example, are common during the early stages of Alzheimer's disease. A confirmed diagnosis of dementia in a patient can be significant in evaluating the possibility of abuse. Moreover, when a caregiver who is told of the diagnosis and informed that disturbed behavior (even insulting and inappropriate actions) can be part of the disease process, it may lessen caregiver stress (a risk factor for abuse).

Elder patients must also be evaluated for depression. Depression is common in abused older people as well as non-abused elderly—in either case, it should be treated.[26] It should be noted that older individuals often do not present with dysphoria as a prominent symptom; apathy and self-neglect are more common presenting symptoms. Such conditions, however, may increase a caregiver's burden, which may then lead to neglect, further self-neglect, and/or abuse. Depression may also interfere with decision-making capacity and cognition in an older person. A useful instrument for screening depression in

Table 3. Geriatric Depression Scale

Choose the best answer for how you feel over the past week.

I. Are you basically satisfied with your life?	❑ Yes	❑ NO
2. Have you dropped any of your interests and activities lately?	❑ YES	❑ No
3. Do you feel that life is empty?	❑ YES	❑ No
4. Do you often get bored?	❑ YES	❑ No
5. Are you in good spirits most of the time?	❑ Yes	❑ NO
6. Are you afraid that something bad is going to happen to you?	❑ YES	❑ No
7. Do you feel happy most of the time?	❑ Yes	❑ NO
8. Do you often feel helpless?	❑ YES	❑ No
9. Do you stay home rather than go out?	❑ YES	❑ NO
10. Do you feel you have problems with your memory or concentration?	❑ YES	❑ No
11. Do you feel it is wonderful to be alive?	❑ Yes	❑ NO
12. Do you feel full of energy?	❑ Yes	❑ NO
13. Do you feel worthless?	❑ YES	❑ No
14. Do you feel hopeless?	❑ YES	❑ No
15. Do you feel that most people are better off than you are?	❑ YES	❑ No

Caps are minus.
A score of -5 strongly suggests depression.

Source: *Reprinted with permission. This scale can be viewed at http://www.stanford.edu/~yesavage/GDS.english.long.html.*

the elder patient is the Geriatric Depression Scale (GDS) (*see Table 3*),[27-28] The GDS is a particularly good instrument as it was specifically developed for use with older persons (age-related norms), can be administered in both oral and written form, and omits somatic items that can erroneously elevate depression scores in elders.[24] Ancillary staff may be trained to administer both the MMSE and the GDS.

When decision-making capacity and cognitive status is established, the patient and caregivers should be interviewed together and separately. The AMA has proposed a series of questions for interviewing older adults (*see Table 4*).[29] Responses, however, must be interpreted in the context of the patient's cognitive status, decision-making capability, caregiver explanations, and the physical evidence available. The stress of the caregiver should be assessed, as caregiver stress is an established risk factor for elder mistreatment. This can be done by asking simple questions such as: "How much time, each day, does it take for you to care for him/her?"; "Do you ever resent that?"; "What is your mood like?"; "What do you like to do for yourself?"; "Do you have enough time for those things?". There are existing instruments designed to measure caregiver burden, but their use appears primarily research-based (ie, for purposes of measuring the effect of various factors or interventions on caregiver stress).[30] The interview is best conducted not in an adversarial manner, but from the perspective that a problem may exist. If abuse and/or neglect are identified, potential solutions should be solicited from all parties—encouraging a climate of collaborative problem solving. Additional guidelines for interviewing elders and their caregivers include ensuring privacy of the interview(s), attending to issues of confidentiality and the limits of confidentiality (ie, noting that accessing the assistance of APS could become necessary), respecting cultural differences, and allowing time to process the issues at hand (*see Table 5*).[31]

Physical Exam

Physical evidence suggesting abuse must also be interpreted with caution. Bruises with an appearance/form of belts, restraints, or handprints strongly suggest abuse. Older people, however, may have chronic illnesses and/or physiologic changes, which can predispose them to manifest signs resembling abuse injuries. For example, changes in collagen in the dermis can result in senile ecchymosis and skin tears—often seen with minor trauma. Elder patients will occasionally present with extensive bruises that can be a consequence of a pruritic skin condition, scratching, and age-related skin changes. Older people may be taking antiplatelets, anticoagulants, or corticosteroids—medication that can further predispose to subcutaneous bruising. Thus, it often can be difficult to determine whether physical signs are attributable to an accident, neglect, abuse, medications, poor health, or age-related changes.

One of the authors was asked to give a deposition in a case in which relatives were bringing a suit against a personal care home for abuse. A frail lady with severe Alzheimer's disease had extensive bruising covering most of her face and body. However, on interview in the hospital, it was noted that the woman's hands were covered with mittens to prevent her from scratching a very pruritic eczematous condition. On review of her medication, it was noted that she was on coumadin. A further review of her international normalized ratios, at the time that the abuse was alleged, revealed values that were 4 times higher than the therapeutic levels. This evidence, and the lack of similar complaints against the facility, prompted the family's legal counsel to drop suit.

Skin conditions that occur with poor hygiene or immobility may be associated with neglect, but again, careful consideration must be given to the context of the situation. For example, older persons may be embarrassed to ask others to provide personal hygiene to them and, thus, the development of perineal or intertriginous rashes may occur in the absence of neglect. Diabetes will also predispose people to intertriginous rashes. Decubitus ulcers may occur in even the best-cared-for individuals if the underlying disease has produced incontinence, malnutrition, and immobility. Decubitus ulcers in an ambulatory patient, however, are strongly suspect and are often the result of forcible restraint.

Fractures often occur in frail individuals in the absence of acute trauma. Simply assisting a frail older person from a sitting position to standing position, by pulling on the arm, may produce a fracture. This has personally happened to one of the authors. In accord, nursing home assistants are specially trained to lift patients from a sitting position by using the chest wall. Persons older than 65 have been observed to account for about half of all radiology department exams.[32]

Fractures of the facial bones or dental injuries, by contrast, are more likely a consequence of abuse. Such orofacial injuries may include lip trauma, bruising of the edentulous ridges or facial tissues, fractured subluxated, or avulsed teeth, fractures of the zygomaticomaxillary complex, maxilla, or mandible, as well as ocular injuries.[1] In addition, fractures occurring in a person not predisposed to fall may signal abuse. Finally, an older person who has fallen frequently and remains without adequate supervision is suffering from a form of neglect.

In evaluating for elder mistreatment, the appearance of the patient may be of decided importance. If the patient

Table 4. AMA Guidelines for Questioning Older Adults about Abuse and Neglect

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things that you didn't want to?
- Has anyone ever taken anything of yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?

Table 5. Strategies for Conducting an Interview

Interviewing the Patient

- Ensure privacy during discussion
- Discuss confidentiality and the limits of confidentiality
- Interview the patient ***apart*** from the caregiver
- Progress from general to specific questions
- Allow time to respond
- Respect cultural differences
- Do not blame the patient (or the caregiver)
- Determine whether there is cognitive impairment

Interviewing the Caregiver

- Ensure privacy during discussion
- Discuss confidentiality and the limits of confidentiality
- Avoid accusations
- Ask about support structure, resources, and assistance
- Identify Adult Protective Services ***as support agencies***
- Ask family members how caregiving has changed their lives: pros and cons
- Ask what assistance would improve the situation for them

Adapted from: *Silverman J, Hudson MF. Elder mistreatment. A guide for medical professionals. N C Med J. 2000;61:291-296.*

appears dirty, unkempt, and has poor hygiene, physical findings take on more significance. In addition, one must look at the physical findings in context of the patient, caregiver, and environment. If there are identified abuse risk factors for the patient and/or caregiver (especially if patient and caregiver accounts of the injury are not consistent and/or are not consistent with the nature of the injury), then abuse should be strongly suspected.

Laboratory Evidence

It is unlikely that radiographic evidence of fractures will be helpful in making a decision whether abuse has occurred. As noted, in some cases elders have been noted to constitute nearly half of those presenting for films.[32] Laboratory evidence of a venereal disease, in contrast, should be taken as prima facie evidence of abuse in an adult with substantial cognitive compromise.

Mandated Reporting

The American College of Emergency Physicians (ACEP) underscores the confidentiality of the doctor-patient relationship and opposes mandated reporting in which the patient is judged to be mentally competent.[33] Mandated reporting does run the risk of disenfranchising the patient, if not placing them in more difficult circumstances—at least in the short run. Further, where a mandated report has been issued, the elder patient may change doctors and, in doing so, lose continuity of care.[34] These professional and ethical concerns notwithstanding, it is imperative to recognize that all states (and the District of Columbia) have enacted laws pertaining to elder abuse and mistreatment. At the time of this writing, 42 states mandate reporting where abuse and/or neglect (including self-neglect) are suspected.[35-36] It is essential, then, for the PCPs to familiarize themselves (as well as their clinician extenders) with their respective state law. The following URL of the National Center on Elder Abuse lists state-by-state contact numbers: (http://www.elderabusecenter.org/report/index.html).

With particularly complex cases, it is often helpful to refer the patient and family to an interdisciplinary geriatric assessment clinic. Such clinics often include the expertise of psychologists and social service workers and, thus, enable a comprehensive biopsychosocial assessment. These clinics are often associated with university geriatric training programs and can provide the patient and family with useful advice and resources to help with common geriatric syndromes, apart from the management of elder mistreatment itself.

Advocacy

As with advocacy in situations of partner abuse, the PCP must balance the healer's desire to intervene with a respect for an adult's autonomy. Particularly in more ambiguous situations (in which the filing of a mandated report may not be called for), the physician may do well to consider Change Theory as proposed by Prochaska and colleagues.[37] Individuals vary in their readiness to change/seek change, and interventions may be tailored congruent with the assessed stage of change (eg, precontemplation, contemplation, action, etc). Often, the availability of information and resources make for most effective advocacy and may stimulate an individual toward taking action(s) that enable greater safety and healthier living. As such, the PCP and physician's office should exist as a wellspring of resource information. Notably, resources should take into account the full context of elder abuse and neglect variables and, thus, include information on caregiver services (as well as assist the mistreated elder). Further, all US counties have senior centers that may provide information, support, and meaningful activity (*see Resources*).

Where ambiguity as to whether elder mistreatment is present remains, the medical record may ultimately provide the most compelling advocacy. Thorough documentation of injuries and signs of concern, including body maps and prudent use of medical photography, may literally chart a course that demonstrates pattern and substantiates the occurrence of elder mistreatment.

Prevention

PCPs have a responsibility to familiarize themselves with elder mistreatment risk factors, screen for them, and if identified, address them during the course of medical care. Physicians should, particularly, be mindful of caregiver stress, so that early and proactive interventions (eg, respite services) may be introduced. In such manner, the subject of abuse and/or neglect may be introduced to families at its first indications (or, ideally, before it happens), and a collaborative solution-focused plan may then be generated.

An older person should regularly be screened for dementia and depression (given the added risks they impose). If a diagnosis of Alzheimer's disease is made, the regional Alzheimer's Association and Alzheimer's Family Relief Line may prove to be to be useful to the elder and their caregiver(s) (*see Resources*). These services can often assist by providing an abundance of educational and resource materials and options. Another organization, which can help with caregiver concerns, is the National Family Caretaker Association (*see Resources*). Where a diagnosed dementia has progressed to the point of compromising decision-making capacity, the PCP (depending upon state law) may be in position to appoint a health care surrogate. Such decisions must be undertaken judiciously and underscore the physician's potential authority to act as an advocate—preventing or mitigating conditions for abuse and/or neglect. Again, where circumstances are particularly complex (involving the elder's medical condition and/or family dynamics), PCPs may wish to refer their patients to a university geriatric assessment clinic.

Resources

- Eldercare Locator—(800) 677-1116; sponsored by the Administration on Aging (http://www.aoa.dhhs.gov/abuse/default.htm). State by state assistance in seeking referral to report suspected abuse & seek services.
- National Center on Elder Abuse—(202) 898-2586; (http://www.gwjapan.com/NCEA/whatnew/index.html). A comprehensive resource site for both the health care provider and private citizen.
- National Resource Center on Domestic Violence—(800) 537-2238.
- Family Violence Prevention Fund—(800) 313-1310.
- Rape, Abuse, Incest National Network—(800) 656-HOPE. [4673]; Sexual Assault & Rape Crisis Resource List (http://www.feminist.org/911/crisis.html).
- National Domestic Violence Hotline—(800) 799-SAFE. [7233]; TDD—(800) 787-3224.
- *Elder Abuse and Neglect: In Search of Solutions*. Public education & resource pamphlet. American Psychological Association (www.apa.org).[38]
- National Family Caretakers Association—301-342-2302. A resource for caregivers. http://www.nfcacares.org.
- Long-term care ombudsman program. Deals with nursing home complaints. http://www.aoa.dhhs.gov/aoa/pages/ltcomb.html.
- US Administration on Aging. http://www.aoa.gov.
- National Citizen's Coalition for Nursing Home Reform. http://www.nccnhr.org. Offers strategies for the betterment of nursing home facilities and their residents; also aids with regulatory and policy development.
- National Aging Information Center. http://www.aoa.dhhs.gov/naic.
- The Alzheimer's Association. A national voluntary health organization that provides information and services to people with Alzheimer's, caregivers, researchers, physicians, and health care professionals. http://www.alz.org/caregiver/programs/internet/govt.htm.

References

1. Fenton SJ, Bouquot JE, Unkel JH. Orofacial considerations for pediatric, adult, and elderly victims of abuse. *Emerg Med Clin North Am*. 2000;18:601-617.
2. Dyer CB, et al. The high prevalence of depression and dementia in elder abuse or neglect. *J Am Geriatr Soc*. 2000;48:205-208.
3. Babysitter's conviction upheld. *Washington Post*. 1988:G6.
4. Moreno S. Prosecutor says woman admitted drugging baby. *Washington Post*. December 2, 1997:C3.
5. Brown D. Sitter's kin ruled negligent in infant's death. *Washington Post*. November 30, 1990:B6.
6. NCEA. The National Elder Abuse Incidence Study. National Center on Elder Abuse; 1998.
7. Heisler C, Tewksbury J. Fiduciary abuse of the elderly: A prosecutor's perspective. *Journal of Elder Abuse and Neglect*. 1991;3: 23-40.
8. Tueth MJ. Exposing financial exploitation of impaired elderly persons. *Am J Geriatr Psychiatry*. 2000;8:104-111.
9. Bird PE, et al. Elder abuse: A call to action. *J Burn Care Rehabil*. 1998;19:522-527.
10. O'Malley TA, et al. Identifying and preventing family-mediated abuse and neglect of elderly persons. *Ann Intern Med*. 1983; 98:998-1005.
11. Lachs MS, et al. The mortality of elder mistreatment. *JAMA*. 1998;280:428-432.
12. Conwell Y. Elder abuse—A risk factor for suicide? *Crisis*. 1995;16:104-105.
13. Moran T. Suffering in silence. Victims of elder abuse rarely ask for help. *Tex Med*. 1998;94:44-46.
14. Lau E KJ. Abuse of the elderly by informal care providers. *Aging*. 1979;299:10-15.
15. Otiniano ME, Herrera CR. Abuse of Hispanic elders. *Tex Med*. 1999;95:68-71.
16. Hudson MF, et al. Elder abuse: Two Native American views. *Gerontologist*. 1998;38:538-548.
17. Moon A, Williams O. Perceptions of elder abuse and help-seeking patterns among African-American, Caucasian-American, and Korean-American elderly women. *Gerontologist*. 1993;33: 386-395.
18. Hogstel MO, Curry LC. Elder abuse revisited. *J Gerontol Nurs*. 1999;25:10-18.
19. Kleinschmidt KC. Elder abuse: A review. *Ann Emerg Med*. 1997;30:463-472.
20. Allan MA. Elder abuse: A challenge for home care nurses. *Home Health Nurse*. 1998;16:103-110.
21. Pennant L. Unresolved Grief as a risk factor for abuse. *Generations*. 2000;24:70.
22. Lo B. *Decision-Making Capacity. Resolving Ethical Dilemmas: A Guide for Clinicians*. Baltimore, Md: Williams & Wilkins, Inc; 1995:82-89.
23. Folstein M, Folstein S, McHugh P. Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12:189-198.
24. What practitioners should know about working with older adults. *Professional Psychology: Research and Practice*. 1998; 29:413-427.
25. Zimmerman M. *Diagnosing DSM-IV Psychiatric Disorders in Primary Care Settings: An Interview Guide for the Nonpsychia-*

trist Physician. 1st ed. East Greenwich, RI: Psych Products Press; 1994:102.
26. Phillips L. Elder abuse and depression overlooked. *Hosp Technol Ser*. 1997;16:3-4.
27. Yesavage J. Geriatric depression scale. *Psychopharmacol Bull*. 1988;24:709-710.
28. Yesavage J, et al. Development and validation of a geriatric depression scale: A preliminary report. *J Psychiatr Res*. 1983; 17:37-49.
29. *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect*. Chicago, Ill: American Medical Association; 1992.
30. Vitaliano PP, et al. The Screen for caregiver burden. *Gerontologist*. 1991;31:76-83.
31. Silverman J, Hudson MF. Elder mistreatment. A guide for medical professionals. *N C Med J*. 2000;61:291-296.
32. Rarey L. *The Impact of the Growing Elderly Population on Medical Imaging Facilities*. Rohnert Park, Calif: Sonoma State University; 1995.
33. ACEP. Management of elder abuse and neglect. American College of Emergency Physicians. *Ann Emerg Med*. 1998;31: 149-150.
34. Hirsch CH, Stratton S, Loewy R. The primary care of elder mistreatment. *West J Med*. 1999;170:353-358.
35. Stiles MM, Perez DA. Recognizing and responding to elder abuse. *WMJ*. 2000;99:8-9.
36. Marshall CE, Benton D, Brazier JM. Elder abuse. Using clinical tools to identify clues of mistreatment. *Geriatrics*. 2000;55: 42-44, 47-50, 53.
37. Prochaska JO, Norcross JC, Diclemente CC. Changing for Good. 1st ed. New York, NY: William Morrow and Company, Inc; 1994.
38. *Elder Abuse and Neglect: In Search of Solutions*. Washington, DC: American Psychological Association PID; 1999.

Physician CME Questions

13. Which of the following has *not* been found to be a reliable risk factor in profiling victims of elder abuse and neglect?
    a. Dementia
    b. Depression
    c. Gender
    d. ADL status
    e. Isolation

14. What percent of older people voluntarily report abuse?
    a. 10-20%
    b. 30-40%
    c. 50-60%
    d. 70-80%
    e. > 90%

15. For the ambulatory elder patient, conditions typically associated with which of the following should serve as a "red flag" that elder mistreatment may be occurring?
    a. Skin changes
    b. Immobility
    c. Fracture
    d. Dementia
    e. Urinary incontinence

16. Of the following persons, who is most likely to perpetrate financial abuse of an elder?
    a. Neighbor
    b. Relative
    c. Salesperson
    d. Nonrelative financial custodian
    e. Financial planner

17. In a patient suffering from advanced dementia, a lab study positive for which of the following should alert the physician to the presence of abuse?
    a. Anemia
    b. Scabies
    c. Urinary tract infection
    d. Venereal disease
    e. Diabetes

Attention *Primary Care Reports* Subscribers

No one knows the clinical information and analysis that primary care physicians want and need as much as readers of *Primary Care Reports*. To tap into that expertise, we are happy to announce that we are opening up our monograph selection process to our readers.

Monographs range from 25-35 Microsoft Word document, double-spaced pages. Each article is thoroughly peer reviewed by colleagues and physicians specializing in the topic being covered. Once the idea for an article has been approved, deadlines and other details will be arranged. Authors will be compensated upon publication.

As always, we are eager to hear from our readers about topics they would like to see covered in future issues. Readers who have ideas or proposals for future single-topic monographs can contact Managing Editor Robin Mason at (404) 262-5517 or (800) 688-2421 or by e-mail at robin.mason@ahcpub.com.

In Future Issues:

Issues in Infant Care—
Edward Onusko, MD, & Mini Pathrose, MD