CD Summary

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OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

GOLDEN YEARS, HIDDEN FEARS

"The abuse of the elderly is one of the most serious social ills facing our country today."
Governor Theodore Kulongoski, February 27, 2004

Mistreatment of older adults in the U.S. is common, with an estimated two million adults ≥60 years of age (two to four percent) abused each year.[1] Elders who experience mistreatment have shortened lifespans and increased morbidity compared to elders who are not mistreated.[2] Because of the relatively large magnitude of the problem, the American Medical Association recommends that healthcare providers routinely ask older adult patients about abuse.[3] In this *CD Summary*, we review available data on older adult mistreatment, and provide screening questions and resources for clinicians.

MISTREATMENT IN THE US AND OREGON

Elder mistreatment refers to intentional actions that cause harm to a vulnerable elder by a caregiver (or another person in a "trust" relationship with the elder), or failure by a caregiver to satisfy the elder's basic needs.[1] Mistreatment includes physical (e.g. hitting, withholding food), verbal (e.g. yelling, threats of violence), neglect, and financial (e.g. misuse of funds, fraud). Abuse can be committed by a caregiver, family member, friend, or spouse.

Because elder abuse is not systematically tracked, the exact number of persons affected is unknown. State Adult Protective Services (APS) agencies receive reports of suspected abuse and investigate cases. A national survey of state APS agencies identified 381,430 cases (6 cases per 1,000 persons >60 years) reported to APS in 2004 in the US.[4]

Of these reports, 88,455 cases were investigated and substantiated as mistreatment. Sixty-six percent of elder victims were female; 43 percent were ≥80 years of age. Among the perpetrators, 53 percent were female, and 75 percent were <60 years. Abusers were most commonly the victim's adult children (33%), and other family members (22%).

The estimate of two to four percent of older adults who experience mistreatment annually corresponds to between 8,764 and 17,527 Oregon adults. The Oregon Department of Human Services Adult Protective Services reports that 5,048 cases of allegations of mistreatment of elders were investigated in 2004. Although data are not available on how many of these allegations were substantiated, there appears to be significant underreporting of events. Nationally, it is estimated that only one in fourteen incidents of abuse come to the attention of authorities.[4]

RISK FACTORS AND CLINICAL FINDINGS

Risk factors for elder abuse include: shared living situation with abuser, dependence of the abuser on the victim, dementia, social isolation, pathologic characteristics of perpetrators such as mental illness and alcohol abuse.[5,6]

Differentiating injuries caused by mistreatment from those that are the result of accident, illness, or aging is frequently difficult. Clinical findings that suggest abuse include: several injuries in various stages of evolution; unexplained or contradictory explanations given by the patient and caregiver; delay in seeking treatment; laboratory findings that indicate under- or over-dosage of medications; STDs; dehydration, or malnutrition; decubitus ulcers; poor hygiene; and signs of depression, agitation, or infantile behavior.[1,2]

SCREENING QUESTIONS

The American Medical Association recommends that healthcare providers routinely ask older adult patients about abuse, using questions about general well-being followed by questions that screen for specific types of abuse. Patients should be interviewed separate from family or other caregivers, in a setting that provides maximum privacy and confidentiality. Questions used in New York and Maine elder mistreatment projects include:

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone ever taken anything that was 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?*

Any affirmative responses should be followed up to determine how and when mistreatment occurs, who perpetrates it, as well as how serious the danger is.

NOW WHAT?

The priority when mistreatment is suspected is to assure the safety of the victim. Healthcare providers may need to consider hospitalization, legal action, and engaging social workers.

Oregon law requires healthcare providers to report suspected abuse to the state Adult Protective Services, which in turn can trigger interventions and services necessary to protect vulnerable older adults. These services include:

- Arranging for the immediate protection of the adult.
- Coordinating evaluations to determine or verify the adult's physical and mental status, if necessary.
- Assessing the adult's ability to protect his or her own interest and give informed consent.

*Elder Mistreatment Guidelines, Mt. Sinai Victim Services, NY, 1988

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- Determining the understanding and willingness of the adult accept protective services.
- Assisting in or arranging the medical, legal or other necessary services, including alternative living arrangements to prevent further abuse.
- Providing advocacy to assure the adult's rights and entitlements are protected.

Unfortunately, a recent study indicated that half of physicians who had identified potential abuse of an older patient in their care had not reported the abuse.[7] Barriers to case reporting include: concerns about the physician-patient relationship and the physician's relationship with caregiver(s), perceived liability, the need to feel certain that abuse is occurring, and the ability to do what the provider feels is in the patient's best interest. While mandatory reporting laws have been criticized as ageist (in that they require reporting even if a competent adult victim doesn't want the case reported), mandatory reporting of elder mistreatment (like child abuse) enables the state to protect persons who cannot or will not protect themselves.

BOTTOM LINE

Increasing awareness of elder mistreatment is an important first step in prevention and intervention. Unfortunately, many healthcare providers are unprepared to screen for abuse or do anything about it. Compounding individual provider needs for training, many institutions or clinics do not have adequate protocols and procedures imbedded in practice that address elder mistreatment. Oregon's population of older adults is increasing and is projected to reach over 24 percent of the total population by 2025. The number of elder mistreatment cases will rise dramatically if we do not work to address this problem.

RESOURCES

If you suspect elder mistreatment or abuse, call:

- your local law enforcement agency.
- your local Agency on Aging. See *www.oregon.gov/DHS/localoffices/index.shtml.*
- DHS at 1-800-232-3020. See *www.oregon.gov/DHS/abuse/mandatory_report.shtml* for information on mandatory reporting.

Additional resources include:

- Fact sheets for primary care practice and for families (developed by the University of Maine and available at *www.umaine.edu/mainecenteronaging/pubandrep.htm#MPPC.*
- Evaluation of Oregon's Response to Adult and Elder Abuse, see *www.co.washington.or.us/deptmts/aging/docs/taskforc.pdf.*
- Governor's Elder Abuse Task Force Report, see *governor.oregon.gov/Gov/pdf/Elder_Abuse_Report.pdf.*

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Influenza Season Update

As in the rest of the nation, influenza activity in Oregon is widespread as of mid-February, with positive culture reports from all over the state as well as increased influenza-like-illness activity in most surveillance regions monitored by Oregon's sentinel providers. Based on our surveillance for hospitalized cases and pediatric deaths, there is no indication that this is a particularly severe season.

To date, 242 influenza A and 43 influenza B viruses have been identified by PCR or culture, similar to last year's numbers at this time. This year's vaccine, while still beneficial, is not an optimal match to the circulating viruses. The influenza A (H1) component is a good match to the circulating H1 virus, which predominated through mid-January. In recent weeks, however an increasing proportion has been identified as influenza A (H3), which is less favorably matched. Also, reports of influenza B (which is also poorly matched) are beginning to significantly increase.