Australian Society for Geriatric Medicine
Position Statement No. 1
Elder Abuse

Revised 2003

1. Elder abuse is any pattern of behaviour which causes physical, psychological or financial harm to an older person. Elder abuse may occur in the community, in residential care or in the hospital setting. Elder abuse may take the following forms:

   Physical Abuse
   The infliction of physical pain or injury, or physical coercion. Examples include hitting, slapping, pushing, burning, physical restraint, overmedication and sexual assault.

   Psychological Abuse
   The infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and/or feelings of shame, indignity and powerlessness. Examples include treating the older person as a child, humiliation, emotional blackmail, blaming, swearing, intimidation, name calling, and isolation from friends and relatives.

   Financial/Economic Abuse
   The illegal or improper use of the older person's property or finances. Examples include misappropriation of money, valuables or property, forced changes to a will or other legal documents, and denial of the right of access to, or control over, personal funds.

   Neglect
   The failure to provide adequate food, shelter, clothing, medical care or dental care. This may involve the refusal to permit other people to provide appropriate care. Examples include abandonment, failure to provide food, clothing or shelter, inappropriate use of medication and poor hygiene or personal care.

2. The medical profession should play a major role in the recognition, assessment and management of cases of abuse, and in the development of policy relating to elder abuse.

3. Regional geriatric services and Aged Care Assessment Teams are the most appropriate agencies to identify, assess and manage cases of elder abuse, and need to be suitably resourced to perform this role.

4. The role of the general practitioner in the assessment and management of cases of abuse is pivotal, and the general practitioner should therefore be part of the referral and decision making process.

5. All health professionals dealing with older people need appropriate education and training programs to enable them to identify cases of elder abuse.

6. Staff of agencies, who may encounter cases of elder abuse, need training in recognition of abuse. Policies and procedures need to be developed by these agencies for management of these cases, and referral of such cases to regional geriatric services is encouraged.

7. It is acknowledged that there is a large amount of stress placed on staff dealing with situations of elder abuse and it is therefore recommended that adequate support and counselling be available to these workers. The joint involvement of two clinicians in the management of all cases of abuse is also recommended.

8. Suggested interventions include:
   - crisis care
   - provision of community support services
   - provision of respite care
   - counselling
   - alternative accommodation
   - legal interventions including police involvement, restraining orders, and applications for guardianship and financial management.

9. At this time the evidence in support of mandatory reporting is not convincing. The consensus of government reports and researchers has been to oppose the introduction of mandatory reporting.

10. Prevention programs are important and should aim to recognise potential cases of abuse. Development of carer support programs may be appropriate.

11. Ongoing research into elder abuse needs to be encouraged and supported.

12. Current community education programs to raise awareness and knowledge of elder abuse need to be expanded.

This Position Statement represents the views of the Australian Society for Geriatric Medicine. This Statement was approved by the Federal Council of the ASGM on 5 September 2003. The revision of this paper was coordinated by Dr Susan Kurrle

BACKGROUND PAPER

Introduction

Elder abuse is not a new phenomenon, however until recently it has gone largely unrecognised in Australia, as it is one of the last forms of familial violence to come to public attention. Interest in mistreatment of older people in Australia initially focused on those in residential care[1]; but in the past ten years, the abuse and neglect of older people in the family home has also achieved professional and public prominence.

The issue has been researched widely in North America, where it has been addressed through a range of measures including mandatory reporting of elder abuse in most states in the USA. Britain, New Zealand, and European countries such as Norway, Sweden, Portugal and Italy, have recognised the problem more recently. At a British Geriatric Society conference on elder abuse in 1988, the first recommendation was that the medical profession should be playing a key role in recognising elder abuse and the factors that lead to its occurrence[2]. In New Zealand, Age Concern has published a comprehensive manual on elder abuse for health professionals and others caring for older people.

In Australia, a number of studies in New South Wales, Victoria, South Australia, and Queensland, have confirmed that elder abuse is a significant problem in this country[3-6]

The States have responded to the problem of elder abuse in a variety of ways. These include the development and funding of specific agencies to assist service providers and older people in the identification and management of elder abuse (South Australia and Queensland), the auspicing of a network of senior social workers to provide an advisory and coordination role in managing cases of abuse (Tasmania), the publishing of a guide for health and community services dealing with elder abuse (Victoria), and the development of interagency protocols and education of service providers in the management of elder abuse (New South Wales and Western Australia).

A number of barriers still exist to the recognition of elder abuse in our community, including lack of awareness of the issues on the part of the medical profession and other health care workers, the inability of victims to report abuse due to isolation or illness, the unwillingness of victims to report abuse because of shame, fear of retaliation on the part of the abuser, and/or fear of institutionalisation, and negative social attitudes towards older people (ageism)[7].

Definition of Elder Abuse

Elder abuse is any pattern of behaviour which causes physical, psychological, or financial harm to an older person. Elder abuse occurs in the context of a relationship of trust between the older person and the abuser, and this therefore excludes self-abuse and self-neglect from the definition. There are different categories of abuse, and it is very important that the specific type of abuse be identified as there are different causal factors and interventions for each type of abuse.

Elder abuse is the abuse or neglect of an elderly person and may take the following forms:

Physical Abuse: The infliction of physical pain or injury, or physical coercion. Examples include hitting, slapping, pushing, burning, physical restraint, overmedication and sexual assault.

Psychological Abuse: The infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and/or feelings of shame, indignity and powerlessness. Examples include treating the older person as a child, humiliation, emotional blackmail, blaming, swearing, intimidation, name calling, and isolation from friends and relatives.

Financial/Economic Abuse: The illegal or improper use of the older person's property or finances. Examples include misappropriation of money, valuables or property, forced changes to a will or other legal documents, and denial of

the right of access to, or control over, personal funds.

Neglect: The failure to provide adequate food, shelter, clothing, medical care or dental care. This may involve the refusal to permit other people to provide appropriate care. Examples include abandonment, failure to provide food, clothing or shelter, inappropriate use of medication and poor hygiene or personal care.

The abuser can be a family member, friend, neighbour, paid carer, health care worker or other person in close contact with the older person. Crime or assault in the street or at home by strangers, and discrimination in the provision of goods and services are specifically excluded.

The Prevalence of Elder Abuse

Overseas studies suggest that 4-10% of clients of aged care services are victims of abuse, while 3-4% of all people aged 65 years and over living at home suffer abuse and/or neglect[8,9]. A 1999 South Australian community based survey identified an elder abuse rate of 3% in the older population[10], and studies in Aged Care Assessment Teams have identified that up to 5% of community dwelling patients referred to the Teams were victims of abuse[11, 12].

There is no difference in the rates of abuse for men and women, but the majority of victims are women, due to the gender proportions among older people. Some overseas studies report no significant health differences between abused and non-abused older people [9]; however others report higher levels of dependency among abuse victims, particularly due to cognitive impairment[4,13] The majority of abusers are family members, either spouse, adult child or other close relative, and they usually live with the victim. They may be financially dependent on the person they are abusing. Although poverty, poor financial circumstances and lack of resources may play a part in the occurrence of abuse, it is seen in all social and economic groups, in urban and rural settings, and in all religious and racial groups[14].

Explanations of the Causes of Abuse

No one factor can explain the complex issue of elder abuse and a number of theories have been put forward. Most researchers would acknowledge that a combination of these are often involved in the occurrence of abuse.

These theories include:

1. **Increased dependency of the older person.** Older people who are helpless or dependent on others for assistance due to physical impairments such as Parkinson's disease or stroke, or cognitive impairments such as dementia, are vulnerable to abuse. In the vast majority of neglect cases, dependency is the major causative factor.
2. **Abuser psychopathology:** The personality characteristics of the abuser are a major factor in the mistreatment of the older person. A growing body of evidence suggests that alcoholism, drug abuse, psychiatric illness and cognitive impairment in the abuser are highly significant as causes of abuse. In many cases of physical and psychological abuse, abuser psycho-pathology is implicated as the major causative factor.
3. **Family dynamics:** In some families violence is considered the normal reaction to stress, and it may continue from generation to generation. In some cases the abuser was abused as a child by the person they are now abusing. Marital conflict resulting in spouse abuse often continues into old age, and in many cases of elder abuse there has been a long past history of domestic violence. Other relationship problems, including the financial dependency of the abuser on the victim, may also be significant[15].
4. **Carer stress:** The responsibility of providing physical, emotional and financial support to a disabled elderly family member can generate a huge amount of stress. In many cases, other causative factors are already present and this stress on the carer appears to be the factor that triggers the abuse.

5. **Carer abuse:** Carer abuse or reverse abuse occurs when the carer is abused by the person they are caring for. Usually it is the wife being abused by her husband, and there has either been a long history of domestic violence, or the recent onset of dementia.

It is very important that these causative factors be examined in the context of a population where an increasing proportion are elderly and there is an increase in the incidence of age related diseases such as dementia; and where government policies are stressing community care and placing extra strain on family carers.

Management and Interventions

In Australia to date, the medical profession has played a minor role in the detection and treatment of elder abuse. Wolf has suggested that the medical profession "can make a major contribution to the advancement of knowledge, practice and policy with regard to elder abuse and neglect", just as it has done with child abuse[16].

Medical practitioners are ideally placed to detect cases of abuse amongst their patients. Knowledge of the risk factors and causes of abuse allows them to identify those patients most at risk of abuse, and may allow preventative measures to be put in place before abuse has occurred. Provision of community services in a situation of caregiver stress, or treatment of psychiatric illness or substance abuse in a potential abuser may assist in averting an abusive situation.

Most authors suggest that a multidisciplinary team, usually from a geriatric health service or Aged Care Assessment Team, should be involved in both the assessment of cases where abuse is suspected or confirmed, and intervention[3, 12, 17, 18]. These teams have extensive contacts with other services and are well placed to receive referrals, assess and manage cases, and make referrals when necessary. It would appear that the combination of geriatrician and social worker is effective for the initial assessment, with the subsequent participation of nursing, occupational therapy, and other team members as necessary. Appointment of a case manager is essential to oversee interventions, provide ongoing support and review and monitor the situation at regular intervals. The joint involvement of two team members in the management of cases of elder abuse is recommended.

It is important to take a non-judgemental approach to elder abuse and in many cases it may be more appropriate to look at the situation as one in which there are two victims, rather than a victim and an abuser. The victim of abuse should always be involved in decisions about his/her care. Unless suffering from mental impairment sufficient to affect judgement, that person is able to make decisions and that right must be respected. Ethical dilemmas may arise where one needs to balance the right of the older person to refuse any assistance with the physician's duty of care.

Options for Intervention

1. **Crisis care**: This might involve admission to an acute hospital bed, or perhaps urgent respite care in a nursing home or hostel, depending on the needs of the victim. In cases of severe physical abuse, the victim often needs to be immediately separated from the abuser.
2. **Provision of community support services**. The full range of community services such as home nursing, housekeeping help, community options or linkage programs, community care packages, meals on wheels, etc. can be used to alleviate situations where abuse is occurring. Assistance with shopping and transport is of practical help to the carer.
3. **Provision of respite**. This may be in-home respite, day-centre respite, or institutional respite. It is particularly helpful when carer stress is a problem and where there has been a situation of neglect. If the victim is quite dependent, then often nursing home care is the only alternative.
4. **Counselling**. This is an important means of intervention. It may involve individual

counselling or family therapy. The aim is to help the victim cope with his/her situation, and find a way to be safe from the abuser. Group therapy may be utilised in situations such as carer support groups. In cases where domestic violence is the main cause of abuse, a referral may need to be made to services for victims of domestic violence.

5. **Alternative accommodation on a permanent basis.** Sometimes this may be necessary. Realistically it usually means institutionalisation, often nursing home placement, for the victim of abuse. However in some situations where reverse abuse or carer abuse has occurred, it has been the abuser who has required nursing home placement.
6. **Legal interventions**. These are hopefully a last resort, but may be the first line of intervention in cases of financial abuse or severe physical abuse where criminal charges may need to be laid. Applications for guardianship or financial management can be made where the victim is unable to make a decision because of cognitive impairment or psychiatric illness. Chamber magistrates or the police may need to be involved if a restraining order is being sought.

It is important that the major cause be identified in each case of abuse, so that interventions can be designed accordingly. Based on the results of Australian research[4,19], cases of abuse due to dependency appear to respond at least initially to provision of community services such as home nursing, housekeeping assistance, meals-on-wheels, and day care, with lessening of abuse. However, institutionalisation is often eventually required because of the high levels of disability and dependency of the victim.

Where abuse is occurring as the result of psychopathology in the abuser, protection of the older person is important, as well as counselling or other treatment to modify the behaviour of the abuser. Sometimes admission of the abuser to hospital is necessary to address a psychiatric illness or drug or alcohol problem.

Mandatory reporting has been suggested as one method of managing this very difficult problem, because it would put the issue of abuse on the social agenda, and ensure adequate funding. However, mandatory reporting stops older people making decisions for themselves, endangers their autonomy, and represents an invasion of privacy. It also creates expectations that when a report of abuse is made, demands for services and other resources will be met. The consensus of government reports and researchers in Australia has been to oppose the introduction of mandatory reporting [20].

Instead of legislation, more resources need to be allocated for research, education, and prevention programs for this increasing problem, and funds are needed to provide adequate community services and accommodation options for the management of abuse once it has been identified.

As the numbers of dependent elderly in the community increase, we can expect to see more cases of abuse, especially neglect and financial abuse, which are closely related to the dependency of the victim. Primary prevention is the preferred intervention for elder abuse and the first and most important step that can be taken to achieve this is to increase the levels of awareness and knowledge of the problem among the medical profession.

References

1. Ronalds, C. (1988) I'm Still an Individual Canberra: Department of Community Services and Health.
2. Tornlin, S. (1989) Abuse of Elderly People: an Unnecessary and Preventable Problem. London: British Geriatrics Society.
3. Kurrle, S.E., Sadler, PM. & Cameron, I.D. (1991) Elder abuse: an Australian case series. Medical Journal of Australia, 155: 150-153.
4. Kurrle, S.E.. Sadler, PM. & Cameron, ID. (1992) Patterns of elder abuse. Medical Journal of Australia 157(10): 673-676.
5. Barron, B., Cran, A., Flitcroft, J. et al. (1990) No Innocent Bystanders: a Study of Abuse of Older People in Our Community. Melbourne: Office of the Public Advocate.
6. McCallum, J., Matiasz, S & Graycar, A. (1990) Abuse of the Elderly at Home: the Range of the Problem. Canberra: National Centre for Epidemiology and Population Health.
7. Kurrle, S.E. (1992) Abuse of the elderly: a hidden problem. Australian Family Physician 21(12): 1742 -1748.
8. McCreadie, C. (1991) Elder Abuse: an Exploratory Study. London: Age Concern Institute of Gerontology.
9. Pillemer, KA & Finkelhor, D. (1988) The prevalence of elder abuse: a random sample survey. Gerontologist, 28(1): 51-57.
10. Cripps D. (2000) Australia's first randomised study of the prevalence and effects of elder abuse in the general community. Proceedings of the Australian Association of Gerontology Conference, Adelaide 25-27 October 2000.
11. Kurrle S, Sadler P, Lockwood K, Cameron ID. (1997) Elder abuse: a multicentre Australian study. Medical Journal of Australia 166:119-122.
12. Livermore P, Bunt R, Biscan K. (2001) Elder abuse among clients and carers referred to the Central Coast ACAT: a descriptive analysis. Australasian Journal on Ageing 20(1); 41-47.
13. Jones, J., Dougherty, J., Shelble, D. & Cunningham, W. (1988) Emergency department protocol for the diagnosis and evaluation of geriatric abuse. Annals of Emergency Medicine, 17(10): 1006-1015.
14. Council on Scientific Affairs, American Medical Association (1987) Elder abuse and neglect. Joumal of the American Medical Association, 257(7): 966-971.
15 Sadler, PM. (1994) What helps? Elder abuse interventions and research. Australian Social Work 47(4): 27-36.
16 Wolf, R.S. (1988) Elder abuse: ten years later. Journal of the American Geriatrics Society, 36(8): 758-762.
17 Working Party on the Protection of Frail Older People in the Community (1994) Report. Canberra: Office for the Aged. Commonwealth Department of Human Services and Health.
18 NSW Advisory Committee on Abuse of Older People (1995). Abuse of Older People: Inter-Agency Protocol. Sydney: Ageing and Disability Department.
19 Kurrle, S.E. (1993) Responding to elder abuse: a follow-up study of intervention and outcomes. Australian Journal on Ageing, 12(4): 5-9
20. NSW Advisory Committee on Abuse of Older People (1997). Mandatory reporting of abuse of older people. Sydney: Ageing and Disability Department.