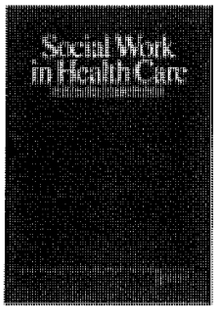
ATTACHMENT [**MO-1**]

This is the attachment marked "[**MO-1**]" referred to in the witness statement of Meghan Jane O'Brien dated 12 August 2015.



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Responding to a "Window of Opportunity": The Detection and Management of Aged Abuse in an Acute and Subacute Health Care Setting

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Responding to a "Window of Opportunity": The Detection and Management of Aged Abuse in an Acute and Subacute Health Care Setting

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Aged abuse can manifest as physical harm, sexual assault, intimidation, blackmail, and social deprivation, misappropriation of funds or property, and neglect. The extent of the problem is difficult to assess in health settings due to underreporting and the fragility and reluctance of the elderly in being able to discuss the issue with health care providers. This appears to be related to the fact that perpetrators are frequently family members with resulting issues of aged dependency, family loyalty, and fear of the consequences of reporting. Of equal importance is a general lack of community understanding of aged abuse, including health professionals who frequently lack the confidence in screening and management to respond appropriately when aged abuse is suspected. Staff knowledge and skills emerge as a deficit in the detection of elder abuse and staff education has been identified as an effective means of improving the recognition of the abused elderly person in acute hospital settings. In addition, there remains a need for effective screening protocols. The aim of this study was to explore the recognition of aged abuse in an acute and subacute hospital setting. This has implications for effective management and community linkage as well as strengthening the knowledge base of issues related to this vulnerable group. The study included a survey and

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interview with hospital staff to explore their response to aged abuse over a retrospective twelve-month period.

KEYWORDS aged abuse, acute health care, subacute health care, hospital staff, screening, family, community links

INTRODUCTION

An increasingly aging population both in Australia and internationally has increased the number of elderly vulnerable to abuse. However, existing statistics on incidence and prevalence suggest a high level of underreporting and underrecognition of what is often an invisible problem (Levine, 2003). Underreporting appears to be related to the fact that the perpetrators of abuse are usually family members or carers. This raises issues of elder dependency on the abuser, family loyalty, and fear of the consequences of reporting (Boldy, Webb, Horner, Davey, & Kingsley, 2002). Of equal importance is a general community lack of understanding and health professionals lack of education in recognition of aged abuse (White, 2000; Levine, 2003; Fulmer, 2002; Trevitt & Gallagher 1996). Yet it is generally accepted that earlier accurate recognition, assessment, and intervention would contribute to a more proactive, preventative, and health-promoting approach.

White (2000) argues that because the aged are frequent users of emergency departments, emergency offers an ideal opportunity to routinely evaluate patients. For many abuse victims, the hospital emergency department is the first point of contact with the health system (Fulmer, 2002; Trevitt & Gallagher, 1996), and may offer a "window of opportunity" for help and support (Kahan & Paris, 2003). Yet despite the potential for detecting abuse, the emergency department is often ill equipped to detect abuse other than serious physical injury (Kahan, 2003; McDonald, 1990). This is particularly of concern when it is considered that of the types of abuse suffered by the elderly, physical abuse is generally agreed to be the least common form of abuse, while financial and psychological abuse are the most common (Trevitt & Gallagher, 1996).

According to a recent World Health Organization (WHO, 2002) report on violence and health, abuse of elderly people dates back to ancient times, yet remained hidden from public view until the late twentieth century. Once viewed as a social welfare issue and problem of aging, abuse of the elderly has now become a major public concern as well as a significant criminal justice issue. The WHO notes that although elder abuse was first identified and researched in developed countries, anecdotal evidence suggests that it is a universal problem. Further, the fact that elder abuse is now being taken seriously reflects a growing international concern about violence and aging.

DEFINITION OF AGED ABUSE

The definition of elder abuse adopted by the International Network for the Prevention of Elder Abuse states, "elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (WHO, 2002, p. 126).

The WHO report on elder abuse proposes that such abuse can be divided into the following categories:

1. *Physical abuse*: infliction of pain or injury, physical coercion, or physical or drug-induced restraint
2. *Psychological or emotional abuse*: the infliction of mental anguish
3. *Financial or material abuse*: the illegal or improper exploitation or use of funds or resources of the older person
4. *Sexual abuse*: non-consensual sexual contact of any kind
5. *Neglect*: the refusal or failure to fulfil a caregiving obligation. This may or may not involve a conscious and intentional attempt
6. *Harm*: afflict physical or psychological harm on the older person (WHO, 2002, p. 127).

A study by Hudson and Carlson (1998) attempted to develop a precise classification and definition of elder abuse, by integrating the views of the general public with those of elder mistreatment authorities. The authors argued that definitions of elder abuse must include the meaning of the lived experience for the victim, because the meaning may be different depending on whether the abuse is an observed experience or a lived experience. Hudson and Carlson noted that the variability in definitions of elder abuse makes comparison of research findings difficult. Similarly, differing definitions of elder abuse impede assessment instrument development, estimates of incidence and prevalence, and the development of appropriate interventions and prevention programs. The findings of the study by Hudson and Carlson (1998) indicated that although there was a high degree of agreement between the general public and experts on a taxonomy of elder abuse, there were also areas of disagreement on what constitutes abuse. Further, analyses of cultural and racial subgroups of the sample provided some significant differences in perceptions of elder abuse. The WHO (2002) describes elder abuse as either an act of commission or an act of omission (i.e., neglect) that may be either intentional or non-intentional. Elder abuse may be physical, psychological (e.g., emotional or verbal aggression), or involve material maltreatment (e.g., financial maltreatment). Regardless of the nature of the abuse, the result is almost certainly unnecessary suffering, injury/pain, a loss or violation of human rights, and a marked decrease in quality of life for the victim. Further, the WHO notes that whether the

behavior is considered abusive, neglectful, or exploitive will depend on the frequency, duration, and severity with which the mistreatment occurs, and the cultural context.

Kosberg and Garcia (1995) reported that a workshop on aged abuse held in South Africa in 1992 made a distinction between elder mistreatment and elder abuse. Elder mistreatment included verbal abuse, passive and active neglect, financial exploitation, and overmedication, whereas elder abuse included physical, psychological, and sexual violence, together with theft.

Extrapolating from five surveys of elder abuse in developed countries dating back to 1988, the WHO (2002) estimates a rate of abuse of from 4–6% among older people (includes physical, psychological, and financial abuse, and neglect). Comparison of these studies is difficult, however, due to differences in the time frames investigated. For example, studies conducted in Canada (Podnieks, 1992), the Netherlands (Comijs, Pennix, Knipscheer, & van Tilberg, 1998), and the United States (Pillemer & Finkelhor, 1988) investigated the occurrence of elder abuse in the "preceding year." A study conducted in Finland (Kivela, Kongas-Saviaro, Kesti, Pahkala, & Ijas, 1992) referred to the occurrence of elder abuse "since age of retirement." In contrast, a study conducted in Britain investigated elder abuse over "the past few years" (Ogg & Bennett, 1992). In a study of non-institutionalized elderly Americans, Pillemer and Finkelhor (1988) estimated the frequency of elder abuse to be 3.2%. A survey conducted in Canada found that 4% of elderly people had experienced some form of elder abuse since turning 65 years of age (Poednieks, 1992). A Dutch study reported a 1 year frequency rate of 5.8% (Comijs et al., 1999). In a national survey of elder abuse in Sweden and Denmark, Tornstam (1989) reported a rate of 8%. It should be noted that each of these studies used different definitions of elder abuse, which again emphasizes the importance of having an integrated definition.

According to Schofield and Mishra (2004), it has been estimated that approximately 4% of older Australians experience some form of elder abuse, with psychological abuse the most common form, followed by physical abuse. Women's Health Australia has estimated that between 1 and 6% of women aged 70–75 years experience elder abuse, including verbal and physical abuse, theft of belongings, and being forced to do things they do not want to do.

Fulmer, Guadagno, Dyer, and Connolly (2004) stated that existing literature supports the following theories of elder abuse:

1. *The Situational Theory*: theorizes that an over burdened caregiver creates an environment of abuse due to their inability to meet the demands of care
2. *Exchange Theory*: proposes that the dependency between the older person and the person committing the abuse is related to long-standing tactics and responses in family life

3. *Social Learning Theory*: advocates mistreatment as a learned behavior influenced by factors in one's environment
4. *Political Economic Theory*: addresses the challenges faced by older people once they lose their role in society and become dependent on others
5. *Psychopathology of Caregiver Theory*: investigates the role of a caregiver with mental health problems and how this may put the elder at risk of mistreatment

Levine (2003) describes elder abuse as "psychodynamically and medically complex" (p. 40), with a wide variety of factors contributing to its occurrence. One approach to describing risk factors distinguishes caregivers/perpetrators and elder abuse victims (Levine, 2003).

Caregiver risk factors include the strain of the demands of care giving, that is, physical and/or emotional exhaustion related to the responsibilities of care (Levine, 2003). There is general agreement in the literature that pathological characteristics of caregivers, especially mental illness and substance abuse, are associated with elder abuse (e.g., Lachs & Pillemer, 2004; Levine, 2003; WHO, 2002). Depression and alcohol misuse appear to contribute to elder abuse (Lachs & Pillemer, 2004). Relatives who are dependent on the elderly for financial assistance or accommodation are at greater risk of becoming abusive. According to Levine (2003), the care of an older relative often becomes the responsibility of the least socially integrated adult child. In this situation, the adult child may be unemployed or experience other psychosocial stressors that may contribute to the risk of abuse.

Cognitive and physical impairment of the older abused person have been identified as victim risk factors. According to Lachs and Pillemer (2004), physical elder abuse is common among dementia patients. The authors suggest that the association between dementia and elder abuse may be due to a high rate of disruptive and aggressive behaviors demonstrated by patients. Such behaviors cause great stress and strain to caregivers and may result in retaliation. Victims of elder abuse are often characterized by social isolation, that is, isolation from friends and family other than the abuser. According to Levine (2003), shared accommodation places older people at greater risk of physical abuse, whereas living alone increases the risk of financial/-material abuse. A lack of community support contributes to social isolation and also the burden attributed to caregivers (Levine, 2003).

The WHO (2002) notes that a variety of interventions for elder abuse have been initiated, including mandatory reporting, protective service units, social service protocols, emergency shelters, support, and self-help groups and consultation teams. However, few of these interventions have been researched/evaluated experimentally or quasi-experimentally and such research is needed.

Staff knowledge and skills emerge as a clear deficit in detection, with the education of medical staff identified as the most effective way of improving the recognition of cases of abuse of the elderly in the acute hospital setting. The documentation of physical signs of abuse and neglect are the areas where nurses have been found to have the most skill and knowledge, with the other types of abuse not being as readily recognized (Trevitt & Gallagher, 1996). Along with arguments for increased education for health professionals about the nature and types of abuse, are calls for effective screening protocols. In the United States it has been claimed that only one in ten cases of abuse of the elderly and neglect are reported (Fulmer 2003). Fulmer (2002) argues that despite the complexity of abuse of the elderly, utilization of protocols for management in acute care, including emergency departments, is feasible. Hudson and Carlson (1998) assert that the use of instruments cannot adequately identify abuse cases but that "professional judgment is always needed when assessing a potential abuse situation" (p. 68). In this respect, an interdisciplinary approach to detection, evaluation and management is crucial (Kahan, 2003).

In a study carried out at St Vincent's Health, Melbourne Australia the research team surveyed allied health, medical, and nursing staff working in emergency, acute, and sub-acute care in the health service.

METHODOLOGY

The research design had three phases. Using a self-report questionnaire (Phase 1) we asked staff to describe patients with aged abuse referred to them within a previous one-month, three-month, six-month, and twelve-month time period (n = 166 with a 94% response rate). We then asked survey respondents to indicate whether they would participate in an interview (Phase 2) and focus group (Phase 3) around their most recent management of a case of elder abuse. The researcher interviewed those consenting to participate using a semi-structured questionnaire format to explore issues related to the detection, management, referral, and follow-up of the elder abuse cases identified. The data was analyzed in terms of presentation as well as the management of the aged person and their family situation. Finally a focus group was held with all staff recruited to the interview stage of the study.

RESULTS

Survey Data

Analysis of the survey data suggested that while 73% of the sample of nursing, medical, and allied health professionals (n = 166) stated that they

were familiar with the concept of aged abuse, only 14% had received any education or training on how to detect or manage this group of vulnerable patients. In addition 32% indicated that they had a good understanding while 54% said that they had a fair to poor understanding of aged abuse.

While 47% of the sample stated that they had never suspected abuse in any of their elderly patients within the previous twelve months, the remaining 53% of the sample described their response to a suspicion of aged abuse in acute and subacute health care in Figure 1.

Staff suspicion was aroused during their observation of the patient and their family or carer (22%), during routine assessment (46%) or when the elderly person was referred to them by another member of the staff (32%). The highest frequency of abuse suspected was ascribed to an adult child (39%) with the same frequencies reported for the spouse, carer, and residential care facility (10%).

Interview Data

The interviewees for this phase of the study included three nursing staff, a physiotherapist, an emergency physician, and six social workers (n = 11) who had worked at St. Vincent's Health from between six months to fifteen years. They had all been directly involved in cases of suspected aged abuse.

Five of the elderly patients described had been admitted through the Emergency Department including three who had suspicious accidents, one presenting with dementia, and the third with a medical issue. Nine of the

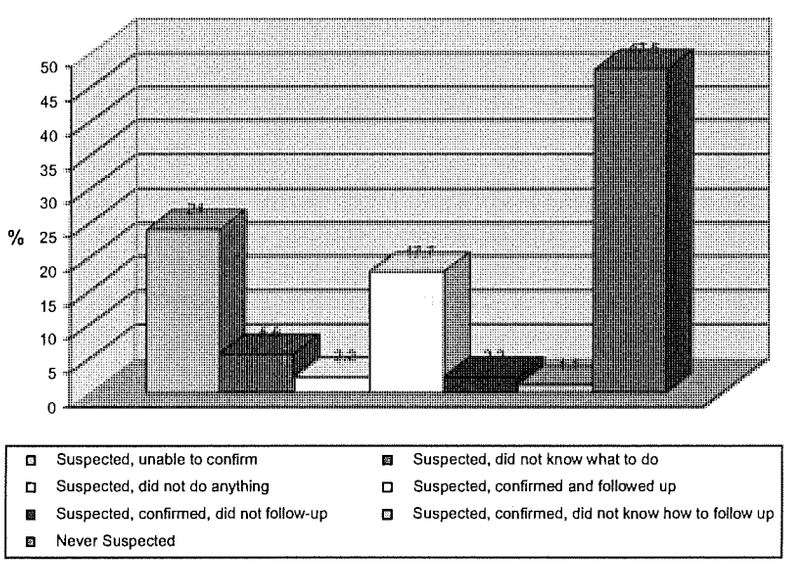

FIGURE 1 Staff response to the suspicion of aged abuse in acute and subacute care.

eleven patients were female. The patients' length of stay ranged from a "few days" to six weeks. Three patients had many previous admissions to the one being discussed and in one instance the abuse became more apparent during the third admission. Nine of the elderly had been subjected to between two and five different types of abuse with misappropriation of funds or property, physical injury, and neglect the most commonly suspected types. In each case the alleged abuser was related to the patient, with ten taking on the role of primary carer, and eight sharing accommodation with the patient. In the seven cases where children were the abusers, six of the victims did not live with a partner. The staff members interviewed stated that they had time to observe interpersonal interactions between family members on the ward, and to work with both the victim and the abuser. In ten instances the abuse was long-standing and had occurred for several years.

The process of care adopted by health professionals included a detailed assessment and interaction with both the victim and the abuser. Two of the non–social work staff referred the patient to the hospital social work department and community resources were accessed in six cases. The latter included primary care, the Department of Human Services, and the Aged Care Assessment Service. A shared goal in the intervention process was to advocate for their admission and stay in the hospital as an opportunity to fully explore and respond to their needs. There were multiple indicators of abuse that informed the professionals' assessment, including direct disclosure by the elderly person themselves or another family member. In some instances the carer disclosed that they physically and verbally abused the patient. In half of the cases, the health professional themselves suspected abuse through their observation of, and interaction with, the patient and their alleged abuser. This related to their observation of unhygienic home conditions, physical neglect of the patient, patient distress, and the absence of visitors.

Staff perception of satisfaction with the care offered

Those staff satisfied with the resolution of the suspected abuse situation reported that separate accommodation had been provided, either a guardianship or administrative order had been sought, an educational intervention with the alleged abuser had taken place, and community workers were monitoring the situation. Another four felt that there had been "some degree of resolution" because they had facilitated better monitoring either through a general practitioner, community nurse, or community worker. They were still concerned, however, about the level of conflict that existed. Three workers felt that the issues were left unresolved because of lost contact with the patient, the client had not wished to enact change, and because the elderly person and the abuser remained in shared accommodation.

Ethical dilemmas faced by interviewees

The interviewees were confronted with ethical dilemmas in their approach to the aged person. In particular, this related to the complicated dependency issues surrounding family and carer perpetrators of abuse. There were additional problems related to disagreement in the care team about the level of intervention required based on assessments of future risk. This was further complicated by the wishes of the patients to return to the abusive situation despite the risk involved. Four of the social workers interviewed discussed how they struggled to know whether intervening was of benefit to the patient given the emotional attachment and level of dependence with the alleged abuser. Particularly when the patient did not wish any action to be taken, interviewees experienced an ethical dilemma in considering whether disrupting the alleged abuser/s–patient relationship, or intervening to prevent further abuse constituted "Patient Centered" practice. In one case, the interviewee expressed difficulty in handling inter-family conflict between a non-abusing family member who wished to take steps to end the abuse and the patient who did not. One interviewee was concerned that raising the issue with the abuser might subject the patient to further abuse, in that the abuser would no longer bring the patient to access medical care. Another interviewee struggled in deciding "who" in the care team should be privy to the information about suspected abuse, and was concerned with not creating prejudice against the family before the claim was substantiated.

Staff attitudes toward mandatory reporting

Three of the eleven interviewees felt that mandatory reporting of aged abuse could have been beneficial. They cited reasons of creating organizational accountability, increased responsibility for monitoring, and the possibility of accessing greater external support in deciding how community resources could be organized and distributed. However, the remaining eight interviewees did not believe mandatory reporting would have benefited the patients. Three felt mandatory reporting would have damaged the already tenuous relationships between workers and alleged abusers, and could therefore close a window of opportunity for intervention. Another two interviewees felt that asking more questions of unwell patients could be distressing for them and were also concerned about creating a poor outcome for the patient, through ruptured family relationships. There was consensus that the outcome would have been no different with mandatory reporting and that professional judgment in reporting aged abuse was adequate.

Results from the Focus Group

A focus group was held with all staff who consented to being interviewed. Four main themes emerged from the discussion.

Issues around the patient

The aged patient may lack competence in discussing the circumstances surrounding their abuse as a result of cognitive deficits, in particular memory or a diagnosed psychiatric condition such as dementia. Their fragility is often further compounded by multiple medical problems and chronic disease, which impacts on their energy and motivation to manage emotional conflict and physical change. In instances where the elderly person is not competent to make decisions about their future, specialist assessment can play a part in supporting hospital staff to plan for a safe environment after discharge from the health service. Where patients are competent they may exercise their right to stay in an abusive environment rather than leave the family or carer to be put in a residential care facility. Their emotional dependency is strengthened by a desire to maintain their independence at whatever cost.

Issues around the carer

The social system in which the aged person is embedded impacts on carer relationships and commitment. The strain of caring can result in non-deliberate neglect with inappropriate care that can harm the aged person. In addition, misguided intentions can result in behavior that, while it may not be deliberately cruel, is misguided and results from frustration, and an inability to cope with the burden of caring. Where the carer attempts to cope by using controlling, restrictive behaviors, this might only increase the aged person's fear. The emotional and physical strain of caring can become intolerable for the best-intentioned carer.

Issues around health care professionals and service provision

The complexity of family relationships and dependency issues surrounding suspected abuse of the aged are subtle and can make detection and referral difficult. Substantiating and gathering information may need to be done over time and involve multiple community contacts and resources. There is always a need to proceed with investigations of abuse of the aged person very carefully and where possible involve other health care professionals, drawing on their perceptions, judgement, and experience. The thrust of current health service provision to keep people in their own homes for as long as possible should always be accompanied by formal supports and monitoring. Health care providers may not have the confidence, compounded by a lack of professional expertise, to take the matter further.

Issues around types of abuse

Financial abuse is common and may be easier to detect than other forms of abuse. In some instances financial exploitation can lead to criminal charges. Families sometimes would rather care for the aged person grudgingly, in order to preserve their inheritance rather than invest money into the best possible care resources. Giving a carer or family member authority for banking can create opportunities for abuse.

DISCUSSION

The results of the study suggested that abuse of the aged person does not lend itself to a clear-cut model like that of child abuse due to the mutual dependency and emotional enmeshment of the abuser and the abused. Early suspicion and identification of risk and an integrated multidisciplinary response across the health service could be effective in responding to the multiple and complex behavioral and social issues that contribute to aged abuse as it presents in emergency, acute, and sub-acute care. Effective use of this "window of opportunity in health care" could extend the level of community response to this vulnerable group of people.

The results of the study suggested:

1. The need for a screening tool for the detection of aged abuse in acute and subacute care.
2. Dedicated health care professionals' time to liaise and implement an intervention in a neutral, protected environment.
3. Educational and professional development programs to increase awareness of aged abuse.
4. Guidelines to facilitate pathways of referral within the health service for health care professionals where they feel there are issues for concern.
5. A program for carer education and community support.no italics or boldface in the numbering

According to a recent World Health Organization (WHO, 2002) report on violence and health, abuse of the aged dates back to ancient times, yet remained hidden from public view until the late twentieth century. Once viewed as a welfare issue alone and a problem of aging, abuse of the elderly has not only become a public concern but also a criminal justice concern. The WHO notes that although aged abuse was initially identified and researched in developed countries, anecdotal evidence suggests that it is a universal problem. The "window of opportunity" for responding to aged abuse in a health service is brief. Health care professionals have the opportunity, however, to make it effective. The identification of abuse

among the vulnerable aged who present at the emergency, acute, and subacute departments of a health service remains a problem for health professionals working in these areas and raises questions regarding the identification of risk, communication of the suspicion of abuse, referral, assessment, intervention, and continued management of this group of vulnerable aged.

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