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IDENTIFYING, SCREENING, ASSESSING, AND INTERVENING IN SUSPECTED ELDER ABUSE CASES; A SUMMARY OF THE LITERATURE

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Abstract

Elder abuse (EA) is a human rights violation that affects older adults regardless of socioeconomic status or culture. In Canada, approximately one in ten older adults have experienced some form of abuse. Despite increased awareness EA is under recognized, and clinicians generally lack the knowledge and training required to address it. There are several factors and signs that can raise suspicion and allow early detection. Various screening tools are available for different settings; however, many are not yet validated, and a gold standard is still to come. Variable decision making capacity and functional dependency pose unique challenges for EA intervention. As there is no elder abuse law in Canada, each province has a unique approach in addressing reported cases. This paper provides an overview of the current literature on EA and suggests a clinical pathway to identify, screen, assess and intervene in suspected EA cases.

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Key Points

Elder Abuse (EA) in Canada is common, affecting 10% of older adults but identification and reporting are infrequent.

There are 5 main types of abuse: Physical, Psychological, Sexual, Financial and Neglect.

Physicians are well suited to identify, screen and intervene in cases of suspected abuse during the provision of routine care.

Early detection and interventions help limit the impact of abuse by treating the underlying physical consequences of abuse, providing community-based services and identifying potentially dangerous environments.

Physicians can increase their clinical skills to address elder abuse by:

(1) Integrating a screening tool (e.g., the Elder Abuse Suspicion Index©) into practice to help identify EA.

(2) Being familiar with the risk factors, triggers and possible signs to screen and assess for EA and the laws and reporting requirements related to elder abuse in their region.

(3) Knowing the resources available to help support interventions for older adult patients who are experiencing elder abuse.

Background and Definition

Attempts to address elder abuse and its consequences have been limited by a lack of high-quality literature and limited awareness. Increased efforts to tackle the issue started to gain momentum after the World Health Organization (WHO) proclaimed elder abuse as a human rights violation in 2002[1].

The prevalence of abuse and neglect in Canada ranges from 4-10% of those aged 65 and over but it is believed that the number may be underestimated as it is often underreported[2]. Elder abuse can have serious consequences such as physical injuries, increased hospitalization and institutionalisation, psychological effects, such as depression and anxiety, as well as an overall increased risk of death[3]. There may also be negative effects on family dynamics.

The WHO defines elder abuse as "a single, or repeated act, or lack of appropriated action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person"[4]. The 5 main types of elder abuse are[3,5-7]:

- Physical abuse: Acts carried out with the intention to cause physical pain or injury, such as direct blows or the misuse of medications or restraints.
- Psychological abuse: Acts carried out with the aim of causing emotional pain or injury, such as verbal humiliation and/or threats of harm, isolation, or abandonment.
- Sexual abuse: Sexual acts that are carried out to an older adult that are non-consensual or any sexual contact with an older adult incapable of giving consent.
- Financial exploitation: Acts of misappropriation of an older adult's money and/or property and fraud. Pressuring an older adult into making changes to wills or financial transactions are also included.

- Neglect and abandonment: the failure of a designated caregiver to meet the needs of a dependent older adult. Acts can be both intentional and unintentional and may include the withholding of medications, not providing proper nutrition and hygiene, or not supplying adequate shelter.

Risk Factors for Elder Abuse

Presentations of elder abuse are heterogeneous and can be easily missed as older adults do not always voluntarily report abuse. For these reasons, clinicians should have a high index of suspicion to properly correlate risk factors with clinical assessment based on history, physical examination, and investigative findings.

Older adults are at risk for abuse regardless of socioeconomic status or culture[8]. There are risk factors that have been identified as making older adults more vulnerable to becoming victims of abuse. These risk factors can be divided into risks relating to the victim, those relating to the perpetrator, and those relating to the relationship and living environment (Table 1)[6,9-11].

Table 1.0 Risk Factors for Elder Abuse[6,9-11]

Victim Risk Factors	Perpetrator Risk Factors	Environmental Risk Factors
Female Sex	Male Sex	Family Disharmony
Cognitive Impairment/Dementia	A Child or Spouse of the Older Adult	Low Income/ Socio-Economic Status
History of Psychiatric Illness or Substance Abuse	History of Psychiatric Illness or Substance Abuse	Living with Many Household Members
Poor Physical Health	Previous History of Family Violence	Low Social Support
Functional Dependence and Frailty	Caregiver Burden or Stress	
Previous History of Family Violence	Financial Dependence on the Older Adult	

Identifying Signs of Elder Abuse

Clinicians face many challenges when assessing for elder abuse[3]. Presence of cognitive impairment can obscure the circumstances, or the details required to raise suspicion. Chronic illnesses and normal physiologic changes of aging in older adults can make it more difficult to identify signs of abuse, and may lead to falsely labelling a finding as caused by abuse when it is in fact a normal sequela of an older adult's medical condition or of the aging process. Cultural barriers may also play a part in hindering the reporting of cases of abuse. These are only some of the reasons why routine screening for elder abuse is not recommended by some entities such as the U.S. Preventive Services Task Force (USPSTF)[12].

However, the clinician still has an important role in identifying signs of abuse and intervening in cases of suspected elder abuse. During the initial assessment of the older adult, general observation of the interaction with the caregiver may raise some red flags (Table 2)[13].

Table 2.0 Observations from Older Adult/Caregiver Interaction that Should Raise Concern[13]

Conflicting accounts of events
Older adult appears to be fearful or hostile towards the caregiver
Caregiver interrupts and answers for the older adult
Caregiver appears unengaged in the caring for the older adult
Caregiver appears overwhelmed, burdened by the older adult
Caregiver appears to lack knowledge of the older adult's basic care and needs
Signs or evidence that either the older adult or the caregiver is abusing drugs or alcohol

Adapted with permission from Rosen T. Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department. Clin Geriatr Med. 2018 Aug 34(3):435–51.

A comprehensive history should be taken with the patient alone and away from the caregiver when abuse is suspected. Interviews should start with less threatening open ended and indirect questions, then lead into more direct questions.

For examples of questions that can be used when taking a history, see Table 5 in "Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department"[13].

If language translation or collateral information is required, professional interpreters are recommended. Non-caregivers should also be interviewed if abuse is suspected. The caregiver should be interviewed separately; rapport may be built by expressing sympathy to caregiving challenges and by avoiding judgemental or accusatory comments during the process.

During the family and social history taking, ask about a history of abusive behaviors, drug or alcohol misuse, recent stressful events, and any relationship issues with the caregiver. Some indicators from the history that may point to possible elder abuse include[13]:

- Unexplained injuries
- A history of repeated injuries
- Older patient referred to as "accident prone"
- Delay between onset of medical illness or injury and seeking of medical attention
- Recurrent visits to the emergency department for similar injuries
- "Doctor shopping" or using multiple physicians and emergency departments for care rather than one primary care physician
- Noncompliance with medications, appointments, or physician directions

During the physical examination, look for signs of despair, fear, and poor eye contact. It is important to note the physical appearance of the patient, the state of their nails, hygiene, nutrition, and grooming. If injuries are suspected, it is important to look at the stage of healing, the size of the bruises, the consistency of the injury with the reported mechanism and to assess for possible mimickers. Physicians should also try to document the clinical findings suspicious of abuse using body charts, and/or clinical photographs. Documentation should also include direct quotes and input from multiple sources with comments about discrepancies and reliability of sources and observations about the interactions of the older adult and their caregivers[14].Where possible, a second staff member, preferably of the same gender as the patient, should be present for the physical examination. Table 3 from Danesh et al highlights some of the cutaneous manifestations, mimickers, and red flags suggestive of elder abuse[15].

For pictures of cutaneous manifestations and mimickers of elder abuse, see figures 1-4 in "The role of the dermatologist in detecting elder abuse and neglect"[15].

Table 3.0 Cutaneous Mimickers of Elder Abuse[15]

Cutaneous Manifesta-	Mimickers	Red Flags
Injury on the back of the hand	Solar purpura and angular hypopigmented scars from repeated occupational injuries Vasculitis Vasculopathy Bateman purpura Steroid purpura Unintentional injury	Size > 5 cm Resembles instrument used (shoe, belt buckle etc.)
Burn injury in stocking distribution	Friction blisters Autoimmune diseases Contact dermatitis	Resembles implement used (cigarette) Immersion burns Tender on exam
Pellagra from vitamin B3 deficiency	Photodermatitis (non nutritional) Photosensitive dermatitis Paraneoplastic syndrome Drug side effects	Dehydration Poor general hygiene (unclean hair and nails, soiled clothes, body odor) Foul smelling decubitus ulcers Flaring of medical conditions suggesting medication withholding Lab investigations suggesting nutritional deficiencies
Perianal contusions	Lichen sclerosis Lichen planus Anal fissures secondary to chronic constipation Iatrogenic injury from catheter placement or perineal	New- onset sexually transmitted infections Pain in genital area Genital bleeding. Extragenital manifestations of abuse Torn or stained underwear
Adapted with permission from Danesh MJ, Chang ALS. The role of the dermatologist in detecting elder abuse and neglect. J Am Acad Dermatol. 2015 Aug 73(2):288.		

Although lab investigations cannot diagnose or exclude abuse, they can help affirm suspicions. Lab findings of anemia, dehydration, malnutrition, unexplained rhabdomyolysis, low levels of prescription medications, if such levels are available, can all increase suspicion of neglect[16]. Toxicology may also be helpful and may indicate overdosing, poisoning, and physical abuse.

Imaging is also helpful for detection of physical abuse, especially in the Emergency Department (ED). Radiographic evidence of injuries due to high energy mechanisms with a patient or caregiver report of a low energy mechanism should make one suspicious of physical abuse[13]. For example, a fracture to the distal ulnar diaphysis suggests an injury sustained in self defense. Injuries at multiple stages of healing particularly in the maxilla-facial area and upper limbs are also suggestive of physical abuse[17]. It is worth noting that the elderly population have co-morbidities that puts them at risk for osteoporosis, impaired balance, and coagulation disorders, which can all factor into the mechanism and presentation of injury. Notably, providing the radiologist with a detailed description of the clinical scenario, including the mechanism of injury, when requesting a study could improve detection of elder abuse in suspected cases[13].

Table 4.0 summarizes some of the common clinical findings in victims of elder abuse[18].

Table 4.0 Common Findings in Cases Identified with Elder Abuse[18]

Observational, Clinical and Laboratory Findings	Clinical and Radiological Findings	History Related Factors
Unkempt patient	Maxillofacial injuries, mostly peri-orbital	Non-compliance with treatment plan
Foul smelling decubitus ulcers	Distal ulnar diaphyseal fracture	Delay of more than 1 day between injury and ED visit
Diarrhea and urine burns/ excoriations	Contusions around the axilla and inner aspects of the arm	
Untreated previous injuries	More than 1 bruise	
Signs of dehydration- hypernatremia, elevated urea/ creatinine ratio, elevated hematocrit	Bruising incompatible with the alleged trauma mechanism	
Signs of malnutrition, anemia, decreased serum albumin and prealbumin levels	Discordance between history and physical findings	
	Patient or caregiver intoxication during the ED visit	
Adapted with permission from Mercier É, Nadeau A, Brousseau A-A, Émond M, Lowthian J, Berthelot S, et al. Elder Abuse in the Out-of-Hospital and Emergency Department Settings: A Scoping Review. Ann Emerg Med [Internet]. 2020 Feb;75(2):186.		

Screening and Assessing for Elder Abuse

Validated screening tools help identify vulnerable adults, help prevent future abuse and reduce its impact, especially for older adults who do not exhibit overt signs of abuse[19]. Unfortunately, there is currently no gold standard test for elder abuse.

Trying to elicit information about such a sensitive topic in a presumably caring relationship between a vulnerable older adult and their caregiver(s) can be challenging. Victims may conceal their circumstances due to fears of being judged or shamed, dependence on the abuser, fear of potential retaliation, and lack of recognition that the behaviour is considered as abusive[20]. Victims with cognitive impairment and/or paranoid delusions also pose unique challenges in that the history may be inaccurate and the clinician would therefore have to rely on their clinical assessment and investigations, which can overlap with signs of chronic illnesses (creating a risk of false negative and/or false positive findings in the evaluation for abuse). Consequently, the USPSTF and the Canadian Task Force on Preventative Health Care do not recommend universal screening for elder abuse, however the Canadian Task Force recommends that physicians should be alert for elder abuse evidence during routine examination and assessments[12].

There has been growing research in the past few decades into developing valid and reliable screening tools to detect abuse in different ways (directly with the patient or by observation), in different contexts (hospital, clinics, long-term care, home care) and in different phases of abuse[20-22]. These interventions also look at ways to address unintended consequences of elder abuse interventions such as invasions of privacy, breaches in confidentiality and inappropriate risk assessments[23].

For information on assessment tools available to be used in the community and their psychometric properties, see Table 1 in "Elder Abuse Assessment Tools and Interventions for use in the Home Environment: a Scoping Review"[22] .

The Elder Abuse Suspicion Index © (EASI© – see Box 1) is a validated tool that can be used to screen cognitively intact patients when abuse is suspected in the primary care setting. It is a six-item questionnaire, five answered by the patient and one completed by the physician and takes roughly two minutes (Box 1)[24]. One or more positive responses in questions 2-6 has a sensitivity of 47% and a specificity of 75% for identifying patients at risk of abuse and should warrant further evaluation. There is ongoing research into applying the EASI © in the long-term care setting (EASI-LTC ©– see Box 2) where residents are at an increased risk of abuse given their frailty and dependence on others[25]. In order to adapt EASI © to the LTC setting, the questions were modified and expanded to 9 with the hope to raise sensitivity to detect abuse and initiate further inquiry (Box 2). The EASI-LTC © is used with residents with a Mini Mental State Examination score of 24 or greater. Further research is underway to validate the responses generated by this assessment tool and set a score which would raise suspicion of abuse and initiate further enquiry by trained personnel[25].

Box 1: Elder Abuse Suspicion Index ©

Questions 1 through 5 are asked of the patient and may be answered "Yes", "No" or "Did Not Answer". Question 6 is answered by the physician and may be answered "Yes", "No" or "Did Not Answer"; 1 or more positive responses on questions 2 to 6 could suggest elder abuse.

Within the past 12 months:

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

4. Has anyone tried to force you to sign papers or to use your money against your will?

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

6. Doctor: Elder abuse might be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the past 12 months?

Note: The Elder Abuse Suspicion Index © was validated to be administered by family physicians on older persons with a Folstein Mini Mental State Examination score of 24 or greater who are seen in an ambulatory setting.

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Additional information about the Elder Abuse Suspicion Index is available at https://www.mcgill.ca/familymed/research/projects/elder

Box 2: Eder Abuse Suspicion Index- LTC ©

Questions 1 through 8 are asked of the resident and may be answered "Yes", "No", "Do Not Know" or "Did Not Answer". Question 9 is answered by the health professional and may be answered "Yes", "No", "Do Not Know" or "Did Not Answer".

1. For approximately how long have you been living here? ______________________

Health Professional: "I am going to ask you about some events that may occur in the lives of older adults. In all the questions, I am referring to any person that you might have contact with (such as family members, friends, people working here, companions, and fellow residents), either in person, by telephone, or on the computer. If you would like a question repeated, please let me know."

Instructions: If the resident has been living in the facility for more than one year, start the following questions with "Within the last year". If the resident has been living in the facility for less than one year, start the following questions with "Since you have been here".

2. Has anyone prevented you from getting or using things that you wanted or needed, such as food, medicine, clothes, glasses, hearing aids, walkers, or wheelchairs?

3. Has anyone prevented you from visiting with family or friends here?

4. Have you been upset because someone treated you unfairly, or talked to you in a way that made you feel shamed, insulted, or manipulated?

5. Have you had a situation where you felt that someone was not taking your needs or concerns seriously?

Instructions: Just remember, for all of these questions we are asking about any person that you interact with (such as family members, friends, people working here, companions, and fellow residents).

6. Has anyone tried to force you to sign papers or to take, use, or spend your money against your will?

7. Has anyone hurt you physically or touched you in ways that you did not want?

8. Has anyone threatened to not help you, to punish you, to hurt you, or made you feel afraid?

9. **Health Professional**: Elder abuse may be associated with findings such as unexplained or non-investigated poor eye-contact, malnourishment, hygiene issues, skin breakdown, cuts and bruises, damaged clothing, physical restraint, and change in behavior (physical, emotional, or sexual). There may also be signs or symptoms sometimes associated with under or over-medication. Did you notice any of these today or in the last 12 months, or have any of these concerns been brought to the attention of the care team?

Note: This version of the tool has yet to be validated in the LTC setting and is currently undergoing copyright protection.

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Additional information about the Elder Abuse Suspicion Index is available at https://www.mcgill.ca/familymed/research/projects/elder

Challenges to screening for elder abuse remain. Clinicians often lack sufficient knowledge and confidence in screening for abuse and are frequently constrained by time and space to obtain sensitive information about abuse and to navigate the complexities in the relationship between the older adult and their caregiver[26]. Virtual Coaching in making Informed Choices on Elder mistreatment Self-Disclosure (VOICES) is a novel approach to identifying elder abuse by empowering older adults with tools to help them self-identify and disclose mistreatment using a digital health tool[27]. While the older adult waits for their appointment with a clinician, they are presented with the VOICES tool through a tablet in which educational modules, followed by a screening process, is applied to assess the user's risk for mistreatment. The screening results determine whether the VOICES tool ends if there is no suspicion of mistreatment or continues if there is suspicion and the clinician should be notified to further assess the concern accordingly. Although it is still in its preliminary phase, the goal for VOICES is to provide older adults with the necessary tools and knowledge to understand elder abuse and empower them in making informed decisions[27].

Management and Intervention

Clinicians are well positioned to identify, screen, and intervene in cases of suspected abuse. Early detection and interventions help limit the impact of abuse by treating the underlying physical consequences of abuse, providing community-based services and identifying potentially dangerous environments. It is important for clinicians to know the federal, provincial, and territorial government's laws into what defines elder abuse, when can confidentiality be breached and if mandatory reporting is warranted.

For information on Elder Abuse and the Law clinicians should be aware of, see sections C and D in "The Canadian Centre for Elder Law Guide to Elder Abuse"[28].

Once elder abuse is suspected, the risk of harm and the urgency to intervene needs to be ascertained. If the risk of harm is imminent, consider emergency support, such as a shelter if only housing is needed or hospitalization if urgent medical treatment is needed and where further evaluation can be conducted while the victim receives treatment[29]. Determining the older adult's cognition should be the next priority to select which of the available screening tools is most suitable. If the person screens positive either by tool or clinical evaluation, a thorough head to toe evaluation looking for signs and complications of abuse should be performed, and findings documented in the chart. It is important to document the clinical findings in a standardized manner and if needed, physical injuries could be photographed with patient consent, to further support the case as written documentation can lack the details needed in describing injuries, especially when cutaneous mimickers are present.

The next step is determining the older adult's capacity to make decisions that may have legal or health consequences. If the older adult is capable and able to understand and appreciate the consequences of the intervention, the clinician can present their concerns with regards to abuse, educate the patient and outline the next steps which include the provision of resources along with an emergency safety plan[30]. If decision making capacity is in doubt, there are various useful tools that can be employed in assessing decision making capacity, including the Hopkins Competency Assessment Test, the Understanding Treatment Disclosure, the MacArthur Competence Assessment Tool for Treatment, and the Aid to Capacity Evaluation.[31] If a person is found incapable, a guardian or substitute decision-maker may be appointed to make decisions according to their values and needs. In cases in which there are concerns that the Power of Attorney is not acting in the patient's best interest or are the abusers themselves, consider involving a social worker, other family members or guardianship through your Provincial/Territorial Public Guardian and Trustee offices[30].

Reviews of published evidence on elder abuse interventions identified a common approach involving interdisciplinary teams, advocacy service intervention, support groups, education, and care coordination[29,32-33]. In addition, the Abuse Intervention Model (AIM) addresses potentially modifiable risk factors in three domains: the Vulnerable Adult, the Trusted Other and the Context of the relationship between an older adult and the trusted caregiver[34]. Additionally, clinicians should provide education and resources (Table 5.0), arrange follow ups to monitor the progression and to determine if further intervention is required, and to work with the patient to devise a safety plan. According to Hoover et al.,[35] each safety plan should be customized to the victim, written down, stored in a safe place, and reviewed periodically by the victim, their clinician, and a trusted care provider. Some of the items that may be included in the plan are: emergent numbers to contact, safe places to go at times of crisis, strategies for reducing harm if the victim will continue to have contact with the perpetrator, and a checklist of essential items to keep together in a safe place[35].

Resource	Description	Contact
Police	Often the first responders in cases of elder abuse.	911 Check to see if your local police service has an elder abuse and/or vulnerable person's unit
Mental Health Crisis Line	Offers support 24/7, crisis team if needed	Know the telephone number for your local mental health crisis line
The Canadian Network for Prevention of Elder Abuse	Local, regional, provincial, and national agency focusing on education and policy development	Check CNPEA for your local elder abuse network.
National Initiative for the Care of the Elderly	Clinical Pocket Cards for different provinces and languages	NICE

The legal requirements to report suspected abuse cases in Canada vary by province and territory. In responding to abuse and neglect, disclosure is permitted without consent in four circumstances[28]: when it is authorized by another law for an individual to respond to abuse, when it is needed to provide assistance to a police investigation, when disclosure must be shared for a service to be provided, when it is required for health and safety reasons. The person's consent should still be sought before disclosing confidential information even if it is not required. To avoid legal consequences, the clinician must be aware of the following factors when encountering a suspected abuse case: the laws of the province/territory the older adult lives in, the setting in which the abuse occurred, and if a criminal act has been committed.

Currently, there is no specific elder abuse law, however, many laws are available that apply to the various types of elder abuse. The Criminal Code provides for offences such as theft, fraud, extorsion, misuse of power of attorney, physical and sexual offences, as well as criminal negligence and the failure to provide the necessities of life[33]. Each province and territory take a unique approach with some having legislation that makes it an obligation to report abuse in certain environments, whereas others have it mandated to report even suspected cases regardless of setting. The Canadian Centre for Elder Law Guide to Elder Abuse outlines the provincial and territorial elder abuse and neglect laws in Canada[28]. This law guide has been updated and will be available later in 2022. For example, Nova Scotia and Newfoundland and Labrador mandate the reporting of elder abuse in any setting by anyone who is aware of potential abuse. In British Columbia, while there is no general public duty to report abuse, there are designated agencies that can investigate concerns of abuse and file a police report if a crime has been committed. In Ontario, the Long-Term Care Homes Act imposes a duty on any staff member or provider of professional services to report to the Director appointed by the minister whenever abuse has, or may occur, to an adult resident in a long-term care home[28].

Summary

Elder abuse and neglect are growing concerns that take many forms and have lasting consequences. Despite the recent rise in awareness, they continue to be underdiagnosed due to patient characteristics, socio-environmental factors, and a lack of knowledge of all parties involved. Clinicians are well positioned to detect abuse; however, they lack the training and knowledge required to intervene in early stages. Despite more research being needed to validate screening tools, based on the current literature, this paper provides an overview of how to identify, screen, assess, and intervene when a clinician is concerned that elder abuse may be present. Knowing the risk factors and augmenting that knowledge with the clinical assessment of a vulnerable older adult can help identify victims of abuse early. In order to respond to suspected cases, the urgency of when to act should be determined, followed by a capacity assessment in order to proceed to the next step of intervention. It is imperative to know one's federal, provincial, and territorial government's laws regarding when confidentiality can be breached and if reporting is mandatory or discretionary. Further research is needed into obtaining a simple valid screening tool that can help flag suspected cases of elder abuse requiring more in-depth assessment and to partner the results with effective interventions that can help ensure the safety and wellbeing of the vulnerable older adult.

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