FORUM III

A Comprehensive Approach to Elder Abuse

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Our understanding of elder abuse—its definition, reporting, treatment, and prevention—is today at about the same state that our understanding of child abuse was at 20 years ago, suffering from a lack of knowledge, reliable data, and consensus about its causes and effective interventions.

In an effort to advance that understanding and to respond to the increased incidence of cases of maltreatment of the elderly, the Jewish Family Services Social Service Centre (JFSSC) of Montreal in 1989 developed a comprehensive approach to elder abuse. This article describes the intervention protocol, staff training, and screening and assessment tools designed to equip JFSSC workers to detect and help prevent elder abuse in their client population.

WHAT IS ELDER ABUSE?

Elder abuse is not a new phenomenon, but as the number of older people, particularly the old-old, has grown in recent years, this problem has increasingly captured the public's attention. It is estimated that 4% of persons 65 years of age and older are mistreated. Elder abuse includes the following components:

Physical abuse—Infliction of pain or discomfort by physical assault, rough handling, restraining, coercing, sexual molestation, and under- and overmedicating (Podniecks, 1988).

Psychological abuse—Infliction of anguish by insulting, humiliating, intimidating, infantilizing, ignoring, frightening, isolating, removing decision-making power, withholding love, and denying access to grandchildren (Pillemer, 1987)

Neglect—Denial of necessities, such as food, health care, companionship, or assistance; an act of omission that results in harm to the older person (Shell, 1982)

Material or property abuse—Exploitation of illegal or unethical funds, assets, or property belonging to an older person, such as coercing them to sign over power of attorney or stealing an older person's possessions (Podniecks, 1988)

According to the 1989 *National Survey on Abuse of the Elderly in Canada*, material abuse occurs more frequently than the other categories of abuse. Abusers tend to be distant relatives or non-relatives, rather than close family members. In contrast, a recent preliminary study on elder abuse in Montreal (Grandmaison, 1988) reported that psychological abuse was by far the most frequent form of abuse reported, affecting three-quarters of all clients.

CAUSES OF ABUSE

Several theories attempt to explain the causes of abuse and maltreatment of the elderly. In many cases, the cause is multifactorial.

Ageism

In modern Western societies, old age is thought of in negative terms. The elderly, rather than being valued for their wisdom and experience, are characterized as being unproductive, forgetful, confused, dependent, sick and feeble. Ageism makes it

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easier for those who are not yet old to ignore the needs or requirements of the older person and even to maltreat them.

Demographic Changes

In Canada, as in the United States, the size and proportion of the older population, particularly the old-old, are increasing dramatically. It is estimated that by the year 2000, nearly 12% of Canada's population, or 3.4 million people, will be 65 years of age or older. Of this group, 777,000 will be at least 80 years old.

The elderly population, of which a large proportion are women, are among the most vulnerable members of society. Home care and long-term care facilities are insufficient to meet their health care needs, resulting in provision of care by adult children to an increasing number of elderly.

Several demographic trends interact to exacerbate the stresses imposed on families who assume the responsibility of caring for their elderly relatives. Families are becoming smaller, which means that the caregiving responsibility is shared among fewer family members. Most often, it is the daughter who assumes that responsibility, but today most women are full-time participants in the labor force. As more mothers have postponed child bearing in recent years, they often face simultaneously the demands of young, dependent children, as well as those of aging parents. Many women today must juggle the demands of careers, growing families, and aging parents.

Finally, as more and more older people live longer and longer, there are now two generations of elderly—the young-old (those between 65 and 75) and the old-old (those older than 75). Many caregivers are approaching old age and are more likely to suffer from failing health and reduced mobility.

Pathology

In some cases, the potential abuser may be intellectually handicapped or mentally ill and unable to tolerate the stresses imposed by caring for elderly parents. For example, an elderly woman's physical or mental condition may have declined so that, rather than her caring for her handicapped child, the child may be forced to take care of her, if no other caregivers are available. Therefore, abuse or neglect may occur because of the handicapped child's incapacity and impaired judgment.

The theory of pathology is also invoked to explain the abuser who has a domineering personality and underlying self-esteem. Such an abuser is easily excitable and has a high level of anxiety and a low level of tolerance. Other adult children who are caregivers for their aging parents are alcohol or drug users.

Developmental Theory

Elder abuse is often the continuation of an earlier abusive relationship and may occur in families with a past history of violence, such as child abuse or wife battering. The extensive literature on child abuse indicates that aggressive behaviors are learned within the home. Thus, maltreatment of family members is cyclic, with a pattern of violence continuing over several generations.

Physical and Mental Impairment as the Cause of Dependency

The older person's reduced ability to function physically or mentally and the loss of his or her work role and productive status have significant effects on family interactions. The aged person, as well as family members, may respond in various ways to this new dependency. The elderly person may strive to perpetuate his or her prior status as decision maker within the family while simultaneously requesting increasing amounts of care and support from the adult child. This maladaptive response to a diminished level of autonomy may be expressed through overly demanding or controlling behavior.

INDICATORS OF ABUSE

Elder abuse shares many characteristics with other forms of family violence. Both victims and families are often socially and sometimes geographically isolated. Victims are in a weakened, powerless, and dependent position in relation to their abusers, many of whom have a history of alcohol abuse, psychopathology, low self-esteem, unemployment, and family violence. The overwhelming majority of abuse victims are women. In many cases, elder abuse is "spouse abuse grown old," and the abuser is very often the caregiver. Table 1 lists high-risk indicators of existing or potential abuse, neglect, and/or exploitation.

PRESERVING THE NATURAL ENVIRONMENT OF ABUSE VICTIMS

Often, older adults do not report maltreatment and seem to prefer to remain in abusive situations for a variety of complex reasons. The fact that there is no mandatory reporting of elder abuse in Quebec and many other localities recognizes the elderly person's right to self-determination; that is, the right to live at risk, as well as to refuse intervention and remain in situations of their own choosing.

These feelings and attitudes, which are shared by many older people, may make them unwilling to seek help for maltreatment.

- fear of being abandoned or placed in a nursing home or institution
- fear of reprisal
- desire to avoid shame and embarrassment
- the belief that the family is beyond scrutiny and not subject to outside intervention
- the shame of having raised a child who abuses them
- fear that abusive children will be jailed

Many older people who have suffered significant losses—of their former status and work role, of their health, and of their loved ones—are very attached to their personal belongings and their homes. They have deep-rooted and comfortable habits in their familiar surroundings. Leaving their natural milieu, even in order to protect themselves, may cause resentment and depression.

In addition, many elderly victims of abuse are unaware of the availability of alternate living arrangements, home support services, and counseling for both themselves and their abusers. This dearth of knowledge is compounded by many social workers' lack of awareness of elder abuse, reluctance to deal with the problem, or lack of information on how to handle it. It was this lack of awareness, knowledge, and reluctance that the JFSSC Project on Abuse and Neglect of the Elderly was designed to counteract.

PROJECT ON ABUSE AND NEGLECT OF THE ELDERLY

In the western part of Montreal, where most of the Jewish community lives, over

Table 1
HIGH-RISK INDICATORS OF EXISTING OR POTENTIAL ABUSE, NEGLECT, AND EXPLOITATION

Client Indicators	*Caregiver Indicators*
Female	
Advanced age—over 75	Impaired mental status
Physical dependence	History of mental illness
Impaired mental status	High stress level
History of mental illness	Alcohol or substance abuse
Alcohol or substance abuse	Financial dependence
Financial dependence or finances managed by others	Inexperience with caregiving
Isolation	Isolation
Past history of abuse, neglect, or exploitation	History of abuse as a child

20% of the population is elderly, and close to half of that age group is over 75 years old. Elderly clients comprise 52% of JFSSC's caseload; half of these clients are severely dysfunctional at the cognitive or physical level. In fiscal 1991, the agency served over 3000 elderly Jews.

Because of the increasing size of its caseload at risk of abuse, JFSSC applied in 1989 for foundation funding to develop a comprehensive approach to elder abuse. Based on the assumption that the most effective way to address the problem of elder abuse is to prevent it, this project provided simple screening and assessment tools that enable social workers to detect which cases are at risk of abuse. It also offered staff training that equipped social workers with the tools needed to detect and handle abusive situations. Its goal is to preserve elderly clients in their natural surroundings whenever possible, respecting their right to self-determination and to live the lifestyle of their choice.

GOALS AND IMPLEMENTATION OF THE PROJECT

Develop Expertise in the Field of Direct Services to Abused Elderly

After undertaking an exhaustive review of the literature on elder abuse and attending several national and local conferences on the subject, a resource file on the problem was created, which facilitates workers' access to valuable information.

Sensitize Workers to the Problems of Abuse

Because abuse is often a clandestine issue, it was necessary to heighten the social workers' awareness of its dynamics, indicators, and causes. The goal of staff training and education was to develop a conscious awareness and open attitude, two essential tools of intervention with elder abuse cases.

Staff training was offered on an ongoing basis through the following means:

- workshops on legal issues regarding elderly victims of abuse
- a clinical day featuring workshops given by experts in the field of elder abuse
- presentations, case conferences, and consultation meetings using audiovisual materials

Develop a Protocol for Intervention

A committee made up of representatives from all the service areas involving elderly clients provided the expertise necessary to identify the interventions required to detect and follow through on cases of abuse and to develop screening and assessment tools. This committee met on the average of once every 3 weeks over a 1-year period to develop the protocol and screening tools.

The resulting protocol is a guide for intervention. It sets out a broad-based theoretical framework to ensure that the basic elements of the screening and assessment procedures are applied in a uniform manner in all JFSSC service points—the three hospital centers and the intake and community units of the JFSSC Elderly Department.

Develop Screening Methods

Systematic screening is the centerpiece of the project. Because violence is often hidden and the victim is reluctant to break the barrier of silence, this screening enables the practitioner to identify risk factors and thus be able to detect actual cases of abuse.

The High-Risk Elderly Screening Tool (Table 2) is completed at the point of entry or re-entry for *all* clients who are 65 years of age or older. Therefore, regardless of the nature of the request for help, this screening tool allows practitioners to be ever mindful of the possibility that the client is actually experiencing abuse.

At intake, depending upon which high-risk indicators of abuse are identified by the screening tool, an intervention code is assigned to each case to indicate the urgency of service provision.

CODE 1: Client is in a life-threatening abusive situation. Intervention will be required immediately. Protective measures must be initiated by practitioner, i.e., court order, hospitalization of client, emergency placement, etc.

CODE 2: Client is not in a life-threatening situation or in immediate danger, but the danger and risk are real and are foreseeable in the near future. Intervention will be required within 4 working days to stabilize the situation, i.e, homemaker services, material aid, medical services, etc.

CODE 3: Client is not in a life-threatening situation or in immediate danger but:

(a) there exists an ongoing situation of abuse, neglect, or exploitation that has only recently been identified and that does not present a danger as defined in CODES 1 and 2. Intervention will be required within 10 working days.

or

(b) the client is at potential risk for abuse, neglect, or exploitation, Intervention will be required within 10 working days.

Develop Methods for Assessment/Treatment

The High-Risk Elderly Assessment and Treatment Plan form is a tool for reflection, bringing together all the various manifestations of the phenomenon of elder abuse in one form (Tables 3 and 4 show parts of this form). It enables practitioners to note clear indicators of abuse that serve as the basis for a very precise treatment plan. It is completed for those cases identified by the High-Risk Elderly Screening Tool as a code 1, 2, or 3; it must be completed within 4 weeks of intake. Subsequently, a High-Risk Elderly Revision Form must be completed every 3 months on all open cases, and a new High-Risk Elderly Assessment and Treatment Plan must be filled out every year on active cases. This procedure is summarized in Table 5.

Develop Public Awareness of the Phenomenon of Elder Abuse

As with other forms of family violence, raising public consciousness of elder abuse is seen as an effective means of prevention. The project heightens community awareness in these ways

- encouraging witnesses to situations of abuse to seek help for the victims
- helping the victims themselves acknowledge their abusive situation
- organizing conferences for senior citizen groups on this issue
- preparing newsletter articles, brochures, and an informational poster

Gather Statistics on the Incidence of Elder Abuse

All screening, treatment plans, and revision forms are analyzed, yielding valuable information on the type of abuse, the referral source, the intervention, and its results. These data are now being examined in an effort to refine the assessment of risk factors that influence the occurrence of abuse. An additional grant is being requested for the purpose of statistically testing the reliability and validity of the protocol forms. The information gathered will be of use in future program planning.

CONCLUSION

With the ending of the foundation start-up grant, the Project On Abuse and Neglect of the Elderly is now fully integrated within the specialized services of the JFSSC Elderly Services Department. The procedures and forms developed for the screening, assessment, and treatment of elder abuse make possible a structured approach to the problem, thereby maintaining JFSSC's primary commitment to safeguarding its elderly clients at risk.

Table 2

JEWISH FAMILY SERVICES HIGH-RISK ELDERLY SCREENING TOOL

PART I

Client Name: _____ Phone # _____ Sex _____

D.O.B. ____/____/____ Civil Status: _____ Municipality _____

Living Arrangements: Alone ☐ With Family ☐ Hospital ☐

Accredited Foster Home ☐ Nonaccredited Foster Home ☐ With Others ☐ _____

Name of Caregiver: _____ Phone # _____ Relationship: _____

No Caregiver ☐

PART II

Source of Screening Information: Self ☐ Other ☐ Name: _____

Relationship to Client _____ Phone # _____

Does Client know that call is being made? _____

Does Client agree to be contacted? _____

PART III

Date of Service Request: ____/____/____ Service Requested: _____

Date of High-Risk Screening: ____/____/____ Practitioner: _____ Service Point: _____

New Beneficiary? Yes ☐ No ☐ If no, identify last service point: _____ Dossier # _____

PART IV CLIENT RISK INDICATORS	**HIGH**	**MEDIUM**	**LOW**	**UN-KNOWN**
MENTAL STATUS	☐ confused	☐ some memory loss and/or orientation variable	☐ no memory loss and fully oriented	☐
MENTAL HEALTH	☐ history of mental illness	☐ evidence of fear, anger, withdrawal, depression	☐ minimal/no emotional disability	☐
PHYSICAL HEALTH STATUS	☐ dependent on others	☐ some assistance required for ADL	☐ independent	☐
DRUG/ALCOHOL ABUSE	☐ active abuse	☐ episodic abuse	☐ no abuse	☐
ISOLATION	☐ isolated from others	☐ limited network	☐ existence of formal and informal network	☐
FINANCIAL RESOURCES	☐ dependent on others for funds ☐ finances managed by others	☐ some financial dependency ☐ some assistance in place for financial management	☐ independent ☐ public/private curator	☐
HISTORY OF ABUSE/ NEGLECT/EXPLOITATION	☐ known history ☐ present report	☐ previous report	☐ no history	☐

Table 2 (continued)

JEWISH FAMILY SERVICES HIGH-RISK ELDERLY SCREENING TOOL

PART V CAREGIVER RISK INDICATORS	HIGH	MEDIUM	LOW	UN-KNOWN
MENTAL STATUS	☐ confused	☐ some memory loss and/or orientation variable	☐ no memory loss/fully oriented	☐
MENTAL HEALTH	☐ history of mental illness	☐ evidence of fear, anger, withdrawal, depression	☐ minimal/no emotional disability	☐
DRUG/ALCOHOL ABUSE	☐ active abuse	☐ episodic abuse	☐ no abuse	☐
ISOLATION	☐ isolated from others	☐ limited network	☐ existence of formal and informal network	☐
FINANCIAL RESOURCES	☐ dependent on elderly person	☐ some dependency on elderly person	☐ independent	☐
STRESS	☐ caregiver is over-whelmed by stress (emotional, social, economic, physical)	☐ caregiver over-whelmed at times	☐ caregiving not found to be stressful	☐

PART VI - WORKER'S COMMENTS/SOURCE OF CONCERN

_____

_____

_____

_____

_____

_____

_____

_____

PART VII - PRACTITIONER'S PLAN

Complete High-Risk Elderly Assessment and Treatment Plan Code 1 ☐ Code 2 ☐ Code 3 ☐

Complete High-Risk Elderly Revision Form Code 1 ☐ Code 2 ☐ Code 3 ☐

Complete Regular Service Point Assessment ☐

No further Social Service involvement required ☐

Service provided: _____

_____

_____

_____

Case Disposition: Open ☐ Closed ☐ Assigned to:

Table 3
BIOPSYCHOSOCIAL SUMMARY OF CLIENT

A) *Intellectual capacities*

	No Problem	Problem - How Does Problem Affect Client?
Orientation - Time		
Orientation -Space		
Orientation - Person		
Short-term memory		
Long-term memory		
Attention		
Comprehension		
Judgement		
Adaptability		

B) *Functional Autonomy*

Does he/she perform the following activities?	ACTIVITY PERFORMED			Activity not performed	Comments?
	Un-aided	With assistance from others	By others		
- serve own meals					
- eat					
- prepare light meals (lunch)					
- prepare full meals					
- take care of own medicine					
- wash self					
- shave					
- take a bath/shower					
- wash hair					
- dress, undress					
- use the toilet					
- get up, lie down					
- walk					
- go outside - summer					
- go outside - winter					
- go up/down stairs					
- do shopping					
- public transit - summer					
- public transit - winter					
- use the telephone					
- do laundry					
- do regular housework					
- do heavy cleaning					
- banking					
- other					

NOTE: This part is excerpted from the High-Risk Elderly Assessment and Treatment Plan.

Table 4

BIOPSYCHOSOCIAL SUMMARY OF CAREGIVER

A) Name of caregiver: _____ Age: _____ Sex: _____

Civil Status: _____

Address: _____ Phone # _____

Relationship to beneficiary: _____

If no caregiver, proceed to Section 5.

B) Intellectual Capacities: _____

C) Affect and emotional condition: _____

D) Health/Physical/status: _____

E) Substance Abuse: _____

F) Financial situation: _____

G) Housing and living arrangements: _____

H) Formal and Informal Support Network: _____

I) Caregiving experience/knowledge: _____

J) Highlight any relevant historical background (eg. Holocaust survivor, recent immigrant, etc.)

K) Comment on whether the caregiver's biopsychosocial condition has changed significantly in the past year:

L) Caregiver behavior regarding assessment and current situation

- ☐ Responds defensively when questioned
- ☐ Responds with excuses
- ☐ Does not want beneficiary to be interviewed alone
- ☐ Refuses needed services on behalf of beneficiary (ex: medical, CLSC, etc.)
- ☐ Refuses needed services for self (ex: respite, homemaker, etc.)
- ☐ Excessively concerned
- ☐ Excessively unconcerned
- ☐ Appears overwhelmed, short-tempered
- ☐ Appears fatigued, stressed
- ☐ Receptive to help/intervention

Comments: _____

NOTE: This part is excerpted from the High-Risk Elderly Assessment and Treatment Plan.

Table 5
SUMMARY OF ELDER ABUSE INTERVENTION PROTOCOL

Code 1	*Code 2*	*Code 3*
Intake will provide crisis intervention *immediately*	Case will be transferred to the Elder Abuse Unit	Case will be transferred to the Elder Abuse Unit
When case is stabilized, will be transferred to the Elder Abuse Unit	Intervention must begin with *4 working days* of the screening	Intervention must it begin within *10 working days* of the screening
The High-Risk Elderly Assessment and Treatment Plan *or* the High-Risk Revision Form must be completed within *4 weeks* of the first intervention	The High-Risk Elderly and Treatment Plan *or* the High-Risk Elderly Revision Form must be completed within *4 weeks* of the first intervention	The High-Risk Elderly Assessment and Treatment Plan *or* the High-Risk Elderly Revision Form must be completed within *4 weeks* of the first intervention
According to the treatment plan, case can be followed and revised every 3 months *or* transferred *or* closed	According to the treatment plan, case can be followed and revised every 3 months *or* transferred *or* closed	According to the treatment plan, case can be followed and revised every 3 months *or* transferred *or* closed

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