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Elder abuse

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MR Black has been a patient of yours for several years. He is 81 and had been living alone in his big old home until his middle-aged son moved in with him in late 2005 after the son's divorce. He has mild hypertension which is being managed with an ACE inhibitor but is otherwise well.

Over the past few months you have noted that Mr Black has lost some weight and is less cheerful than usual. When you question him he also says that he doesn't feel up to bowls any more. After a presentation with bruising on his arms and trunk, you become concerned, questioning whether he has an underlying malignancy.

With investigations all being within normal limits you question him a little more, exploring his relationship with his son. He eventually admits that they are not getting on well, that his son shouts at him for being slow and old, and has even hit him on a few occasions. Mr Black says that he doesn't like his old friends from bowls dropping by any longer, as they irritate his son.

You refer Mr Black to your local aged-care assessment team. The social worker visits and reports that Mr Black's son was very hostile when she visited and initially would not let her in. She felt quite intimidated by him and arranged for Mr Black to be seen urgently in the geriatric medicine clinic.

When seen in the clinic on his own by the geriatrician, Mr Black is noted to have bruising of different ages on his trunk and upper arms. He admits to physical abuse from his son, and also says that his son often asks him for money. He said that he loves his son and feels that he could not refuse him anything. His son denied that any of this had happened.

The aged-care assessment team makes an application to the Guardianship Tribunal for a financial manager for Mr Black, to prevent further misappropriation of his money, and they also organise for some assistance with shopping.

You agree to visit Mr Black at home on a regular basis. His son is angry at this "outside interference" and eventually moves out. Mr Black's friends are now able to visit and he also returns to bowls.

The author

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Background

ELDER abuse tends to be a hidden problem, although recent media attention on a case of alleged sexual abuse in a nursing home resident in Victoria has raised awareness of this issue.

In this case the abuse occurred within a residential care facility, but abuse can occur in many settings, and most abuse occurs within the family home, at the hands of family members or carers.

Like child abuse and domestic violence, it is a form of family violence, and until the late 80s very little was known about its occurrence in the Australian community. However over the past 15 years, research throughout the country has confirmed the significance of abuse as a social, medical and legal problem in the Australian community.

The exact prevalence of abuse is unclear, but international research suggests that between 3% and 6% of older people living in the community are victims of elder abuse. Australian research indicates that about 5% of people presenting to aged-care services are victims of abuse, and this is probably an underestimate due to marked under-reporting of the problem.

The prevalence of abuse in residential aged-care facilities is unknown, and abuse in nursing homes and hostels may occur at the hands of family members, other residents or staff.

GPs are ideally placed to identify potential and actual cases of abuse.

During the past 15 years, state, territory and Federal governments have addressed the problem by developing specific policies on elder abuse and education and training programs. Most agencies dealing with older people now have protocols in place for the management of elder abuse.

There is no specific legislation relating to elder abuse and there is currently no mandatory reporting of elder abuse. However, from April 2007 the Federal government has made it compulsory for serious physical abuse and sexual abuse in high-care residential care facilities to be reported to the police.

Most cases of elder abuse are assessed and managed by geriatric health services and, in particular, aged-care assessment teams, with involvement of other service providers. The medical profession in general, and GPs in particular, are less commonly involved, and it is vital that this situation changes (see Role of the GP, below). There are a number of reasons why medical practitioners have not been involved in the past and these persist into the present:

- There is a lack of awareness of elder abuse, which is now being addressed with education and training at both the undergraduate and postgraduate levels.
- Ageism is a concern, particularly at the clinical level. Signs and symptoms of abuse may be ascribed to the ageing process or ignored; reports from older patients of abuse may be dismissed as due to dementia or psychotic illness.
- There is a lack of scientific knowledge compared with other areas of medicine, which increasingly rely on evidence-based guidelines and treatment. There are no validated effective screening tools, diagnosis may be difficult because of the physiological and psychosocial complexity of older people, and there are no randomised trials on useful or effective interventions. For a condition with a significant prevalence there are still remarkably few published papers in the medical literature.
- Many doctors feel discomfort dealing with abuse, particularly in a family situation. There is a lack of training in this area for physicians and concern that when both victim and abuser are patients, the important doctor-patient relationship will be lost.
- The structure of medical practice and time constraints on appointments mean there is rarely time for a full exploration of problems. This is particularly in so general practice and the hospital emergency department, where pressure of patient numbers means only a short amount of time is available for assessing the presenting problem.
- Fear of legal action may prevent involvement in abuse situations. Being called to testify in court is a stressful and time-consuming activity, and GPs may be reluctant to write reports for an Application for Guardianship.

Role of the GP

It is essential that the medical profession become involved in identifying, assessing and managing elder abuse for a variety of reasons.

Older people are the greatest users of health services, and more than 90% see their GP at least once a year. GPs are therefore ideally placed to identify potential and actual cases of abuse and, with their often long-standing knowledge of, and relationship with, the older person and their family, they can have an important role in assessment and management.

Older people suffering from elder abuse have been shown to have much higher levels of morbidity than age-matched controls and are more likely to die. Impairment and disability play a significant part in the occurrence of elder abuse and often there is much that can be done to improve an older person's physical and mental health and general function.

Thus GPs can make important contributions in the areas of identifying abuse, assessing function, treating illness and improving disability.

Definition of elder abuse and why it occurs

ONE of the reasons why elder abuse has remained under-recognised and under-reported is because of difficulties with the definition. It is impossible to identify a problem if we have not adequately defined it, and having a simple, widely accepted working definition of elder abuse is important.

The following definition has been in use among medical and allied health professions in Australia for some time:

Elder abuse is any pattern of behaviour that causes physical, psychological, financial or social harm to an older person. The abuse occurs in the context of a relationship between the victim and the abuser.

This definition excludes self-mistreatment and self-neglect. The abuser may be a family member, friend, neighbour, paid carer or other person in close contact with the victim.

Most often the abuse occurs in people aged 65 or older. However, abuse of vulnerable adults can occur in all age groups, and a 45-year-old person with multiple sclerosis may be as much at risk of abuse as an 80-year-old with Parkinson's disease.

There are different categories of abuse and it is important to identify the specific type of abuse, as there are different contributory factors and interventions for each type. The abuse may be physical, sexual, psychological or financial, or through neglect.

Reasons elder abuse occurs

Research and clinical experience show a number of factors that clearly contribute to the occurrence of abuse, and a combination of these are usually involved in abusive situations. Risk factors that are often easier to identify in the primary care situation include the following:

Increased dependency of the older person

Older people are more vulnerable to abuse when they are helpless or dependent on others for assistance. This dependency may be due to physical impairments such as Parkinson's disease or stroke, or cognitive impairments such as dementia.

Abuser psychopathology

The personality characteristics of the abuser are a major factor in the occurrence of abuse. Alcoholism, drug abuse, psychiatric illness and cognitive impairment in the abuser are highly significant as contributory factors. In many cases of physical and psychological abuse, abuser psychopathology is implicated as the major contributory factor.

In cases where carers are abused by the people for whom they are caring, dementia or psychiatric illness is frequently present in the abuser. Many carers of people with dementia experience aggression from the person for whom they are caring at some stage in the illness.

Family dynamics

In some families violence is considered the normal reaction to stress, and this may continue from generation to generation. For example, the abuser may have been abused as a child by the person they are now abusing.

Marital conflict resulting in spouse abuse can continue into old age, and in many cases of elder abuse there has been a long past history of domestic violence. When two or more generations live together, inter-generational conflict can occur due to different values and expectations.

Carer stress

The responsibility for providing physical, emotional and financial support to a dependent older family member can generate great stress. Illness in the carer, financial difficulties, inadequate support and lack of recognition for the caring role, and personal difficulties, can all contribute to this stress.

In many cases, other contributory factors are already present and an additional stress on the carer appears to be the factor that triggers the abuse.

Changing population demographics

It is very important to look at contributory factors in the context of a population in which an increasing proportion are elderly and there is an increasing prevalence of age-related diseases such as dementia.

Government policies are advocating community care and, in light of the limited resources available, are possibly placing extra strain on family carers.

The abuser

In elder abuse occurring in the community, most abusers (80-90%) are close family members — either the victim's 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.

Research suggests that spouses tend to be involved more in physical abuse, and children in financial abuse. Australian and overseas studies show that about half the abusers will have significant problems of their own, including physical and mental health problems.

In elder abuse occurring in residential care, the abuser may be another resident, a family member or friend, or a staff member.

Although poor financial circumstances, poverty and lack of resources may play a part in the occurrence of abuse, elder abuse is seen in all social and economic groups, in urban and rural settings, and in all religious and racial groups.

Identifying elder abuse

ONE of the major problems in dealing with abuse is the difficulty we may have in recognising it. It is necessary to be on the alert and have a high index of suspicion because symptoms and signs of abuse are often subtle, and may be attributed to the ageing process because the person is old and frail.

The following symptoms and signs are suggestive of abuse. However, it is important to remember that the presence of one or more of the signs listed below does not necessarily establish that abuse is occurring, as many of these are seen in frail older people with chronic disease.

Ageing skin may bruise more readily, bones may fracture more easily due to osteoporosis, and falls may occur more often due to degenerative changes or disease in the CNS. Most medical practitioners should have the clinical experience to differentiate between symptoms and signs due to pathological changes and those due to abuse.

Physical abuse

This is the infliction of physical pain or injury, or use of physical coercion. Examples include punching, kicking, beating, biting, burning, pushing, dragging, scratching, shaking, arm twisting and any other physical harm to an older person.

It includes physical restraint such as being tied to a bed or chair or being locked in a room. It also includes the overuse or misuse of medication.

Sexual abuse

This is any form of sexual intimacy or sexual behaviour between two or more people, without consent, or through use of physical force or the threat of force, or emotional intimidation. Examples include sexual harassment, forced viewing of pornographic literature, inappropriate use of enemas, vaginal or perineal creams, and oral, vaginal or anal rape.

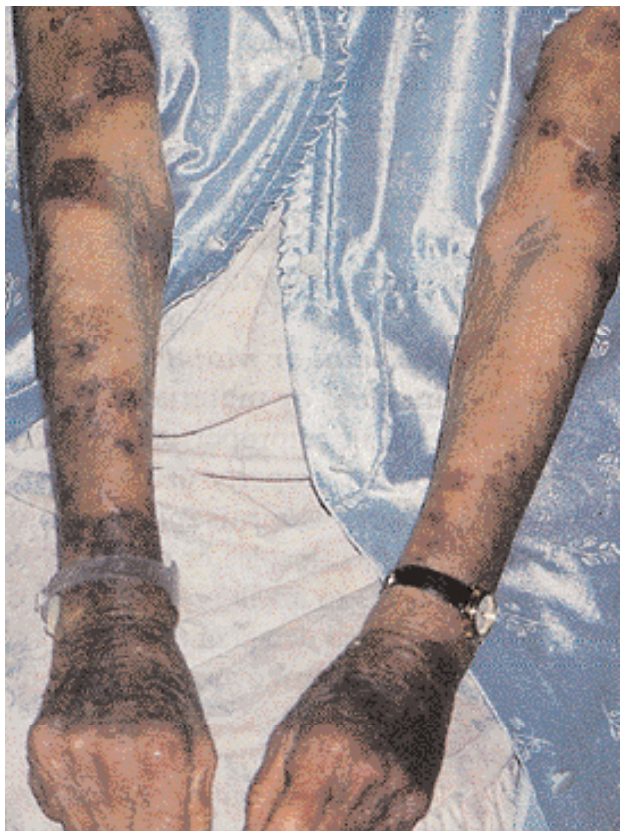
Psychological abuse

This is the infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and feelings of shame and powerlessness. Examples include being shouted or sworn at, threatened, humiliated, intimidated, bullied, emotionally isolated by withdrawal of affection, or emotionally blackmailed.

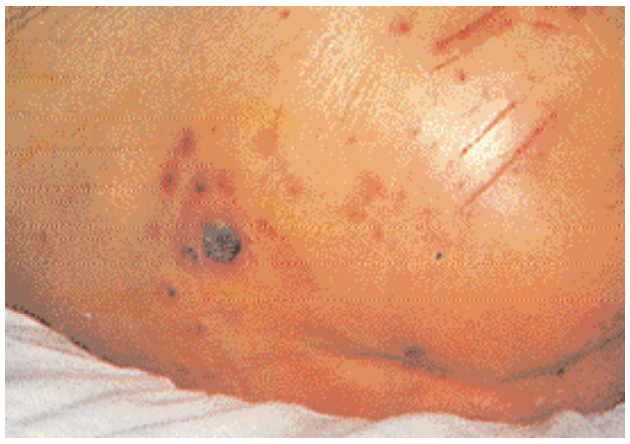
Psychological abuse is usually characterised by a pattern of behaviour repeated over time and intended to maintain a hold of fear over the older person.

Indicators of physical abuse

- Look for a history of unexplained accidents or injuries. Has the older person been to several different doctors or hospitals? It is important to check on conflicting stories from the older person and carer, and on discrepancies between the injury and the history. There may have been a long delay between the injury occurring, and reporting for treatment.
- Any story of an elderly person being accident prone should be viewed with suspicion, as should multiple injuries, especially at different stages of healing, and untreated old injuries.
- Look for bald patches, and signs of bruising on the scalp. This may be indicative of hair pulling.
- Watch for black eyes and subconjunctival haemorrhages. Look at the nose and lips for swelling, bruising, lacerations and missing teeth. Fractures of the skull, nose and facial bones should always alert you to the possibility of abuse.
- On the arms look for bruising, especially bruises of an unusual shape. Consider belt buckles, walking sticks, hair brushes or ropes as instruments of injury. Look for pinch-marks and grip-marks on the upper arms. Victims of abuse are sometimes shaken. Look for bite marks or scratches.
- Look for burns from cigarettes, or chemical burns from caustic substances. Glove or stocking distribution of burns suggest immersion in hot or boiling water.
- Look for rope or chain burns, or other signs of physical restraint, especially on the wrists or around the waist. Older people may be tied to a bed or chair or even to a toilet.
- On the trunk look for bruises, abrasions and cigarette burns. Ribs may be fractured if the victim is pushed or shoved against an object or piece of furniture.
- On the lower limbs look for bruising, rope burns, abrasions, lacerations or evidence of past or present fractures.
- There may be evidence of overuse or misuse of medication, for example, over-sedation in the middle of the day.



Bruising on a patient's arms caused by her daughter pulling her out of a chair.



Cigarette burns on the back (inflicted by son).

Indicators of sexual abuse

- Examine the genital area and thighs for bruising, bleeding and painful areas.
- Examine the breasts for bruising or bites.
- Check for torn, stained or blood-stained underwear.
- Look for evidence of sexually transmitted disease.
- Watch for difficulty with walking or sitting, or discomfort when bathed or toiletted.

Instruments of abuse can include belt buckles, walking sticks, hair brushes or ropes.

Financial abuse

This is the improper use of an older person's money, property or assets by another person and may be more easily detected when older people are visited in their own homes.

This may be difficult for a medical practitioner to ascertain and may require advice from the older person's solicitor or accountant. Referral to a social worker within an aged-care service may also be appropriate.

Neglect

This occurs when the carer deprives an older person of the necessities of life. Neglect may include the withholding of adequate food, shelter, clothing, medical care or dental care and may be intentional or unintentional. Neglect may also involve the refusal to permit others to provide appropriate care.

Indicators of psychological abuse

- The older person may be huddled when sitting, and nervous with the family member or carer nearby.
- Insomnia, sleep deprivation and loss of interest in self or environment may occur.
- Fearfulness, helplessness, hopelessness, passivity, apathy, resignation and withdrawal may be evident. Look for paranoid behaviour or confusion. Look for anger, agitation or anxiety. Many of these signs may be attributed to psychiatric disorders or delirium.
- Watch how the older person behaves when the carer enters or leaves the room. There may be ambivalence towards a family member or carer. Often there is reluctance to talk openly, and the older person avoids facial or eye contact with both medical practitioner and carer.

Indicators of financial abuse

- There may be loss of money ranging from removal of cash from a wallet to the cashing of cheques for large amounts of money.
- Sudden or unexplained withdrawal of money from a bank account may occur.
- There may be a sudden inability to pay bills or buy food.
- Bank books, credit cards and cheque books may be "lost".
- There may be a loss of jewellery, silverware, paintings, even furniture.
- An unprecedented transfer of money or property to another person may have occurred.
- A new will may have been made in favour of a new friend or another family member.
- Power of Attorney may be obtained improperly from an older person who is not mentally competent.

Indicators of neglect

- If food or drink are being withheld there will be malnourishment, weight loss, wasting and dehydration, all without an illness-related cause. The older person may have constipation or faecal impaction.
- There may be evidence of inadequate use of medication, for example, an older person with Parkinson's disease who is very stiff and immobile because of withholding of levodopa.
- There may be evidence of unmet physical needs, such as decaying teeth or overgrown nails.
- The older person may be lacking necessary aids such as spectacles, dentures, hearing aids or a walking frame.
- There may be poor hygiene or inadequate skin care. The older person may be very dirty or smell strongly of urine or be infested with lice. There may be a urine rash with excoriation and chafing.
- Clothing may be dirty and in poor repair, it may be inappropriate for the weather or for the person's gender.
- In some cases when the older person is immobile they may develop pressure areas over the sacrum, hips, heels or elbows.
- Sometimes medical care and attention are withheld until the older person is almost moribund.

Assessing elder abuse

General principles for assessment

IT is necessary to gain the consent of the patient for any assessment and, while the patient may be happy to be interviewed and examined, there are often situations when the victim of abuse does not wish any further action to be taken.

Older people may be reluctant to report abuse by a family member or carer on whom they rely for their basic needs. There may be shame if a close family member is the abuser, or there may be fear of retaliation or fear of institutionalisation.

If the person does not give consent to further action and is competent to make that decision, the decision must be respected. One important issue for GPs is the well-founded concern that if they confront the abusive situation openly or take action in contravention to the wishes of the patient or perhaps the family, the patient will simply move to another GP.

It is important to take a non-judgmental approach to cases of abuse and often it is most appropriate to look at the situation as one in which there are two victims, rather than a victim and an abuser. Attention must be paid to resolving the unmet needs of both victim and abuser rather than simply identifying abuse and punishing the guilty party.

In many cases when the GP is involved in identification and management, they have a good knowledge of both victim and abuser and may be in a doctor-patient relationship with both parties. However, this may create problems in management, preventing further action on the part of the GP and necessitating referral to another service.

If the person does not give consent to further action and is competent to make that decision, the decision must be respected.

The assessment process

It is important to know the past medical and psychiatric history of the patient, their present medical problems and their current medication. Much of this should be readily available to the GP.

It is important to look for the geriatric syndromes that may be underlying the presentation. Cognitive decline is often not recognised, and reversible problems such as depression or chronic UTI need to be identified and treated. Delirium needs to be identified and the underlying cause treated.

Disorders such as Parkinson's disease may present with the 'negative' symptoms of slowness in walking and inability to perform self-care tasks such as doing up buttons or cleaning teeth, symptoms often attributed to the ageing process.

However, patients with Parkinson's disease respond very well to medication and referral for rehabilitation. Patients with progressive disability due to a previous stroke may also benefit from a further period of targeted rehabilitation.

When there is any suspicion or suggestion of elder abuse, the possible victim should be asked about the situation as sensitively and tactfully as possible. When there has been a longstanding relationship of trust between patient and doctor this may be somewhat easier than if a relative stranger is asking questions.

Indirect questions are less confronting and may elicit more information than asking directly about abuse. Sometimes it may take several consultations and many assurances of confidentiality before the situation is clear.

A full physical examination may reveal untreated medical problems such as hypertension, mild heart failure, diabetes, UTI or constipation, which may all be impacting on the patient's function, dependency levels or mental state.

The examination may reveal some of the signs of abuse described before. The patient's level of speech and need for assistive devices such as hearing aids or spectacles should be noted.

As part of the examination it is important to check the patient's cognitive state, and the Mini-Mental State Examination is a useful screening test.

Dementia is a condition of high prevalence but is not always diagnosed early in the disease process. It is highly significant as a risk factor for abuse, as the person with dementia may be a victim of abuse (particularly financial abuse), but may also be an abuser if they become physically or verbally abusive towards their carer.

It is absolutely imperative to know if a person has mental capacity, that is, they are competent to make decisions. This is relevant in all aspects of management from the taking of a history through to arranging appropriate interventions. If a person is incapable of giving an accurate history because of dementia or psychiatric illness, involvement of others (family members, friends or service providers) is essential.

If there is no enduring guardian or Power of Attorney in place, a substitute decision maker may need to be appointed to assist where decisions have to be made about future management.

It is important to remember that capacity is task specific, and a person with dementia may be quite able to make reasonable decisions about what they wish to wear or eat for dinner, but may not be able to consent to a major surgical procedure or make financial decisions.

While it is ultimately a legal decision as to whether a person is competent or not, the opinion of the attending medical practitioner is very important.

Depression is another quite common condition in older people that can contribute to, or be caused by, abuse. The use of a screening tool such as the Geriatric Depression Scale can reveal underlying depressive illness, which may respond well to medication or psychotherapy.

Chronic eating disorders have been identified in some older women who are victims of abuse, and this type of anorexia needs to be recognised and addressed.

A functional assessment should be performed. Is the patient independent in self-care and activities of daily living or do they need assistance in some areas? This dependence on others for assistance is a risk factor for abuse and in some cases it can be improved by rehabilitation or provision of aids.

Gathering background information is another very important part of the assessment process. Interviews with the carer, with family members and friends can provide a lot of useful and corroborative information.

Management

MANAGEMENT of elder abuse may require the involvement of several individuals or service providers. Ideally interventions seek to achieve freedom, safety, the least disruption of lifestyle, and the least restrictive care alternatives.

Addressing underlying medical problems in both victim and abuser is essential. Two of the major risk factors for abuse are the dependency of the older person because of physical or cognitive impairment, and psychopathology in the abuser.

Reducing symptoms of disease, improving physical function and treating psychiatric illness or substance abuse are clearly important ways to improve a potential or actual abusive situation.

In cases of severe physical abuse, the victim often needs to be immediately separated from the abuser, which requires admission to an acute hospital bed. The GP may be involved in making this referral, then the geriatrician, hospital social worker and other members of the geriatric health service can also provide assessment and advice on future management.

The full range of community services such as home nursing, housekeeping help, continence advice, Community Options or Linkages projects, and Meals on Wheels can be used to alleviate situations in which abuse is occurring.

Assistance with shopping and transport is of practical help to the carer. Case management is often required because of the complexity of the situation and the likelihood that multiple services will be involved.

The key worker will be responsible for coordinating services provided to the older person and may be an aged-care assessment team social worker, community nurse or Community Options worker.

Reducing symptoms of disease, improving physical function and treating psychiatric illness or substance abuse are clearly important ways to improve a potential or actual abusive situation.

Provision of respite is another useful intervention. This may be in-home, day-centre or institutional respite and is particularly helpful when carer stress is a problem, and when there has been a situation of neglect. If the victim is quite dependent, respite care in a nursing home is often the only alternative.

Counselling is an important means of intervention and may involve individual counselling or family therapy. The aim is to help the victim cope with their situation, and assist them to find a way to be safe from their abuser. It is also important that the victim be given assistance to recover from the impact of the abuse.

In some cases the GP may wish to undertake some of this counselling, but more

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often this would be done by a social worker.

When domestic violence is the main cause of abuse, a referral may need to be made to the appropriate services for victims of domestic violence. These services include counselling, dedicated police officers with specific training in domestic violence, and access to refuges.

Unfortunately, most domestic violence services are oriented towards younger women, and many are unsuitable for a frail or disabled older person.

It is very important to acknowledge the treatment needs of the abuser. When abuser psychopathology is a major causative factor, admission to hospital may be necessary to address the psychiatric illness or drug or alcohol problems. Psychological counselling, which allows the abuser to talk openly about their behaviour, may be beneficial.

Alternative accommodation on a permanent basis may be necessary. Realistically this usually means institutionalisation — often nursing-home placement — for the victim of abuse. However, in some situations in which carer abuse has occurred it is the abuser who requires nursing home placement.

Legal interventions are, hopefully, a last resort, but may be the first line of intervention when criminal charges need to be laid in cases of financial abuse or severe physical abuse (particularly when there is a history of domestic violence).

Older people who are competent to make their own decisions can, with support if necessary, access mainstream legal services, for example, to revoke a Power of Attorney or evict an unwelcome person from their home. Chamber magistrates or the police may need to be involved if an apprehended violence order or restraining order is sought.

Applications to the state Guardianship Board or Guardianship Tribunal can be made if victims are unable to make a decision for themselves. Guardianship boards or tribunals provide substitute decision-making functions for people who are unable to make decisions because of a disability. This disability may be a dementing illness, head injury, psychiatric illness, or physical or intellectual disability.

Guardianship boards can be accessed by any individuals or service providers who have a genuine concern for the welfare of the person with a disability.

Strategies for intervention and management of elder abuse

Identification of abuse, neglect or exploitation in an elderly person

- Take a history from the victim of abuse
- Perform a thorough physical examination and assess mental competence
- Document any injuries, evidence of neglect, threats or allegations of violence
- Interview the abuser separately if possible
- Liaise with family members and service providers to confirm details of abuse
- Consider the need for immediate removal of the victim from the abusive situation

Victim is **CAPABLE** of making decision

UNWILLING to accept intervention

- Assure the victim of continued support and provision of assistance when requested
- Legal intervention may be necessary if a criminal offence has been committed or the victim's life or health are in danger
- Arrange a follow-up visit and monitoring of the situation when possible. If not possible, document and withdraw

WILLING to accept intervention

- Establish the needs of the victim
- Provide information about abuse and arrange counselling if appropriate
- Arrange appropriate community services
- Encourage activities and contact outside the home situation
- Assess the need for, and acceptance of, respite care in the home, day centre or institution
- Explore the victim's desire or need for alternative accommodation
- Assist with legal intervention if appropriate, eg, guardianship, financial management, police restraining order

Victim is **INCAPABLE** of making decision

UNWILLING to accept intervention

- Ensure the least restrictive intervention is considered
- Arrange appropriate support services
- Arrange monitoring and follow-up of the situation
- Guardianship — a legally appointed guardian has oversight of health care and treatment, accommodation and provision of appropriate services to the victim
- Financial management
- Comprehensive assessment by mental health services for crisis intervention
- Involuntary psychiatric admission via the Mental Health Act
- Restraining order
- Police intervention if a serious crime has been committed

Conclusion

AS the numbers of dependent older people in the community increase, we can expect to see more cases of abuse. To date there has been a general reluctance among the medical profession to become involved with elder abuse to the same degree as with child abuse. This is disappointing when you consider the significant contribution made in the arena of child abuse when physicians have been in the forefront of research and practice.

There is a great deal the medical profession can offer in identifying, assessing and managing elder abuse. As Dr Mark Lachs wrote in the *New England Journal of Medicine* in 1995

… the proper management of elder abuse can produce improvement in quality of life that rivals or exceeds the gains made when doctors aggressively diagnose and treat heart disease, pneumonia, diabetes, and other organic illnesses.

Author's case study

Carer abuse

MR and Mrs Jones had been married for 45 years when Mr Jones developed Parkinson's disease and dementia. Despite Mrs Jones' general poor health and increasing frailty, she continued to provide all care for her husband.

Mr Jones refused to allow the Home Nursing Service to assist in showering him until his wife fell in the shower and broke her wrist. When the visiting nurse attempted to shower him, he grabbed at her breasts and made suggestive comments. A male nurse took over care and no similar behaviour occurred.

Once his wife's wrist fracture was healed, Mr Jones insisted that his wife shower him. The male nurse continued to visit to supervise medication and noted that Mrs Jones often had bruising on her face. She explained that she had hit her head on the door during the night, or had fallen against a piece of furniture.

Eventually she admitted that her husband had got angry with her and occasionally hit her. She felt that it was her fault, as she must have provoked him.

The nurse spoke with the Jones's GP, who visited and examined Mrs Jones. He noted bruising of different ages on her face, trunk and arms. A referral was made to the aged-care assessment team who arranged regular in-home respite for Mrs Jones, as well as assistance with showering for Mr Jones.

Mrs Jones underwent considerable counselling to help her deal with the culmination of many years of low-grade domestic violence. Eventually Mr Jones required nursing-home placement. Mrs Jones' health improved markedly and she became very involved in a local handicraft group.

Online resources

- Guardianship Tribunal of NSW: www.gt.nsw.gov.au
- Australian Government Department of Health and Ageing: www.health.gov.au
- Aged Care Accreditation Agency: www.accreditation.org.au
- Aged Rights Advocacy Service: www.sa.agedrights.asn.au

GP's contribution

DR SUE PAGE
Lennox Head, NSW

Case study

AFTER Annie's husband died I used to visit via the laneway at the back of her house without disturbing her dependent alcoholic son, who had moved into the main home.

She was in her late 70s and housebound because of osteoarthritis and disability related to stroke and cardiovascular disease. Since many of her friends had died or had relocated to be nearer family, she really looked forward to my visits, preparing afternoon tea using her best china.

After a while Annie become withdrawn and almost furtive in her manner: not wanting to spend time talking and constantly listening to see if we had disturbed her son.

I was concerned she had become depressed and, wanting to ensure this was not through lack of services, arranged a case conference with her team of private and community health providers.

About the same time, Annie's son arrived at the surgery requesting a letter of support for him to obtain Power of Attorney for his mother, whom he described as demented.

At the case conference one of the team mentioned her concern that Annie's son wanted to sell the house, so that Annie would soon need nursing-home placement. My reply was that he could not, as the house was owned by Annie.

It then transpired that the son had misrepresented himself to the other providers as Annie's carer, progressively taking control of decisions relating to her care, including the timing and nature of visits, and dominating any consultations.

It was then considered that the son might intend acquiring Annie's assets by coercion and that perhaps some of Annie's recent "falls" may have been bruising relating to abuse.

Questions for the author

If the Power of Attorney had been granted, would the son have been able to sell his mother's house without a requirement to provide for her ongoing care?

Yes. An enduring Power of Attorney gives the attorney (the son) the right to make legal and financial decisions on behalf of the principal (Annie), and these decisions may not be in the best interests of the principal.

What is the difference between a Power of Attorney and a Guardianship Order?

A Power of Attorney specifically gives the attorney the right to make legal and financial decisions on behalf of the principal. It cannot be used to make medical or lifestyle decisions.

A guardianship order involves the appointment of a guardian as a substitute decision maker for a person who, because of disability, is no longer capable of making decisions for themself.

Guardianship refers to lifestyle decisions such as accommodation, services, health care, and medical and dental consents, not to financial management decisions.

How realistic is it to expect Annie's son's behaviour to change with open disclosure? Can Annie continue to live at home with community support or is there no alternative to placing her in nursing-home care?

Annie's son's behaviour is unlikely to change. To protect Annie, an Application for Financial Management should be made so that Annie's property and finances are protected.

If Annie's dementia has rendered her unable to make decisions, an Application for Guardianship should also be lodged so that lifestyle decisions can be made in her best interests.

General question for the author

With baby boomers increasingly looking to share houses with their children or other carers, does knowledge of the risk factors for elder abuse suggest protective mechanisms that can be set in place to protect the rights of elderly people who intend residing with others?

Any such accommodation arrangements should be made with the assistance of separate legal advice for each party entering into the arrangement, to ensure their rights and assets are protected for future use

How to Treat Quiz

Elder abuse — 27 October 2006

INSTRUCTIONS

Complete this quiz to earn 2 CPD points and/or 1 PDP point by marking the correct answer(s) with an X on this form. Fill in your contact details and return to us by fax or free post.

FAX BACK	FREE POST	ONLINE
Photocopy form and fax to (02) 9422 2844	How to Treat quiz Reply Paid 60416 Chatswood DC NSW 2067	www.australiandoctor.com.au/cpd/ for immediate feedback

1. Which TWO statements best apply to elder abuse in our community?

- ❑ a) Most abuse occurs within the family home at the hands of family members or carers
- ❑ b) Between 10% and 15% of people presenting to aged-care services have experienced elder abuse
- ❑ c) Recent legislation has made reporting of elder abuse mandatory
- ❑ d) Like child abuse and domestic violence, elder abuse is usually a form of family violence

2. Helen, 80, lives with her unemployed daughter Judy. Helen has late-onset schizophrenia and has recently accused Judy of stealing her belongings and money. Judy is dismissive of Helen's concerns stating, "It's just her schizophrenia". Which TWO statements apply to this situation or to abuse in general?

- ❑ a) Theft of Helen's belongings is highly unlikely because paranoia is part of Helen's illness
- ❑ b) GPs are often reluctant to become involved in possible elder abuse
- ❑ c) Questioning Helen and Judy together would establish whether this is a real problem or a psychotic symptom
- ❑ d) GPs are often in the difficult position of being doctor to both abused person and the abuser

3. Helen has become more strident in her accusations against her daughter and now accuses Judy of 'manhandling' her. While taking Helen's blood pressure you notice that she has bruises on her upper arms. Which TWO actions are you most likely to take?

- ❑ a) Increase Helen's antipsychotic medication
- ❑ b) Arrange a health assessment in the home, allowing you to have time alone with Helen
- ❑ c) Make a time with Judy to discuss how she is coping with caring for her mother
- ❑ d) Report Judy to the police, as it is obvious she is abusing her mother

4. You conduct the health assessment at Helen's home. At your suggestion Judy reluctantly has a cup of tea in the kitchen while you examine Helen. You note other bruises on her trunk that appear to be of different ages. Her Mini-Mental State Examination (MMSE) score is 29. Which THREE other physical findings would alert you to the possibility of physical abuse?

- ❑ a) Bald patches and bruising on the scalp
- ❑ b) Laceration to the nose and lips
- ❑ c) Enlarged liver and spleen and widespread petechiae
- ❑ d) Missing teeth

5. In addition to the bruising on her arms, you find cigarette burns on Helen's legs. You explain to Helen that you are concerned her daughter has been hurting her and wish to report it to the police. Helen says she does not want to call the police but just wants not to be hit and to have her possessions back. Which TWO actions would be in the best interest of Helen and Judy?

- ❑ a) Report the abuse to the police (as a crime has been committed) irrespective of Helen's wishes
- ❑ b) Decide to take no action, as Helen does not wish you to
- ❑ c) After discussion with Judy and Helen, refer them to the local aged-care assessment team (ACAT) to help look at ways to decrease both of their stresses
- ❑ d) Make a further appointment with Judy and Helen to follow up on Helen's health assessment

6. If a victim of elder abuse has been judged incapable of making decisions and is unwilling to accept intervention, which of the following legal options are available (choose THREE)?

- ❑ a) Guardianship
- ❑ b) Involuntary psychiatric admission
- ❑ c) Documenting the abuse, and withdrawing from the case if it is not possible to arrange follow-up
- ❑ d) A restraining order

7. Tom, a long-distance truck driver with five small children, is away for long periods. Tom's mother, Peg, lives with the family, after having a stroke. Peg can walk and bathe with help. Which THREE features are most likely to suggest that Peg is being neglected?

- ❑ a) Weight loss
- ❑ b) Decaying teeth
- ❑ c) Urine rash with excoriation
- ❑ d) Depression

8. Jenny, Tom's sister, visits from overseas. She brings Peg to you because she is concerned about large pressure areas on Peg's sacrum. How would you decide if these areas are signs of neglect (choose TWO)?

- ❑ a) Exclude treatable physical disease
- ❑ b) Ask Peg directly if she has been neglected
- ❑ c) Screen for dementia with an MMSE
- ❑ d) Fully assess mental capacity by asking Jenny questions such as, "Can Peg choose what she wants to wear or have for dinner?"

9. Peg tells you that Felicity, Tom's wife, often leaves her alone all day. She spends hours at a time sitting in soiled underwear and often has no food from breakfast to dinner. How would you manage this problem (choose THREE)?

- ❑ a) Referral to the local ACAT
- ❑ b) Address underlying medical problems
- ❑ c) Avoid discussing the situation with Felicity
- ❑ d) Suggest counselling for Peg

10. Which of the following statements is true (choose ONE)?

- ❑ a) Only doctors can access the services of the Guardianship Board for a patient
- ❑ b) Only social workers can access the services of the Guardianship Board for a patient
- ❑ c) Any individual or service provider can access the services of the Guardianship Board for a patient
- ❑ d) Only mental-health magistrates can access the services of the Guardianship Board for a patient

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The mark required to obtain points is 80%. Please note that some questions have more than one correct answer. Your CPD activity will be updated on your RACGP records every January, April, July and October.

NEXT WEEK Surgery is the only proven intervention for the comorbidities caused by obesity. The next How to Treat examines the indications, types and expected outcomes of modern bariatric surgery. The authors are **Dr John Jorgensen**, consultant surgeon, upper gastrointestinal surgical unit, St George Hospital, Sydney, NSW; **Dr Grant Beban**, fellow, upper gastrointestinal surgical unit, St George Hospital; **Dr Michael Talbot**, senior lecturer, University of NSW, upper gastrointestinal surgical unit, St George Hospital; **Dr Ken Loi**, consultant surgeon, upper gastrointestinal surgical unit, St George Hospital; and **Nazy Zarshenas**, accredited practising dietitian, upper gastrointestinal surgical unit, St George Hospital.