Elder abuse and the community psychiatric team

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To date, there are few reports on the extent of elder abuse among patients referred to old age psychiatry services. This study examined suspected cases of abuse among new referrals to a community psychiatric team for the elderly, at a time when guidelines and procedures for the detection and management of elder abuse were about to be introduced. Of 74 cases assessed, seven (almost 10%) were probably being abused. Several types of abuse were described, with no single pattern, and the professional responses therefore needed to be flexible. The impact of introducing the guidelines will be assessed later.

Elder abuse was first recognised as a significant issue in the 1970s but in the UK research and practice initiatives have lagged behind those in the USA (Glendenning, 1993). Recently there has been a resurgence of interest in this area, but obstacles to research have been encountered (Bennett & Ogg, 1993). We have argued elsewhere (Kerr *et al*, submitted) that the development and introduction of guidelines and procedures for the identification and management of abuse will stimulate practice and research. At this stage, there is a place for smaller, service-based studies to generate new hypotheses and evaluate responses, prior to population studies. Mental health problems appear common in both abusers and abused (Homer & Gilleard, 1990), but there have so far been few reports from psychiatric services about the nature and extent of problems of elder abuse encountered in practice and the responses to them.

Following increased national awareness of elder abuse (Department of Health Social Services Inspectorate, 1992), a joint policy for managing the abuse of vulnerable elders has recently been agreed in Cambridge between Cambridgeshire Social Services and the two local NHS trusts. These guidelines (similar to policies introduced elsewhere) define the term 'elder abuse', suggest possible indicators and risk factors, and outline procedures to follow if a case is suspected.

The study

The purpose of this study was to examine the detection of elder abuse in the community before the guidelines were introduced. If cases were suspected, the form of abuse and the way in which it was managed were noted. The individual cases identified are summarised below (see Appendix).

Patients aged 65 or over living in the southern half of Cambridge city who were referred for the first time to the local community resource team over a seven-month period were included in the study. All new referrals in this period were routinely assessed using a standardised assessment form, introduced for the new community care provisions in early 1993. The form is completed by the community psychiatric nurse (CPN), occupational therapist (OT) or social worker (SW) assigned to the case, and may take three to four weeks to complete in full, with information supplied by patients, relatives and other caregivers. Among a range of questions to determine relevant risk factors is a direct question about the risk of elder abuse. Data from completed forms were collected on a computerised database.

Each case was then discussed briefly with the CPN, OT or SW involved, to establish whether they had any concern that the patient was at risk of abuse, even if this suspicion was insufficient to have been documented. The nature, degree and context of the suspected abuse were noted as were the professional responses and the outcomes of the cases. In the absence of an agreed classification of abuse, we used four broad categories: physical abuse (including sexual abuse), psychological abuse, financial abuse and neglect.

Findings

During seven months, from April to October 1993, 105 new referrals were made to the team, and, of these, 74 had fully completed assessments. Reasons for incomplete assessments were varied, including refusals, deaths, alternative care arrangements and changes in staffing.

Only one case was documented as being at risk of abuse (Case 1). However, following discussion with team members, a further six cases were felt to have been at risk at some time during the

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study period. Non-documentation of potential cases was due to factors such as lack of clear evidence, difficulty in recognising the abuse at the time of assessment, and concerns about the efficacy or adverse effects of intervention.

In practice, it was difficult to distinguish different types of abuse, but among the seven cases below, four probably involved physical abuse, four psychological abuse, four financial abuse, and one neglect, combined in several different ways. In one case (Case 3), the abuse was perpetrated by the spouse alone, and in another (Case 6) by the spouse and other family members. In two cases (Cases 2 & 7), sons and daughters-in-law were responsible, and in Case 1 an unmarried son was the abuser. In a further case (Case 4), several children seemed to be colluding, and care staff were involved in the final example (Case 5). The responses made were varied, but in no case did arrest or prosecution ensue, and in no case was an urgent intervention made to remove the victim to a place of safety. In Cases 1 and 3, the three older people involved all died soon after referral. Four cases were admitted to long-term care in hospital (Case 6) or residential/nursing homes (Cases 3, 5 & 7), and another (Case 4) seems likely to require residential care. Case 2 was admitted to an acute psychiatric ward and then discharged to the care of other family members.

Comment

Recent research has stressed the varied nature of cases and moved a long way from a simple carer-stress model (Pillemer, 1994). The characteristics, especially the mental state, of the abuser have been emphasised, and also the observed dependency (e.g. financial and emotional) of the abuser upon the victim (Phillipson, 1993). The cases below illustrate the heterogeneity of the problem.

This study does not allow any inferences about the prevalence of abuse in the community or the completeness of its detection, but our enquiries suggested that nearly 10% of cases newly referred to the community team were at possible risk. Whether other cases were missed, or whether re-referrals (n=95 in the same period) were at higher or lower risk, is uncertain. However, even in the absence of established procedures, team members were aware of at least some instances of possible abuse, but encountered difficulties in defining it, separating it from the pre-existing family context and knowing how to proceed with identified cases. We found that firm evidence for physical abuse was particularly hard to obtain, while evidence for other forms of abuse seemed more clear-cut. Despite the shortcomings of the evidence, we felt that these cases probably did represent real abuse of vulnerable elderly people, since concern was often raised from several sources (neighbours, family and home care staff).

It appears that professional responses to abuse have so far been rather tentative possibly due to the lack of management guidelines. This results in individual practitioners feeling isolated with the burden of responsibility for worrying cases. Our cases support the suggestions (McCreadie & Tinker, 1993) that responses will need to be individually tailored, and also demonstrate that drastic consequences may ensue from interventions (Case 3).

To develop and support the guidelines, we are introducing a training package for staff, to raise awareness of elder abuse and to improve skills in its detection and management. We will repeat this study after the training period, to compare the rate of detection of abuse, with particular regard to documentation. We hope that more confident and effective professional responses will result from increased awareness of this challenging social problem.

Appendix: Cases of suspected abuse

Case 1

Mrs A, was a 77-year-old widow with dementia, living with her son, both known to have fiery tempers. The care assistant felt he was giving her extra medication to keep her quiet and the neighbours had expressed concern too. The family had been divided years before by Mrs A leaving her husband, and she was only reunited with her son through a charity three years ago. The son, who had an alcohol problem, gave up work, ostensibly to care for his mother, but others felt he was in fact living off her money.

Reponse and outcome. Definite evidence of abuse was not obtained, but there was sufficient concern to record her as being at risk. She died of heart disease six months after referral.

Case 2

Mrs B, a 70-year-old Turkish lady, presented with a late onset psychosis. She had been brought to Britain to live with her son and his Thai wife in a one-bedroomed flat. Mrs B and her daughter-in-law spent most of the day at home together. On the infrequent occasions when the daughter-in-law went out, Mrs B was locked in the flat. She reported that her daughter-in-law was hitting her, to which she apparently retaliated.

Response and outcome. Daughter-in-law took an overdose. Mrs B was successfully treated in hospital, following which arrangements were made for her to return to the rest of the family in Turkey.

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Case 3

Mr and Mrs C lived together and consistently refused help. She was 91 years old with depression, mild cognitive impairment and poor vision, and he was 86 with a previous stroke, deafness and osteoarthritis. She was usually very caring of him. The referral followed concern that she was hitting him, though no definite evidence was forthcoming.

Response and outcome. Both sustained falls at home and were admitted together to a nursing home, where they died shortly afterwards, within two days of each other.

Case 4

Mrs D was a 95-year-old lady with deafness, moderately severe dementia and a tendency to wander. She lived initially in sheltered accommodation which could no longer cope with her needs. The family were reluctant to sell her house to allow the capital to finance residential care for her. They displayed more interest in their inheritance than in her welfare.

Response and outcome. Against the advice of her CPN and social worker, the family took her to live with them in another town. The situation rapidly broke down, with the family demanding her return to Cambridge as the responsibility of the local authority.

Case 5

Mr E, a 75-year-old man with Parkinson's disease and dementia, lived in a sheltered flat. The care staff were unable to support his needs, and restricted his freedom of movement and choice of activities. The community OT felt that the housing organisation was exploiting him by charging considerable amounts of money without providing the level of care or stimulation that he required.

Response and outcome. He was visited regularly to monitor the situation and encourage more input from care staff. He later suffered a stroke and moved to a residential home.

Case 6

Mrs F, a 57-year-old lady with severe presenile dementia, was living with her husband and two children. Physical bullying and coercion by her family were suspected, although no proof was obtained.

Response and outcome. Her illness progressed rapidly and she was admitted to a psychiatric continuing care ward. The family were offered ongoing support.

Case 7

Mrs G, an 80-year-old lady, lived with her son and his wife in a rented first floor flat. The son and daughter-in-law worked long hours and spent little time at home. Mrs G was referred with suspected dementia, but on psychiatric examination there was no cognitive impairment. Instead, it was felt that the main problem was the family situation. Mrs G resented her daughter-in-law and would refuse to get out of bed to wash or care for herself. The family did not insist that she did so, leaving her in bed where she became grossly neglected. Her son was also appropriating her pension and attendance allowance as 'rent' while refusing home care or day care.

Response and outcome. Following tactful discussions, she moved to residential care and thrived there.

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