

# FACTORS INFLUENCING HEALTH-CARE PROFESSIONALS IN IDENTIFYING AND MANAGING ELDER ABUSE: A PRELIMINARY REPORT

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**Background:** The prevalence rate of elder abuse in Canada is 4%. Literature suggests the majority of cases are not identified and reported by health-care professionals.

**Methods:** To assess factors influencing health-care professionals in identifying and managing elder abuse, we surveyed the health-care staff at the four health centres affiliated with St. Michael's Hospital. We received 53 out of 81 self-completed questionnaires (65% response rate).

**Results:** 51 cases of elder abuse were suspected over the preceding 12 months, and of these, only 2 cases were reported to the authorities. Only 1 respondent knew of a written protocol for elder abuse at their health centre. 5 respondents reported knowing of a list of community resources available at their practice centre. Attitudes which may deter health-care professionals from reporting suspected cases of elder abuse included uncertainty about diagnosis and legal responsibilities, and concern for the victim's outcome as a result of reporting. Likert scales were used to quantify health-care workers' knowledge of risk factors (12.34±2.50 out of 17), knowledge of the history and physical (7.74±2.10 out of 13) and familiarity with elder-abuse laws (2.74±1.89 out of 7). Postgraduate training in elder abuse was associated with improved scores in knowledge of history and physical and legal aspects of elder abuse (p-values 0.050 and 0.046, respectively). The majority of health-care professionals would welcome additional training (64.2%).

**Conclusions:** These results suggest possible improvements to the detection and management of elder abuse via post-education training and on-site availability of written protocols.

*Key words:* elder abuse, risk factors, knowledge, attitudes, practice

## INTRODUCTION

Health Canada defines elder abuse as including neglect in addition to physical, psychosocial and financial forms of mistreatment.<sup>1</sup> Abuse is distinguished from other crimes committed against the elderly, in that the perpetrator occupies a position of trust.

In 1990, Podnieks conducted a cross-Canada tele-

phone survey of a randomized sample of 2,000 elderly persons living in private homes. When asked if they had been abused by any caregivers since the age of 65, about 4% (95% CI 2.5% to 5.5%) had experienced some form of abuse. At the time of the study, this equated to approximately 98,000 elderly Canadians.<sup>2</sup> In 1999, the number of persons over the age of 64 was 3.8 million, equating to 12% of Canada's population. The 1999 General Social Survey (GSS) by the Canadian Centre for Justice Statistics conducted a similar study to that by Podnieks. Only 1% of the elderly population reported being a victim of physical or sexual abuse; however, 7% reported having experienced emotional or financial abuse.<sup>3</sup>

In spite of the 4% prevalence rate of elder abuse and the Canadian guidelines which indicate that *physicians should be alert to indications of elder abuse and should take measures to prevent further abuse*,<sup>4</sup> literature has shown that elder abuse is under-detected and under-managed. In a study conducted in Michigan, only 2% of the total reported cases of elder abuse was made by physicians.<sup>5</sup> Another study approximates that only one out of 14 elder-abuse cases is brought to the attention of authorities.<sup>6</sup>

The purpose of our study, therefore, was to survey health-care professionals in a primary care setting, to elucidate the barriers in detecting and managing geriatric abuse. Factors investigated included: knowledge of elder abuse risk factors, proficiency in doing a pertinent history and physical examination, awareness of legal responsibilities, and attitudes towards elder abuse management. We hope our findings will direct future education and policy development.

## METHODS

The main research tool was a self-completed questionnaire. After pre-testing the instrument with 10

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health-care personnel, we made further revisions and modifications.

Inclusion criteria were all physicians, residents, dietitians, occupational therapists, nurses, and social workers working at any of the four community health centres affiliated with St. Michael's Hospital between February 1 and March 31, 2001. Excluded from the study were individuals who were on maternity leave, away on clinical teaching or were advisors to the study. The study population consisted of 81 eligible individuals. St. Michael's Hospital is a large, academic hospital with a special interest in inner city health.

A cover letter explaining the purpose of the study was included with each questionnaire, along with an inter-hospital return envelope. Weekly reminders were published in the staff newsletter for 5 consecutive weeks, after which non-responders were mailed a second copy of the survey. Respondents were kept anonymous.

We assessed the profile of the respondents by demographic information, occupation, number of years in practice and their practice's patient profile. We asked them the number of suspected cases in the preceding 12 months of elder abuse that they had encountered, and of those, how many were reported. As the questionnaire was anonymous, there was no way to confirm that all the reported cases were unique. Respondents were also asked if they were aware of a written management protocol or a list of community supports available at their health centre.

The next segment contained several statements pertaining to educational issues. Health-care professionals were asked to recall if they had education on elder abuse during their undergraduate training, had formal education on elder abuse during their post-education period, and whether they have read a journal article on elder abuse. Views on the current adequacy and future role of education on elder abuse were elicited.

To assess whether health-care professionals know what the risk factors for elder mistreatment are, respondents were presented with 13 characteristics of victims and perpetrators. They had to identify which of the 13 were true risk-factors for elder abuse, including physical, sexual, emotional, and financial abuse. One point was given for every correct identification, and a Likert-scale with a maximum score of 13 was calculated. Similarly, to determine if workers knew how to perform a relevant history and physical for a suspected case of elder

abuse, respondents were given 17 statements. They had to correctly identify what information on history and which observations on physical examination were relevant, and a Likert-scale score out of 17 was assigned. The questions were designed based on the information published in the 1994 Canadian periodic health examination and other literature.<sup>4,7,8</sup>

To ascertain health-care workers' familiarity with federal and Ontario provincial laws on elder abuse, respondents had to correctly determine from seven statements which of the laws were true or false.

The scores obtained for knowledge of risk-factors, knowledge of history and physical, and familiarity with laws were then further analyzed using a t-test assuming unequal variances, to determine whether the mean value of a continuous outcome variable in one group differed significantly from that in another group. McCreddie et al<sup>9</sup> has shown that younger GPs were more likely to correctly identify risk situations. Jones et al<sup>10</sup> found that emergency physicians who had some educational training in elder abuse reported significantly more cases than those who did not have such teaching. The comparison groups that we chose to consider were: occupation, age, number of years in practice, gender, undergraduate training in elder abuse, reading a journal article related to elder abuse, and post-education training in elder abuse. P-values <0.05 were considered statistically significant.

The final section of the survey comprised 14 statements as potential reasons for not reporting a suspected case of elder abuse. Respondents were asked to evaluate these statements by choosing "agree", "disagree", or "uncertain".

This study was approved by the ethics review board of St. Michael's Hospital, Toronto.

## **RESULTS**

After the two mailings, 65% (n = 53) responded, which included physicians, residents, nurses, dietitians, and an occupational therapist (Table 1). The mean  $\pm$  SD age of the respondents was 39  $\pm$  10 years (range 27 to 59 years), practising for 11  $\pm$  10 years (range 1 to 35). On average, the health-care professional saw 72 patients a week (range 5 to 500) of which 20 (range 0 to 250) were 65 years or older. The ratio of male:female respondents was 13:40.

Only 47%, 40% and 77% could remember having undergraduate training, having post-education

**Table 1.** Occupations of the Respondents

	Eligible	Respondents	Response Rate (%)
MD	41	28	68
Resident	16	10	63
Nurse	17	13	76
Dietitian	2	1	50
Occupational Therapist	1	1	100
Social Worker	4	0	0
Total	81	53	65

training, and reading a journal article on elder abuse, respectively. Table 2 shows other perceptions that the respondents had pertaining to elder-abuse education.

In the assessment of identifying risk-factors for elder abuse, the mean  $\pm$  SD score was  $12.34 \pm 2.50$  (range 6 to 16) out of 17. In evaluating the respondents on how to conduct a focused history and physical examination, the average score obtained was  $7.74 \pm 2.10$  (range 3 to 11) out of 13. In the t-test assuming unequal variances analysis, respondents who had postgraduate education in elder abuse scored better. We also noted considerable uncertainty among the surveyed health-care workers in response to their familiarity with federal and provincial elder-abuse legislations. The mean  $\pm$  SD score was 2.74 (range 0 to 7) out of 7. Respondents who were males, physicians or residents, or had post-education training in elder abuse scored higher (Table 3).

Including all the respondents, over the past 12 months, only 51 cases of elder abuse were suspected. Of these, only two cases were eventually reported to the authorities. As this is an anonymous survey, there is recall bias and no method of contacting each respondent to ensure that each of the 51 reported cases was unique. The reasons for not reporting a suspected case of elder mistreatment are

**Table 2.** Educational Experience and Perceptions

Statement	% Agree
I recall having at least one formal educational session on elder abuse during my training.	47
I have attended at least one post-education session on elder abuse.	40
I have read at least one journal article on elder abuse.	77
Current education efforts are inadequate.	70
Elder abuse should be part of in-service training for all health-care staff.	96
I would like more formalized training on elder abuse.	64

**Table 3.** Respondent Characteristics showing a Statistically Significant Difference in Likert-scale Scores for Knowledge of Risk Factors, Knowledge of a Focused Elder Abuse History and Physical Examination, Knowledge of Federal and Provincial Elder-Abuse Laws

**Knowledge of a focused history and physical** (mean score  $\pm$  SD =  $7.74 \pm 2.10$ , out of 13)

	Score	p-value
Post-education training		0.050
No	7.38	
Yes	8.29	

**Knowledge of elder abuse laws** (mean score  $\pm$  SD =  $2.74 \pm 1.89$ , out of 7)

	Score	p-value
Gender		0.049
Female	2.42	
Male	3.69	
Occupation		0.027
Physician, Resident	3.03	
Other	2.00	
Post-education training		0.046
No	2.71	
Yes	2.83	

listed in Table 4.

Of the health-care professionals, 70% believed that current education efforts in elder abuse are inadequate and 64% would like more formalized training in the area.

Finally, only one respondent knew of an elder abuse management written protocol available at their health centre. Only five of all the respondents were aware of a list of community services available at their health-services centre.

**Table 4.** Reasons for Not Reporting a Suspected Case of Elder Abuse

Reasons	% Agree
Not confident about diagnosis.	81
Uncertainty about the elder mistreatment prevention laws.	70
Uncertainty on how to report suspected case.	64
The victim is reluctant to press charges against a close relative or caregiver in fear of isolation.	47
The victim may suffer reprisals, loss of autonomy or relocation.	45
Inadequate community resources to respond to identified cases.	40
Denial by the individual or caretaker.	38
Health-care professional-patient confidentiality issues.	38
The victim wants to avoid embarrassment.	30
Concern that the identity of the reporter will be revealed.	15
Dissatisfaction with the response from authorities when cases were previously reported.	13
Do not want to get legally involved.	9
It is the patient's responsibility to report mistreatment.	8
Mistreatment involves only minor injuries or subtle signs.	4

## DISCUSSION

Several issues can be raised to challenge the results presented in this study. Firstly, the professional health-care workers at St. Michael's Hospital may not be truly representative of all their colleagues across Canada because this is an academic hospital with a special interest in inner city health. Secondly, no social workers responded to the questionnaire and this may affect the generalizability of the results. Finally, the data is subject to recall bias.

While this survey was conducted at only one institution, the preliminary findings of this study still highlight several areas of concern. In particular, the poor performance among health-care professionals in identifying risk factors for elder abuse, performing a focused history and physical examination and knowing their legal obligations, as evidenced by the low Likert-scale scores, are all areas for improvement in geriatric care.

Undergraduate training in elder abuse and personal reading have not remedied these problem areas; however, post-education training has been shown to be associated with improved focused history and physical and knowledge of legal responsibility scores. Whether this result is due to intrinsic group differences or due to a true causal effect cannot be determined at this moment. As 64% of respondents would welcome additional teaching in elder abuse, this would be an opportunity for implementing in-service training or continuing education workshops. Having a written management protocol as well as a list of community resources on-site may also prove useful. We recommend the development of a reliable assessment tool for use in the primary-care setting.

To address the attitudinal barriers faced by health-care professionals, namely uncertainty about the diagnosis and fear that reporting would only worsen the victim's outcome, staff should be encouraged

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to exercise a team advocacy approach. In this model, all members of the interdisciplinary team make the diagnosis, assist the victim in finding community services, and inform the victim of his or her rights.

Finally, at the primary health-care team level, there is a need for all professionals to contribute to current discussions on elder abuse and its management.

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