

Editorial, Age and Ageing

Intervening to reduce elder abuse; challenges for research (801 words)

Claudia Cooper, Clinical Reader in old age psychiatry, UCL: Division of Psychiatry

Gill Livingston, Professor of Old Age Psychiatry, UCL: Division of Psychiatry

In the UK the Department of Health defines abuse as “a violation of an individual's human and civil rights by another person(s)” (1). Abuse is a spectrum of behaviours and degrees of behaviours, which we often artificially dichotomise. In research, “cases” of abuse have been identified by setting thresholds for the severity or frequency of an abusive behaviour that constitute “significant” abuse. One in four vulnerable older people in studies are sometimes abused and only a small proportion of this is currently reported (2;3). In recent surveys, 16% of long term care staff have reported committing significant psychological abuse (2); and over 80% of nursing home staff have observed abuse (4).

In this journal, Avalon et al's review of interventions to reduce elder abuse is useful and timely, in an area which in which research is difficult. Elder abuse is a hidden offence. The victims are frequently vulnerable, and do not report abuse because they are frightened, embarrassed or unable to report it because of dementia. Some older people may fear the reaction of the perpetrator, on whom they often depend, or blame themselves(5).

Asking carers about perpetrated abuse

Some studies have asked paid or family carers to self-report abusive behaviours. Family carers appear willing to report abusive behaviour (6) which is often a response to stress and burden for which they want help. Care workers reporting abuse face potential adverse legal, employment and social consequences, and anonymous reporting may be necessary to accurately measure it (7;8).

In the only intervention study to measure abusive behaviour by family carers as an outcome, we found no evidence that the START (STrategies for RelaTives) intervention, which reduced carer anxiety and depression, reduced their reported abusive behaviour. For ethical reasons we frequently intervened to manage concerning abuse reported in both groups, which may have masked an intervention effect (9;10). Measuring abuse is necessary to develop interventions to reduce it, but there are ethical dilemmas regarding how to manage concerning cases detected, or in deciding to measure abuse anonymously so they cannot be managed. Four of the five studies reviewed by Avalon et al that sought to reduce psychological abuse by paid carers through education, communication training and support did so significantly, although only one was a randomised controlled trial and was thought to be potentially contaminated. This is promising, but further trials are needed before a definitive intervention can be implemented.

Reducing physically restraint

Over half of reviewed studies sought to reduce use of physical restraints, such as bilateral bed rails, belts, and fixed tables in a chair, in institutional settings. In most jurisdictions, use of restraint is subject to legal safeguards. While any unnecessary restraint is considered unacceptable, opinions about the relative harms of using sedating psychotropic medication or physical restraint to manage behavioural disturbance that may otherwise cause harm vary between countries. Some describe the use of psychotropic drugs in this context as

chemical restraint, although this medication may be given to treat an underlying problem rather than to prevent the recipient's movement. In the UK physical restraint is only legally acceptable if the person is likely to suffer harm unless proportionate restraint is used, and it is the minimum amount of force for the shortest time possible(11). No UK research studies have included physical restraint as an outcome, probably because no level of ongoing physical restraint would be considered acceptable. By contrast there has traditionally been a preference for use of seclusion and physical restraint in preference to chemical restraint in the Netherlands, although this is changing (12). This review found that interventions to educate front line staff about harms caused by physical restraint, and teach alternative, person-centred care strategies successfully reduced physical restraint. Similar programmes have been successful in reducing antipsychotic use in care homes (13).

Increasing professionals vigilance for and reporting of abuse

Two of the reviewed studies looked at whether interventions changed frequency of abuse reporting or assessment. The first found a non-significant increase in elder abuse reports in Japan after introduction of the elder abuse prevention and caregiver support law; the second that an educational intervention did not significantly increase the proportion of clinicians routinely assessing for abuse, although abuse status was more frequently charted. While these results are discouraging current evidence and clinical experience suggest that teaching health professionals how to detect and manage abuse improves their knowledge about doing so although it may also lead to an increase in reported abuse (14;15).

Conclusions

Elder abuse is a topic with personal, ethical and socioeconomic ramifications. Compared with other forms of interpersonal violence it is under-researched. Avalon et al's review clarifies the existing, limited evidence base. Interventions to educate staff and reduce restraint use have demonstrated clear efficacy and should be implemented. More work to develop definitive interventions to reduce other forms of abuse is now needed.

Key points

1. One in four vulnerable older people may experience abuse and only a small proportion of this is reported.
2. Researching elder abuse brings challenges, including how to ethically manage cases reported, and whether to collect data anonymously.
3. The best evidence for reducing abuse currently is in care homes, where interventions to educate front line staff about harms caused by physical restraint, and teach alternative, person-centred care strategies have successfully reduced physical restraint in some countries.
4. We do not yet have evidence-based interventions to reduce abuse perpetrated by family carers or paid carers working in people's homes.

Key words: elder abuse, dementia, ethics of research, restraint

Reference List

- (1) Department of Health. 'No Secrets' Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. 2000.
- (2) Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. *Age and Ageing* 2008 Mar;37(2):151-60.
- (3) Cooper C, Katona C, Finne-Soveri H, Topinkova E, Carpenter GI, Livingston G. Indicators of elder abuse: A crossnational comparison of psychiatric morbidity and other determinants in the Ad-HOC study. *American Journal of Geriatric Psychiatry* 2006 Jun;14(6):489-97.
- (4) Pillemer K, Moore DW. Abuse of Patients in Nursing-Homes - Findings from A Survey of Staff. *Gerontologist* 1989 Jun;29(3):314-20.
- (5) Moon A, Tomita S, Jung-Kamai A. Elder Mistreatment Among Four Asian American Groups: An Exploratory Study on Tolerance, Victim Blaming and Attitudes Toward Third-Party Intervention. *Journal of Gerontological Social Work* 1993;36:153-69.
- (6) Cooper C, Selwood A, Blanchard M, Walker Z, Blizard R, Livingston G. Abuse of people with dementia by family carers: representative cross sectional survey. *British Medical Journal* 2009 Jan 22;338.
- (7) Natan MB, Lowenstein A, Eisikovits Z. Psycho-social factors affecting elders' maltreatment in long-term care facilities. *Int Nurs Rev* 2010 Mar;57(1):113-20.
- (8) Cooper C, Dow B, Hay S, Livingston D, Livingston G. Care workers' abusive behaviour to residents in care homes: a qualitative study of types of abuse, barriers and facilitators to good care and development of an instrument for reporting of abuse anonymously. *Int Psychogeriatr*. In press 2012.
- (9) Livingston G, Barber J, Rapaport P, Knapp M, Griffin M. **START (STrategies for RelaTives) study: a pragmatic randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of a manual-based coping strategy programme in promoting the mental health of carers of people with dementia.** *Health Technology Assessment* 2014;18(61):1-242.
- (10) Cooper C, Barber J, Griffin M, Rapaport P, Livingston G. **Effectiveness of START psychological intervention in reducing abuse by dementia family carers: randomized controlled trial** . *Int Psychogeriatrics*. In press 2015.
- (11) Department of Health. The Mental Capacity Act. 2005.
Ref Type: Statute
- (12) Steinert T, Noorthoorn EO, Mulder CL. The use of coercive interventions in mental health care in Germany and the Netherlands. A comparison of the developments in two

neighboring countries. *Frontiers in Public Health*
2014 Available from: URL:

<http://journal.frontiersin.org/article/10.3389/fpubh.2014.00141/full#B37>

- (13) Fossey J, Ballard C, Juszczak E, James I, Aldler N, Jacoby R, et al. Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster randomised trial. *British Medical Journal* 2006 Apr 1;332(7544):756-758A.
- (14) Richardson B, Kitchen G, Livingston G. The effect of education on knowledge and management of elder abuse: a randomized controlled trial. *Age and Ageing* 2002 Sep;31(5):335-41.
- (15) Cooper C, Huzzey L, Livingston G. The effect of an educational intervention on junior doctors' knowledge and practice in detecting and managing elder abuse
COOPER2012. *Int Psychogeriatr* 2012 Sep;24(9):1447-53.