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Elder Mistreatment Reporting: Differences in the Threshold of Reporting between Hospice and Palliative Care Professionals and Adult Protective Service

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Abstract

Background: Underreporting of elder mistreatment by health professionals is a significant problem.
Purpose: To investigate differences in elder mistreatment reporting threshold between hospice/palliative care (HPC) professionals and Adult Protective Services (APS); explore factors for not reporting elder mistreatment.
Design: Cross-sectional questionnaire.
Setting/Participants: Four HPC teams and 42 APS workers in one county.
Methods: Five hypothetical elder mistreatment case vignettes along a spectrum of severity were scored on Likert scales for likelihood of reporting or accepting the cases. HPC professionals were surveyed about their knowledge and beliefs about reporting elder mistreatment.
Results: All 42 APS workers and 74% of 73 ($n = 54$) HPC professionals completed the survey. In all but the most severe case of abuse, APS was more likely to accept reports of elder mistreatment than HPC professionals were in reporting ($p < 0.002$). HPC professionals had reported a mean of 2.5 (±2.8, standard deviation [SD]) cases in the last 5 years. Thirty percent of HPC professionals had suspected cases of elder mistreatment that was not reported in the last 5 years. The median difference between the total number of suspected and reported cases was 2 (±4.6, SD). Eleven percent had ethical concerns about reporting and 63% were concerned about practical consequences of reporting. Only 37% correctly identified the reporting agencies that have jurisdiction over abuse that occurs in long-term care. Correct identification of long-term care reporting agencies correlated with whether the HPC professional had training in elder mistreatment ($r = 0.35$, $p = 0.009$). Although 96% would report physical abuse that they witnessed, only 63% would report abuse verbalized by the patient.
Conclusion: There is evidence that significant differences exist in elder mistreatment reporting thresholds between APS and HPC professionals. This finding should encourage HPC professionals to discuss with APS the cases they are unsure about reporting. Future research is need on elder mistreatment in the HPC setting.

Introduction

Elder mistreatment is a complex, multifactorial phenomenon that significantly impacts the quality of life of its victims.[1] It is thought to be the predominate form of family violence in the hospice and palliative care (HPC) setting.[2] Most HPC patients and families have multiple risk factors for elder mistreatment, e.g., dependence on others for caregiving, cognitive confusion, and caregiving stress. Elderly HPC patients are therefore at high risk for mistreatment.[3] For these patients, the HPC team may be the only health professionals involved who have the opportunity to detect and report mistreatment.

Elder mistreatment involves an interplay of medical, psychological, social, financial, and legal factors. To add to the complexity, elder mistreatment presents in different but overlapping forms: physical, emotional, and sexual abuse; financial exploitation; neglect by others; and self-neglect.[4] It is thus a mixture of related but heterogeneous concepts that can be difficult "to put your hands around." The result is that an estimated 84% of elder mistreatment cases go unreported.[5]

Health care professionals are in most states mandated by law to report suspected elder mistreatment.[6] Prior studies of health professionals have found several barriers to reporting. A recent study found physicians to be internally con-

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flicted in their perceptions about mandatory reporting.[7] Another study found a lack of knowledge on how to report mistreatment to be the most significant obstacle to primary care physicians making a report in the community.[8] Reasons given by paramedics and emergency medical technicians for not reporting included: (1) unsure which authorities take reports; (2) unclear definitions; (3) unaware of mandatory reporting laws; and (4) lack of anonymity.[9] In another recent study, physicians gave the following reasons for failing to report suspected elder mistreatment: denial of abuse by the patient (23%), uncertainty about reporting procedures (21%), uncertainty about reporting laws (10%), and the abuse involved only subtle signs (44%).[10]

We hypothesized that differences exist between the HPC professionals' threshold for reporting elder mistreatment and the threshold for accepting such reports by Adult Protective Services (APS). Because there is no gold standard or medical criterion for reporting, there is no absolute threshold to which HPC professionals can be compared. Therefore, the primary aim of this pilot study is to compare the threshold of reporting by HPC professionals to the APS threshld of accepting reports using the same hypothetical cases of elder mistreatment. Secondary objectives of the study are to explore other potential barriers to reporting elder mistreatment among HPC professionals.

Methods

Three home hospice teams and one home palliative care team in Orange County, California participated in this study. The Orange County APS agency also participated. Participation in the study was entirely voluntary. The study was approved by the Institutional Review Board of the University of California, Irvine. The inclusion criteria were either (1) a practicing licensed professional involved in the care of elderly HPC patients or (2) a case worker for the participating APS agency.

A survey was distributed anonymously to all potential subjects. The survey consisted of demographic questions and five hypothetical elder mistreatment scenario cases (see Appendix). The scenarios or vignettes were developed by two palliative medicine geriatricians (S.L., K.M.J.), based upon their experience with an Elder Abuse Forensic Center and home hospice. The vignettes were reviewed by an expert panel of elder mistreatment professionals consisting of a gerontologist (A.W.), and five APS supervisors. This panel confirmed face validity and content validity that these vignettes accurately represented cases that would be seen in the real world. Other studies have used similar expert panels to establish validity of vignettes in abuse situations.[11] These case vignettes were designed to represent a spectrum of possible elder mistreatment severity but were presented in no particular order. HPC professionals were asked to rank their likelihood of reporting the cases on a six-point Likert scale from 1 (definitely report) to 6 (definitely not report). APS staff was asked to rank their likelihood of accepting the same cases using a parallel Likert scale. Because of the anonymous and voluntary nature of the survey, demographic information could not be collected on nonrespondents.

The survey to HPC professionals included the following additional questions. At the beginning the survey, they were asked how many cases of elder mistreatment they reported in the last 5 years. Near the end, the survey asked how many cases of elder mistreatment they had suspected in the last 5 years. Subjects were also asked to select from a list of potential concerns they had about reporting elder mistreatment, including ethical concerns, and reasons they believed past cases were not reported. They were then encouraged to write in additional ethical concerns and reasons for not reporting in two separate open-ended questions. Subjects were also asked if they had received training or education on elder mistreatment and if so, where this took place (e.g., during school or on the job). The survey asked HPC professionals if they would agree to report the following: (1) physical abuse that they observed, (2) physical injury indicating abuse, (3) verbal report of abuse by the patient, and (4) psychological or financial abuse. Subjects were asked to rank their agreement on a Likert scale from 1 (strongly agree) to 6 (strongly disagree). On a similar Likert scale, another question explored whether the subjects knew they had immunity under the law for liability resulting from the mistreatment report. The survey inquired about the subjects' knowledge of reporting by asking to whom they would report mistreatment in the community and in long-term care facilities. For these two questions they were given the choices of APS, ombudsmen, and law enforcement and asked to select all that applied.

Data analysis was performed using the statistical program, SPSS version 14 (SPSS, Chicago, IL). Frequencies and descriptive statistics were calculated for demographic variables and responses to the survey questions. Because the APS responses were highly skewed toward acceptance of reports, the Mann-Whitney nonparametric test was used to test for difference of group means (between HPC professionals and APS social workers) in the responses to the case vignette survey questions. Tests of association of the number of suspected and reported cases with independent variables were bivariate two-tailed Pearson correlations.

Results

Of the 73 surveys sent out to HPC professionals, 54 (74%) were returned. All 42 APS surveys were returned. Table 1 shows the demographic characteristics of those who completed the surveys. The majority of HPC professionals were nurses (63% registered nurses and 5.5% licensed vocation nurses) with the next largest group being social workers (15%). A high proportion of HPC (82%) and APS (88%) participants were women. There were significant differences in age, educational level, and years in the profession between HPC and APS professionals (Table 1). Seventy-four percent of HPC professionals reported they had received education or training about elder mistreatment in school (26%), at work (20%), or both (28%).

Significant differences were found in the threshold of reporting between APS and HPC professionals in all the mistreatment cases but the most severe (Table 2). HPC professionals had reported a mean of 2.52 ($\pm$2.79, standard deviation [SD]) cases in the last 5 years with a range from 0–10 cases. Eighteen HPC professionals (33.3%) had not reported a single case in the last 5 years. Thirteen (24.1%) had not suspected any cases of mistreatment in the last 5 years. Sixteen HPC professionals (29.6%) had suspected cases that

Table 1. Descriptive Demographics of the Subjects

	Palliative care, n = *54*	*APS,* n = *42*	p *value*
Median age group	51–60	41–50	0.014[a]
Female gender	44 (82%)	37 (88%)	0.48[b]
Median education level	Bachelors	Masters	0.017[a]
Occupation			
Social worker	8 (15%)		
RN	34 (63%)		
LVN	3 (5.5%)		
MD	4 (7%)		
Dietician	1 (2%)		
Chaplain	3 (5.5%)		
Missing	1 (2%)		
Median years in profession	11–15	6–10	0.023[a]

[a]Independent *t* test.
[b]χ^2 test.
RN, registered nurse; LVN, licensed vocational nurse; MD, medical doctor.

they did not report. The mean number of suspected cases that were not reported was 3.88 (± 4.6, SD) with a median number of 2 cases. There was no correlation between the number of reported or suspected cases and professional discipline or whether the subject had training in elder mistreatment.

Six HPC professionals (11%) had ethical concerns about reporting and 34 (63%) were concerned about the practical consequences of reporting. These practical concerns were as follows: 12 (22%) had concerns about the family, 8 (15%) had concerns about the patient, 7 (13%) had concerns about legal consequences, 2 (4%) had concerns about their employment, 4 (7%) thought it could not happen under good hospice or palliative care, and 15 (28%) had other concerns. Ten people (18.5%) expressed multiple concerns. Responses to the open-ended questions regarding not reporting and ethical concerns are summarized in Table 3.

Although 70.4% ($n = 38$) correctly identified the reporting agency for patients in the community, only 37% ($n = 20$) correctly identified the reporting agencies in long-term care. Correct identification of long-term care reporting agencies correlated with whether the HPC professional had training in elder mistreatment ($r = 0.35$, $p = 0.009$).

HPC professionals were confident in reporting physical abuse when they witnessed it, with 96% ($n = 52$) agreeing or strongly agreeing to report. Fewer professionals (77.8%, $n = 42$) agreed or strongly agreed to report when they saw physical injury indicative of physical abuse or when the suspected form of abuse was psychological or financial (81.5%, $n = 44$). Only 63% ($n = 34$) agreed or strongly agreed to reporting abuse when verbally expressed by the patient. Table 4 lists the percentages of agreement to report by the type of suspicion. Nearly all (96%, $n = 52$) understood they were protected from civil and criminal liability when they made a report in good faith.

Discussion

This study showed that given the same case scenarios, APS workers expressed a higher willingness to accept cases of potential mistreatment than HPC professionals' stated willingness to report. This finding has potential implications on the threshold with which HPC professionals decide when to report elder mistreatment. Because there is no accepted gold standard for the threshold of reporting, when a specific suspected case of elder mistreatment should or should not be reported is sometimes difficult for health professionals to determine. In California, the legal standard for mandated reporting is "reasonable suspicion." The state Welfare and Institution code defines "reasonable suspicion" as a suspicion "that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when

Table 2. Differences in Elder Mistreatment Reporting Threshold between Adult Protective Services and Palliative Care Professionals

Case vignette number (In order of severity, top being most severe)	*APS willingness to accept*[a] *(mean)*	*Palliative care willingness to report*[a] *(mean)*	p *value*
1	1.07	1.30	0.137
2	1.12	2.35	<0.001
5	1.33	2.02	0.002
3	2.02	4.61	<0.001
4	4.1	5.28	<0.001

[a]Likert scale: 1 = definitely report, 6 = definitely not report.

TABLE 3. HOSPICE AND PALLIATIVE CARE PROFESSIONALS' RESPONSES TO OPEN-ENDED QUESTIONS

Discipline	*Reason for not reporting*	*Ethical concerns*	*Frequency of similar comments by discipline*
Nurse	"It was determined after further investigation and appropriate action was taken, it did not need to be reported"		Total = 7: 6 nurses, 1 social worker
Nurse	"After consulting with other team members, abuse was not found"		Total = 4: 1 nurse, 1 chaplain, 1 dietician, 1 unknown
Nurse	"Was reported to [hospice] social worker."		
Nurse	"The MSW determined it was not abuse."		
Social worker	"APS doesn't do much"		
Social worker		"APS does nothing."	
Chaplain	"Lack of education surrounding reporting incidences of abuse."		

appropriate upon his or her training and experience, to suspect abuse."[12] While health professionals may not understand how to apply this abstract legal standard, what is clear about this standard is that health professionals need not investigate or prove that mistreatment has occurred before reporting. California state law is explicit that the health professional should not feel obligated to investigate or prove that elder mistreatment occurred.[13] This sense of obligation to prove the mistreatment may be a contributing factor for under-reporting of elder mistreatment and may contribute to the twofold difference between the number of suspected cases and the number of reported cases stated by HPC professionals.

A more practical standard than the legal standard is the threshold by which APS accepts or declines the report from the health professional. What the HPC professional must deal with in the real world is not the legal abstract standard but whether the APS worker on the other end of the telephone will take their report. HPC professionals can be encouraged by this study's finding (that APS worker may have a lower threshold of accepting a report) to contact APS for questionable or borderline cases to see if their suspicion is reportable.

As with other challenging or complex decisions, the decision to make an elder mistreatment report is often made by the HPC interdisciplinary team. The likelihood of reporting was not related to the professional discipline (e.g., social workers were not more likely to file a report than other disciplines) nor with the experience, education, or training of the professional. This lack of cross-disciplinary variation may be a reflection of a team consensus to report. Several HPC professionals wrote in comments that another team member or members convinced them the case was not mistreatment. While a multifaceted perspective generally reveals the true situation more accurately, overdependence on the team approach runs the danger of "group think" and squashing of valid assessment by individual professionals. California state law places the mandatory reporting responsibility on the individual health professional and states clearly that this responsibility cannot be passed onto or relieved by another individual, even for example by a supervisor.[14]

Practical and ethical concerns exist amongst HPC professionals about reporting. Practical concerns about the impact on the family of reporting were as prevalent or more so than the concerns about the impact on the patient. Given the fact that HPC professionals are trained to view the patient and their family as the treatment unit, this balance of concerns is not surprising and may be appropriate. HPC professionals must balance the risk that a report may offend the patient or family (and thereby making the situation more difficult for the HPC team) against the potential benefit that APS may help to resolve the situation or protect the vulnerable elderly patient. The literature describes cases of ethical struggle by both nursing and social work about reporting elder mistreatment.[15,16]

TABLE 4. HOSPICE AND PALLIATIVE CARE PROFESSIONAL'S AGREEMENT WITH WILLINGNESS TO REPORT ELDER MISTREATMENT

	Number of hospice and palliative care professionals						
Type of suspicion	*Strongly agree*	*Agree*	*Somewhat agree*	*Somewhat disagree*	*Disagree*	*Strongly disagree*	*Missing*
Observe incident of physical abuse	44 (81.5%)	8 (14.8%)	2 (3.7%)	0	0	0	0
Physical injury indicative of physical abuse	29 (53.7%)	13 (24.1%)	7 (13%)	2 (3.7%)	2 (3.7%)	0	1 (1.9%)
Suspected psychological or financial abuse	22 (40.7%)	22 (40.7%)	8 (14.8%)	1 (1.9%)	0	1 (1.9%)	0
Verbal report of abuse from patient	22 (40.7%)	12 (22.2%)	15 (27.8%)	3 (5.6%)	2 (3.7%)	0	0

Two HPC social workers in this study felt that APS was of no help, and other HPC professionals did not report because they were able to take “appropriate action” to resolve the concerns. While such views are understandable for the immediate case at hand, they miss the larger societal context and impact. At-risk caregivers are likely to find themselves in a similar situation caring for another patient in the future when the HPC staff may not there to support them. APS could then be in a better position to take action at that time if there is a prior reported history. Underreporting may further reduce the already limited resources of APS, since budget justification is often based upon the local government’s perception of the scope or size of the problem. Reporting elder mistreatment can give APS the ability and resources to take action in the future.

Education of HPC professionals about elder mistreatment reporting is still needed, especially in the long-term care setting. Although most HPC professionals were able to correctly identify APS as the agency for reporting mistreatment in the community, only 37% was able to identify the ombudsmen or law enforcement as the correct reporting agency in long-term care under California law. This inability to identify the correct reporting agency in long-term care correlated with the lack of formal training the HPC professional had received in elder mistreatment. Not knowing where to report the mistreatment has been shown to be a barrier to reporting by health professionals.[9] Though education is not the complete solution to under-reporting, it has been shown to increase the willingness of health professionals to report.[17] Education may be the best and easiest place to start and should be view as part of a multifactorial intervention to improve elder mistreatment reporting.

There are several limitations to this pilot study. The small size of the study and the fact that the study was done in one county may limit the ability to generalize the results. APS agencies of other counties may not be as well trained or educated. There may be recall bias, particularly in the number of reported and suspected cases. As memory fades, health professionals may recall fewer cases than the number they actually reported or suspected. The study did not examine the actual number of cases reported by the teams nor did it confirm the actual training the HPC professionals received. There also may be a selection bias. Professionals not interested in the topic of elder mistreatment may be less likely to complete and return the survey. The problem of underreporting may be greater than what this study shows.

This exploratory study is an initial, broad descriptive survey of elder mistreatment reporting among HPC professionals. The preliminary findings of this survey will hopefully spur future, more in-depth research into this important subject, including a comprehensive evaluation of the challenging process of deciding when to make an elder mistreatment report. Though this study was not designed to examine the prevalence of elder mistreatment reporting or of elder mistreatment itself, it does demonstrate that HPC professionals see and report elder mistreatment.

This study highlights many aspects of elder mistreatment in HPC that need future research. Prospective studies are needed to determine the prevalence of elder mistreatment in each of its various forms in the HPC population and to determine the actual degree of reporting. More research is also needed to explore more in-depth the barriers and concerns that lead to underreporting by health professionals. Future research can examine the nature of the ethical concerns about reporting. Qualitative research using focus groups or structured individual interviews are needed to explore the complex process of deciding when to report elder mistreatment. This study suggests that health professionals need criteria to decide when a confused patient who reports mistreatment is credible. Research should focus on the reliability of confused patients for emotionally traumatic events such as mistreatment. Finally future research should help distinguish elder mistreatment indicators from the natural dying process, e.g., when is a pressure ulcer the result of neglect versus progression of disease.

Conclusion

Significant differences exist between the threshold by which HPC professionals report elder mistreatment and the threshold APS uses to receive reports. This finding should encourage HPC professionals to contact APS when they are unsure about reporting. This exploratory pilot study points to the need for future research on the topic of elder mistreatment in HPC, including a more in-depth analysis of the decision-making process of reporting.

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Appendix A. Elder Mistreatment Case Vignettes

Please circle a response to indicate whether you would/would not report the cases below as elder abuse:

1) Mrs. Williams is an 80-year-old widowed female with stage 4 breast carcinoma, with multiple metastasis including bone and lung. She is prescribed morphine slow-release tablets and morphine elixir as needed for her breakthrough pain. Until recently she had 24-hour caregivers, but 3 months ago her daughter moved in with her to care for her. Her pain since has been poorly controlled. On your visit you find Mrs. Williams agitated and moaning in pain. Her bottle of morphine elixir is empty even though a 3-week supply of the medication was delivered a couple of days ago. Several days later you get a call from the pharmacy informing you that they are denying the prescription for refill of morphine elixir because it was refilled 3 days ago. On inquiry you find out that the patient's daughter called the pharmacy pretending to be a hospice nurse.

(1) Definitely report (2) Probably report (3) May report

(4) May not report (5) Probably not report (6) Definitely not report

2) Mrs. Martin is an 84-year-old female with high blood pressure and end stage renal disease. She lives with her 90-year-old husband who also has multiple medical problems. On your home visits you notice that your patients' clothes are stained with food and that her personal hygiene is poor. On walking up to her room you have a hard time trying to maneuver yourself between the multitude of boxes and other belongings piled up in the house. Mrs. Martin herself looks dehydrated and malnourished. On taking her vitals you notice that Mrs. Martin's blood pressure is very high. You ask her husband to tell you the type and doses of her medications, and note that he is unable to do so.

(1) Definitely report (2) Probably report (3) May report

(4) May not report (5) Probably not report (6) Definitely not report

3) Mr. Davis is a 76-year-old man with end-stage dementia who lives at home with his wife. She recently hired 24-hour caregivers through an agency because she was not able to care for him by herself. Mr. Davis often refuses to eat and needs one-on-one assistance with feeding. The family has refused modes of artificial nutrition. During a recent visit you notice bruises around his mouth. Concerned you mention this to the family. Two days later the patient develops congestion with cough and starts vomiting chunks of food and is admitted to the hospital for aspiration pneumonia. Later the patient's son tells you that he has caught the caregivers force feeding his father with a syringe.

(1) Definitely report (2) Probably report (3) May report

(4) May not report (5) Probably not report (6) Definitely not report

Appendix A. Elder Mistreatment Case Vignettes (Cont'd)

4) Mr. Kellogg is a 72-year old ex-smoker under hospice care for end-stage chronic obstructive pulmonary disease (COPD), who lives with his caring wife of 38 years. He is on multiple medications including home oxygen and oral prednisone for his emphysema. He is also on calcium supplements for possible osteoporosis from taking prednisone for many years. On your home visits you have been noticing multiple skin tears and bruises. On a weekend you receive a call from the wife saying that Mr. Kellogg had a fall and is now unable to get off from the floor. This is his first fall and results in fracture of his right hip.

(1) Definitely report (2) Probably report (3) May report

(4) May not report (5) Probably not report (6) Definitely not report

5) Mr. Winkelman is a 92-year-old male with history of dementia with psychosis who has lung cancer. He lives at home with his wife and granddaughter. He has a paid caregiver who comes in for 8 hours, 5 days per week. Recently Mr. Winkelman is not able to ambulate independently, is often agitated, but always looks clean and well cared for. During your home visit he complains to you that the caregiver stole his money. On talking to his family, they tell you that the caregiver is kind and has been extremely helpful in taking care of the patient and that Mr. Winkelman does not keep any money with him.

(1) Definitely report (2) Probably report (3) May report

(4) May not report (5) Probably not report (6) Definitely not report