

Elder Abuse in Nursing Homes: How Do We Advance the Field of Elder Justice?

Elder abuse (EA) is a common, fatal, and costly public health issue that affects an estimated 10% of the 64.9 million community-dwelling U.S. elderly adults (1). The White House, U.S. Preventive Services Task Force, U.S. Department of Justice, Centers for Disease Control and Prevention, Institute of Medicine, and Administration for Community Living have all called for EA to be named an urgent public health issue. An estimated 1.4 million people reside in nursing homes (2), but little is known about EA among these residents.

Lachs and colleagues (3) examine the prevalence and correlates of resident-to-resident elder mistreatment (R-REM) of 2011 residents in 10 New York state nursing homes from 2009 to 2013 (3). The overall prevalence of R-REM was 20.2%. Prevalences of different types of mistreatment were 9.1% for verbal abuse, 5.2% for physical misconduct, 0.6% for sexual misconduct, 4.0% for invasion of privacy, 0.9% for menacing gestures or facial expressions, and 0.3% for unwanted caregiving. Younger age, better cognition, living in a dementia unit, heavier staff workload, and seasons other than summer were associated with a greater likelihood of R-REM in this cross-sectional study. Case-finding approaches for EA included resident self-reports, staff interviews, staff case reports, facility case reports, researcher observations, and medical record reviews.

The study has notable strengths. First, it presents a novel analysis of the R-REM point-prevalence estimates of a large sample in randomly selected facilities with an 83% participation rate. Second, it used several case-finding approaches and obtained perspectives from perpetrators, victims, and witnesses of abusive events. Finally, the measurements dealt with multiple layers of information, including time, location, perpetrator characteristics, and clinical factors of R-REM. However, several aspects of the study warrant caution.

Different definitions could influence the prevalence estimates. Lachs and colleagues regarded any case of negative, aggressive, or unwelcome interaction (such as invasion of privacy) between residents that could cause distress in a recipient as potential R-REM. Use of a more stringent definition would yield a different result. This point is illustrated by a study (4) that used 5 criteria to assess the prevalence of EA in elderly Chinese adults in Chicago. The prevalence of psychological abuse varied from 1.1% to 9.8%, and overall EA varied from 13.9% to 25.8% depending on the criteria used to define it (4). Complexities of the definitional criteria for EA have triggered much debate about the true prevalence across settings.

Elder abuse is multifaceted and encompasses psychological, physical, and sexual abuse; neglect; and financial exploitation. It is a form of violence that is inter-

connected not only between individuals but also across relationships, generations, and settings. Further, EA varies greatly in the global context. It would be interesting to explore the issues of financial exploitation, neglect, and other forms of psychological abuse along with verbal abuse (4, 5). In Lachs and colleagues' study, "invasion of privacy" and "inappropriate caregiving" contributed 21.3% of the 407 cases of R-REM and accounted for 4.3% of the overall prevalence. However, whether some of these events, which included going into another person's room unasked and unwanted caregiving from other residents, should be considered abuse may be questioned. Conceptual clarity is needed to consider the breadth and depth of R-REM because some persons might categorize such events of sufficient severity as EA.

Lachs and colleagues were unable to explore cultural variations in the definition, measurement, risk and preventive factors, and consequences of R-REM. Understanding such variation is essential given the increasingly diverse and aging population who might face different individual- and facility-level obstacles to recognizing, reporting, and seeking help for R-REM. Community-based participatory research principles hold promise for approaching EA among elderly people from diverse and marginalized cultures (6).

Despite these cautions, Lachs and colleagues have paved the road for future EA research, which should further leverage ecological approaches to understand the issue at individual (for example, sociodemographic, cognitive, physical, social, and psychological contributors), interpersonal (such as staff-resident, resident-resident, and resident-family relationships), and environmental (for example, characteristics of facility, for-profit status, and policies) levels. Longitudinal studies are needed to examine the incidence, risk and protective factors, and consequences of R-REM in representative populations. Rigorous studies and innovative approaches are needed to evaluate and develop evidence-based, culturally appropriate intervention strategies because none currently exist (7). In addition, we should explore the use of technology, such as computerized data collection and camera monitors, to measure and prevent EA (8). But we cannot wait for the results of such research before implementing interdisciplinary collaborations at the community, state, and federal levels to promote social justice and advocate for enhanced nursing home infrastructure and staff competency to protect residents. At the same time, we must recognize that residents may be both victims and perpetrators of EA and avoid blaming victims or resorting to interventions of convenience, such as the use of chemical sedation and physical restraints. Recent data suggest that 57% of the complaints received by the

Long-Term Care Ombudsman Program since 2000 involve resident evictions from nursing homes, with many of those evicted experiencing neuropsychiatric symptoms associated with dementia (9). It is critical to support the facility, staff, and family to care for these vulnerable individuals and prevent them from being perpetrators and victims of R-REM.

National strategies are needed to engage the collective efforts of federal and state government agencies, health care facilities, and social service and health professional organizations to enhance resources and legislation to better monitor, screen for, and manage EA in nursing homes. Facilities need to establish adequate infrastructure and workforce to protect residents from abuse, and they should further invest in behavioral health counseling and staff and family training (1, 10). States should enact rigorous regulations for case reporting and integrate efforts from local social service agencies, law enforcement officials, and the Long-Term Care Ombudsman Program to protect residents' rights (1, 10). Federal spending on programs for violence against women was 54 times greater than that for EA, and the federal legislation (Elder Justice Act) aimed to address EA has not been implemented because of insufficient funding and resources (1, 10). Globally, EA disproportionately affects people in developing countries with rapidly growing elderly populations and resource constraints. Thus, such organizations as the World Health Organization, United Nations, U.S. Agency for International Development, and other international nongovernmental organizations must also develop coordinated strategies to tackle the global public health issue of EA. This must be done to address the social and cultural determinants of EA in our increasingly diverse population.

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Grant Support: By the National Institute on Aging (grants R01 AG042318, R01 MD006173, R01 NR14846, R01 CA163830, R34MH100443, R34MH100393, P20CA165588, R24MD001650, and RC4 AG039085), Paul B. Beeson Award in Aging, The Starr Foundation, American Federation for Aging Research, John A. Hartford Foundation, and The Atlantic Philanthropies.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M16-1161.

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Ann Intern Med. 2016;165:288-289. doi:10.7326/M16-1161

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