

8

Case studies

Overview

The case studies below illustrate some situations where abuse has occurred, but are certainly not stereotypical. They were drawn from World Health Organization, United Nations, United Kingdom, American and Australian literature and Victorian experience.

8.1 Abuse by a carer

A distinction is drawn here between a carer, and a care worker or volunteer who might be employed or under the auspice of a health service, local government, not-for-profit or private organisation providing services to older people and to carers.

In the context of this discussion, a carer can be a family member, friend or neighbour. A minority of carers may deliberately mistreat the person they care for due to the demands of their caring role.

Possible elements include:

- an older person is substantially dependent on the carer
- the likelihood that mistreatment is not necessarily linked to the amount of care provided
- the demands of caring may be continuous
- the carer may not be coping with the demands of caring
- the carer is often remorseful and shocked by their behaviour
- the carer often has no previous history of maltreatment or abuse
- harm may be intentional or unintentional
- the impact of carer behaviour or treatment can cause physical or psychological harm or neglect.

Four types of situations that could be attributed to ‘carer stress’:

The daughter responsible for the 24-hour care of her father with Alzheimer’s disease who threw a dish at him after his afternoon feeding took two hours.

The wife of a man with a recent leg amputation who screams at him to move faster while helping him to the bathroom (Breckman and Adelman p. 60).

A 79-year-old woman suffering from heart disease, Parkinson’s disease and dementia who was abused by her 60-year-old daughter, who, despite support from a local day hospital, visiting nurse and respite care, became extremely agitated and frustrated by the demands of caring for her mother. The visiting nurse observed slapping and rough handling of the mother with resultant bruising. A guardian was appointed until a residential aged care placement could be made (*No Innocent Bystanders* p. 32).

A 76-year-old man, frail and suffering slight confusion, who was abused by his 70-year-old wife and family. His wife and children wanted him to go to a psychiatric institution because they refused to care for him. His wife continually force-fed and over-sedated him, frequently bruising him badly. She finally force-fed him with tranquillisers and had him admitted to a regional psycho-geriatric hospital as a demented person (*No Innocent Bystanders* p. 32).

Two situations below indicate neglect by a carer which may or may not be intentional or deliberate or due to incompetence:

An 89-year-old woman, frail, demented and with a severe prolapse, was cared for by her 40-year-old son who had a mild intellectual disability. A guardian was appointed and the woman was admitted to an aged care home because of the inappropriate care provided at home and the inability of the son to recognise his own limitations (*No Innocent Bystanders* p. 34).

A 57-year-old woman, very frail and suffering from manic depression, lived with her 60-year-old husband, who was physically and mentally competent but avoided any responsibility for care, leaving her incontinent in bed, alone for many hours and generally refused to acknowledge her increasingly debilitated condition. After intervention, a community nurse arranged daily home help, meals-on-wheels and personal care for bathing and dressing. While the situation improved for the woman, she still required more help with hygiene during the day and night (*No Innocent Bystanders* p. 34).

In such cases, an older person will be substantially dependent on the person responsible for the neglect.

Typical interventions will involve either providing extra support for the carer, or finding alternative carers. Two of the cases described above could equally have fallen within the category of family violence.

8.2 Family violence

In the context of family violence, an older person is not necessarily dependent.

Possible elements include:

- destructive family relationships
- the perpetrator is usually a partner, adult child, or other family member
- a dysfunctional family relationship is often long standing
- family violence may have been a long-term feature of the family's life
- the impact is usually physical or psychological harm.

If the older person and the perpetrator are partners, and the older person is dependent, the difference between this situation and abuse by a carer may be a matter of interpretation. Case (including risk) assessment, will be significant to determine the appropriate type of intervention and its efficacy.

The typical partner abuse situation is likely to be long standing and difficult or impossible to resolve satisfactorily. The 'presenting problem' of abuse will be attributable to this dysfunctional relationship, rather than simply being a response to the stresses of caring.

Mr Washington, age 74, was hospitalised for an infected leg ulcer. Mrs Washington stated (to the doctor) that she frankly didn't want to talk about her husband and that she didn't want him to come home. She went on to say that she had thought about divorcing her husband for most of their married life, and that she had suffered a lot. 'After five years of getting him through two surgeries and nursing him at home and catering to his every wish and whim, I've got to start paying attention to my own health and peace of mind'. To the social worker, Mr Washington screamed, 'Doesn't she know I could lose my leg? Doesn't she care? She slapped me around before but now that I'm better, she's going to find out who's boss' (Breckman and Adelman p. 101).

8.3 Abuse by a dependent adult

In this instance of abuse, an older person is not necessarily frail.

Possible elements include:

- an older person's adult child may have a behavioural disorder associated with mental health issues, alcoholism or acquired brain damage, or an older person's partner may have dementia
- a perpetrator has disability or behavioural issues that explain continuing dependence on an older person
- an older person feels responsible for the perpetrator's welfare
- the impact of abuse may be physical, psychological or financial harm or neglect.

In this instance, the abuser is the elderly person's son or daughter, and has some form of disability, which is the main reason for their continuing dependence.

Mr and Mrs O'Reilly, aged 84, suffered violence and threats at the hands of their son Gerald, aged 50. Gerald had been schizophrenic since his teens. He had lived with his parents most of his life. Mrs O'Reilly described how there had been 'a series of attacks' by Gerald against his father over thirty years: 'In later years he'd break up furniture... He loved breaking up glass. Picks up the nearest thing, you know, throws it.' The parents told of how 'cranky' Gerald was in the mornings, and how they could not go into the kitchen if he was in a bad mood. Over recent years he had begun to be violent towards his mother as well. The family had been known to the regional aged care service for many years. Help with house cleaning was arranged through HACC services. Recent interventions included referral to the local police and the mental health emergency team. The father wanted Gerald removed from the house but the mother would not countenance this. Subsequently Gerald was arrested for assaulting his father and the police, and was prevented from returning to his parents' house by his bail conditions. However, his parents let him return a few months later, as well as paying his fine (Sadler 1993).

The daughter of (an older woman) moved in with her, and has never contributed in any way to her mother's support. 'I support her. She has epilepsy and is on disability. She's supposed to give me \$50 a month but never does. She even stole a \$25 gift certificate I won. We haven't gotten along ever. It's only nice when she's not here' (Pillemer p. 154).

Such cases, in which the perpetrator is dependent on the older person, comprised two-thirds of all physical abuse cases in one American study (Pillemer 1985). The older person may or may not be frail, but is obviously vulnerable because of their close proximity to the perpetrator. One factor which may complicate intervention is the older person's sense of having a continuing responsibility for the welfare of the abuser. Agencies such as psychiatric services may consciously or unconsciously share this assumption that a parent, even if growing older, is responsible for supporting a child with a disability. Appropriate intervention may need to concentrate on finding alternative supports, such as accommodation, for the abuser. Protocols should be clear on the role of specialist agencies and their contribution to the supervision of abusive clients.

8.4 Abuse by a person with dementia

Violence is emerging as a significant clinical challenge in families living with a relative diagnosed with Alzheimer's disease or a related dementia.

Estimates are that 57–67 per cent of dementia patients manifest some form of aggressive behaviour, that is, verbal outbursts, physical threats, and/or violence (Paveza et al. p. 493).

Possible elements include:

- destructive family relationships
- the demands of caring may be continuous
- an older person is substantially dependent on the carer
- the carer may not be coping with the demands of caring
- the carer may not be receiving adequate support to support the caring role
- the carer is often remorseful and shocked by their behaviour
- the carer often has no previous history of abuse
- harm may be intentional or unintentional
- the impact of carer behaviour or treatment can cause physical or psychological harm or neglect.

Typically, one member of an elderly couple has dementia and behaves abusively towards their partner who is their primary carer. For example:

'Well, she'd bang on the door at 2 am and accuse us of things. She accused me of killing her brother and waged war with both her fists. First she slapped me... and then she waded in with her fists.'

The carer (daughter) expressed more concern about the disruption and inconvenience the aggression caused the family, rather than a concern about her own safety (Cahill and Shapiro 1993 p. 12).

Aggressive encounters occur in all types of relationships including same-sex, transgender and male/female relationships. In the latter, where males are usually stronger physically, female caregivers may feel intimidated. A recent study found that, in a sample of 24 spouses and 15 non-spouses of dementia sufferers, 14 female elderly spouses claimed that aggressive incidents really frightened them:

'A couple of times he tried to hit me. Once he did get me. I think once he did get the kitchen knife but I sort of got it from him... Well, when he threatened to kill me that was very frightening because, you know, he wasn't a big man but he's got a terrible lot of strength' (Cahill and Shapiro 1993 p. 13).

The aggressive behaviour may or may not be one-sided for example:

Violence has been conceptualized differently in dementia patients and caregivers, with a focus on aggressive symptoms in dementia patients and abusive and neglectful behaviours in caregivers. Our findings suggest that severe violence expressed towards a family carer is not rare. Given this intensity of patient aggression, it is understandable that some violent caregivers describe a mutually violent relationship with the patient... Although abusive behaviour by the dependent older person cannot justify the response of the caregiver, the development of primary prevention strategies requires a better understanding of both patient and carer behaviours (Paveza et al. p. 493).

8.5 Conflict in a shared household

In this type of situation, an older person may not be particularly dependent on other members of the family, therefore the problem is not one of carer stress. Rather, the issue may be that an older person feels trapped in a household that they are no longer the head of, or have the degree of independence desired.

Possible elements include:

- an older person has been moved into or is sharing the household with an adult relative or child or vice versa—there might also be partners involved with families of their own
- these types of living situations may cause conflict around autonomy or the right to make decisions
- the situation has become intolerable for one or both parties
- an older person or other party requires help to find alternative accommodation
- the basis of the shared arrangement is unclear
- step-family arrangements may contribute to the complexity of the situation
- the impact is psychological or financial harm.

The aim of the intervention in this type of situation will usually be to help an older person re-establish an autonomous household, either by moving out or by persuading the other people to move out. If frailty precludes a move to complete independence, the compromise may be supported accommodation. Financial difficulties may be present.

Beyond the issue of how accommodation is physically shared, older people speak of how changes in social roles have created situations where they end up abused or neglected.

Some claim that formerly, women remained at home and were the primary carers for children and dependent older adults and looked after the household. When that relationship changes and all adults in the family go out to paid jobs there is minimal capacity left for caring, which may result in emotional neglect and often physical neglect of older people. Stress levels in the home are often high, due to the pressures on the middle generation, who come home from their jobs and lack patience in relating to and caring about their older family members. The result can be often verbal and sometimes even physical abuse.

Many older people—even while naming and discussing such behaviour as abusive—excuse their children. They recognise that their children are living under a great deal of stress and instead place the primary blame on government social and economic policies.⁴⁹

8.6 Financial exploitation

Possible elements include:

- destructive family relationships
- greed of family members
- adult children expecting to receive aspects of inheritance on their terms
- reluctance by the older person to contact police when perpetrators are family members
- harm is generally intentional
- the impact is usually psychological harm, though other forms may also be evident for example, neglect.

⁴⁹ Refer to the World Health Organization, 2002, *Missing voices: views of older persons on elder abuse*, WHO/INPEA, Geneva.

The following four cases are drawn from VCAT records:

A 78-year-old woman, suffering diabetes and legally blind, was under pressure from her brother to leave her unit to his son and daughter, rather than sell it to provide an in going fee to a residential aged care service (low-level care). The woman also said that her brother had earlier tried to deprive her of money and goods from their parents' will. The woman was referred to a solicitor who encouraged her to sell the unit.

An 81-year-old woman, frail and schizophrenic, lived alone and allowed no one into the house. She was 'befriended' by a young woman who arranged to do all her shopping and banking, with the result that each fortnight her entire pension was spent but no food was bought. Her daughter made an application to VCAT which resulted in the older woman being admitted to a psychiatric hospital in a very frail and undernourished state. The young woman disappeared after the police had been alerted.

Mrs D, aged 83, had been steadily declining with dementia. While still mentally competent, Mrs D had signed an Enduring Power of Attorney (EPA) (refer to definitions [10.6 Enduring powers of attorney \(financial\)](#) and [10.7 Enduring powers of attorney \(medical treatment\)](#)), appointing her daughter as attorney. The daughter arranged for Mrs D to move in with her. Later she sold Mrs D's home, arranged for Mrs D to move into a cheap supported residential service, bought an interstate property with the \$180,000 proceeds of the house sale, and left Victoria. The matter was brought to VCAT, who revoked the EPA as not being in Mrs D's interests and appointed State Trustees instead. However, the Police Fraud Squad believed the money could only be retrieved by civil action as no crime had occurred; on this view, an EPA gives the attorney unfettered discretion to deal with the estate.

A 76-year-old man with limited mobility, incontinence and dementia, was placed in a supported residential service. There he was visited and constantly pressured by his son into giving him significant amounts of money.

Some of these cases will involve the kinds of fraud or theft that are readily dealt with by the police and the courts, once notified. Other cases, however, are less clear cut, either because there are doubts about the real wishes of an older person who is facing conflicting family pressures, or because there are doubts about the person's competence. In the latter case, the Public Advocate and VCAT may need to become involved and intervene.

8.7 Physical abuse

Types of abuse rarely exist in isolation from one another. This means that if suspicion or evidence exists of some type of abuse, then symptoms and behaviours could indicate physical or psychological abuse as well as neglect.

Possible elements include:

- destructive family relationships
- harm is generally intentional
- the impact is often physical and psychological harm
- for professional staff (no matter where they work) should be alert and act on suspicion, but not assume a particular cause exists
- multisector and multidiscipline case coordination provides a fuller case history and offers the capacity to manage presenting circumstances more effectively
- the perpetrator is usually the partner or adult child
- a history of abuse exists.

Mrs Smith is a resident in a high care aged care facility, is physically dependent and has lost the means of effective communication and unable to advocate for her own needs.

Her daughter spends significant time at the facility and insists on independently providing as much care for her mother as possible. This includes washing, changing of incontinent aids, dressing, assistance with meals and drinks and pressure area care.

The daughter confidently states she is able to provide the care for her mother when she is visiting the facility without staff assistance. She constantly expresses to staff how much she loves her mother and how important it is for her to be with her mother as much as possible.

Staff at the facility allowed the daughter to attend to these needs in the belief that they are supporting the caring relationship. The daughter often talks about how she previously cared for her mother when her mother was at home.

At different times staff of the facility have noticed some bruising and mild abrasions on Mrs Smith and have put this down to her general frailty and thinning skin that bruises easily.

One afternoon a newly employed staff member checks on Mrs Smith to see if the daughter needs any assistance with her mothers care. The staff member forgets to knock on the door before he enters and finds the daughter in the throes of slapping her mother.

The daughter is very defensive on being approached and angry at the intrusion of the staff member into her mother's room.

The situation escalated and it became clear that staff had spoken to the daughter previously about being careful when tending to her mother, noting that at times she was very abrupt or not as careful as she could be, when providing care to her mother.

Staff also did not feel they had the right to intervene or interfere too much in the care that the daughter was providing when in the facility.

At a later date it transpired that Mrs Smith had been removed from the care of her daughter at home some years earlier, following substantiated complaints by neighbours to the police that Mrs Smith was being physically abused by her daughter.

8.8 Sexual abuse

Possible elements include:

- harm is generally intentional
- destructive family relationships may already exist
- the capacity of all service providers to recognise and manage aspects of trauma in an older person is important
- service providers need to understand the complexity of sexual abuse and its impact on an older person
- respect for individuals' values and rights is important
- older people and their ongoing relationship with family members need to be recognised

The following two examples highlight a range of considerations for discussion:

Ms S, a 62-year-old woman, was forced to perform oral sex by a stranger, something she had never done before. She told the police she had been raped and was taken to the hospital for a sexual assault forensic exam.

Ms S was so ashamed about performing oral sex that she told no one the assault had been oral. As can be expected, the vaginal exam showed no signs of assault, and the police became suspicious of Ms S's claim.

Eventually the woman's sexual assault case was dropped. Only in counselling months later, after questioning about how the assault happened, did the woman break down and disclose that she had been orally assaulted.

Dorothy is a 68-year-old widow. Her son, Tony is separated from his wife and his adult son, James, moved into Dorothy's house. Although space is limited, Dorothy was happy with the arrangement because it meant she now had company.

About a month later, Dorothy came home one day to find Tony watching pornographic videos. She told him clearly she did not approve of this and would not allow it in her house. Tony made light of the situation and continued watching the videos several times each week. James also started watching the videos with his father.

Dorothy took to locking herself in her room when these movies were on, as she found the situation distressing.

During a visit to her practitioner, the doctor noticed that Dorothy looked upset and displayed symptoms of depression. Dorothy disclosed to the doctor what had been happening and said she did not know what to do.

The doctor assisted Dorothy in thinking through her options regarding this case of sexual harassment, including seeking assistance from other family members, friends and the police. The doctor would support Dorothy whatever her decisions were.

8.9 CALD background

Service providers should provide client-centred care in all cases of service response. When elder abuse is a concern, it is even more important to implement this approach. When the older person has a culturally and linguistically diverse background additional understanding and awareness must be taken into account pertinent to the culture and life course of the older person.

Possible elements include:

- destructive family relationships may already exist
- older people and their ongoing relationship with family members need to be recognised
- respect for individuals' values and rights is important
- multisector and multidiscipline communication and consideration
- staff need to recognise and act on suspicion of criminal activity
- staff need to understand discreet cultural norms and expectations
- established agency elder abuse policy and procedures are important
- the establishment of local interagency elder abuse protocols may assist.

The following example highlights a range of considerations for discussion:

Older woman with a Polish background (Mrs P) living at home with her only child, now adult son.

Mrs P receives a range of services, such as brokerage via EACH from a mainstream service; HACC social support (Planned Activity Group (PAG) and one-on-one from an ethno-specific service), the family local GP; specialist medical services, alternative medical services, pharmacies and hospital emergency departments were involved.

Mrs P verbally indicated (speaking in Polish) to the PAG coordinator that her son was hitting her. Mrs P stated he was nervous. The PAG coordinator was also employed by an ethno-specific service.

The PAG coordinator consulted with senior management at the ethno-specific service about the best way to proceed. A senior manager with previous experience in a related sector recommended the development of a monitoring strategy for Mrs P to address suspicions, as well as ensuring any workers employed by their agency were safe.

Mrs P made excuses for her son's behaviour: 'He is my son, he is always nervous.'

This was brought to the attention of the manager in the ethno-specific service and strategies were put in place to ensure the safety of staff in the client's home while the PAG was closed for a number of weeks over the Christmas period.

Mrs P came to the PAG just before Christmas with a red mark on her face.

The case manager from the other community aged care service, then informed Mrs P's son that the ethno-specific service was concerned about abuse towards Mrs P by him.

The son contacted the ethno-specific service aggressively wanting to make a complaint about staff refusing to come into the home. The manager maintained the policy of the service regarding the balance between duty of care of staff and privacy of Mrs P. The son accused the manager of making allegations that he was molesting his mother, which the manager had not referred to at all.

Through brokerage services, a one-on-one social support worker (who could speak Polish) was allocated to work with Mrs P while the PAG was closed. The support worker attended doctors appointments with the son and Mrs P; visited the house with other workers as well as accompanied Mrs P on walks in her local neighbourhood.

The support worker was deliberately not told of suspected abuse of Mrs P prior to the first visit to Mrs P's home. The manager did not want to pre-empt or influence an outcome, leaving the situation open to see what the direct care worker would ascertain from her own experience. The manager ensured before the visit that the worker was not at risk and was safe.

The manager met with the worker the next day and asked for information on how the first visit went. The direct care worker said she thought Mrs P was being abused by her son as Mrs P had told her (in Polish) that she was being hit.

The worker was then informed of what was known of the alleged abusive situation. The manager ensured that an aspect of the monitoring approach was that the worker would never be isolated in the house with the son and Mrs P. The worker agreed to this.

The manager discovered that other service providers had decided to withdraw services from the home as staff did not feel safe and the son was aggressive. This information nor the reason for the decision to withdraw services had been shared with other providers. Threats against other service providers by the son also continued to come to light throughout the process.

The PAG manager contacted the other community care service providers to discuss management of the situation.

As this was occurring over the Christmas period, a case management meeting was not possible until two weeks after Christmas. Who was to attend needed to be well thought through. In some circumstances it would be appropriate for the primary carer to attend if it is clear that discussion around service support, respite opportunities and the general situation concerning alleged abuse would warrant this approach.

In this instance the case management meeting occurred without the son present, enabling providers to discuss the situation in general and management strategies like what role each organisation would take, who would coordinate matters between all services involved and tease out the perpetrator's motives. The police had not been involved.

The manager of the ethno-specific service checked back on client case notes to get a better idea of past service provision and found that the son had taken Mrs P out of a nursing home.

A joint application by two agencies was made to VCAT and OPA for the appointment of an independent guardian.

Apart from suspicion of physical abuse the following day-to-day situation was occurring:

- the son was taking his mother (Mrs P) around to GPs for prescriptions to meet her health needs, but the son would not let Mrs P take her medications as prescribed
- the son forced Mrs P to wear and walk in ill-fitting shoes that did not assist with her swollen legs and feet which were part of her health condition
- the son would not let Mrs P sleep at home during the day when she was tired, he kept her awake
- the son kept Mrs P away from workers who could speak Polish
- Mrs P's health in general was deteriorating and she was often in hospital emergency departments, and would then go home.

The family GP was treating Mrs P. The son always attended GP appointments with Mrs P. The situation was not seen as empathetic to the needs of Mrs P.

Mrs P's health deteriorated to the point where she was admitted to hospital. Mrs P died in hospital.

The process to appoint an independent guardian came through after Mrs P's death.

Lessons learned

- Planned, well-considered action within an agency and between agencies is essential.
- All providers involved with the older person should be involved in planned case management or care coordination meetings tasks, such as understanding roles, perpetrator management, gathering information and arriving at a similar understanding of what the allegations of suspicions are.
- Draw in additional relevant expertise as soon as possible, including cultural consultation where appropriate, to help understand cultural context of statements, behaviours, values and family expectations.
- Agencies should be clear about a practice response, as to where privacy ends and duty of care for all parties involved commences.
- An improved understanding of elder abuse, family/carer dynamics and appropriate responses required.

8.10 VCAT cases

VCAT frequently deals with financial affairs, protecting people, particularly older people, from financial exploitation. Refer to [7.1.2 The Victorian Civil and Administrative Tribunal—Guardianship List \(VCAT\)](#) for further information.

Possible elements include:

- possible pre-existing unhealthy family relationships
- older people and their ongoing relationship with family members
- legal representation for the older person
- communication between multiple jurisdictions and agencies
- advocates to pursue and act on behalf of older people when required.

Many of the hearings occur because the (non-disabled) applicant wants legal authority to do something which the applicant already believes is in the person with a disability's best interests, for example:

(Typically) the applicant needs legal authorisation to move money or sell property. Unless the bank or estate agent is convinced that the person signing the form has the legal authority to do so, the transaction may not proceed. One typical case involved Mr Nicholson, an 86-year-old man living in an aged care home. His son applied to be appointed to become administrator to authorise him to pay his father's bills, and to sell his father's house if necessary. The board duly appointed him administrator (Carney and Tait p. 57).

In other cases there may be a dispute between family members about the most appropriate way to handle an older person's financial affairs. Such disputes may or may not involve allegations that someone has acted or is likely to act dishonestly, for example:

One case involved an 81-year-old woman, Mrs M, living in a residential aged care home (high care). Her grandson had visited her husband who was living in the low-care section of the aged care home, and taken away some key documents such as a will, signed cheques made in the grandson's name, and taken a TV set. The grandson also lived rent-free in the grandparents' holiday house. Mrs M's daughter was appointed administrator and the grandson stopped the questionable practices.