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## Elder Abuse and Neglect

### The Problem of Elder Abuse

Elder abuse in domestic settings – i.e., in a person's own home, apartment, or other non-institutional living arrangement – is a serious problem, affecting hundreds of thousands of elderly people across the country. The problem is largely hidden under the shroud of family secrecy. The signs of elder abuse are subtle and often not recognized, leading to gross under-reporting of the problem.

The 2004 Survey of Adult Protective Services (APS), the most rigorous national study of state-level data, indicates that there are 8.3 reports of abuse for every 1000 older Americans. The study found that, overall, in 2003, APS agencies received 565,747 reports of suspected elder abuse and compared with 482,913 reports four years ago in 2000. In the overwhelming majority of cases (89.3%), the alleged abuse was reported to have occurred in a domestic setting.

In the first National Elder Abuse Incidence Study in 1996, it was estimated that only 21% of cases of abuse and neglect were reported to adult protective service agencies, with the remaining 79% not reported. These figures indicated that almost 4 times as many incidents of elder abuse, neglect, or self-neglect were unreported as those that were actually reported. (National Center on Elder Abuse. September 1998. *National Elder Abuse Incidence Study: Final Report*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families and Administration on Aging.)

In 2000, neglect of the elderly was the most frequent type of elder maltreatment (48.7%); emotional/psychological abuse was the second (35.5%); physical abuse was the third (25.6%); financial/material exploitation was the fourth (30.2%); and abandonment was the least common (3.6%).

Adult children comprised the largest category of perpetrators (47.3%) of substantiated incidents of elder abuse; spouses were second at 19.3%; other relatives were third at 8.8%; and grandchildren followed last with 8.6%.

Three out of four elder abuse and neglect victims suffer from physical frailty. About one-half (47.9%) of substantiated incidents of abuse and neglect involved elderly persons who were not physically able to care for themselves, while 28.7% of victims could care for themselves marginally.

Some experts estimate that only one out of fourteen domestic elder abuse incidents (excluding self-neglect) comes to the attention of authorities. Based on these estimates, somewhere between 820,000 and 1,860,000 elders were victims of abuse in 1996, indicating that the majority of cases went unreported to state protective agencies. (Tatara, R. November 1997. "Reporting Requirements and Characteristics of Victims." *Domestic Elder Abuse Information Series #3*, Washington, DC: National Center on Elder Abuse)

From 1986 to 1996, there was a steady increase in the reporting of domestic elder abuse nationwide, from 117,000 reported cases in 1986 to 293,000 reported cases in 1996 - a 150.4% increase. According to the National Center on Elder Abuse, most victims of domestic elder abuse were caucasian, 18.7% were black, 10.4% were Hispanic, and 1% each were Native Americans and Asian Americans/Pacific Islanders for the reporting year 2003.

In 1996, 22.5% of all domestic elder abuse reports came from physicians and other health care professionals; 15.1% from other care service providers; 16.3% from family members and relatives; and the remainder from other reporting sources: police, friends, neighbors, clergy, banks/business institutions, etc.

**Sex of Victims:** The majority of elder abuse victims are female. However, over the last six years, the gender gap has narrowed. In 1990, 68.3 percent of all reports involved female victims. In 1996, the incidence was 67.3.

**Sex of Perpetrators:** In 1990, the majority of perpetrators were male – 54.7 percent male, and 42.1 percent female. By 1996, the ratio of male to female perpetrators had changed to a degree where there was no significant difference between the two sexes. In the 2000 data, slightly more than half (52.7%) of the perpetrators were female.

**Relationship of perpetrator to victim:** Adult children are the most frequent abusers of the elderly – 36.7 percent in 1996. Other family members and spouses ranked as the next most likely abusers of the elderly. Other family members comprised 10.8 percent in 1996, while spouses comprised 12.6 percent.

Particularly in the case of adult children, abusers often are dependent on their victims for financial assistance, housing, and other forms of support. Oftentimes they need this support because of personal problems, such as mental illness, alcohol or drug abuse, or other dysfunctional personality characteristics. The risk of elder abuse seems to be particularly high when these adult children live with the elder.

Of the spouses who abuse, a substantial proportion of these cases are domestic violence grown old: partnerships in which one member of a couple has traditionally tried to exert power and control over the other through emotional abuse, physical violence and threats, isolation, and other tactics.

**Substantiation of reports:** The majority of elder abuse reports are substantiated after investigations. In 1996, 64.2 percent of all reports made were substantiated: 31.7 percent were self-neglect cases, 25.4 percent were cases of abuse by others, 7.1 percent were unknown.

It is widely believed that elder abuse is greatly under-reported, and that the above figures represent a fraction of the actual abuse occurring in this country.

## **Definitions**

Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 *Amendments to the Older Americans Act*. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes. Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly. Broadly defined, however, there are three basic categories of elder abuse:

- (1) domestic elder abuse;
- (2) institutional elder abuse;
- (3) self-neglect or self-abuse.

In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity. Domestic and institutional elder abuse may be further categorized as follows:

**Physical abuse** is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. It may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, it may also include the inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.

**Sexual abuse** is defined as non-consensual sexual contact of any kind with an elderly or disabled person or with any person incapable of giving consent. It includes but is not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

**Emotional or psychological abuse** is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

**Neglect** is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

**Exploitation** is defined as misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

### **Possible Indications of Neglect and Abuse**

The following descriptions are not necessarily proof of abuse, neglect, or exploitation. But they may be clues that a problem exists, and that a report needs to be made to law enforcement or Adult Protective Services.

#### **Physical Signs**

- Injury that has not been cared for properly
- Injury that is inconsistent with explanation for its cause
- Pain from touching
- Cuts, puncture wounds, burns, bruises, welts
- Dehydration or malnutrition without illness-related cause
- Poor coloration
- Sunken eyes or cheeks
- Inappropriate administration of medication
- Soiled clothing or bed
- Frequent use of hospital or health care/doctor-shopping
- Lack of necessities such as food, water, or utilities
- Lack of personal effects, pleasant living environment, personal items
- Forced isolation

#### **Behavioral Signs**

- Fear
- Anxiety, agitation
- Anger
- Isolation, withdrawal
- Depression
- Non-responsiveness, resignation, ambivalence
- Contradictory statements, implausible stories
- Hesitation to talk openly
- Confusion or disorientation

#### **Signs by Caregiver**

- Prevents elder from speaking to or seeing visitors
- Anger, indifference, aggressive behavior toward elder
- History of substance abuse, mental illness, criminal behavior, or family violence
- Lack of affection toward elder
- Flirtation or coyness as possible indicator of inappropriate sexual relationships
- Conflicting accounts of incidents
- Withholds affection
- Talks of elder as a burden

#### **Signs of Financial Abuse**

- Frequent expensive gifts from elder to caregiver
- Elder's personal belongings, papers, credit cards missing
- Numerous unpaid bills
- A recent will when elder seems incapable of writing will
- Caregiver's name added to bank account
- Elder unaware of monthly income
- Elder signs on loan
- Frequent checks made out to "cash"
- Unusual activity in bank account
- Irregularities on tax return
- Elder unaware of reason for appointment with banker or attorney
- Caregiver's refusal to spend money on elder
- Signatures on checks or legal documents that do not resemble elder's signature

**Self-neglect is the most common form of elder abuse, accounting for nearly half of all cases.**

**Physical abuse, neglect, and abandonment are next most common.**

**Most elder abuse occurs in the home; most at risk are those with dementia.**

**Two types of abuse are special to the elderly population: financial abuse and nursing home abuse.**

**The large majority of elder abuse cases are not reported or investigated.**

### **Self-Neglect**

Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

Signs and symptoms of self-neglect include but are not limited to:

- dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene;
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no indoor plumbing, no heat, no running water);
- unsanitary or unclean living quarters (e.g., animal/insect infestation, no functioning toilet, fecal/urine smell);
- inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g., eyeglasses, hearing aids, dentures); and
- grossly inadequate housing or homelessness.

### **Ten Concepts on Aging**

The best time to learn how to grow old with dignity and grace is during the younger years, and the best place is everyday life. Understanding all aspects of the aging process enables us to understand more clearly those who are aged. The following general statements offer a foundation for studying the aging process.

- ***Aging is Universal.*** It is common to every population and is not just a modern-day phenomenon in western civilization.
- ***Aging is Normal.*** 'Growing up' is spoken of with respect; 'growing old' with fear. This fear develops from the stereotyped picture of aging as a loss of faculties, beauty, energy, and memory.
- ***Aging is Variable.*** Each individual ages in a unique way. The state of later life develops from former personal life patterns.
- ***Dying is Normal and Inevitable.*** It is difficult for many to accept the idea that while a full, satisfying life is being lived, death can be anticipated as a meaningful closure of life.
- ***Aging and Illness are Not Necessarily Coincidental.*** The stereotype image again lingers, but individuals should prepare for healthy old age through improved living habits in early and middle years.
- ***Older People Really Represent Three Generations.*** The group known as the "aged" covers the years 65-112, representing two, and often three, generations and may include parents, grandparents, and great-grandparents. No other age group includes such diversity.
- ***Older People Can and Do Learn.*** Capacity to learn new things and re-learn the old is not necessarily diminished by old age. Learning patterns may change from youth and the speed of learning may slow, but learning ability appears to be culturally determined, not restricted by years.
- ***Older People Can and Do Change.*** As one grows older, many adjustments become necessary. Mates die, housing situations change, new activities are developed, and new friendships established.
- ***Older People Want to Remain Self-directed.*** Where dependency on others for decision making exists among older people, it has often been learned as a direct result of loss of a sense of purpose and self respect. To prevent this loss when older adults undergo life changes, their self-direction and sense of

control should be maintained as much as possible, even if they become dependent in some ways.

• **Older People are Vital Human Beings.** Although physical disability is often associated with mental inadequacy, it should be recognized that the need for physical help in crossing the street does not mean that the person does not know where he is going.

*Adopted from the Texas Department on Aging, Ombudsman Certification Manual.*

## **Issues Facing Vulnerable Adults**

### **Isolation**

Isolation and self-neglect are common among people who are elderly or have disabilities. Isolation is defined as not participating in activities that require contact with people. Although this problem applies to people regardless of their education, income, ethnicity, geographic location, or social lifestyle, people who are most at risk of isolation are frail or chronically ill, widowed or divorced and live alone. They are also more likely to be female, may also have reduced resources, and may be members of a marginalized minority group. Isolation may lead to loss in personal integrity, estrangement from family and friends, inability to care for one's self and deterioration of the ability to think and make decisions.

Isolation can result in self-neglect, which is a form of elder abuse when living conditions are potentially life threatening. Isolation may lead people to be self-neglecting to the point that they deny any physical or mental problems and refuse help from family and friends. Isolated people usually have less support and interaction from others (often due to the deaths of a spouse, friends or primary caregiver); reduced coping skills; are less able to make decisions; are at greater risk of depression, substance abuse, mental impairment, or mental illness; have lost self-esteem; and may be unable or refuse to accept changes or acknowledge a need for help.

Isolation and self-neglect require individual or community intervention. Communication and attention other persons provide can improve the self-esteem and lifestyle of an isolated elder. They can act as confidantes, assist with errands or housekeeping, or meet transportation needs. People who are isolated can benefit from support groups for people living alone. Support groups are effective because they provide the opportunity for sharing experiences, mutual support, and problem solving. Intergenerational programs can help reduce isolation for older people. These might include community initiatives in which older people are recruited and trained to assist in child care centers and schools. Many other volunteer opportunities in hospitals, nursing homes, food pantries, battered women's shelters and other not-for-profit organizations exist which can both reduce isolation and restore a sense of purpose to an older person's life.

### **Depression**

Depression affects about 15 out of every 100 adults older than age 65. Once diagnosed, it is very treatable.

**How to Recognize Depression:** Recognizing depression in the elderly and people with disabilities is not always easy. Vulnerable adults with depression may not know how to explain how they feel. They also may fear that they will be labeled as "crazy" or as having character weakness. Vulnerable adults and their families may dismiss depression as a passing mood.

**Common Symptoms:** Symptoms may include persistent sadness, feeling slowed down, excessive worries about finances or health, frequent tearfulness, weight changes, pacing and fidgeting, difficulty sleeping, difficulty concentrating, and physical symptoms such as pain or gastrointestinal problems.

**Causes:** Since depression is commonly due to biological changes in the brain, it is likely to occur for no apparent reason. Biological changes to the brain and body, medical illnesses, or genetics may put groups like elderly people at greater risk of depression. A specific event like retirement or the loss of a partner or loved one may lead to depression--it is normal to grieve over such events, but if the grief persists, it may be a sign of depression. Illnesses such as cancer, Parkinson's disease, heart disease, stroke, or Alzheimer's disease may cause late-life depression. These diseases may also hide symptoms of depression.

**Suicide and Depression:** Suicide is more common in older people than in any other age group. The population over age 65 accounts for 25 percent of the nation's suicides. Suicidal attempts or serious thoughts about suicide should be taken seriously and evaluated by trained mental health staff.

**Treatment:** Most people can improve dramatically with treatment, which may include psychotherapy, antidepressant medications, and other procedures. Psychotherapy can play an important role with or without medications. There are many forms of short-term therapy (10 to 20 weeks) that have proven to be effective. Antidepressants help restore the balance and supply of neurotransmitters in the brain. Mixing doses, taking the wrong amount, or suddenly stopping antidepressants may result in negative effects.

**Assessing a Person with Depression:** The first step is to make sure the person gets a complete physical checkup because depression may be a side effect of another medical condition. If the person is confused or withdrawn, accompany the person to the doctor, or where possible, arrange for an in-home assessment. The doctor may refer the person to a psychiatrist. If the person is reluctant to see a psychiatrist, try to assure the person that an evaluation is necessary to determine what treatment is needed. Other approaches would be to reduce the person's isolation by helping them to get involved with church activities, the local senior center or other community forums.

### **Self-neglect**

Self-neglect occurs when individuals fail to provide themselves with whatever is necessary to prevent physical or emotional harm or pain. The reasons that vulnerable adults neglect their own needs are often complicated, and frequently people are unaware of the severity of their situation.

**What are the signs?** Some common signs that may indicate self-neglect include obvious malnutrition; being physically unclean and unkempt; excessive fatigue and listlessness; dirty, ragged clothing; unmet medical or dental needs; refusing to take medications or disregarding medical restrictions; home in a state of filth or dangerous disrepair; unpaid utility bills; lack of food or medications.

**What are the causes?** Depression can cloud a person's view of the world and their circumstances, leading to self-neglecting behavior. Often, elderly people lose their motivation to live due to their loneliness and isolation. Other reasons that elders neglect themselves can include unexpressed rage, frustration, or grief; alcoholism or drug addiction; and sacrificing for children, grandchildren, or others at the expense of their own unmet needs. Finally, mental or physical illness can quickly result in the deterioration of an elder's ability to adequately provide for their own needs.

**What can be done to help?** As much as possible, respectfully involve the elder in the effort to determine the cause of their particular case of self-neglect. Sometimes understanding and cooperation can be reached simply by having someone acknowledge and discuss their situation with them. If appropriate, ask the question, "What would make life meaningful for you again?" Allow them to express their feelings; this could reveal both the cause of the problem as well as its solution.

Depending upon the circumstances, other helpful actions could include: medical or dental treatment; anti-depressant medications; helping them get involved in a favorite old hobby or providing transportation to a social group; getting them a pet; confronting them with their self-neglect; getting family members involved. When drug or alcohol addiction is the issue, hospital-based treatment is frequently the best solution.

Sometimes the cause of elders neglecting themselves is directly related to the influence of someone else in their life. Perhaps the elderly individuals are sacrificing their needs in order to care for grandchildren or an ill spouse. Intervening in such situations often requires extreme caution, as the elder may be resistant to any change which threatens the relationship.

### **Medication/Substance Abuse**

Using medications wisely and substance abuse are concerns that apply to all age groups. But due to several factors, the elderly and people with disabilities are at a greater risk for having trouble with both areas.

**Using Medications Wisely:** Medicines help people live longer and more productively every day. But because they are powerful substances, the consequences of using them can be dangerous, even deadly. Drugs can affect different people in different ways. The elderly are at risk of misusing medications because they generally take more of them than other age categories and because reactions to medications change as the body ages. People who are elderly or have disabilities need to take responsibility for finding out about the drugs they are using. They should give doctors, pharmacists, and health professionals clear information about their current medications. They should also consult with those same people to learn more about new medications prescribed for them.

**Substance Abuse:** Coping with a disability or aging isn't easy. Therefore, some people who are elderly or have disabilities may turn to drugs and alcohol. Others may have struggled with substance abuse for decades.

Vulnerable adults must be aware that even small amounts of drugs or alcohol can seriously hurt them. Alcohol can produce a dangerous reaction with acetaminophen, antibiotics, antidepressants, muscle relaxants, or sleeping medication. Alcohol, marijuana, and other drugs affect memory, ability to solve problems, and reaction time. Prolonged use of alcohol, tobacco, and other substances may have serious long-term health effects. For more information about the risks of substance abuse, consult with rehabilitation specialists or health professionals or contact organizations such as Alcoholics Anonymous or Narcotics Anonymous. If people who suffer from chronic pain fear they are abusing pain medication, they should consult with their doctor to learn

about other pain-reduction methods such as special exercises and biofeedback.

### **Bladder Incontinence**

**What is it?** The loss of the ability to control urination can range from minor leaking to the loss of large amounts of urine. It is a symptom, not a disease, and is not uncommon. In many cases the problem can be cured, or at least made more manageable. People with bladder incontinence should see their doctor, especially since it can be caused by another medical problem that needs treatment. Incontinence doesn't need to interfere with a person's quality of life.

**What causes it?** Some temporary causes of bladder incontinence include urinary tract infections, vaginal infection or irritation, constipation, or side effects of medication. Other causes are not temporary but can still be treated, such as weak pelvic floor muscles due to pregnancy and childbirth, hormonal imbalance, weak bladder, weak urethral sphincter muscles, overactive bladder muscles, blocked urethra, nerve disorders, and immobility.

**Warning signs:** Urine leakage that prevents activities or causes embarrassment; leakage that began after a surgery, such as a hysterectomy or prostate surgery; inability to urinate or urinating more frequently than usual; needing to rush to the bathroom and losing urine if the person doesn't arrive in time; pain when urinating or when the bladder is filling.

**What can be done?** Treatment depends on what is causing the problem. Medications can include antibiotics for infections, hormone replacement therapy, and drugs for bladder or sphincter control. Other successful treatments include biofeedback, pelvic muscle exercises, bladder training, and dietary changes. In some cases surgery will be recommended by the doctor.

### **Bowel Incontinence**

**What is it?** Incontinence is the loss of normal control of gas or stool. Its severity ranges from mild difficulty with gas control to severe loss of control over liquid and formed stools. This problem affects as many as 1 million Americans, and many effective treatments for bowel incontinence are available.

**What causes it?** Chronic constipation is one of the most common causes, since it weakens the muscles surrounding the intestine and bowel. Other causes are diarrhea; stress, nerve or muscle damage; emotional disturbance; improper diet; chronic laxative use; gynecological, prostate, or rectal surgery; hemorrhoids or rectal prolapse, and a decreased awareness of the sensation of bowel fullness.

**Warning signs:** Any difficulty in controlling gas or bowel movements that causes embarrassment or concern is adequate reason to consult a doctor. Any signs of bleeding should immediately be reported to the doctor.

**What can be done?** Sometimes simply changing a person's medication can cure the problem of bowel incontinence. Other treatments include dietary changes, simple muscle strengthening exercises, constipating medications, and biofeedback. In some cases, surgery may be required.

### **Dementia and Alzheimer's Disease**

#### **What is Dementia?**

Dementia is a medical condition that affects the way the brain works. Sometimes incorrectly referred to as "senility," it involves a gradual deterioration of cognition (thinking/information processing/decision making abilities, as well as memory). It also affects behavior to a point that interferes with customary daily living activities. Dementia can affect all aspects of mind and behavior, including memory, judgment, language, concentration, visual perception, temperament, and social interactions. Contrary to popular belief, dementia is not a normal outcome of aging, but is caused by diseases that affect the brain. One of these diseases is Alzheimer's disease.

#### **What is Alzheimer's Disease?**

Alzheimer's disease is a devastating condition that eventually erodes all cognitive and functional abilities, leading to total dependence on caregivers and eventually to death. It affects about four million Americans and prevalence of the disease increases dramatically with age. About five percent of all cases have been associated with a genetic tendency. The majority of cases affect the population on a random basis. Scientists are still researching possible risk factors that cause the disease, as well as treatment.

## Communicating With People Who Have Dementia

It is important to be conscious of verbal and nonverbal actions when communicating with people who have dementia. Skillful communication skills can be taught to caregivers and family. This can enhance family interaction, and management of the person's environment as well as the lives of people who have dementia.

- Try to be aware of everything a client may be doing. If he doesn't appear to be listening or receptive, leave the patient alone. Tell him that you understand he doesn't want to talk.
- Be sensitive to a client's nonverbal communication. Be aware of your nonverbal messages. Adopt positive, pleasant nonverbal behaviors to be reassuring and encouraging.
- Try to avoid situations that are known triggers to resistant behavior. Change how activities are introduced
- Give patient as much control as possible.
- Explain what you are doing (again and again if necessary). If resistant behavior continues or worsens, stop.
- Make the client feel like you are there for him. Look directly at him and show you are giving him your undivided attention.
- If the client is able to converse, avoid ambiguous questions and ask "yes" or "no" questions whenever possible.
- Speak slowly with a calm, reassuring tone of voice. Use single words and simple sentences.
- Avoid distracting background noises.
- Give the client ample time to respond. Repeat question or instructions if there is no response within a couple of minutes.
- Be consistent. Use the same word for the same thing.
- Provide affectionate encouragement. Use diversion and humor to overcome resistance.
- Match your verbal communication to the client's ability.
- If a client is talking to you but not making sense, search for important clue words and repeat them back to show that you are connected with him.
- Break down tasks into individual steps to be done one at a time.
- Don't pretend to understand confused speech.
- Don't force the client to do anything.
- Don't attempt to force the person to be oriented to present-day reality.
- If the person is 'time-traveling' (appears to be re-living the past) demonstrate empathy with what the person is feeling about the past. Help the person review his or her life if he or she is able to reminisce.

## Coping With Schizophrenia

Many adults come to the attention of protective services because of problems associated with schizophrenia. Not infrequently, the problems are associated with the client's noncompliance with medications or other treatments for their condition.

### Preventing Noncompliance Through Communication

- Noncompliance is a major reason that medications are not more effective in keeping people with schizophrenia out of the hospital. Persistent noncompliance may worsen the overall course of the schizophrenic illness. However, don't blame or scold the mentally ill person for stopping medication. Expect some amount of noncompliance, and try to understand what the reasons are, even if they are not rational. Find a perspective on medication that both you and the person with the illness can agree on. Persuade: Don't coerce.
- Have the person who is most influential with the mentally ill person do the talking. Focus on the possible day-to-day benefits of the drug.
- Try to match the notion of taking medication with achieving one's life goals. Find out what they want to accomplish and explain how medicines might help them get there.
- Try to have uniform agreement within the greater family about the need for medication. Otherwise, the person may play family members against each other. Do not get into a direct confrontation about medicine. Confrontation is counterproductive.
- Families and other concerned persons should understand and be genuinely sympathetic about the side effects caused by neuroleptic medications. Be sure the person with schizophrenia is informed in advance about the side effects of medications. A side effect will often be accepted if the patient has been warned about it in advance. Feeling like a zombie and feeling restless or jittery are commonly reported side effects associated with noncompliance. Concerned families should advocate to the doctor assertively on behalf of their relatives for aggressive side effect treatment.

### Preventing Other Noncompliance

- **Believe in compliance** - About one-third of people with schizophrenia say that they stay on medicine primarily because other people think it's important.

- **Prevent relapse** - Preventing relapse includes finding the most effective drug, the best dose for the person, and aggressively treating the early signs of relapse.
- **Simplify the drug regimen** - Complex drug regimens can cause noncompliance. The pharmacist can be a major ally when reviewing and simplifying drug regimens.
- **Make transitions seamless** - Minimizing the likelihood of noncompliance starts during inpatient treatment. Arrange for outpatient benefits (e.g., Medicaid), an appropriate living situation, and psychiatric aftercare.
- **Provide concrete directions** and review them with the patient.
- **Foster the therapeutic alliance** - Many aspects of the clinical relationship provide consumers with incentives to maintain compliance. Find a doctor or treatment system that works well with families, especially regarding cross-communication and side-effect management. Use hospitalization as a last resort to stabilize the person's acute symptoms and establish a plan for better compliance.
- **Recommend depot drug delivery** - Converting from an oral to an injectable form of medication during hospitalization may improve compliance.
- **Organize the family** - Get as many family members as possible to go to educational sessions or meetings so that everyone can present a consistent and coherent message about compliance.
- **Try to avoid direct power struggles**
- **Resort to involuntary commitment when necessary** - After involuntary commitment, about two-thirds of the patients say that they understand why they had to be committed.

*Adapted from an article by Dr. Peter Weiden.*

## Fraud and Exploitation

**Fraud by Friends and Family:** New "best friends"; thieving "caregivers"; religious con-artists; financial abuse by family members. This is exploitation and should be reported to Adult Protective Service.

*Report instances of fraud as described below to the appropriate Attorney General's office in your State or contact your APS office for the appropriate referral.*

**Home Equity Fraud:** Homeowners may be tricked into signing over the deeds to their homes. Often this scam is done by a person pretending to be a repairman or someone offering another service. The elderly person signs a contract believing it to be for roof repair, for example, and does not read it carefully enough to realize that it is a deed to their own home.

**Telemarketing Fraud:** Some examples of telemarketing schemes which target elders are the "You Are A Winner!" pitch, which misleads victims with a non-existent prize in order to get them to buy something; offers to "get your stolen money back for you"; great loans or "fixing" bad credit; fantastic low prices on merchandise; any caller requesting a client's bank account or credit card number.

**Mail Fraud:** If it sounds too good to be true, it probably is. Encourage the elderly person to watch out for fake contests, prizes, lotteries, chain-letters, insurance deals, land and advance-fee selling swindles, franchise and charity schemes, work-at-home and fraudulent diploma schemes, and promotions for fake health cures, beauty devices, and diets.

**Health Fraud:** Some health fraud scams to watch for are advertisements for fake "cures"; fraudulent medical and health services marketed via the television or telephone (victims send in their money and never receive the ordered item or receive a copy rather than an authentic product); "free" hearing tests and hearing aids; health care fraud where phony or real physicians take advantage of patients as a means of getting money from the victim's insurance company; and bogus insurance companies.

## Why Does Elder Abuse Happen?

### **Family Situations and Elder Abuse**

Family situations that can contribute to elder abuse include discord in the family created by the older person's presence, a history and pattern of violent interactions within the family, social isolation or the stresses on one or more family members who care for the older adult, and lack of knowledge or caregiving skills.

Intergenerational and marital violence can persist into old age and become factors in elder abuse. In some instances, elder abuse is simply a continuation of abuse that has been occurring in the family over many years. If a woman has been abused during a 50-year marriage, she is not likely to report abuse when she is very old and in poor health.

Sometimes, a woman who has been abused for years may turn her rage on her husband when his health fails. If there has been a history of violence in the family; an adult child may take the opportunity to "turn the tables" on the abusing parent by withholding nourishment or by overmedicating the parent. But that doesn't have to be the case—many adult children who were badly treated by their parents become attentive caregivers.

Family stress is another factor that can trigger elder abuse. When a frail or disabled older parent moves into a family member's home, the lifestyle adjustments and accommodations can be staggering.

In some instances, the financial burdens of paying for health care for an aging parent or living in overcrowded quarters can lead to stress that can trigger elder abuse. Such a situation can be especially difficult when the adult child has no financial resources other than those of the aging parent.

Sometimes, there may be marital stress between an older couple when they must share a home with their adult children. Or, the new living arrangements could cause tension between an adult child and his or her spouse. When problems and stresses mount, the potential for abuse or neglect increases.

Social isolation can provide a clue that a family may be in trouble, and it also can be a risk factor for abuse. Social isolation can be a strategy for keeping abuse secret, or it can be a result of the stresses of caring for a dependent older family member. Isolation is dangerous because it cuts off family members from outside help and support they need to cope with the stresses of caregiving. Isolation also makes it harder for outsiders to see and intervene in a volatile or abusive situation to protect the older person and to offer help to the abuser.

### **Caregiver Issues and Elder Abuse**

Personal problems of the caregiver that can lead to abusing a frail older person include caregiver stress, mental or emotional illness, addiction to alcohol or other drugs, job loss or other personal crises, financial dependency on the older person, a tendency to use violence to solve problems. Sometimes the person being cared for may be physically abusive to the caregiver, especially when the older person has Alzheimer's or another form of dementia.

Caregiver stress is a significant risk factor for abuse and neglect. When caregivers are thrust into the demands of daily care for an elder without appropriate training and without information about how to balance the needs of the older person with their own needs, they frequently experience intense frustration and anger that can lead to a range of abusive behaviors.

The risk of elder abuse becomes even greater when the caregiver is responsible for an older person who is sick or is physically or mentally impaired. Caregivers in such stressful situations often feel trapped and hopeless and are unaware of available resources and assistance. If they have no skills for managing difficult behaviors, caregivers can find themselves using physical force. Particularly with a lack of resources, neglectful situations can arise.

Sometimes the caregiver's own self-image as a "dutiful child" may compound the problem by causing them to feel that the older person deserves and wants only their care, and that considering respite or residential care is a betrayal of the older person's trust.

Dependency is a contributing factor in elder abuse. When the caregiver is dependent financially on an impaired older person, there may be financial exploitation or abuse. When the reverse is true, and the impaired older person is completely dependent on the caregiver, the caregiver may experience resentment that leads to abusive behavior.

Emotional and psychological problems of the caregiver can put the caregiver at risk for abusing an older person in their care. A caregiver who is addicted to drugs or alcohol is more likely to become an abuser than one who does not have these problems. Indeed, caregiving can lead to greater use of alcohol, in an attempt to manage stress. Also, a caregiver with an emotional or personality disorder may be unable to control his or her impulses when feeling angry or resentful of the older person.

### **Elder Abuse and Substance Abuse**

Substance abuse has been identified as the most frequently cited risk factor associated with elder abuse and neglect. It may be the victim and/or the perpetrator who has the substance abuse problem. Substance abuse is believed to be a factor in all types of elder abuse, including physical mistreatment, emotional abuse, financial exploitation, and neglect. It is also a significant factor in self-neglect.

Researchers and practitioners have observed the following patterns with respect to perpetrators of elder abuse who abuse drugs or alcohol:

- Persons with alcohol or substance abuse problems may view older family members, acquaintances, or strangers as easy targets for financial exploitation. The perpetrator may be seeking money to support a drug habit or because they are unable to hold a job and have no source of income.
- Perpetrators may move into an older person's home and use it as a base of operation for drug use or trafficking.
- The research on domestic violence shows that abusive partners are more likely to be violent while they're under the influence of drugs or alcohol. The relationship between domestic violence and substance abuse, however, is not fully understood. Although it has been assumed that alcohol and drugs reduce users' inhibitions, it has also been observed that perpetrators of domestic violence use drugs and alcohol to rationalize their behavior.
- Caregivers who are having difficulty coping with the demands of providing care may use drugs as a misguided coping mechanism.

They have observed the following patterns with respect to victims who abuse drugs or alcohol:

- Alcoholic or substance abusing older persons are at risk for several reasons. They may have substance abuse related impairments, such as cognitive loss, that reduces their ability to resist or detect coercion or fraud. Physical disabilities associated with substance abuse increase risk by rendering the older person dependant on others for assistance or care, and giving caregivers physical access to the older person and their home. Caregivers are also likely to have access to an older person's financial resources and to wield significant influence.
- Seniors may be encouraged to take drugs or drink excessively, or even forced to do so. A perpetrator's motive may be to make the older person easier to exploit financially or, in the case of illegal drug use, less likely to report. Abusive caregivers may encourage older people to drink excessively or use drugs to make them more compliant or easier to care for.
- Some victims use drugs or alcohol as a coping mechanism to relieve their anxiety and fear.
- Seniors who have longstanding alcohol or substance abuse problems are likely to have poor relationships with their families or to be estranged entirely. If the older person needs care, their family members may be unwilling to help or may harbor resentments that impede their ability to provide good care.

Older persons who self-neglect are likely to have substance abuse or alcohol problems.

### **Cultural Values Play a Role**

Cultural values, beliefs, and traditions significantly affect family life. They dictate family members' roles and responsibilities toward one another, how family members relate to one another, how decisions are made within families, how resources are distributed, and how problems are defined. Culture further influences how families cope with stress and determines if and when families will seek help from outsiders. Understanding these factors can significantly increase professionals' effectiveness. Colleagues, co-workers, and clients themselves, and members of the community members are workers' most valuable resource in the role of culture. Although it is not possible to achieve an understanding of all the diverse cultures workers are likely to encounter, learning what questions to ask is an important first step:

- What role do seniors play in the family? In the community?
- Who, within the family, is expected to provide care to frail members? What happens when they fail to do so?
- Who makes decisions about how family resources are expended? About other aspects of family life?
- Who, within the family, do members turn to in times of conflict or strife?
- What conduct is considered abusive? Is it considered abusive to use an elder's resources for the benefit of other family members? To ignore a family member?
- (With immigrant seniors), when did they come to the U.S. and under what circumstances? Did they come alone or with family members? Did other family members sponsor them and, if so, what resources did those family members agree to provide? What is their legal status?
- What religious beliefs, past experiences, attitudes about social service agencies or law enforcement, or social stigmas may affect community members' decisions to accept or refuse help from outsiders?
- Under what circumstances will families seek help from outsiders? To whom will they turn for help (e.g. members of the extended family, respected members of the community, religious leaders, physicians)?
- What are the trusted sources of information in the community? What television and radio stations, shows, and personalities are considered reliable? What newspapers and magazines do people read?
- How do persons with limited English speaking or reading skills get their information about resources?

The answers to these questions can provide guidance to professionals in working with members of diverse ethnic and cultural communities. They will help workers understand expectations and dynamics within families and determine what services will be most appropriate and acceptable. They will help workers identify trusted persons who can be called upon for help. Finally, they can provide insight into promising approaches and vehicles for spreading the word about available services.

### **How Can We Prevent Elder Abuse?**

The first and most important step toward preventing elder abuse is to recognize that no one—of whatever age—should be subjected to violent, abusive, humiliating, or neglectful behavior. In addition to promoting this social attitude, positive steps include educating people about elder abuse, increasing the availability of respite care, promoting increased social contact and support for families with dependent older adults, and encouraging counseling and treatment to cope with personal and family problems that contribute to abuse. Violence, abuse, and neglect toward elders are signs that the people involved need help—immediately.

Education is the cornerstone of preventing elder abuse. Media coverage of abuse in nursing homes has made the public knowledgeable about—and outraged against—abusive treatment in those settings. Because most abuse occurs in the home by family members or caregivers, there needs to be a concerted effort to educate the public about the special needs and problems of the elderly and about the risk factors for abuse.

Respite care—having someone else care for the elder, even for a few hours each week—is essential in reducing caregiver stress, a major contributing factor in elder abuse. Every caregiver needs time alone, free from the worry and responsibility of looking after someone else's needs. Respite care is especially important for caregivers of people suffering from Alzheimer's or other forms of dementia or of elders who are severely disabled.

Social contact and support can be a boon to the elderly and to the family members and caregivers as well. When other people are part of the social circle, tensions are less likely to reach unmanageable levels. Having other people to talk to is an important part of relieving tensions. Many times, families in similar circumstances can band together to share solutions and provide informal respite for each other. In addition, when there is a larger social circle, abuse is less likely to go unnoticed. Isolation of elders increases the probability of abuse, and it may even be a sign that abuse is occurring. Sometimes abusers will threaten to keep people away from the older person.

Counseling for behavioral or personal problems in the family can play a significant role in helping people change lifelong patterns of behavior or find solutions to problems emerging from current stresses. If there is a substance abuse problem in the family, treatment is the first step in preventing violence against the older family member. In some instances, it may be in the best interest of the older person to move him or her to a different, safer setting. In some cases, a nursing home might be preferable to living with children who are not equipped emotionally or physically to handle the responsibility. Even in situations where it is difficult to tell whether abuse has really occurred, counseling can be helpful in alleviating stress.

### **Preventing Exploitation Through Money Management**

An estimated 500,000 older people in the United States need help with their financial affairs. As a result, a new field called daily money managers is evolving to provide money management services. Daily money managers organize and keep track of financial and medical insurance records; establish a budget; help with check writing and checkbook balancing; and administer the benefits of people who can't manage their own financial affairs. Private pay money managers typically charge \$25 to \$100 an hour, but some states and communities have free or very affordable money management services for vulnerable adults, particularly those who are low income. Although it is difficult to generalize the total cost, many clients require only a few hours of services each month. Some local governments and community organizations also offer reduced-fee or free services for low income clients.

**Do You Know An Elder Who Needs a Daily Money Manager?** With the elder's help or permission, review his or her checkbook, bank statements, and canceled checks. Look for things such as payments for medical bills that already have been paid; numerous payments to credit card companies, home shopping networks sweepstakes or other contests; unusually large charitable donations; failure to track deposits or expenditures; lost checkbooks or bank statements; numerous transfers from savings to checking accounts; or consistent or unusual payments to a questionable recipient. Review bills and correspondence and watch for letters from creditors or past-due notices. The review may indicate that a daily money manager is needed.

*If your review gives you reason to believe that a caregiver, family member, or friend is improperly using the elder's resources for their own benefit, report the situation to Adult Protective Services. If you and the elder decide that a daily money manager would*

be helpful, interview several candidates. Get references and talk with their clients. Contact the local Better Business Bureau, chamber of commerce, local consumer protection agency, or area agency on aging.

**For More Information:**

**American Association of Daily Money Managers**, P.O.Box 55, Silver Spring, MD 20918; 1-301-593-5462. The association can provide names of daily money managers in the community or nearby.

**A Questionnaire for Caregivers**

Providing care for an elderly or disabled adult requires a lot of patience, time, and love. All too often, caregivers run the risk of neglecting themselves, affecting their ability to provide adequate services. The following questionnaire can be used as a guideline to assess the stress-level of caregivers.

If you answer "yes" to one or more of the following questions, you might consider seeking professional help or turning to whatever support system you have developed:

- Are you getting enough rest?
- Are you neglecting your own health?
- Is constant surveillance required as part of your care tasks?
- Have you turned to drugs or alcohol or increased their intake to deal with stress?
- Have your feelings toward the person you are caring for become more negative?
- Is the person you are caring for ever physically or verbally abusive toward you?
- Does the person you are caring for need legal assistance with things like estates, trusts, or living wills, which may be beyond your knowledge?
- Does the person you are caring need to be transported often?
- Are you overwhelmed because you are taking care of more than one person at a time?
- Are financial constraints interfering with your ability to follow medical advice?
- Are problems from your family's history resurfacing and contributing to the problem?
- Does your spouse resent the amount of time you spend as a caregiver?
- Are you confused, fearful, or angry as a result of being a caregiver?
- Is your family communicating regarding the division of responsibilities?

*Adapted from "Taking Care of Aging Family Members: A Practical Guide" by Wendy Lustbader and Nancy R. Hooyman (New York: The Free Press, 1994).*

**Autonomy and Self-Determination**

Professional practice in the field of elder abuse prevention is guided by principles that highlight clients' freedom and civil liberties. In working with victims and vulnerable persons, professionals look for ways to prevent abuse that promote autonomy and self-determination. Autonomy, which comes from the Greek word for "self rule," is the ability or capacity to make informed choices, free of coercion, based on one's own personal beliefs and values. All adults are presumed to have decision-making capacity and are therefore afforded the right to self-determination, that is, the freedom to make decisions for themselves in all areas of their lives. The concept of autonomy reinforces this right to be free from unwanted interference, which means that there must be legal justification for any curtailment of autonomy.

**Exceptions to Client Autonomy:** Although the principals of autonomy and least restrictive alternatives apply to most cases, there are two situations in which clients' personal freedom may be compromised in favor of other compelling interests. Two legal principles may come into play in those situations:

***Parens Patriae*** : When individuals are deemed incapable of protecting themselves from harm, society assumes responsibility for providing protection. *Parens patriae*, or the "state as parent," is a common law principle, which authorizes the state to act as a benevolent parent to protect its citizens who are impaired and cannot protect themselves. It allows for government entities, including APS, to initiate both voluntary and involuntary services for individuals who cannot protect themselves.

**Police Power:** The right to autonomous decision-making must also be weighed against the State's interest in preserving and protecting life and property. The principle of police power gives police the authority to curtail and control certain personal behaviors to protect the public welfare, as well as individuals. Police may intervene to protect individuals and the community from physical harm or the threat of harm, loss of assets and property, and public nuisances.

**Least restrictive alternatives:** In offering service options to their clients, professionals look for the least restrictive alternatives - interventions that cause the least disruption or change in the older person's circumstances and which maximize their independence and freedom. For example, if an individual is having trouble managing his or her financial affairs as a result of

forgetfulness or other cognitive impairments, a very effective means for stopping the abuse would be to petition a court to appoint a guardian. Guardianship, however, is a very restrictive alternative in the sense that it strips people of very basic civil liberties. The principle of least restrictive alternatives dictates that other less restrictive options, such as informal money management, be considered prior to considering this option.

### **Adult Protective Services**

Adult Protective Services (APS) are provided in each State to elderly and disabled persons who are reported to be victims of abuse, neglect, or exploitation. The definitions used to identify older persons and disabled persons vary from state to state. Contact your nearest **Adult Services and Aging office** or local law enforcement agency.

Members of South Dakota's Indian Tribes should note that Tribal Ordinances may have different definitions of abuse, neglect and exploitation and different reporting requirements. Check with the authorities in your area.

#### **How the System Works**

- Someone suspects that a person who is elderly or has disabilities has suffered from abuse, neglect, or exploitation.
  - Person calls the report into an abuse hotline or to a local APS office.
  - Staff assign a priority to report depending on how urgent it seems to be.
  - If an emergency, staff immediately call law enforcement, emergency medical staff, or hospital, depending on the situation.
  - Report is forwarded to local staff for investigation, or to other entity if the situation falls outside of APS jurisdiction.
  - **Local Staff Begin Investigation.**
  - Staff may telephone someone who knows the alleged victim or visit with the alleged victim, depending on the situation.
  - Based on what is learned, staff determine how to proceed.
  - **Local Staff Continue Investigation.**
  - Alleged victims are visited within a certain timeframe, depending on the urgency of the case.
  - Worker contacts other parties who might know about alleged maltreatment.
  - Worker evaluates the information gathered, discusses case with supervisor as necessary, and decides if the person needs protective services.
  - **When Staff Cannot Confirm Maltreatment:**
  - The case is closed. Staff may refer the client to other resources in the community, as appropriate.
  - **When Staff Confirm the Maltreatment:**
  - Facility investigators report their findings to the appropriate authority for action as needed.
  - Staff who live in the community may offer services on a voluntary or involuntary basis depending on the degree of existing danger and the client's ability to understand the situation. Services may be direct and/or purchased or arranged through another agency or community resource. Victims who have the capacity to understand their circumstances have the right to refuse services, regardless of the degree of danger.
  - **Clients Have the Right to Self-Determination**
- Competent adults have the right to make decisions about their own lives, including the right to refuse help from adult protective services. In some states competent adults may refuse an investigation as well as services.

### **Reporting Abuse, Neglect, Exploitation in South Dakota**

If you know or have reasonable cause to believe that someone needs protection, *make a referral to Adult Services and Aging.*

#### **What to Report**

- The date and time of the incident
- Your name, address, and phone number. Anonymous reports can be accepted, however, an anonymous referral is more difficult to substantiate.
- The nature of the problem; precipitating incident; persons involved; name of caretaker, next of kin or guardian (if any); composition of household; perceived functioning level of the client.
- Reason for referral, remedy desired, previous incidents if known.

## **Confidentiality**

All reports are confidential. Civil and criminal immunity is available for good faith reports by employees, agents or members of medical or dental staff of facilities regulated by the Department of Health.

## **Non-Legal Interventions**

- Linkages with appropriate resources, such as home health services, adult day care, adult foster care or respite care.
- Referral for legal assistance for power of attorney, durable power of attorney for health care, or other legal advice.
- Referral to counseling, support groups, or medical/mental health providers.
- Nutritional assistance
- Case management

## **Legal Interventions**

- Emergency commitment of the mentally ill or developmentally disabled
- Guardianship of the person
- Conservatorship for property
- Referral for appointment of a representative payee

Referral for further investigation by law enforcement for violation of Chapter 22-46, abuse, neglect, or exploitation of a disabled adult, or for investigation of other criminal offenses committed against elderly.

## **References and Resources**

*Department of Justice Office of Violent Crime, Statistics 2001,*  
[http://www.ojp.usdoj.gov/ovc/ncvrw/2001/stat\\_over\\_7.htm](http://www.ojp.usdoj.gov/ovc/ncvrw/2001/stat_over_7.htm)

*Elder Abuse and Neglect: In Search of Solutions* ,American Psychological Assn  
[www.apa.org](http://www.apa.org)

*Elder abuse: When you suspect a loved one's mistreatment,* Mayo Foundation for Medical Education and Research

National Center of Elder Abuse (NCEA)  
<http://www.elderabusecenter.org>

Administration of Aging  
[http://www.aoa.gov/eldfam/Elder\\_Rights/Elder\\_Abuse/Elder\\_Abuse.asp](http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/Elder_Abuse.asp)

Clearinghouse on Abuse and Neglect of the Elderly (CANE), University of Delaware  
CANE-UD@udel.edu

## **Goals for Elder Abuse Home Study Program**

1. The reader will learn what behaviors indicate the possibility of elder abuse
2. The reader will learn what risk factors increase the likelihood of elder abuse
3. The reader will know what behaviors constitute elder abuse
4. The reader will know how to refer suspected cases of elder abuse

# HOMESTUDY POST TEST

## Circle the Correct Answer for Each Question

All questions are based on information contained in this CEU publication.

1. **Elder abuse victims are typically:**
  1. female
  2. have a disability
  3. living with the abuser
  4. all of the above
2. **The most common form of abuse is:**
  1. physical
  2. abandonment
  3. neglect
  4. self-neglect
3. **Perpetrators are typically:**
  1. male
  2. female
  3. adult children
  4. spouses
4. **What was the percentage of increase in the reporting of elder abuse from 1986 to 1996?**
  1. 50%
  2. 80%
  3. 150%
  4. 183%
5. **Neglect involves**
  1. shoving, pushing, hitting
  2. enforced social isolation
  3. failure to provide for necessary home services
  4. Using the financial resources of the older adult.
6. **Possible signs of abuse are:**
  1. frequent use of hospitals or health care resources
  2. non-responsiveness
  3. frequent checks made out to "cash"
  4. All of the above
7. **A sign of possible depression in an older adult is:**
  1. weight change
  2. pacing and fidgeting
  3. physical symptoms
  4. all of the above
8. **Which is typically NOT a cause of self neglect?**
  1. dementia
  2. substance abuse
  3. lack of education
  4. isolation
9. **Depression affects what percentage of older adults?**
  1. 25%
  2. 15%
  3. 30%
  4. 28%
10. **What is the most frequently cited risk factor associated with elder**
  1. financial stress to caregiver
  2. isolation
  3. substance abuse
  4. disability of the older adult
11. **If you think an older person suffers from depression, you should first:**
  1. refer them to a psychiatrist
  2. refer them to counseling
  3. refer them for a physical exam
  4. none of the above
12. **The risk of suicide in the aged is**
  1. less than in younger adults
  2. greater than that in younger age groups
  3. consistent with that of all other age groups
13. **Client self-determination does NOT apply in which situation?**
  1. the individual has a physical disability
  2. the individual has chosen to give assets to others
  3. the individual is at risk of losing their property through fraud
  4. a report has been made to Adult Protective Services
14. **Reports to Adult Protective Services are:**
  1. confidential
  2. always treated as an emergency
  3. always involves legal action
  4. all of the above

Complete and return this form after reading this home study. Earn a score of 80% or better and we will send you a certificate for .2 CEUs.

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4. Other topics you'd be interested in? _____					