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Elder Abuse: The Ethical Dilemma

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Introduction

In this paper, elder abuse is simply defined as any action, which, regardless of intent causes harm to a senior. This definition might appear simplistic but the difficulties in identifying and dealing with abuse are far from simple. Although many of those difficulties arise from practical considerations, many also relate to the myriad of ethical dilemmas which confront workers involved in this area of community service.

It is recognised that there are no prescriptive rules to making difficult ethical decisions. Nevertheless, examination of all the information concerning the case and consideration of existing legal, professional and personal ethical ideals and standards can offer some guidance in case management. However, although these standards offer some structure to the decision making process, there are few absolutes in ethics and so community workers will often need to apply the moral ideals of autonomy, goodness and justice as guidelines in dealing with these ethical dilemmas

The abuse of seniors is not a new problem. Rather it is the recognition of the nature and extent of the problem which is recent. There are few laws which govern this type of abuse, no national policies to direct those who work in the field, and only a small number of agencies who have any protocols for workers dealing with elder abuse. As a consequence it is often up to the individual worker to make the practical and ethical decisions about which interventions are preferable and what outcome is best to enhance the well-being of the senior concerned.

The paper discusses the nature of elder abuse in society, it considers the social, professional and personal ethics community workers use to deal with abuse, and it lists some strategies to ensure the rights of seniors are protected and the incidence and severity of elder abuse are curtailed.

Australia is an aging society. And this aging will continue, with the number of people over sixty-five years increasing by 31 per cent and those over eighty years of age increasing by a massive 70 per cent before the year 2021 (Kendig & McCallum 1986). There are many dilemmas involved in providing aged care during times of such growth in the numbers of older people. With regard to the services necessary to meet the needs of a rapidly aging population, the Minister for Aged, Family and Health Services, Peter Staples correctly states that older Australians are entitled to live with security and peace of mind during their later years. He suggests that the Commonwealth Government has provided a support package for community based seniors which promotes both security and provides quality health and aged care services for seniors. He then proudly states that this package gives Australians "an aged care system equal to the best in the world" (Staples 1992).

The current Home and Community Care (HACC) program is part of this package of aged care. This program aims to both maintain the aged at home with optimal independence and quality of life and to prevent inappropriate admission to an institution (DCS&H 1987).

However some would disagree with Minister Staple's claim about the world-class quality of community aged care. HACC is not a "panacea" for seniors and does not meet all their needs nor the needs of family caregivers (Hicks 1986). Hicks, in writing on social policy and aged care, questions just who community care does help and suggests that it increases rather than decreases the burdens of care for the wives and daughters of the frail aged.

HACC was introduced to provide services and support for older people in the community. However, although only 6 per cent of seniors live in an institution, residential care, such as nursing homes, receives ten times the funding allocated to community care (Grimes 1987). While there has been some increased spending on community aged care - from $32 million in 1977 to $101 million in 1987, in the same period there has been a massive increase in institutional spending - from $96 million in 1973 to over $1 000 million in 1986 (Minichiello 1989). The proliferation of funding for nursing homes which commenced in the 1960s could suggest that residential care was considered the best option to meet the needs of the elderly at that time. The cynic could be excused for asking whether the current move to keep seniors at home, that is keeping them out of nursing homes, is based on the moral rightness of community care for today's seniors, or perchance is it based on economic and political expediency? If indeed community care is preferable, then there is a moral responsibility to provide adequate funding for such care.

It is this inequitable funding, where 94 per cent of the aged who live in the community receive only 10 per cent of the funds, which is at the heart of the dilemma of aged care. Difficulties arise when, in times of recession, community service funding decreases but there is no corresponding decrease in the demand for services. With the present government priority aimed at keeping older people in the community, the question arises "where should the money be spent?" To date funding has been directed toward the residential sector of aged care to the detriment of community care. With this current emphasis on maintaining seniors at home it is unethical that adequate support should not be available for family members, many of whom are conscripted to care for frail aged

relatives. This is indeed an example of public or bureaucratic abuse of dependent seniors and their carers.

Public Abuse of Seniors

The inequitable distribution of funds for aged care and the onerous responsibility thrust onto families, who generally receive insufficient support in the caring role, raise a number of ethical dilemmas in caring for seniors. In terms of the construct of aged care, public abuse by the bureaucracies which perpetuate these inequalities is a major form of elder abuse which must be recognised and addressed if we are ever going to be able to tackle the more private domestic issues of the abuse of seniors. With limited community services to help them meet the onerous responsibilities for their duty of care, many older caregivers are themselves victims of the public abuse of seniors. If there is an expectation that families will care for frail aged relatives then there is a corresponding obligation that they receive adequate community resources, guidance and support to fulfil the caring role. Yet the current level of community care is barely adequate to meet the most basic needs of seniors, let alone to provide optimal independence, dignity and quality of life.

Community care today does not mean care "by the Government" for people "in the community" (Henderson 1985). When the rhetoric is stripped away, community care is not even the range of domiciliary services the term implies, rather it is usually onerous, long-term care given by wives and daughters with very little help from others (Jorm 1988; Rossiter 1984). What then is involved in this concept of care?

The Office of the Minister for the Aged stated that

> *community care appears to be a euphemism for family care and governments have been slow to provide appropriate support services and programs for families who provide this care. And furthermore family care is usually care by women who most often reduce themselves to a dependent state in order to provide it.*

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This statement was made in 1985; unfortunately it is as valid today as it was then. The great majority of family care is humane and effective and invariably carried out at great personal sacrifice. The family in general and children in particular are frequently viewed by public agencies, such as courts, hospitals, medical and welfare practitioners, as the logical answer to the care of frail, confused and incompetent older people. For example, for seniors who have been confined to hospital care, it is suggested that discharge planning has been effective when a senior is discharged to the care of a spouse or grown children (Kosberg 1983).

Similarly the Department of Community Services and Health discusses family members when describing carers for older people. They define a carer as :

the person who is providing substantial, constant, long term personal care for someone with an illness, disability or infirmity. The person is often a family member with whom they share the home, and whose care is essential to enable the person to continue living at home. (DCS&H 1991)

Let us consider these terms: *Substantial* means exactly that, full time carers give a very high average of more that forty hours per week "personal care", similar to that given in a nursing home, plus many more hours of general or indirect care (Ory et.al. 1985). *Constant*, for most wives and residential daughters, means a commitment to the caring role for 24 hours per day, seven days per week. *Long term* invariably implies that the carer continues until they, or their frail relative, needs admission to institutional care - or until one of them dies.

The costs of caring are very high. Most family carers are themselves elderly and as a group were identified decades ago as "the hidden patients" because they report higher than average doctor's visits and health problems (Fengler & Goodrich 1979). Carers have limited opportunities for independent life or for outside work, and they have little chance for privacy or a social life. The economic costs of caring are also high but there is no re-

imbursement for the full financial costs of caring, there are few tax rebates for carers, there is no minimum wage, nor a 37.5 hour week, no shift allowances for evenings, nights or weekend duty, nor on-call rates for the 24 hours per hour day that they must be available. Few have a mandatory four weeks annual leave and there is no retirement age for carers (Kingsley 1992). Is it any wonder they cry out for help and support in the caring role?

Social Abuse of Seniors

Besides public abuse of seniors there are also the negative community stereotypes about older people with which many seniors have to contend. They are subject to social abuse in a society which allows ageist attitudes toward old people, harassment of seniors, discrimination against aged people, and denigrating of the elderly to the ranks of second-class citizens. Whilst society holds these negative views of older people it will never accept responsibility for their welfare and will be content to pass the responsibility of care onto families. Until these attitudes change, aged care will continue to be a family affair, and the abuse of older people will remain a private, under-disclosed and often ignored social problem which is accepted in silence by the community at large.

In a society where one in five people condones violence of some degree toward women; it appears only natural that there should be an acceptance of violence toward older people, the great majority of whom are female. This is the same society which considers violence within the domestic sphere to be a private family matter. Violence is a common feature of many households, often resulting in a high base line tolerance and unconscious acceptance of abuse. At the same time many families accept the social taboo that life within the family is sacrosanct and that violation from outsiders is unacceptable. From childhood many people have learned the association between love and violence, especially from parents who "had to be cruel to be kind". As unacceptable childhood behaviour is often controlled by physical means, many seniors accept the moral rightness of physical force. The

acceptance of force can become so internalised by elderly victims, they feel the punishment must have been deserved and is therefore warranted.

This begs the question; if the victim does not feel abused is the diagnosis of abuse warranted, and who has the right to define it as such? Similarly, there is the question of judging or labelling specific behaviour as abuse, or a particular person as an abuser. Where is the point at which negative behaviour becomes abusive, and when does neglectful care, even if it is unintentional, become abuse? Further, in a society which compels families to accept responsibility for aged care whilst giving them insufficient resources to carry out that role, who has the moral right to pass judgment and label a family carer as an abuser? Is pouring blame or shame on a family abuser the most effective community worker response to an abusive situation, or should practitioners support carers and acknowledge the positive contribution they make to aged care? These questions raise the issues of who is the social arbitrator of what constitutes abuse, when it should be so labelled, and how the problem should be resolved..

Family Abuse of Seniors

In the main, the abuse of seniors occurs within the private sphere of the family home. In many cases, the abuser is both a relative and a co-resident of the older person for whom they have some caregiving responsibility. Research and experience suggest that those most likely to abuse an older person tend to be highly stressed by their responsibilities and have some difficulty in coping with the physical, emotional and economic costs of caring. There is often a history of substance abuse, of past emotional or psychological problems, of prior dysfunction in family relationships, or of some level of violence within the family unit. Similarly abuse is more likely in families where the senior at risk lives with their primary carer, where more than one generation live together, and where the senior is dependent on the carer for physical care, emotional support or financial security. They are often physically and/or mentally frail, many have a low self image of their worth to either

themselves or society, and, over the years, a large number have abused substances such as alcohol and medications (Kosberg 1988; Pilemer & Finkelhor 1988; OPA 1990).

Dealing with elder abuse within the family relationship can become very complex, especially in cases where the abuse is a continuation of domestic violence, where it is the frail relative who abuses their carer or where they abuse one another. Decisions concerning elder abuse can be further confused when there is difficulty in determining whether neglect is abuse or just poor care, or in deciding who is the most abused, the senior by their carer or the carer by society. Superior assessment skills and fine judgment are often required to unravel the intricacies of a complex case of elder abuse.

Just because they are "family" does not guarantee efficient or compassionate care. All too often the added responsibility of having to care for a dependent, and often confused, relative can result in intolerable stress on the family system. The disruptions which arise from the demands of continuous care can lead the family to seek institutional placement for their elderly relative (Kendig 1986). Unfortunately hostel and nursing home admission is not always approved by Aged Care Assessment Teams, nor are beds always readily available on demand. Many carers experience a sense of frustration and hopelessness and it is at this time that they may seek professional help.

Ethical Issues in Dealing with Elder Abuse

It is when community workers become involved with clients that ethical issues come into play. If a family seeks outside help without the approval of the senior, an exclusive relationship can develop between the carer and the professional which alienates the senior. By their very involvement, workers may see the family as their client and unintentionally collude with carers to enforce the family's will over that of the aged relative. This is essentially a violation of the senior's right to autonomy and justice. Dealing with families

in cases of suspected or actual abuse can present ethical dilemmas to the professional who must choose between two sometimes contradictory professional obligations :

1. to provide the intervention necessary to ensure client welfare;

2. not to interfere with a client's freedom or autonomy.

In this situation who is the client - the family or the senior? How are the family's rights balanced with those of the senior, and how can a practitioner legitimise professional coercion, such as working with the carer or making decisions without the informed consent of the older person? The general societal ethic suggests action which does not meet the wishes of the older person are only justified when:

1. there is a grave threat to basic social values or to fundamental social institutions;

2. there is clear and present danger that very great or irreversible harm will occur unless prompt preventive action is taken by an agent of society (Rhodes 1986).

At first sight these conditions seem straightforward. However, there is a high degree of ambiguity as issues such as "present danger" and "irreversible harm" are open to individual interpretation. The community worker is thus called upon to determine whether the client is in imminent danger of irreversible harm, and whether or not they must be removed from the "at risk" situation. If this decision does not concur with that of the carer or indeed the senior, the worker is required to make a moral judgment as to whose rights are to be upheld. In the case of the elderly client who suffers from an altered mental state, these difficult decisions may be made by medical practitioners or the Public Guardian.

Unfortunately, in many abuse cases, community workers find the easiest option is to assess the need for immediate action. This decision frees them from the obligation to sit back and analyse the ethical issues inherent in the case. As a consequence they rush into action. All too often this "need to act" results in the worker flooding the home with community services, or the victim being removed from danger - into an institution. Such actions not only fail to acknowledge the real issues of the abuse, but they can also cause

additional harm to a victim who has already been maltreated. The more potential a worker has to cause harm or negative outcomes for a senior, albeit unintentionally, the greater moral obligation they have to ensure that no harm occurs to any client as a result of their actions.

Besides legal guidelines and general societal ethics, more specific professional ethics also play a role in dealing with elder abuse. Whilst ethics relate to the ideals and moral standards which guide interpersonal behaviour and interactions, professional ethics present an ideal for professional behaviour and interactions with clients. In practice, professional ethics refer to the standards which professions lay down to guide the conduct of members. However, there may be problems when practitioners operationalise these abstract standards into the real world of community practice. For example, both professional ethics and good practice require that a senior's autonomy is safeguarded and that all decisions are based on a client's informed consent. Keeping in mind that informed consent is the "non intervention" in a client's life without their full permission (Lowenberg & Dolgoff 1985), many community workers fail to maintain this standard when they plan interventions without the senior being fully informed and involved. The issues of autonomy, voluntariness and the competence to make choices, are central to informed choice. It is the professional responsibility of community workers to ensure these rights are honoured, even if seniors make decisions with which the worker might disagree.

As professionals, community workers are committed to serve clients, irrespective of their age, gender, race, religion wealth, personal attractiveness or social worth. And, regardless of the nature of the client or their particular problems, community workers are also committed to maintain the autonomy, dignity and well-being of clients and to uphold their rights at all times. These values originated from the philosophy of Kant (1948) who states "every person is an end in his/her self, and no person should ever be used as a means to another person's end or purpose. This premise has resulted in the classic values of individuality, non-judgmental acceptance of others, and self-determination. Although

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these are laudable values they can become contaminated and result in value confusion which makes it difficult for workers to solve ethical problems, and can lead to a sense of powerlessness in dealing with a complex case. All too often the problem becomes "too hard" and workers take the stance that "I'm not equipped to deal with the problem - there is nothing I can do - so I haven't acknowledged it (Bookin & Dunkle 1985)".

The ease with which community workers maintain professional ethics while dealing with complex problems is influenced by their own life experience, their professional knowledge and their personal value system. A worker's dealings with abuse are affected by their acceptance or rejection of violence within the family, their stereotypes about older people, what position they feel seniors should occupy within society, and their beliefs about whose responsibility it is to care for seniors. Worker case identification and intervention are determined as much by their personal values as by their level of knowledge and experience in the area. A community practitioner who countenances violence as acceptable behaviour may reject the significance of a case of physical abuse. Another who has frequently worked with one type of problem may more readily identify that type of abuse, to the detriment of other categories of behaviour. Again, based on past experience, it is not unusual for one community worker to identify a case as severe abuse while a colleague might define it as moderate or even mild.

A worker's ability to achieve the professional ideal is fraught with difficulty as they come to terms with the complex issues of elder abuse. It is the existence of professional ethics, often spelt out in agency policies and protocols which can help overcome the individual differences in values and experience. and so ensure that clients receive high quality service. Agencies are strongly urged to work in conjunction with professional bodies to develop and implement such protocols into their practice.

Strategies to deal with the Dilemmas of Elder Abuse

Those involved with elder abuse would agree that there are probably more questions than answers in dealing with this type of abuse. In many cases the situation is complex, there is no clear-cut right or wrong, and no cut and dried distinction between who is the abused and who the abuser; in all there is a myriad of ethical dilemmas to be confronted. We have said that some strategies would be offered to help deal with both the prevention of abuse, and with cases of actual abuse. It is not our intention to offer a list of prescriptive do's and don'ts, rather some general strategies, which fit into the ethical paradigm, will be suggested. As ethical issues can be considered in terms of the ideals of autonomy, no harm and justice, so the strategies to deal with the dilemmas of abuse can also be considered under these conceptual headings.

Autonomy is vital to seniors, if they are to retain their dignity and enjoy the freedom, rights and choices they are entitled to as first-class citizens. Included is the assumption that no community worker will deal with a senior without their full involvement and informed consent. Autonomy also requires community workers to treat clients with respect, to honour their rights and freedom of choice, and to ensure that seniors are in full control of all decisions which affect their health and well-being.

No harm means that no action should cause any hurt to a senior. This maxim requires that all interventions be carefully considered to ensure no harm occurs to any of the parties involved, especially to the elderly victim of abuse. Because the actions of community workers have the potential to harm a client, these workers have an added responsibility to ensure their actions do not contravene the client's wishes or best interests. This ideal, which is also known as "non maleficence", is closely tied to the ideal of "beneficence" which states that not only should actions not cause harm, they should also be directed toward doing good. Although there are difficulties in defining what is meant by the term "doing good", if workers carefully consider what benefit their client will receive from interventions, their actions will tend to enhance rather than harm client well-being.

Justice is an essential component of dealings with any client, regardless of their age or the nature of their problem. In elder abuse cases, justice demands that actions are fair and equitable, whether they be between a victim, and a perpetrator or the family or between the family unit and the bureaucracy.

Together these concepts comprise a large portion of the ethical construct used to deal with elder abuse. Concepts such as autonomy imply the senior has the mental competence to make decisions and informed choices. Where a senior has an altered mental state, the community worker must take extra precautions to safeguard the older person's rights. In some cases the worker will advocate on behalf of the older person, while more serious cases can be referred to the Public Guardian for determination.

The following list, although by no means exhaustive, is designed as a guide to the type of strategies which are necessary if the incidence and severity of abuse against seniors are to be curtailed. Ideally, many of these strategies should be available to the whole community; however, until such time that all citizens are equally empowered and have equal access to community resources, positive discrimination toward seniors is a necessary deterrent to elder abuse. Obviously, some of these actions could be applied to more than one category of the paradigm, and many will be appropriate to both preventing abuse and dealing with existing cases. For clarity, actions which appear best suited to either prevent or deal with abuse, are listed separately .

1. Strategies to Promote Autonomy of Seniors

(a) *To prevent abuse*

* Enhancement of the worth and value of seniors to themselves and to their community, by allowing them to make a worthwhile contribution to their family and community.

* Empowerment of seniors to demand and enjoy their rights as first-class citizens.

* Acceptance, by mentally competent seniors, of their responsibility to become involved in their own welfare and to be involved in all decisions which affect their life.

* Education of seniors toward protective personal behaviours.

* Protection of senior's right to freedom of choice and informed consent.

* Acceptance of the right of seniors to take risks.

* Empowerment of carers to demand and expect adequate services - to fully support them in the caring role, and to meet their needs and those of their frail relative.

* Acceptance of the right of seniors/caregivers to refuse offered community services.

* Development of a unit, e.g. a Seniors' Justice Unit where seniors may gain help advice, legal information, or to take grievances against family, community workers or police.

(b) To deal with existing abuse

* Community worker acceptance that a mentally competent senior is telling the truth when they disclose abuse.

* Provision of support and counselling to re-build the abused senior's personal dignity and self-worth.

* Acceptance of the right of seniors not to disclose abuse.

* Acceptance of the right of seniors to refuse intervention into the abusive situation.

2. Strategies to prevent harm occurring to Seniors

(a) To prevent abuse

* Development of clear agency policies and practical guidelines for dealing with both aged clients and with cases of potential abuse.

* Use of team approach to consider difficult recommendations about client care.

* Encouragement of community worker recognition of personal attitudes and values about older people which might influence their work with seniors.

* Implementation of strict agency protocols to safeguard client confidentiality.

* Staff training about procedural, legal and ethical issues of dealing with elder abuse.

* Provision of quality support and supervision of community workers.

* Expansion of community services for caregivers, such as in-home and residential respite, counselling, increased financial assistance, and guidance to carry out that role.

* Implementation of effective hospital discharge planning to ensure seniors are not discharged into a domestic situation where they are at risk of abuse.

(b) To deal with existing abuse

* Development of programs to assist both perpetrators and victims of elder abuse.

* Use of counselling and support before more restrictive measures are used to deal with abuse.

* Avoidance of assigning blame or shame should govern interventions wherever possible.

* Agency interventions to be appropriate and only as intensive as the situation requires.

* Recognition that inappropriate interventions can cause more harm than no intervention.

* Recognition of the limits of the worker / agency to solve a problem, and when to pass the case to a more appropriate body.

3. Strategies to ensure Social Justice for Seniors

(a) To prevent abuse

* Education of the community to affirm the worth and value of seniors to society.

* Community education to eliminate both the negative social attitudes and negative discrimination against seniors.

* Adequate financial reimbursement to carers for the economic costs/penalties of caring.

* Enhancement of existing protective/Public Guardian legislation to safeguard fairness and equity for seniors.

* Increased police powers to intervene in cases of suspected abuse.

(b) Dealing with existing cases

* Development of strategies to ensure the automatic solution to cases of abuse is not to separate parties by admitting the victim to residential care.
* Implementation of the full course of the law (where necessary) to ensure the safety of the senior and fair judgment for the perpetrator.
* Protective measures to ensure the safety of community workers who have to intervene in cases of abuse.

Conclusion

It would be like preaching to the converted to say that elder abuse is an incredibly complex problem which contains more ethical and practical dilemmas than most social issues. Nevertheless, this does not mean we can take the easy option and continue to underestimate the existence or the severity of elder abuse in society today. Rather, now is the time to accept the challenge of dealing with this type of abuse and to develop practical guidelines and ethical protocols to prevent abuse from occurring and to curtail the extent of existing cases.

As no standardised ethical protocols are available, it is requisite that workers conform to current law, to social mores and professional ethics, as well as to their personal value base and code of ethics. There will be times when these various ethico-legal codes either do not cover the case at hand or they are in conflict, and it is in these situations that workers, in conjunction with their team, have to make the difficult decisions. Accurate assessment of the case, correct diagnosis of the problem and its underlying causes, detailed consideration of all the possible interventions and their outcomes, adherence to the ethical paradigm of autonomy, goodness and justice, and full consultation with all parties will all contribute toward the best possible actions being taken to fulfil the needs of the senior concerned.

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