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Risk assessment and intervention for vulnerable older adults

Both internal factors, such as cognitive impairment, and external factors, such as inadequate housing, can threaten the health and safety of older adults.

ABSTRACT: The aging of the Canadian population presents medical and ethical challenges for clinicians. Increasingly, there is a need to address the issue of vulnerable older adults who live at risk in the community. Many have significant cognitive, psychiatric, and physical problems yet do not seek assistance. Assessment and intervention in these cases requires an interdisciplinary approach. An understanding of risk factors, the clinical evaluation process, competency issues, and basic management strategies is integral to good care.

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In 2006, 13.7% of Canadians and 14.6% of British Columbians were over the age of 65 years.[1] Baby boomers will soon become seniors, and the aging of the Canadian population will accelerate.[2] The medical and social needs of older adults present a unique challenge to health care providers. For example, the prevalence of dementia is increasing, and issues such as abuse and neglect of the elderly are receiving much-needed attention.[2-5]

Geriatric specialists are frequently called upon to assess and manage vulnerable, community-dwelling individuals. Opinions regarding capability and safety are often needed. The older person in question may ignore medical advice, refuse facility placement, experience exploitation, suffer from self-neglect, drive dangerously, or live in an unsuitable environment. The situations are rife with medical, ethical, legal, and social complexities.[5] Questions of capacity, confidentiality, beneficence, and autonomy inevitably arise.

It is important to recognize that vulnerable seniors suffering from mental illness, cognitive deficits, or functional impairment are not necessarily incapable of making decisions. They may still be able to direct their own medical care and manage their finances. Informal or formal supports are sometimes all that is necessary to keep the individual in the community. Appropriate interventions may be simple or highly complex and need to be determined on a case-by-case basis. For some, driving cessation is required; for others, involuntary hospitalization or placement is the only option.

Older adults may become vulnerable and live at risk because of cognitive, psychosocial, and/or physical problems.[6,7] Recognition, evaluation, and treatment of this population requires a multimodal, interdisciplinary approach. In the absence of validated screening and decision-making tools, thorough clinical assessment is essential.

Risk factors

The terms "risk" and "vulnerability" imply the possibility of an adverse outcome or injury. Both internal and external factors can contribute to vulnerability and risk.[4-6,8-10]

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Internal risk factors include:
- Increasing age.
- Female gender.
- Medical comorbidities.
- Substance abuse.
- Mental illness.
- Cognitive impairment.
- Sensory impairment.
- Impairment in activities of daily living (ADL).
- Malnutrition.

External risk factors include:
- Lack of social network.
- Dependence on a care provider.
- Living alone.
- Lack of community resources.
- Inadequate housing.
- Unsanitary living conditions.
- High-crime neighborhood.
- Adverse life events.
- Poverty.

An essential component of risk assessment includes an examination of an individual's strengths, resources, and willingness to accept intervention. Clinicians must weigh all these factors in forming an opinion.

Red flags

Vulnerable older adults should be screened for cognitive deficits and mistreatment. The presence of certain indicators should raise suspicion of abuse or neglect.[4,5] These indicators include:
- Repeated ER visits or hospital admissions.
- Neglect of medical problems.
- Lack of follow-up for appointments.
- Noncompliance with medication.
- Acute deterioration in ADLs or cognition.
- Unexplained weight loss or failure to thrive.
- Poor grooming or hygiene.
- Inappropriate or soiled attire.
- Refusal of appropriate and needed assistance (e.g., home care, meal delivery).
- Threat of eviction.
- Infestations (e.g., lice, bed bugs, rodents).
- Motor vehicle accidents or moving violations.
- "Doctor shopping."
- Decline in financial status.
- Victimization, exploitation.
- Sudden appearance of new "caregiver."

Physical examination of the vulnerable or abused elder may reveal cachexia, dehydration, malnutrition, burns, bruising, dental decay, decubitus ulcers, odor, lack of cleanliness, and gait abnormalities.[4,9]

Behavioral indicators include confusion, disorientation, fearfulness, suspicion, infantile or regressed behavior, hopelessness, suicidal thoughts, impaired insight, and poor judgment.[4]

Clinical assessment

The setting and circumstances of each case will vary, and considerable flexibility is required when evaluating safety and looking for indicators of neglect or abuse. Assessments may involve considerable time and require several visits from different professionals. Collateral information is essential and may come from a variety of sources, including medical records, family physicians, relatives, friends, home care personnel, neighbors, landlords, and police.[5] Vulnerable adults are often not forthcoming or reliable informants. They may lack insight and refuse assistance.

Caregivers may be responsible for abuse or neglect. In such cases, the assistance of social services, adult protection services, police, the public guardian and trustee, and the courts may be necessary. Referral to geriatric outreach services is often warranted. If mistreatment is suspected, it should be reported to a designated agency, such as the local health authority, for investigation. If a crime is suspected, it must be reported to the police.

Comprehensive geriatric assessment should include a client interview, physical examination, and review of medical history and medication usage. Laboratory and radiographic studies may be clinically indicated. Basic cognitive testing and screening for psychiatric disorders is recommended.[11] It is important to explore potential financial, physical, emotional, and sexual abuse. Finally, the clinician needs to address functional abilities and existing supports.[4,5] Detailed documentation is essential in these matters because of potential legal implications.

Basic financial capability should be assessed if cognitive impairment is apparent or exploitation is suspected. It is also important to determine the presence of a proxy decision-maker (e.g., power of attorney, committee).

Evaluation of the older person's willingness to accept support and assistance is essential. A history of previous refusals or lack of cooperation is an important consideration.

Safety issues involving medication management, fire hazards, suicidal ideation, falls, driving, wandering, and aggression need to be identified. If a language barrier or sensory impairment is present, efforts must be made to enhance communication.

Home visits

A home visit by a health care provider is frequently needed to assess an individual's safety.[4,5] Many older adults can present well in structured settings such as hospitals. They may conceal their deficits for fear of being institutionalized.[12]

Gaining entry into an individual's home can be challenging. Permission is needed except in cases where imminent harm is suspected. It is important to reassure the individual that you are there to assess for health problems and the need for services. Stress your

desire to keep the older adult safe and functioning in the community. If you suspect abuse or neglect, be forthright about the issue. Many older adults will feel a sense of relief rather than anger.

On some occasions, joint visits with home care staff or police may be necessary. Many police departments have dedicated elder abuse constables. Building managers, family, and friends can assist with gaining access to the home. Attention to personal safety is paramount. If the individual has a history of violence or aggression, police presence should be requested. The accompanying box describes considerations for a home visit.

Intolerable risk and capability

Risks can be "tolerable" or "intolerable," "actual" or "potential." The presence of intolerable risk necessitates an assessment of decision-making capacity.

Intolerable risk involves dangerous behaviors or circumstances that can cause serious and imminent harm. Examples include physical aggression, abuse, exploitation, severe self-neglect, and sudden deterioration of health. Inability to protect oneself from danger or victimization is another example of intolerable risk.

Capable adults have the right to live at risk but should be offered support and assistance. Incapable adults (even those with significant physical and cognitive impairment) may be able to function in the community if they accept appropriate services and interventions.

Incapable older adults who live with intolerable risk require urgent intervention. If there is immediate danger to self or others, the older adult may need involuntary hospitalization. In other instances, it may be appropriate to utilize resources such as respite services, facility placement, seniors' day hospitals, or home care services.

Unfortunately, the current provincial mental health and guardianship legislation does not offer detailed criteria to guide decision making. Disagreements among clinicians, lawyers, risk managers, and ethicists are not uncommon. The situations that arise may elicit strong emotions.

It is important to understand that individuals are presumed to have capacity. The onus is on clinicians and courts to prove incapacity. Contrary to popular belief, capacity is not a global construct. It is domain-specific and decision-specific. Capacity is not based on a particular test result or diagnosis.[13-17]

Decision-making capacity requires that an individual have an understanding and appreciation of the situation or problem at hand. Articulation of alternatives, choices, benefits, and risks is expected. The person must be aware that the issue in question relates to him or her specifically. Traditionally, capacity assessments relied heavily on verbal skills and were less focused on executive function (e.g., problem solving, reasoning, planning, task initiation) and ability to perform activities of daily living.[13,14,17]

Adults with normal scores on cognitive tests are not necessarily competent, and those with abnormal scores are not necessarily incompetent.[15,18] Each situation is unique. Vulnerable older adults are difficult to identify and diagnose because many retain adequate social and communication skills.[14] They may claim to have abilities and skills that are inconsistent with their actual performance in the community.[14]

An individual with significant memory impairment but preserved insight and judgment may retain decision-making capacity. Another individual with intact memory, language, and orientation might be incapable because of impulsivity and poor judgment.

Deficits in certain cognitive domains can be difficult to capture.[14-16] For example, frontal and executive dysfunction are not always apparent in a structured clinical environment. Frontal dysfunction can manifest with behavior change, self-neglect, and poor insight. Individuals with this type of impairment can be easily influenced, coerced, and exploited. They may be unable to extricate themselves from harmful circumstances because of apathy or lack of problem-solving ability.[14] Executive function has been found to be a better predictor of decision-making capacity than global cognitive ability.[16]

Experts in the field of capacity and mistreatment have suggested that vulnerable adults may retain decision-making ability but lack the ability to execute or demonstrate these decisions during everyday functional tasks.[14,16] Memory disturbance, lack

Key considerations during a home visit

Dwelling and yard

Consider overall maintenance, cleanliness, and security. Take note of vehicles, stairs, smoke detectors. Note any water or fire damage and fire hazards. Review access to neighborhood amenities such as bus stops, grocers, banks.

Within the home

- Consider utilities and appliances. Look for clutter, garbage, signs of hoarding, unopened mail, overdue bills, spoiled food, infestations, cigarettes, liquor. Check stairs, railings, food, over-the-counter and prescription medication, assistive devices (cane, walker, grab bars).
- Physical appearance and well-being of older adult.
- Consider dress, hygiene, and grooming. Assess vital signs, body habitus, color, skin turgor, gait, balance, transfers. Note mood, behavior, level of cooperation.

of initiative, depression, anxiety, and paranoia can prevent people from implementing their choices and thus make them incapable. The focus of assessments should therefore be on functional ability for self-care and protection. In these cases "actions may speak louder than words."[14,16,19]

Self-neglect

Self-neglect is an increasingly prevalent and poorly understood social and medical problem. It is a multifactorial behavioral entity that involves the inability or refusal to attend to one's health, hygiene, and personal and environmental needs.[4,5] It is the most common reason for referral to adult protection services.[8] Self-neglect is distinguished from neglect proper, which is a form of elder abuse.

Self-endangerment may occur because of unsafe behaviors. Self-neglect is an independent risk factor for mortality and institutionalization.[8,10] Older adults who neglect themselves typically live in conditions of extreme isolation, filth, and squalor. They often hoard and have rodent and insect infestations.[5,20] They generally have poor insight, see nothing amiss with their circumstances, and refuse offers of help.[20] Self-neglecters risk eviction as a result of safety hazards and complaints from neighbors.

Self-neglect cases are controversial. Clinicians frequently debate whether self-neglecters represent a medical or social problem, particularly if dementia or severe mental illness is not present.[4,8] In the end, it is largely a matter of semantics. If self-neglecters are incapable and are ill, it would be negligent for health professionals not to intervene.

Risk factors and warning signs have been studied and are similar to those discussed under "Red flags." Many self-neglecters suffer from dementia, depression, or both.[8,6,10] Executive dysfunction is frequently present.[8,19]

Case identification is difficult because affected individuals do not seek assistance and have few supports. Physicians are more likely to see self-neglecters in emergency rooms or inpatient settings rather than in ambulatory care.[5] Presentation of these cases provides a rare yet crucial opportunity for intervention.

Self-neglect is an independent risk factor for mortality and institutionalization.

Assessment and intervention approaches are similar to those used for other vulnerable older adults. Collateral information should focus on the severity, chronicity, and trajectory of the problem. Medical, cognitive, functional, and psychiatric evaluations are required. Capacity must be assessed. Reversible medical causes should be treated. Involuntary commitments and proxy decision-makers can be used if less invasive measures fail or are inappropriate.

Approach to intervention

The goals of intervention in cases of vulnerability are to promote autonomy, ensure safety, reduce morbidity and mortality, maximize function, and improve quality of life.[5] Individuals should be offered support and assistance such as home care, day programs, ongoing medical follow-up, housekeeping, meal delivery, and transportation programs. Hospitalization and facility placement may be required, depending on the needs of the individual.

An individual's autonomy should only be infringed upon with significant justification. Formal measures are not a panacea, and can precipitate a decline in the health and well-being of the individual they were designed to protect.[12] The least invasive measures should always be used in accordance with the individual's previously expressed wishes and values. Vulnerable older adults need to be involved as much as possible in decision making.

If financial concerns are identified, a financial capacity assessment is appropriate. In British Columbia, referral to the public guardian and trustee may be helpful. If the older adult is deemed incapable of managing his or her finances and has an enduring power of attorney, it should be enacted. If not, committeeship of estate can be pursued through the courts or the public guardian and trustee. Lesser measures, such as pension trusteeships, may be appropriate in some cases.

Committeeship of person is rarely required. If the incapable individual refuses support and assistance or is being abused, it may be a necessary measure. The provincial Mental Health Act can be used to admit individuals to hospital in an effort to protect them and prevent physical or mental deterioration.

If cognitive or psychiatric disorders are present, reversible causes should be sought and treated. The use of medications may be appropriate. Crimes against older adults should be reported to the police for investigation. Cases of suspected abuse need to be referred to a designated agency, such as a regional health authority.

Capable adults who refuse intervention should be offered information regarding services that are available.[21] Ideally, a primary care physician will be involved. Health units or home care staff may be able to provide informal assistance that is acceptable to the individual.

Physicians should familiarize themselves with local resources, which may differ from one community to another. Health units or home care services, geriatric outreach teams, the public guardian and trustee, victim services, legal aid, police, and health authorities can often provide needed advice, support, and assistance.

Summary

As the population ages, physicians of all specialties will encounter older adults who are vulnerable and living at risk because of physical, cognitive, psychiatric, or other impairments. The management of these individuals is complex and requires an interdisciplinary approach.

Assessment requires knowledge of the risk factors and the indicators of neglect and abuse. A home visit is frequently needed. An awareness of what constitutes intolerable risk can help determine when immediate intervention is warranted. Establishing the older adult's capacity to make and implement decisions is a crucial component of every assessment.

Once assessment indicates that intervention is required, support and assistance can be offered. The goals of intervention include promoting autonomy, reducing morbidity and mortality, and improving the older adult's quality of life.

Competing interests

None declared.

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Suggested reading

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