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Research

Elder abuse and neglect: A survey of pharmacy students' opinions, experience, and knowledge

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Abstract

Purpose: To determine pharmacy students' awareness of state reporting laws for elder abuse and neglect (EAN) and recognition of the signs and symptoms. An additional purpose was to understand whether education on EAN was needed in the pharmacy curriculum. A voluntary survey was distributed to 365 third- and fourth-year pharmacy students; 328 were returned with usable data. The questions on EAN were organized into three general areas: opinion, experience, and knowledge.

Results: With regard to opinion, 98% of responding students felt that identifying EAN was important, and 76% felt that educational content about EAN should be included in the curriculum. Only 23.4% of responding students felt adequately trained to report a case of suspected EAN. While 24% of responding students had suspected a case of EAN at some point in time, only 1.8% had ever reported a case of EAN. Moreover, 44% of responding students correctly identified that Illinois law required them to report a suspicion of EAN, 7.3% answered no, and 48.6% did not know. Other sections investigated whether pharmacy students were familiar with the culture of EAN and able to identify common signs and symptoms of EAN. Overall, 60% correctly identified family members are more often abusers than strangers; 92.3% correctly identified that dementia makes an older adult more vulnerable to abuse.

Conclusion: Overall, this study found a need to educate pharmacy students on the issue of EAN. Pharmacy students must be aware of the signs and symptoms to detect EAN. They must also understand reporting responsibilities.

Keywords: Pharmacy education; Geriatrics; Curriculum; Elder abuse and neglect; Mandated reporting

Introduction

In the United States, the "Baby Boomers" have a significant effect on national demographics. The number of Americans aged 65 years or older numbered 43.1 million in 2012. This represented an increase of 7.6 million or 21% since 2002. By 2040, the number of older persons will be about 79.7 million.[1] With this segment of the population growing, the problem of elder abuse and neglect (EAN) warrants attention.

States' define elder abuse according to their unique statutes, and definitions vary from state to state.[2] Researchers and health care disciplines have also identified the problem but with some variation. Common characteristics include the action be intentional, cause harm or serious risk of harm, and involve a vulnerable older person. Some definitions also stipulate a special relationship exist between the perpetrator and victim, for instance, where there is the expectation of trust. In general, the major types of elder abuse include physical, emotional, sexual, financial, and neglect. Self-neglect may be more common than any other form of abuse or neglect by others. The term refers to

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refusal or failure to provide oneself with the goods or services to meet basic needs.[2,3]

Studies have reported a range in the incidence and prevalence of EAN. In the National Elder Mistreatment Study, one in ten community-dwelling adults 60 years or older reported some type of abuse (excluding financial) in the past year. The prevalence by abuse type was 5.1% for potential neglect, 4.6% for emotional abuse, 1.6% for physical abuse, and 0.6% for potential sexual abuse.[2] In a second national study, 3005 community-dwelling persons aged 57–85 years were asked about their experience with mistreatment in the past year. The most commonly reported abuse was verbal. Overall, 9% of respondents reported being insulted or put down by a family member.[4] More recently, the New York State Elder Abuse Prevalence Study reported a one-year incidence rate of 7.6% for any form of elder abuse found. Financial exploitation in the year preceding the survey was the most common form of mistreatment reported by respondents. This study estimated that only 1 in 24 cases came to the attention of programs and authorities.[5] Victims may be unwilling or unable to acquire help. They may fear of retaliation from the abuser or believe there is no safer alternative to their current situation.[6,7] Barriers to reporting EAN among health care professionals include a lack of knowledge in recognizing and reporting, concern about the legal ramifications, and fear of losing patient trust.[6] Perpetrators of EAN are more often family members rather than stranges.[3] The complexity of the EAN is due, in part, to underreporting.

All health care professionals should see themselves as responsible for addressing EAN. With a mindset of collective responsibility to report suspected EAN, more victims can be identified and intervention can begin. Pharmacists have been referred to as gatekeepers who can meet the pharmaceutical needs of older adults but also watch for their safety.[7] The American Bar Association assembled comparison charts of reporting requirements by state statutes, current as of December 2006.[8] By individual state Adult Protective Service laws, pharmacists are explicitly identified as mandatory reporters in ten states; however, the statues governing reporting are complex. Multiple states require "any person" who suspects abuse to make a report, and pharmacists obviously fit within this condition. Finally, pharmacists may fit within broader, non-specific categories of other states' statues such as "health care practitioners."[8] These references to pharmacists, whether specific or broad, implicate pharmacists in the majority of states as mandatory reporters. Illinois law requires pharmacists to report suspected elder abuse; however, mandatory reporting only applies if the person thought to be abused is unable to make a report. A potential influence on health care professionals' detection and reporting rates of EAN is the instruction received on the topic during their training programs.

In this article, the authors describe a survey administered to pharmacy students at Midwestern University (MWU) Chicago College of Pharmacy. The survey items related to students' experience, opinions, and knowledge of EAN. The topics covered included the following: prevalence, types of abuse, risk factors, consequences, and the reporting process. Prior to the study design, a review of the literature was conducted to learn of previous studies of health care professionals and/or students as it relates to knowledge of EAN. Dental and medical students as well as physical therapists were among the study populations found.[9–11]

Review of the literature

A survey was administered to 291 first- and second-year dentistry students at the University of California, Los Angeles.[9] The instrument consisted of questions in the following areas: prior training and education in geriatrics and elder abuse, perceptions of the culture of EAN, and knowledge of mandated reporter legal responsibilities and protections. Only 6% of responding students reported ever receiving training on elder abuse. With regard to general perceptions of the issue of elder abuse, the students' level of knowledge varied. Students understood that EAN takes place. Overall, 67% answered false to the statement "Abuse and neglect of older adults are rare" and 84% answered false to the statement "Mistreatment in later life only happens to people who are vary frail." However, there was greater uncertainty with other statements. A majority of students (57%) answered unsure to the statement "Most abuse of older adults occurs in nursing homes." Survey results also revealed a lack of knowledge of the reporting process itself and the protections that are guaranteed to mandated reporters. Information from the study resulted in the development of curriculum units on EAN inserted throughout the educational program.[9]

In the discipline of medicine, 202 fourth-year students at the University College London and the University of Birmingham, UK, were surveyed on their recognition of elder abuse in a dementia patient.[10] A fictional vignette introduced the patient and then students were asked to classify 13 responses for managing her behavior as abusive or not-abusive. The authors concluded that the students were successful at recognizing not-abusive care, for example, arranging an identification bracelet and asking a doctor about medication that might help the situation. In contrast, students were not as effective at recognizing abusive care. Only 14% and 56% of responding students, respectively, identified accepting someone was not clean and locking someone in alone as abusive. Of interest, teaching about elder abuse did not always correlate with the ability to identify abusive care.[10]

A third publication describes the extent of elder abuse knowledge among 118 physical therapists in Michigan.[11] In the first part, common signs or symptoms of physical abuse were presented. The average number of correct answers on these ten statements was 7.2. Of the responding students, 92% and 94%, respectively, identified untreated injuries and