



# elder abuse

**A review of evidence for prevention**  
from the UK focal point for violence and injury prevention

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## About the UK focal point for violence and injury prevention

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The 49th World Health Assembly (1996) declared violence a major and increasing global public health problem. In response, the World Health Organization (WHO) published the *World Report on Violence and Health* and initiated a major programme to support and develop violence and injury prevention work globally. As part of this programme, each member state has designated a national focal point for violence and injury prevention. The network of focal points works with the WHO to promote violence and injury prevention at national and international levels, develop capacity for prevention, and share evidence on effective prevention practice and policy.

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### Acknowledgements

We would like to thank Dr Ruth Hussey, North West Regional Director of Public Health, for supporting the promotion of evidence-based injury prevention. Our thanks extend also to Karen Hughes, Lee Tisdall, Lindsay Furness, Gayle Whelan and Donna Halliday (Centre for Public Health, Liverpool John Moores University), for their help in planning, writing and preparing this booklet.

## A summary of evidence: promising interventions to prevent elder abuse

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**Encouraging positive attitudes towards older people:** through the use of education programmes for health care workers (e.g. as part of core training for key staff). These programmes can increase interest shown in the care of older people and reduce elderly stereotypes.

**Providing support for caregivers:** such as peer and professional support groups, respite care and psychological programmes such as anger management and depression management. These programmes can increase social contact, address caregiver burden and reduce emotional distress.

**Increasing identification and referral of those abused:** through the use of screening tools and training for health and other professionals. Training programmes can increase knowledge and level of comfort in handling cases of abuse among professionals.

**Supporting those abused:** through multi-agency work to ensure efficient reporting and management of elder abuse cases in the community. This can help ensure that older people receive appropriate support and care.

Elder abuse can be defined as ‘a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person’ (1). Mistreatment of older people can occur in the home (e.g. by family, friends, carers or home helpers) or in institutional settings such as nursing or care homes by professional health care staff. One of the most common forms of abuse is neglect or failure to fulfil a care giving responsibility. Although this may be intentional, often there may be no intent for the perpetrator to cause physical or emotional harm. Other types include: psychological or emotional abuse (e.g. denying freedom or respect, removing personal control from the lives of older people, bullying or threats of withdrawing care); financial abuse (e.g. exploiting the wealth of an older person to their deprivation, including misappropriation of property and affairs); physical abuse (e.g. hitting or slapping, physical restraint or unnecessary sedation with medication); or sexual abuse (e.g. rape) (2).

### **Elder abuse in the UK: some facts**

- Women are more likely to be victims of elder abuse than men;
- Perpetrators of abuse are more likely to be male. However, males and females are equally likely to commit financial abuse;
- Perpetrators of abuse are most often partners, spouses or other family members;
- The most common type of mistreatment is neglect, followed by financial abuse;
- Reports of maltreatment are greater among those in the oldest age categories (85+) compared to younger age groups (65 to 85);
- The prevalence of maltreatment increases with declining health.

Source: Biggs et al, 2009(3).

Although the definition of old age is often debated, the majority of literature recognises an older person to be anyone over the age of 65. Many cases of elder abuse remain hidden to authorities, making it difficult to determine the extent of the problem. However, a UK study of over 65s living in private households found that 2.6% had experienced maltreatment by a family member, friend or care worker in the past year (3). The prevalence of abuse is known to be higher among impaired older people in receipt of care. For instance in a study of family carers of people with dementia, over 50% reported some kind of abusive behaviour towards their dependent, with verbal abuse the type most commonly reported (4). The effects of mistreatment or neglect can be distressing and wide ranging and can include psychological and emotional problems such as anxiety and depression, physical injuries such as bruises and fractures, and economic impacts such as unrecoverable loss of savings (5).

Certain groups of people are more likely to experience elder abuse than others. These include females, those of older age (e.g. 85 and older compared to 65 to 84 years), and those of lower socio-economic position/status (3). Furthermore, a number of factors are thought to increase the risk of an older person being maltreated, such as mental disorders, cognitive and physical impairments and social isolation (5). Several factors have also been associated with perpetration, including dependency on their victim for housing and finance, financial difficulties, personality disorders, alcohol or drug abuse, and mental health problems. The quality of the carer/person relationship prior to being cared for may also be an important factor. For instance, better quality past

relationships (e.g. more communal in nature) have been associated with more rewarding carer/cared-for relationships and less carer depression and potentially harmful behaviours (6). Poorer quality living conditions can also play a role, with abuse more likely to occur where there is overcrowding or a lack of privacy. Furthermore, at a societal level, holding ageist attitudes (e.g. beliefs that older people are frail, weak and less important in society) can make maltreatment more tolerable and of low perceived importance (5). This may provide an overall context in which mistreatment is accepted.

As with all forms of violence, elder abuse is preventable. However, there is a paucity of quality research on prevention, meaning that evidence-based programmes are few and far between. This document highlights the types of programmes that have been implemented and documented to prevent or reduce elder abuse in the UK and elsewhere and examines evidence for their effectiveness. It includes interventions that: encourage positive attitudes towards older people; provide support for informal caregivers; increase identification and referral of those abused; and provide support for elderly victims. Although it is not the main focus of this document, legislation can also play an important role in the protection of older people from abuse.

## Legislation in the protection of older people from abuse

Legislation has a key role to play in the protection of older people from abuse. Its enforcement sends a clear message across society that older people are valued and that their abuse or neglect is not acceptable. Although there is no one legislative act covering their protection in the UK, a variety of laws deal with a wide range of related issues (7). For instance, in the UK, legislation ensures that:

- Physical, sexual, financial and emotional abuse and neglect towards elderly people are punishable offences (see below for examples);
- There is a minimum standard of care within institutions;
- Those working with vulnerable adults are vetted prior to employment;
- There is a framework in place to make decisions on behalf of adults who lack decision-making capacity; and
- Health and social care workers who report colleagues for elder abuse or neglect are protected from reprisal or victimisation by their employers.

### Legislation for the protection of older people includes:

*Offences Against the Person Act, 1861*: sets out offences that affect the physical health and well-being of another person, including assault;

*Public Interest and Disclosure Act, 1998*: provides a mechanism for protecting workers from reprisal or victimisation if they report colleagues who mistreat or abuse patients;

*The Care Standards Act, 2000*: sets out national minimum standards for residential care homes, nursing homes and domiciliary care;

*Mental Capacity Act, 2005*: introduces a framework for health and social care workers and others to make decisions on behalf of adults who lack decision-making capacity. Among other things, the act allows a public guardian or attorney to make decisions on their behalf once they lose

the ability to do so and makes it an offence for a guardian/relative or carer to ill-treat or wilfully neglect a person in their care who lacks capacity;

*The Domestic Violence, Crime and Victims Act, 2004*: introduced a new offence of familial homicide, of causing or allowing the death of a child or vulnerable adult (including those of older age whose ability to protect themselves from violence is impaired);

*Safeguarding Vulnerable Groups Act, 2006*: introduced a new “vetting and barring” process to protect vulnerable adults from harm by employees or volunteers. Employers are required to check employees working with vulnerable adults against a list of those barred by the Independent Safeguarding Authority (ISA).

## 1. Encouraging positive attitudes towards older people

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Negative attitudes, prejudice, and stereotypes towards older people (e.g. that they have little value or worth in society, are weak and frail, or have little control over their own life) can affect the ways in which they are treated and cared for by family, carers and society at large. Consequently, interventions that encourage positive attitudes and respect among carers and the public have the potential to offer protection against abuse or neglect.

### 1.1 Education for health and social care workers

For professional carers, education programmes have been used to reduce negative attitudes and increase/improve quality of care. Programmes vary in nature, but typically include education on the ageing process and elder abuse, as well as the development of skills (e.g. interpersonal skills) for working with older people. While research is lacking,

some evaluations have reported an improvement in attitudes towards elderly patients (8,9). For instance in Australia, a structured educational programme was provided early in nurses' training, incorporating placements in nursing homes to create positive learning experiences. The programme included sessions on interpersonal skills, health assessment, anatomy and physiology, and was accompanied by tutorials to discuss the ageing process, myths and facts of ageing, expectations, concerns and feelings. Following the programme, increased interest was shown in the care of older people and elderly stereotypes had reduced (8).

In England, the Dignity in Care campaign aims to change attitudes towards older people in care through raising awareness of the need for dignity and respect, and motivating health and social care workers (as well as members of the public) to take action. For instance, the campaign invites health and social care workers to become dignity champions; people willing to challenge negative attitudes and disrespectful behaviour and promote dignity within their workplace (10). A Dignity in Care guide is available to help organisations improve dignity and respect within the services they provide (11). Although no studies have measured whether a positive attitude can reduce the risk of abuse perpetrated by professional care staff, it is an essential foundation for the provision of high-quality care and may make abuse more likely to be reported.

## **1.2 Public education**

Mass media campaigns can be used to raise awareness of elder abuse across society, create positive attitudes towards older people, and encourage action to prevent or reduce abuse. In England, the Dignity in Care campaign raises

awareness of respect for older people among the general public (10). In Scotland, the “See the person, not the age” campaign is run by Help the Aged to encourage people to see the valuable skills, experiences and abilities older people have to offer (12). The message that older people are not worthless is disseminated via television adverts, printed media and a website. At a wider level, the International Network for Prevention of Elder Abuse initiative (INPEA) works to disseminate information about (and prevent) elder abuse globally (13). The initiative hosts an annual World Elder Abuse awareness day. Due to the difficulty in evaluating mass media campaigns, little is known about their ability to affect behavioural change such as perpetration of abuse or neglect. However, raising awareness of elder abuse as an issue amongst the public, and challenging any negative societal attitudes towards older people, are both important steps to increasing protection of the elderly and may mean that abuse or neglect is less likely to be tolerated.

## 2. Support for informal caregivers

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Informal caregivers of older people can include (adult) children, spouses or other relatives, or friends and neighbours. Caring for an elderly person can be a physically and emotionally tiring experience and can often lead to psychological distress such as depression, anxiety and social withdrawal (5). Without proper support, those undertaking informal carer responsibilities can become socially isolated, especially if the dependent person is homebound. Negative emotions (e.g. anger) that can sometimes arise from caregiver burden and stress are thought to increase the risk of potentially harmful behaviour

towards an elderly dependent (14). Thus, in some instances, caregiver programmes that provide support and address the psychological consequences of their responsibilities may help protect against abuse. However, little is currently known about whether such programmes can or do improve the care and treatment of elderly dependents, or affect levels of maltreatment or neglect.

## **2.1 Support and advice**

One method of increasing support for informal caregivers is through the use of peer and professional support groups. These allow carers to discuss problems with people in similar situations, increase their social networks, and gain information and advice about caregiving and caring responsibilities. Support groups may be face-to-face, or computer-based for those finding it more difficult to leave the home. Little is known yet about the effectiveness of these initiatives. One computer-based programme implemented in Norway provided caregivers with access to information (covering health topics such as dementia and stroke, how to care for elderly patients, and being a family carer) along with an online discussion forum. The forum allowed carers to gain verbal and visual contact with others (via the use of a videophone), provide information and share problems. After participating in the study for seven to twelve months, no reductions in carer stress or mental health problems were recorded, but carers reported greater social contacts and increased social support (15). In the US, a similar computer-based programme for caregivers of people with Alzheimer's disease (the ComputerLink project) reported increases in the confidence of caregivers' decision making following participation, but not perceptions of social isolation (16,17).

This is perhaps indicative of the complex nature and multiplicity of factors involved in caregiving for older people.

## **2.2 Respite care**

Respite programmes provide care for an elderly dependent person to give caregivers a break from the burden of their responsibilities. These can range in duration from a matter of hours to weekend breaks (or even longer periods, e.g. one to two weeks). Evaluations of day care schemes for elderly patients suggest that with consistent and long-term use, they can reduce perceptions of caregiver burden, worry and strain, as well as psychological problems such as depression and anger (18,19). However in general, the evidence base is limited and little is known about effects on abusive behaviour, or on the older people receiving care.

## **2.3 Psychological programmes**

Psychological programmes are sometimes offered to carers to lessen emotional distress. These initiatives can include anger management, depression management and cognitive behavioural therapy, and can be offered to those experiencing psychological problems or those who have abused or neglected their elderly dependents. There is some evidence that they can reduce levels of caregiver distress and burden (20,21), as well as increase caregiver satisfaction (21). For instance, in the US, anger management and depression management programmes were offered to female caregivers of relatives with dementia. The anger management intervention explored reasons for caregiver frustration, taught strategies for relaxing, and developed cognitive skills such as positive self-talk and assertiveness. The depression management programme explored

relationships between mood and pleasant events, developed problem solving skills to overcome barriers to engaging in pleasant activities, and discussed ways to balance time between personal activities and caregiver responsibilities. The interventions took place over a three to four month period, and were associated with reductions in levels of anger or hostility and depression, as well as an increase in perceived self-efficacy (22). Anger management programmes can also be effective in reducing caregiver strain, depression and anxiety when targeted at abusive caregivers (23).

### **3. Increasing identification and referral of those abused**

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Abuse of elderly people often remains hidden from authorities or even the wider public. However, its detection is essential in ensuring appropriate care and support is provided, not only to stop further violence, but to reduce the psychological consequences of abusive experiences. Through routine check-ups or treatment in settings such as emergency departments, general practices, mental health departments and dental surgeries, health care professionals are in ideal positions to detect abuse in elderly patients.

#### **3.1 Training for health and social care professionals**

It is essential that health and social care professionals can identify cases of elder abuse and know what action to take if a case is detected. Training programmes have been designed for health professionals in a variety of settings, which aim to: raise awareness of elder abuse; educate about the signs and symptoms of maltreatment; and teach

strategies for managing cases of abuse (e.g. in Nottingham, the Comprehensive Learning Resource [24]). Health care training can improve knowledge (25,26) and level of comfort in handling elder abuse and neglect (27). However, little is known about its effectiveness in preventing violence, or protecting victims from further abuse. Furthermore, in some instances (including institutional settings where abuse is being perpetrated by a colleague), although abuse may be identified, workers may not wish to report it through fear of breaking professional loyalty, fear of repercussion from employers, or sympathy with the perpetrator (28). Thus, even with training in place, positive effects may not lead directly to improvements in the protection of older people. In the UK, a number of professional organisations (e.g. the Nursing and Midwifery Council, NMC; and the Community District Nursing Association, CDNA) have published guidelines for health workers on the identification, prevention and management of abuse in practice settings (29,30).

### **3.2 Screening for elder abuse**

Screening tools are often used by health professionals to aid detection of abuse among patients. These consist of a series of questions completed either by patients or their caregivers, and are designed to identify common signs and symptoms of maltreatment. Possible signs include having: cognitive impairment; a history of past abuse; alcohol problems; conflicts with family members; over-demanding behaviour; or suspicious falls or injuries (30). One such screening tool is the Elder Abuse Suspicion Index (EASI) which has reported some promising results in terms of acceptability and detection (31). While the use of reliable and valid screening tools can identify abused older people (30-33),

concerns have been raised about their use. For instance, signs and symptoms of abuse in older people may also be signs of chronic illness (e.g. weight loss, falls or injuries) and may lead to incorrect detection of abuse. Alternatively, the abuser may attend the health care setting with the patient, or even complete the screening tool, making disclosure difficult or unlikely (34). Thus, despite positive reports, screening tools for elder abuse should be used with caution and to raise awareness of the potential for abuse rather than detect actual abuse (34). Although screening alone cannot protect those mistreated from further violence, it is an important step in eventual referral to appropriate social, medical, psychological or legal services.

## EASI (Elder Abuse Suspicion Index) tool

The EASI screening tool was developed for use by health professionals to improve detection of abuse among older patients. Initial testing of the tool found that it had an estimated sensitivity and specificity of 0.47 and 0.75 and took less than two minutes to complete. In addition, 97% of doctors who tried the tool thought it would have a positive impact on their practice (31). There are six questions in total; five intended for the older person to answer (when asked by the doctor), and one intended for the doctor:

Within the past 12 months:

1. Have you relied on people for any of the following: bathing; dressing; shopping; banking; or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6. (For doctor) Elder abuse may be associated with findings such as: poor eye contact; withdrawn nature; malnourishment; hygiene issues; cuts; bruises; inappropriate clothing; or medication compliance issues. Did you notice any of these today or in the past 12 months?

### 3.3 *Mandatory reporting*

In a number of localities (e.g. certain states in the US and Australia, and in Israel), health and social care professionals are required by law to report any case of suspected elder

abuse to authorities. Mandatory reporting is thought to hold a number of benefits; it brings cases of abuse to the attention of authorities so that appropriate support can be provided and it raises public and professional awareness of the problem of elder abuse (34). However, the effectiveness of mandatory reporting for elder abuse has not been well researched or evaluated and several ethical concerns have been raised, including the reduction of control an older person has over his or her life (34). Additionally, it may cause retaliation by the abuser towards health care professionals or the older person, or deter older patients/people from using health care services (27).

## **4. Support for elderly victims / potential victims**

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Support can also be provided for victims or potential victims of abuse. This can include, for instance: raising awareness of the different types of maltreatment; education about how to prevent them; encouraging reporting; and developing appropriate support to manage cases of reported abuse.

### **4.1 Education**

Increasing awareness among older people of what is acceptable and unacceptable caregiver behaviour, and of available support and advice services, can help encourage victims to report maltreatment. For instance, in Canada, a media campaign was launched with the tag line “Respect our elders”, which aimed to increase awareness of abuse and local services offering help and advice. The campaign used radio and television slots, posters, flyers and

newspapers to disseminate information, and information was placed where older people were most likely to see it (e.g. pharmacies, meals-on-wheels, centres for elderly people, doctor surgeries). Although the campaign was not evaluated, it had the ability to deliver essential information to those that might be experiencing abuse (35). In the UK, along with national campaigns run by organisations such as Help the Aged and Action on Elder Abuse, information is sometimes distributed locally through adult protection services, highlighting the issue of elder abuse and encouraging victims to contact services and helplines for advice and support.

## **4.2 Helplines**

In the UK, Action on Elder Abuse run a free, national helpline for victims of elder abuse or those concerned for an abused friend or relative. The helpline offers information on the nature of elder abuse, advice on services available to those affected, and emotional support from trained volunteer staff. It currently handles around 4,000 calls about abuse or neglect each year (36). Although calls to the helpline have been analysed to learn more about the types of abuse that occur and the types of calls made to the line (37), little is known about the impact of the helpline on those in need of support.

## **4.3 Adult social care services**

Adult protection is available in the UK for elderly people who are experiencing abuse or poor quality care. This is often incorporated within broader services such as adult social care services or safeguarding. The Department of Health's document *No Secrets: guidance on developing and*

*implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, issued in 2000, aimed to improve the care provided to abused adults, and set out a framework to ensure efficient management of cases by agencies such as the police, social services and health services. If a case of elder abuse is notified to adult social care services, an investigation can ensue to determine the facts of the case, establish the needs of the victim and determine what follow-up action will be taken (38). This may include, for instance, supportive or therapeutic programmes, suspension, disciplinary action, or in some cases criminal prosecution of staff. There is little research on the effectiveness of multi-agency responses to elder abuse in the UK but their existence is important in ensuring that cases are managed quickly and effectively and appropriate support is provided for victims and their families. Moreover, there is evidence from the US that multi-agency work in adult protection can have beneficial effects on elder abuse reporting and service effectiveness. For instance:

- In some areas of the US, Elder Abuse Forensic Centers (EAFC) have been established to address cases of abuse. The centres employ professionals from a wide range of disciplines, including social workers, law enforcement officers, medical professionals, mental health professionals, domestic violence workers, and victim advocates. An evaluation of the first EAFC reported that it enhanced the efficiency and effectiveness of those who address elder abuse within a community (39);
- Vulnerable Adult Specialist Teams (VASTs) have been developed in some US states. These are multi-agency teams that include adult protective services, criminal

justice services and medical services to examine the physical and psychological consequences of abuse. An evaluation of one such team suggested it was helpful in confirming abuse and persuading the client or family to take action (40);

- In California, a Senior Crime Prevention Unit was established that managed the investigation, prosecution, community outreach and prevention of elder abuse. The unit included prosecutors, investigators and victim advocates, who: investigated cases; initiated criminal charges; provided court support; assisted with restraining orders; and provided referral to services. Educational materials to raise awareness of elder abuse were distributed to the elderly via a range of media. Although no formal evaluation was completed, the number of elder abuse cases referred to law enforcement rose following the unit's establishment (41).

## 5. Summary

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There has been increasing recognition of elder abuse as a health and social issue both in the UK and elsewhere over the past decade, together with an increasing focus on respect and dignity when providing care. Despite a range of interventions being implemented to address these concerns, there is still a lack of high-quality research that evaluates programmes, making it difficult to draw conclusions about their effectiveness and to make firm recommendations for practice. There are a number of promising interventions that can address factors associated with abuse (e.g. improve knowledge and skills, reduce caregiver burden and stress,

increase detection of abuse, and ensure appropriate responses to elder abuse). However, little is known about whether these interventions can or do prevent or reduce abuse. Such interventions include:

- Training for health professionals. This can include training for those who may be in contact with victims (to increase identification and referral to appropriate support services), and for those working closely with older people (to create positive experiences, challenge negative attitudes and ensure that the correct skills are developed for working with older people);
- Screening for elder abuse. However, with concerns raised about its use, tools should predominantly be used to raise awareness of abuse, rather than detect it;
- Providing support for caregivers in the form of peer and professional support groups, respite care, and psychological programmes such as anger or depression management; and
- Social or protective services which have been developed to respond to allegations of abuse and mistreatment.

Less is known about the effectiveness of public information campaigns, education for older people, helplines, or mandatory reporting, and benefits would be gained from further research in these areas.

All references are included in the online version of this document, available from:

**[www.preventviolence.info](http://www.preventviolence.info)** and **[www.cph.org.uk](http://www.cph.org.uk)**

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This booklet is one of 11 reviews presenting a public health overview for the non-specialist. They have been produced with funding from the Government Office North West (GONW). Other booklets in this series cover: falls in older people, sports injuries, road traffic accidents, childhood injuries, burns, child maltreatment, youth violence, intimate partner violence, sexual violence, and self harm and suicide.

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Published: September 2010

ISBN: 978-1-907441-83-7 (print version)

ISBN: 978-1-907441-84-4 (web version)

