Elder Abuse and Neglect

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Abstract

Elder maltreatment was first mentioned in a scientific publication in 1975; nowadays elder abuse has gained the necessary visibility to become internationally recognised as a global public health and social matter. However data and studies on this specific form of violence and the understanding of the phenomenon are still quite limited; recent meta-analysis tried to estimate the scale of the problem and indicated a combined prevalence for overall elder abuse in the past year between 14.3% and 15.7%, psychological abuse being the most common form of elder abuse both in community and residential settings.

Scientific reviewed by Professor Tan Maw Pin.

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Elder abuse and neglect (EAN) has extensive effects on the quality of life, morbidity and mortality of older adults, and health workers are in a unique position to identify it.

The global elderly population is increasing dramatically worldwide, from 900 million in 2015 to nearly 2 billion in 2050, so the incidence and prevalence of EAN will increase as well concomitantly. Identification and management of elder abuse need to be a priority of healthcare providers. At the same time, urgent steps should be taken by policymakers around the globe targeting the population changes and risk factors for EAN comprehensively, from every possible aspect.

Keywords

Elder abuse and neglect · Self-neglect · Elder maltreatment · Primary health care (PHC) · Family medicine

18.1 Introduction

Elder maltreatment was first mentioned in a scientific publication in 1975 when a health professional from the United Kingdom wrote a letter to the BMJ calling for action on "granny battery": "just another manifestation of the inadequate care we as a profession give to elderly population and their relatives who are left to cope with them unaided and supported by us" [1].

It took more than 40 years before elder abuse gained the necessary visibility to become internationally recognised as a global public health and social matter [2–5]. Nowadays elder abuse is also considered a violation of human rights by organisations such as the World Health Organization (WHO) [6] and the United Nations (UN) as stated in the principles for older persons [7]. The European Union in the Charter of Fundamental Rights (Art. 25) [8] also "recognises and respects the rights of older people to lead lives of dignity and independence, and to participate in social and cultural life" [2].

Despite the increased awareness and call for urgent action by major international agencies such as WHO [9], data and studies on this specific form of violence and the understanding of the phenomenon, beginning with terminology and definition, remain limited [3–5, 9].

18.2 Definition and Subtypes

18.2.1 Elder Abuse and Neglect Definitions

Elder abuse was first described as "granny battering" in BMJ in 1975 and is today known as elder mistreatment, abuse of older adults or senior abuse [1–3]. Recently "elder abuse and neglect" and its acronym EAN have gained scientific acceptance and validation as a more comprehensive and all-inclusive denomination will also be used in this text.

Table 18.1 Widely accepted EAN definitions

UK's Action on Elder Abuse, 1995	The US National Academy of Sciences, 2003
Elder abuse is 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 [12]	*Elder mistreatment*: (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm [13]

In addition to terminology, also the definition varies among international agencies, academics and researchers as well as across countries and cultures indicating the complexity of the concept and the philosophical and cultural believes entailed [3, 9–11]. The definition adopted by the WHO and other agencies such as the International Network for Prevention of Elder Abuse (INPEA) [2, 6, 10] was developed by the "UK's Action on Elder Abuse" organisation in 1995 [12]. The US National Academy of Sciences proposed another widely accepted definition presented in Table 18.1, which includes intention and inadvertent [13].

Both definitions present some limitations being based on relationships or at least an expectation of trust between victim and offender. Such definitions exclude any criminal actions performed by strangers [10].

The lack of a standardised, unanimous definition results in ramifications at numerous levels. It affects different disciplines including academia and policymakers, as well as the development and evaluation of various interventions [5, 9, 10, 14]. The WHO along with many scientific experts are now urging for a consensus on definitions, subtypes, and categorisation as well as research methods on the topic [9].

18.2.2 Subtypes

Elder abuse and neglect can take many different forms, as shown in Table 18.2. Although specific subtypes are subjected to cultural differences and vary from country to country, the five widely accepted types of EAN are psychological/emotional or verbal abuse, physical abuse, sexual abuse, financial/material abuse and neglect/abandonment [2–4, 10, 15].

Some studies also include more specific kinds of violence, namely, violence of personal rights [2]. Moreover, some experts debate whether self-neglect should be classified as a specific form of elder abuse or not. Some interpretations consider self-neglect related to elder mistreatment; however recently experts have been questioning such categorisation, just as suicide is not considered a form of murder [15]. Self-neglect is an extreme deficiency of self-care, and it can be associated with hoarding and other mental health disorders such as additions or health conditions and disability. It can occur at any age, although it is most common among the elderly; the signs of self-neglect are presented in Table 18.2 and may include, for example, malnutrition, dehydration, poor hygiene, noncompliance to medical prescriptions or medication misuse [10].

Table 18.2 Subtypes of EAN and related examples

Subtype	Definition	Examples
Physical abuse	The infliction of pain or injury, physical coercion or physical or drug-induced restraint	• Being pushed • Being grabbed • Being slapped • Hit with an object
Psychological/verbal abuse	All actions inflicting mental pain, anguish, or distress on a person through verbal or nonverbal acts	• The use of abusive language • Manipulation • Bullying • Blackmailing • Shouting at • Threatening • Humiliating • Isolating the older person • Infantilising the person
Sexual abuse	Non-consensual sexual contact of any kind or sexual exposure; terror in intimate relations that has the intention to control the partner or a person and is only one-sided	• Unwanted intimacy • Touching in a sexual way • Rape • Undressing in front of the victim • Sexually slanted approaches
Financial abuse or exploitation	All actions of illegal or improper use of an elder's funds, property or assets	• Swindling • Disappearance of money or goods • Obstruction in managing one's own money • Legacy hunting and extortion
Neglect	The refusal (active neglect) or failure (passive neglect) of a designated caregiver to meet the needs of a dependent older person	• Malnutrition • Inappropriate clothing • Decubitus ulcers • Deterioration of health • Poor Hygiene • Lack of needed aids or medical equipment
Violation of personal rights	A violation of an individual's civil or human rights by any other person or persons	• Violation of privacy • Violation of the right to autonomy and/or freedom • Refusing access to visitors/isolating the elder • Reading or withdrawing personal mail
Self-neglect	Adults not willing or not able to perform essential everyday self-care tasks such as providing food, clothing, adequate shelter or obtaining adequate medical care and services necessary to maintain physical and mental health, well-being, personal hygiene and managing financial affairs	• Poor overall self-care • Unsafe or unclean living conditions • Inadequate or inappropriate clothing • Absence of needed eyeglasses, hearing aids, dentures, etc. • Unexpected or unexplained deterioration of health • Drug misuse, etc.

As abuse of older people can be an act of commission or omission (neglect), it is of great importance to clarify that abuse can be deliberate and intended as opposed to accidental or unintended. This, however, may be related to sociocultural contexts and varies from county to county. Scientifically and for research purposes, abuse can be categorised as intentional or unintentional, although it is worth noticing that for various reasons, intentional injuries may be misclassified as unintentional or of undetermined intent which makes analysis and interpretations complicated and speculative [9].

18.3 Epidemiology

Estimating the scale of the problem presents methodological limitations starting from the scarcity of studies and scientific data to the lack of shared indicators and a consensus on definitions which results in difficulties in comparing data [2, 3, 9–11, 14]. Data on prevalence is substantially affected by under-reporting [2–4, 9, 10], which is calculated to be as high as 80%, and may be caused by social norms, fear of retaliation or inability to communicate [2, 11].

18.3.1 Prevalence of EAN

Recent systematic reviews estimate the combined prevalence for all types of EAN in the past year to around 15% [3, 5]. The most common forms of maltreatment appear to be psychological abuse (11.6%), followed by financial exploitation (6.8%) and neglect (4.2%) while physical (2.6%) and sexual abuse (0.9%) proved to be less prevalent [3, 11]. Due to cultural differences and lack of consensus on definitions, national and regional prevalence rates differ significantly [2, 3, 5, 10, 11, 16]. Examples of prevalence in different countries worldwide can be seen in Table 18.3.

Table 18.3 Examples of EAN prevalence in different countries

Region or country	Elder abuse prevalence (%)
Canada	4
China	36.6
Croatia	61.1
India	14
Ireland	2.2
Israel	18.4
Peru	79.7
United States	10
United Kingdom	2.6
Overall elder abuse prevalence 14.3–15.7%	

18.3.2 Prevalence of EAN in Residential Settings

The few available studies on EAN in residential settings depict a critical and pervasive situation [11, 17]. Compared to the community settings, maltreatment prevalence rates in institutions appear to be higher for all types of violence with psychological violence being the most common followed by physical maltreatment; specific percentages are reported in Table 18.4.

A meta-analysis reveals that 64% of residential workers reported abusing older residents in the past year, while more studies are needed to calculate the overall prevalence of older residents disclosing EAN in residential settings [11].

The prevalence of EAN in institutional settings varies substantially from country to country. In several studies, it was found to be more common in residential settings compared to the community setting, ranging from 31% in Israel to 78.8% in Germany [11].

Potential explanations for such variations are complex as shown. While further research is needed, it is already clear that an association can be noticed between the increasing dependency of older people and EAN prevalence both in community and institutional settings [11]. In residential homes, a significant correlation was found between abuse and a high ratio of residents per registered nurse [9]. Moreover, time pressure, shortage of staff and emotional exhaustion have been reported in most cases of abuse [11, 18], as shown in Fig. 18.1.

Table 18.4 Prevalence of EAN per subtype in community and residential settings

Type of violence	Community setting (%)	Residential setting (%)
Psychological abuse	11.6	38.4
Physical violence	2.6	14.1
Financial exploitation	6.8	14
Sexual abuse	0.9	1.9
Neglect	4.2	11.6

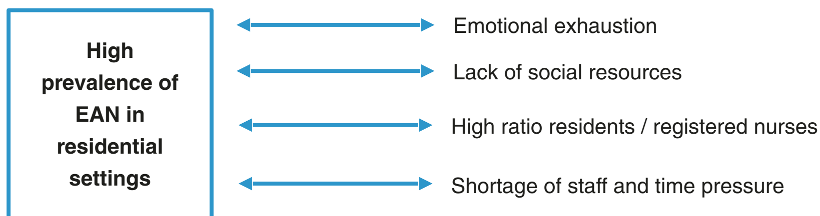


Fig. 18.1 Causes and correlations of EAN high prevalence in residential settings

18.4 Aetiology and Risk Factors

18.4.1 Social-Ecological Model

EAN is a complex and multidimensional phenomenon that involves many factors at the individual, relationship, community and societal level [10, 14] as per the socio-cultural context conceptual model suggested by the US National Research Council, shown in Fig. 18.2 [13]. The model explores the interaction of different factors while considering the sociocultural context in which EAN takes place [4, 5, 10].

Current literature indicates that maltreatment can be triggered by many different factors, their combination and interaction, yet more studies are needed to better understand the complex and specific dynamics [3, 9]. Nevertheless, researchers have shown evidence of some risk factors at individual levels relating to the offender (stress, insufficient training), to the victim (high dependency, mental disorders), to the relationship level (co-dependency, financial needs), to the community level (social isolation) and to the societal level (ageism, poverty) [4, 5, 9, 10].

18.4.2 Risk Factors at Individual Level: Victim

Health: Poor health has been consistently associated with EAN across countries [5]. Evidence shows the main health risk factors for EAN are physical disability and mental impairment [9].

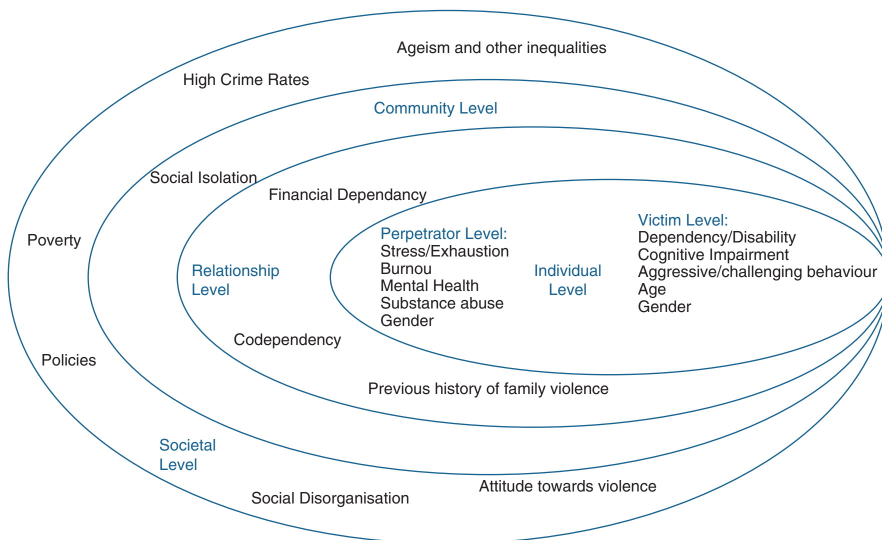


Fig. 18.2 Risk factors for EAN: the sociocultural model

Dependency and Disability: EAN is consistently associated with dependency or physical disability [3, 5, 9]. Some studies show the risk of abuse can increase up to four times in cases of a high level of dependency [9].

Cognitive Impairment: Dementia is believed to be a specific risk factor for EAN [2, 5, 9]. Data across countries shows higher rates of elder maltreatment among older people with Alzheimer's disease and other forms of dementia (up to 14%) compared to the general population. Similarly, family caregivers of people with dementia report higher levels of perpetration (12%) than those of caregivers of relatives without dementia (4%) [9].

Aggressive or Challenging Behaviour: Studies suggest that disruptive patients' behaviours can play a role in EAN and should not be ignored as risk factors, especially in institutional settings [5, 9, 19]. Caregivers often report nocturnal agitation, wandering and aggression may trigger verbal and physical maltreatment [9]. Challenging behaviour is common among patients suffering from all types of dementia as well as other health conditions, and caretakers should be specifically trained on how to respond [9, 19].

Age: Literature shows the risk of EAN increases with age, especially among people 74 years and older [5, 9, 20]. Specifically, the risk for each type of abuse varies across age groups and countries [9].

Gender: Some studies indicate that women are at higher risk for EAN [5, 9, 15, 20]. Moreover, women seem to experience most of the most severe cases of physical and emotional abuse, and a recent WHO study revealed more women than men were reported to be victims of sexual abuse and physical injuries [9]. Recent literature reviews on EAN prevalence show similar rates for men and women [3], but some researchers believe this may be due to under-reporting by women as a consequence of gender roles, norms and level of education [20].

18.4.3 Risk Factors at Individual Level: Perpetrator

Generally abuse of old people can be the result of the offender's lack of knowledge and competence; it can be secondary to a pre-existing difficult family relationship or to a form of dependency, as well as the result of stress and frustration in a household lacking support or in a residential institution in shortage of staff [9, 10, 19].

Stress: Taking care of older people can be stressful, especially if the person is highly dependent or aggressive. Studies show that high levels of stress and the magnitude of care burden involved in caring for older people with behavioural problems are precipitating factors for EAN. Specific training, implementation of appropriate protocols and organisation of the work lower the risk of burnout and exhaustion of caretakers. Moreover, families caring for high dependency people need to be adequately supported [9].

Mental Health and Substance Misuse: Caregivers who perpetrate maltreatment against older people are more likely to present substance misuse issues than the

caregivers with no abusive behaviour [5, 9, 14, 16]. Care staff who reported using alcohol to cope with work-related stress were more likely to report being involved in abusive situations, as were family caregivers who used alcohol to relieve stress [9].

EAN perpetrators are also more likely to present mental health problems, most commonly depression [3, 5, 9, 14]. Parents caring for their grown up offspring who suffer from mental disorders are at high risk for EAN. Another study found that the majority of patients admitted to a locked psychiatric unit for assault had attacked a family member, either a spouse or a parent [21, 22].

Gender: Literature shows that both men and women are capable of EAN; the difference lays in the type of abuse. Women appear more likely to be involved in neglect while men are more likely to be responsible for severe physical abuse and sexual abuse [9].

18.4.4 Risk Factors at Relationship Level

Social relationships, such as relations with peers, intimate partners, parents or children and family members in general, are also considered important factors in EAN causality within the sociocultural model, including:

Codependency: Some researchers report relationship dynamics as a major factor in the maltreatment of older people [5, 9, 21]. In this context "Codependency refers to a relationship in which a person is controlled or manipulated by another who is affected with a pathological condition" [21]. Abuse may thus be the result of a strong mutual reliance between the victim and the perpetrator. Studies also suggest that codependent individuals also have greater difficulties leaving stressful relationships and are less likely to seek medical attention [21].

Financial Dependency: Depending on the victim for accommodation and financial support appears to increase the risk of EAN [5, 10]. A European study found that almost 50% of perpetrators were living on the pension and welfare benefits of the older victim as their only source of income [9].

Family Violence: Family relationships, both present and past, play a significant role as risk factors for EAN. Intimate partner violence may be lifelong and persist to old age [23], when it may be regarded as a form of elder abuse. Children who have witnessed intimate partner violence all their lives, once adults may feel ambivalent about caring for their ageing parents [24].

18.4.5 Community Level

The community may also play a role in EAN, increasing as well as mitigating the risk of abuse [5]. Strong evidence indicates that at this level of the sociocultural model, the key risk factor is social isolation.

Social Isolation: In institutional settings, lacking family members and having few visitors are associated with a high prevalence of maltreatment. In community settings living with someone does not necessarily prevent isolation. Low social support, loneliness and lack of social networks among the older persons seem to further perpetuate maltreatment [14], while having a social network reduces the risk [9].

18.4.6 Risk Factors at Societal Level

At the society level, recent studies indicate that EAN is influenced by high crime rates, social disorganisation and lack of social resources and poverty [14]. Moreover, maltreatment is affected by other societal factors such as culture, ethnicity and policies [5, 14]. Ageism, inequality and permissive attitudes towards violence could also be associated with EAN. However, more research is needed to fully understand such potential relationships [5, 9].

18.5 Consequences of EAN

All types of EAN are associated with severe individual consequences and great societal costs as shown in details in Table 18.5 [5]. These include not only negative health outcomes but also economic ramifications. Financial abuse can seriously affect every aspect of the older person's life, including housing and self-sufficiency, as they often survive on limited resources [9, 14]. In Queensland, Australia, the financial exploitation of older people was estimated to range from 1.8 to 5.8 billion A$ for the 2007/2008 fiscal year [9].

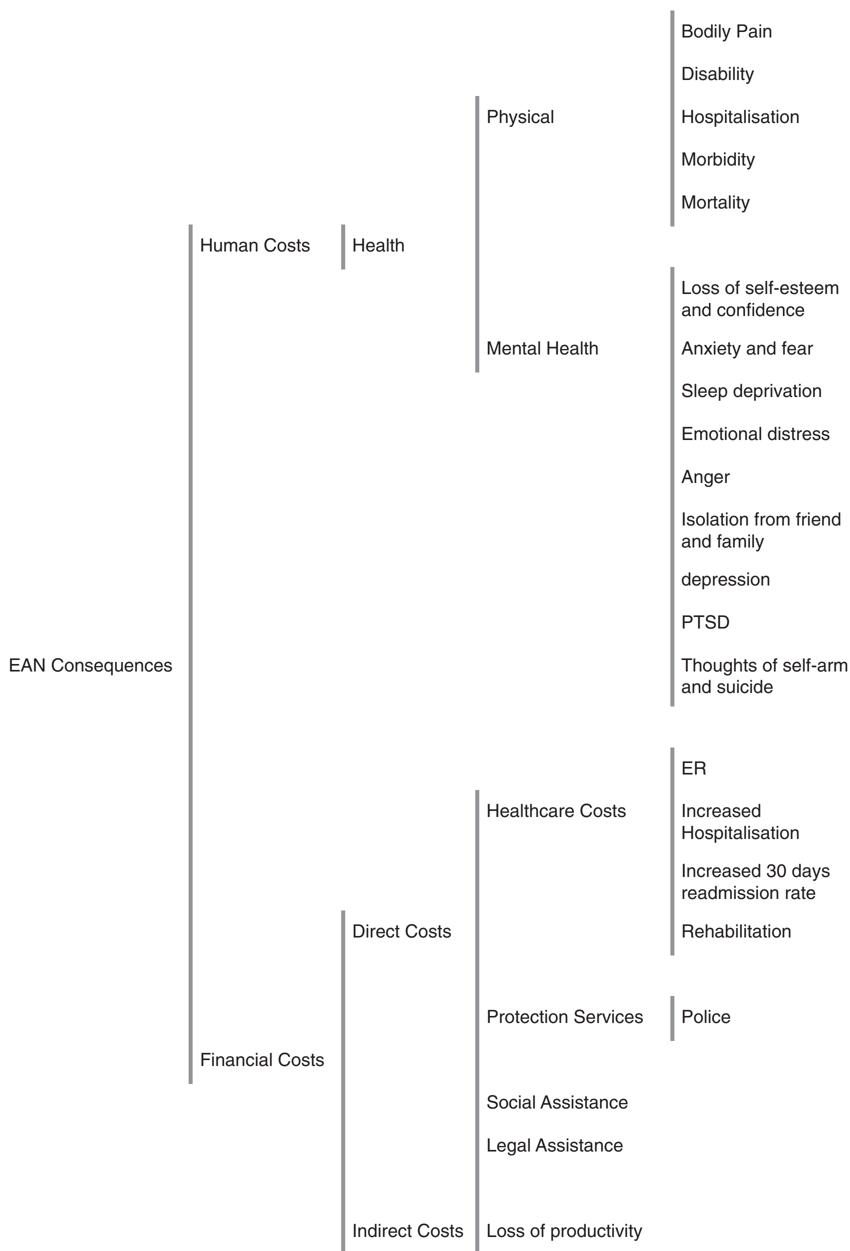
18.5.1 Health Costs: Physical

At the individual level, EAN may lead to short- and long-lasting physical and mental outcomes, including psychological distress, morbidity and mortality. Health consequences range from worsened quality of life, bodily pain and disability to invasive medical procedures and hospitalisation. Moreover, longitudinal cohort studies have demonstrated an association between EAN and premature mortality, especially in black populations. Due to the under-diagnosis and under-reporting of EAN, data on its health consequences and costs are lacking. More studies are needed to gain a better understanding of the scale of the problem, including information on mortality, since comparisons of mortality data often challenge as a result of lack of accuracy and incomplete information [9, 16].

18.5.2 Health Costs: Mental Health

With respect to mental well-being, abuse among older people can result in loss of self-confidence and self-esteem, helplessness, anxiety and fear, sleep disturbances and posttraumatic stress disorder. Victims also tend to develop emotional distress

Table 18.5 Consequences of EAN [9]



EAN Consequences	Human Costs	Health	Physical	Bodily Pain
				Disability
				Hospitalisation
				Morbidity
				Mortality
			Mental Health	Loss of self-esteem and confidence
				Anxiety and fear
				Sleep deprivation
				Emotional distress
				Anger
				Isolation from friend and family
				depression
				PTSD
				Thoughts of self-arm and suicide
	Financial Costs	Direct Costs	Healthcare Costs	ER
				Increased Hospitalisation
				Increased 30 days readmission rate
				Rehabilitation
			Protection Services	Police
			Social Assistance	
			Legal Assistance	
		Indirect Costs	Loss of productivity	

and anger; isolation from family and friends is also common. Longer-term and more severe EAN may result in worse mental effects, such as depression and thoughts of suicide or self-harm. Studies indicate the lasting effects of maltreatment on older people: Some described their experiences as “devastating”, something they feel they will never fully recover from [9].

18.5.3 Financial Costs

The overall disease burden of EAN is very high. In addition to the human costs, emerging evidence also shows that EAN has great economic costs, direct as well as indirect [9]. The direct cost arising from maltreatment is attributed to increased healthcare costs to treat and rehabilitate the maltreated elderly. Older adults who suffered maltreatment were found to have longer hospital stays and higher rates of utilisation of emergency services compared to their non-maltreated counterparts as well as higher 30-day readmission rates [14, 16].

In the United States, it was estimated that injuries due to EAN have contributed more than US$ 5.3 billion to the annual healthcare expenditure while in Australia hospital admissions for EAN were estimated to cost between AUD 9.9 million and AUD 30.7 million for 2007/2008 [9].

Other direct costs include social and legal assistance as well as police and protection services [9, 14]. In institutional care settings, costs would also involve maltreatment prevention (staff training and adequate staffing) as well as identification and management (developing specific protocols, staff training) [9].

18.5.4 Indirect Costs

Indirect costs as a consequence of EAN include loss of productivity of caregivers and family members, inability to continue with activities of daily life, diminished quality of life and lost investment in social capital [14]. Estimates on the economic burden for such indirect cost for EAN are not available worldwide but similar to other forms of violence are likely to be substantial [9].

18.6 Identification and Management of EAN

Elder abuse and neglect (EAN) has extensive effects on the quality of life, morbidity and mortality of older adults. Health workers are in a unique position to identify it and have, at least, a moral obligation to do so [9, 14, 15].

Much of the current information on interventions in healthcare settings is focused on hospital-based programs and relies mostly on publications from North America [25]. The availability of professions and professionals differs significantly in a hospital versus community setting and across countries. Roles and tasks of each profession in the management of EAN cases may also differ accordingly [26].

Most recommendations in the literature have not been evaluated thoroughly [26]. As Baker et al. point out, some interventions may have negative consequences and even endanger elders (e.g. breaching patient confidentiality), and thus care should be taken not to harm [14]. Taking all this into consideration, we propose a simplified yet comprehensive approach for the identification and management of elder abuse, presented in Table 18.6, which may be useful in primary and other healthcare settings. *It is important to highlight that not all tasks are necessarily the physicians'*,

Table 18.6 Assessment and management of EAN[a]

I. Suspect				
Disclosure by patient	*Third party* Raises suspicion	*Screening* (see Sect. 18.7.2)	*Indicators?* Risk factors or "red flags" (see Table 18.7)	*Indicators +* If risk factors/"red flags" are positive seek additional information, e.g. past medical records
II. Evaluate cognition, competence and functional ability				
Cognition and mental status	*Function*	*What is the legal status of the patient?*		
	Assess ADL, IADL	If incompetence or physical disability causing dependency is suspected, consider legal obligations and additional clinical evaluation to guide further assessment and management		
Evaluate for dementia, depression, delusions, impaired judgment, etc.				
III. Obtain bio-psycho-social history				
From patient	*In private*	*Other causes?*	*Ask questions about abuse*	*Collateral history* From family, caretaker or others without breaching confidentiality or compromising safety
If capable of giving information	Separate patient from caretaker/ family, etc. Address confidentiality issues	Ask questions to assess for possible differential diagnoses which explain findings	For example, EASI© (Table 18.8)	
IV. Perform physical examination				
In private	*General*	*Complete physical examination* including:	*Injuries*	*Specialists*
After obtaining consent	Vital signs Appearance	Mental status	Inspection	Arrange examination by specific specialists in case of relevant findings, e.g. procto/genital examination
If abnormal findings: ask for more details (e.g. explanation to bruises)	Hygiene	Neurological exam	Palpation	
	Nutritional status	Fundus oculi in case of suspected head injury		
	Hydration status			

(continued)

Table 18.6 (continued)

V. Order laboratory and imaging				
General	*Injuries*	*Head*	*Other*	*Consent*
Laboratory tests and imaging to assess general condition, control and evaluation of chronic diseases, nutritional state and possible differential diagnoses	Imaging to evaluate potential acute and past injuries	Consider head imaging (e.g. CT) if a head injury is suspected or if there is any mental deterioration	Specific tests according to suspected abuse type (e.g. check STDs if sexual abuse is suspected, perform toxicological screening if poisoning is suspected)	Should be obtained from the patient, or if incapacitated, act according to local laws
VI. Primary management				
Summarise	*Treat and plan treatment*	*Document*	*Home visit*	*Difficulties*
Available information and findings and consider differential diagnoses, including self-neglect	For all problems on the list (including injuries/medical and mental health/ functional issues)	History, physical exam, laboratory tests and imaging results	Consider	With treatment plan: address
Form a biopsychosocial problem list		Use text, body charts, photographs		
VII. Consult/refer/report: multidisciplinary team				
Competent and independent patient:	*Incompetent patient:*	*Unclear competence or physical dependence:*	*Address:*	*Report or refer*
Discuss options with the patient; address patient barriers to action; discuss safety plan; refer; report according to local laws	Consult multidisciplinary team; report according to local laws, and act according to guidance (e.g. by protective services)	Consult multidisciplinary team; report according to local laws, and act according to guidance (e.g. by protective services)	– Context – EAN risk factors – Caretaker burden – Cultural issues	To community services Community and/ or legal interventions as required

(continued)

Table 18.6 (continued)

VIII. Follow-up				
Injuries	*Problem list*	*Patient*	*EAN—competent patient*	*EAN—incompetent patient*
Healing	Examples: Chronic conditions-compliance/control	Mental health, cognition, psychosocial support	Discuss with patient	Discuss with APS/multidisciplinary team/guardian/other
New	Follow-up after sexual assault	ADL, IADL		
Function	Home visit to follow up on living conditions			
Rehabilitation				
Pain management				

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ADL activities of daily living, *IADL* instrumental activities of daily living, *APS* adult protective services

[a]Please note that the order of actions (for I to VIII) and specific team members' roles may differ according to circumstances, clinical judgment, local laws and services

and some tasks could be done by other team members according to local possibilities. It is very important to appoint a team mtember to serve as a case manager to coordinate efforts and tasks. Our outline, for simplification, groups actions to be taken in different steps. Yet it is important to note that some of the actions are intertwined, and changes in the order of actions may be suitable. *Because the laws and services may differ among countries and states, this chapter is not intended to replace the need to seek local information and advice on specific cases.*

18.6.1 Suspect

The most important task of healthcare providers (HCPs) who acknowledge the high prevalence and serious impacts of EAN is to have a high index of suspicion. Since older adults may be relatively isolated with few social contacts, any contact with HCPs may serve as a window of opportunity to assess "red flags", risk factors and possible EAN. Raising suspicion and beginning the evaluation process are some of our most important roles, which cannot be underestimated [27].

So when should HCPs suspect EAN? When an older patient discloses any type of abuse or neglect spontaneously or after screening; when a third party (e.g. neighbour) raises a suspicion; and when there are major risk factors or "red flags" linked to EAN as shown in Table 18.7. Behavioural or mental health changes, clinical, laboratory or imaging abnormal findings should also be considered as "red flags". Whenever EAN is suspected, other risk factors and or "red flags" should be investigated (e.g. looking for past information in the medical records) [5, 16, 28].

Table 18.7 Risk factors and “red flags” for EAN

Risk factors			
Patient:	*Caretaker or perpetrator:*	*Relationship:*	*Environment:*
• Dementia	• Social factors, e.g.:	• Previous family violence	• Living with perpetrator
• Physical disability	– Unemployment	• Family conflicts	• Physical isolation
• Dependence	– Divorce	• Codependency	• Social isolation
• Chronic disease	– Criminal activity	• Financial dependency	• Unsuitable/unsafe living conditions
• Age >75 years	• Physical health issues or disability		• Lack of medications
• Gender F > M	• Mental health issues		• Lack/inappropriate aids or necessary medical equipment
	• Addiction		• Lack or inappropriate food
	• Caretaker burden		• Signs of possible violence (e.g. marks on furniture; internal locks; objects used for restraining)
	• Lack of knowledge/training		
Symptoms/signs/behaviour			
Patient’s symptoms:	*Patient’s behaviour:*	*Patient’s mental health:*	*Caretaker’s behaviour:*
• Pain	• Fear, anger	• Depression	• Delays/prevents access to care
• Disability	• Helplessness	• Anxiety	• Avoidance
• Functional decline	• Loss of confidence	• PTSD	• Blames patient
• Hospitalisation	• Noncompliance	• Sleep disorders	• Body language
	• Delayed access to care	• Self-harm	• Physical/verbal abuse in presence of staff
	• Missed appointments	• Self-neglect	• Tries to manipulate patient/staff
	• Multiple or insufficient visits	• Substance abuse	• Leaves incompetent patient unattended (abandonment)
	• Reported behavioural problems	• Suicidal thoughts or attempts	
	• Avoids making decisions	• Delusions	
Physical/laboratory tests/imaging			
Physical findings—injury:	*Physical findings—neglect:*	*Lab findings:*	*Imaging findings:*
• ll types of injuries: hematomas, cuts, bruises, burns, fractures, scars, etc.	• Malnutrition	• Nutritional deficits	• Fractures in various healing stages

(continued)

Table 18.7 (continued)

• Different stages of healing	• Dehydration	• Dehydration	• Intracranial bleeding
• Location suggesting nonaccidental aetiology (e.g. in axillae; inner aspects of arms; maxillofacial)	• Poor hygiene	• Uncontrolled chronic diseases	• Other internal organ injuries visible in imaging
• Inconsistent with the reported mechanism	• Inappropriate clothing	• Positive toxic screen	• Findings inconsistent with the reported mechanism
• Uncommon patterns	• Pressure sores	• Positive STDs	
• Broken teeth	• Rashes	• Low levels of prescribed medications	
• Object impressions: ligature marks, belt/ finger impressions, object shaped burns, etc.	• Infestations		
• Recurrent/ unexplained falls	• Uncontrolled medical conditions		
• Palpation: tenderness (deeper injuries)			
• Unusual hair loss patterns			
• Genital/perianal			
findings			
• Bleeding			
• Hemotympanum			

18.6.2 Evaluate Cognition, Competence and Functional Ability

All medical actions should be guided by the legal status of the patient. This will determine whether the patient can consent to further examination and whether there is a duty to report and act according to official guidance, e.g. by adult protective services. Furthermore, in some countries any additional questioning and workup, after the establishment of a reasonable suspicion, may be considered as interfering with formal investigations and should be avoided. Therefore, one of the earliest steps should be the evaluation of the patient's competence, cognition, mental health and functional ability.

There is a tendency to consider patients either capable or incapable of making their own decisions. However *decision-making capacity* (DMC) is rather a spectrum, a gradual correlation between a specific issue and the older adult's ability to make a decision about it.

Cases at the extreme of the cognitive spectrum can be easily appraised with the help of brief assessment tools (e.g. MMSE); in unclear cases, patients that present "grey area" scores on the cognitive spectrum may require additional evaluation [16]. In such cases the Hopkins Competency Assessment Test may be useful [16, 29]. It is important to note that in many countries, this evaluation should be performed by specific consultants (e.g. geriatrician, psychiatrist, neurologist) in order to be valid in legal proceedings. Whenever the patient's DMC is impaired or questionable, further consultation and or reporting is required (Sect. 18.6.7).

Functional status (ADL, IADL) should be evaluated since many elders may be functionally dependent due to physical impairment despite having full DMC. In such cases, the person may not be able to care for himself which could imply a duty to report as well. All HCPs should be aware of local laws on EAN reporting. Always consider self-neglect as a potential differential diagnosis (Sect. 18.6.6).

18.6.3 Obtain Biopsychosocial History

(a) **General considerations**: It is preferable to obtain information directly from the patient whenever possible. When addressing sensitive issues and especially psychosocial history, the patient should be interviewed in private, separately from family, caregiver and/or suspected abuser [30]. Health providers should always address confidentiality, explaining health professionals' legal limitations as well as obligations, such as the duty to report according to local laws.

Questions, as well as responses, should be respectful and nonjudgemental, whether addressed to the patient, caretaker or suspected abuser.

Trying to understand the context, including the social and financial resources, is an important part of the evaluation [31]. It is important that providers understand and address barriers which may prevent elders from disclosing abuse even when asked directly (Sect. 18.6.7d).

Giving different answers/versions, especially if these do not seem to explain clinical findings (e.g. visible wounds), should be noted and documented [31].

Questions should explore risk factors for EAN; any symptom, sign or condition that may be considered as a "red flag" for EAN, conditions that may mimic EAN.

(b) **Asking the older patient about abuse or neglect**: Asking about abuse is not easy, but necessary at least when "red flags" or significant risk factors are observed. The Elder Abuse Suspicion Index—EASI©, shown in Table 18.8, is a simple tool developed for family physicians to assess for abuse in patients with a MMSE of 24 or greater in ambulatory settings [32]. It was used in a multi-country pilot study by the WHO working group on elder abuse and found to be a valid and simple tool covering all important categories, suitable for various geographical and cultural contexts [31].

(c) **Collecting information from a third party**: Collateral history may help obtain a full picture; however, some important aspects should be considered: (a) a possible breach of patient's confidentiality; (b) possible escalation of the violence, caused by pressuring the caretaker/family member who may be the perpetrator endangering the patient; and (c) possible legal consequences, including possible harm to the official investigation. Thus, whenever the patient is competent, HCPs should receive consent before any discussion with a third party. Whenever the patient is incompetent, the collateral history may be the only one available. In this case questions should be asked as far as necessary for immediate treatment and to establish a reasonable suspicion of EAN, with further actions directed according to local laws, e.g. formal report to APS.

Table 18.8 Elder Abuse Suspicion Index (EASI©) [32]

EASI© questions 1 to 5 asked to the patient; question 6 answered by doctor. Within the last 12 months:				
1	Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?	Yes	No	Did not answer
2	Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	Yes	No	Did not answer
3	Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Ye	No	Did not answer
4	Has anyone tried to force you to sign papers or to use your money against your will?	Ye	No	Did not answer
5	Has anyone made you afraid, touched you in ways that you did not want or hurt you physically?	Yes	No	Did not answer
6	*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 last 12 months?	Yes	No	Not sure

The EASI© was validated for family physicians to administer to older persons with a Mini-Mental State Examination score of 24 or greater who are seen in ambulatory settings. A response of "yes" on one or more of questions 2 through 6 may establish concern

The Elder Abuse Suspicion Index (EASI©) by Yaffe MJ, Wolfson C, Lithwick M, Weiss D used with permission from Mark Yaffe, October 3, 2020 (mark.yaffe@mcgill.ca). For more information, see Yaffe MJ, Wolfson C, Lithwick M, Weiss D. *Development and validation of a tool to assist physicians' identification of elder abuse: The Elder Abuse Suspicion Index (EASI ©). Journal of Elder Abuse and Neglect, 2008; 20 [3]: 276–300.* https://www.mcgill.ca/familymed/research/projects/elder

18.6.4 Physical Examination

(a) **General considerations**: Whenever possible the examination should be carried out in private and should be proceeded by an explanation to and consent from the patient. Physical signs may reflect either injuries, including the use of restraints (such as ropes, belts, etc. which may leave ligature marks and are in many countries considered unacceptable), neglect or their consequences. The patient should be assessed for any abnormalities in vital signs, appearance, nutritional and hydration status. Signs of neglect or abuse may include lack of appropriate clothing, lack of hygiene (e.g. bad odour, dirty clothes, soiling), weight loss or malnutrition as presented in Table 18.7.

A complete physical exam should be performed to assess for general health and control of chronic conditions. A full mental status and neurological exam—including fundus examination—is necessary, especially whenever there is an abnormality or a possibility of a head injury.

(b) **Examination of injuries**: The patient should be carefully inspected from head to toe, looking for visible injuries, e.g. hematomas, bruises, burns, cuts/lacerations, abrasions, scars, deformations and object impressions (e.g. evidence of restriction or ligature marks, injuries caused by specific objects as belts, cigarette burns, etc.) [30]. Careful palpation should follow, to identify possible deeper injuries after the disappearance of the superficial signs.

Severity of injuries may vary widely, and different patterns may be found in different medical settings. A review of injuries associated with elder abuse found that two-thirds of injuries were to the upper extremity and maxillofacial region, followed by the skull and brain (12%), lower extremities (10%) and torso (10%). Though no injuries can be considered specific/pathognomonic some may be highly suggestive, considering possible mechanisms of injury, e.g. contusions and abrasions to axillae and inner aspects of arms as a result of grasping by the abuser, use of restraints or attempted self-defence by the victim [30, 33]. The majority of the injuries were of a mild nature, highlighting the opportunity and importance of identification and early intervention in primary care, possibly preventing significant morbidity or mortality [33].

(c) **Additional examinations by other specialists**: Whenever history or findings are suspicious of possible sexual abuse, the genitalia, rectal and oral regions should be examined by especially trained professionals [28]. Arranging for an examination by other specialists may also be necessary when abnormalities in other organs or systems are found such as ENT in cases of hemotympanum, nose bleeding, etc. Examination by a forensic specialist may also be indicated or required. Some of these experts may be available only in the hospital setting. The HCP in the community should take an active role in arranging for necessary examinations and if necessary hospitalising the patient, especially if there is a risk of noncompliance or loss of follow-up.

18.6.5 Laboratory and Imaging

When suspecting EAN, laboratory exams and imaging can offer useful information about general health, nutritional and hydration state, well or poorly controlled chronic conditions and potential differential diagnoses [30]. Some tests can be performed in primary care settings while others will require hospital settings depending on medical urgency, available facilities and patient and caretaker cooperation, among other factors. Consent to testing is essential, and in the case of an incapacitated older person, one must act according to the local laws (e.g. consent from the guardian, APS, court order, etc.).

(a) **Laboratory tests**: Various diseases and conditions can mimic abuse in older patients. For example, fractures may be caused by osteoporosis; hematomas or other skin marks could be caused by thrombocytopenia, senile purpura, steroid purpura, bleeding disorders or drugs [28]. Medical reasons for excessive bruising should be ruled out by performing blood coagulation studies and platelet counts [28, 30]. Specific exams should be considered according to abuse type: If sexual abuse is suspected, consider testing for STDs. Toxicological screening can be used to rule out poisoning or drug abuse. Medication blood levels should be tested when relevant, e.g. when intentional or unintentional misuse of medications is suspected. Low or undetectable levels of prescribed drugs may indicate neglect in a dependent older person; the presence of toxins or medications that were not prescribed to the patient may indicate intentional poisoning [28].

(b) **Radiology and imaging**: Radiographs and other imaging tests should be ordered to assess recent injuries as well as to rule out older ones. Despite the lack of pathognomonic lesions and signs of EAN, in a recent report of two emergency room cases, Wong et al. suggest that some of the findings in child abuse could also be found in elder abuse cases. Such shared characteristics may include (a) injuries which are not consistent with the reported mechanism, (b) injuries in multiple stages of healing which may include deformations as a result of old injuries and (c) patterns uncommon in accidental injury [34]. Several authors, mainly in emergency room settings, emphasise the importance of providing radiologists with detailed history when ordering radiographs, as well as the radiologist matching injury patterns with mechanisms of injury in the elderly. Improved bilateral cooperation between treating physicians and radiologists is critical for increasing the detection of elderly abuse cases [34, 35]. This is probably true in primary care settings as well.

It is of paramount importance to remember that in elders even minor head trauma can cause significant morbidity and mortality, as well as functional decline. Whenever there is a suspicion of such an injury, the evaluation should include a head CT [36].

18.6.6 Primary Management

(a) **Summarising information**: Possible differential diagnoses could be established after integration of data collected from history, physical examination, laboratory tests and imaging. Since there are no pathognomonic findings that distinguish accidental injuries from those caused by physical elder abuse, it is important to evaluate risk factors and circumstances as well [33]. One important possible differential diagnosis that should be considered is self-neglect. Creating a bio-psycho-social problem list which includes medical conditions, injuries, functional impairment, mental health issues as well as other consequences of abuse or neglect are useful for planning treatment, intervention and follow-up.

(b) **Treatment**: A comprehensive treatment plan should be based on the problem list, addressing each of the problems, and is beyond the scope of this chapter.

When suspecting self-neglect physicians should look for and address underlying conditions: cognitive impairment, depression, mental retardation, physical disability, psychological distress, lack of social support, etc. [4].

In cases of sexual abuse, WHO guidelines recommend that women should be given antibiotics to prevent and treat STDs without prior testing (chlamydia, gonorrhoea, trichomonas and syphilis if common in the area) as well as HIV preventive medications and offered hepatitis B vaccination [37]. When treating an older adult who was sexually abused, the HCP should consider these same principles, while weighing pros and cons according to the specific clinical case.

(c) **Documentation**: In cases of suspected EAN accurate documentation has medical, legal and forensic implications [30]. Documentation should use objective descriptive language, without interpretations or accusations. It is important to

remember that the HCPs' main concern is the safety of the patient. Due to legal issues (e.g. guardianship of an incompetent older adult), the information might be available to the perpetrator. This is of major concern with the increasing use of electronic medical records and increasing access to the records by patients and caretakers. HCPs should document history as well as direct quotations and describe observations of patient behaviour, interaction between patient and caregiver, reactions to questions and physical examination findings. Injuries should be described and also drawn on body charts. Photographing injuries is also recommended, and consent should be obtained from patients with mental capacity. If a crime is suspected, photographs should be taken by the police. In the absence of a professional medical photographer, use a digital camera, and include the patient's name and date as well as a ruler in the photograph. Both close ups and distant pictures should be taken to provide perspective and location of lesions and at least two different angles for three-dimensional lesions [16, 28, 30].

(d) **Home visit**: A home visit by one of the HCPs or by social services may add valuable information, but the frequency of such visits differs significantly between countries. Discussing the possibility of EAN in the home setting can be tricky, as the perpetrator may be present [31]. Nevertheless, identification of neglect and self-neglect can be enhanced significantly by home visits. In an Irish study, 91 out of 120 GPs (76%) responded that they identified cases of EAN during a home visit. In this study self-neglect and neglect were more common than physical abuse [38]. A home visit may reveal numerous "red flags" which may be related to direct observation of relationships and living arrangements, neglect (e.g. unsuitable or unsafe living conditions including poor hygiene, lack of food, inadequate equipment) and signs of possible physical violence (e.g. marks on furniture; internal locks; objects used for restraining). The safety of the healthcare professionals should be taken into consideration when planning such visits. A joint visit by professionals from different disciplines may enhance the team's safety as well as effectivity.

(e) **Difficulties with a treatment plan**: Health providers should consider and address any possible factors, including those related to EAN, that may affect clinical findings or outcomes. For example, when a patient with an uncontrolled chronic illness is deprived of medications, the HCP should address the issue to make sure that medications will be available. Transfer to another medical provider should be considered in cases of resistance to or sabotage of medical interventions [39].

18.6.7 Consulting and Reporting

(a) **Action guided by the status of the patient**: As specified above the legal status of the patient is influenced by the decision-making capacity (DMC) and in some instances by functional dependence (Sect. 18.6.2). The older patient may not be able to take actions against an abuser due to either impaired DMC or

significantly compromised physical functional ability. Thus, when abuse or neglect is suspected, the options on how to proceed depend on these parameters. All HCPs should know and follow local laws and criteria for mandatory reporting:

- **Competent and independent patient**: Whenever the patient's DMC is preserved, abuse or neglect should be discussed with the patient directly in private. We propose that the *LIVES* model's principles presented in WHO's clinical handbook for cases of intimate partner or sexual assault of women can be adapted for EAN cases. The LIVES model guides the health provider's response after disclosure of abuse, providing first-line support, and useful job aids can be found in the handbook [37].

  L*isten and* ***i****nquire about patient's needs and concerns*: Listen to the patient closely with empathy, without judging. Ask open inviting questions such as "How can we help you?" "Is there anything that you need or are concerned about?" Notice the body language.

  V*alidate*: Show that you understand and believe the patient and that she/he is not to blame. Respond to feelings, e.g. acknowledge that anger with perpetrator is a valid feeling.

  E*nhance safety*: Discuss the immediate risk of violence and a plan for protection if a violent event happens or if there is a threat of such an event. Examples of safety planning for elders include planning a place to go to and having essential phone numbers and a checklist of essential items to keep together in a safe place [16, 28]. When there is immediate danger, urgent measures to increase safety may include moving out temporarily (e.g. hospital admission, placement in a shelter or other type of facility) or a court protection order [31].

  S*upport*: Provide information and help connect to services and social support. Resources may differ between countries and regions and may include both governmental and non-governmental organisations/services such as adult protective services (APS); helplines (telephone/internet) [5]; community services; legal services; day centre, etc. A patient-centred approach, discussing with patient various possibilities and asking for consent before sharing information are recommended.
- **Incompetent patient**: In most countries when an older person is not legally competent, there is a duty to report abuse or neglect to adult protective services, to the police or other specific agencies. Usually, in such cases the assessment and intervention regarding the abuse/neglect will be formally guided by them.
- **Unclear competence of the patient or physical dependence**: Further evaluation by an interdisciplinary team is necessary to determine the status of the patient and whether there is a duty to report and act according to formal guidance.

(b) **Addressing context, perpetrator, caretaker and caretaker burden**: PHC teams are in a unique position that enables them to meet and confer with various members of the family and address caretaker burden as well as

relationship issues. Their ongoing relationship, which frequently involves multiple members of the same family, may enable them to perceive even subtle changes.

Addressing caretaker burden is a cornerstone in the management and prevention of EAN [5]. HCPs can help promote the connection and relationship between elderly people, their family and caregivers. Alleviating stressors that cause abuse may be necessary so that the family can provide care for the elderly at home [16]. In one study, for example, Korean social workers shared that they may decide not to carry out a mandatory report because they feel that the family member(s) can be helped to care for the elder in the home environment while improving in the areas that create abusive behaviours [40].

The perpetrator may be a family member or an external person, including a hired caretaker. Interventions with perpetrators of EAN will mostly be provided by other stakeholders, though there is not enough research on their long term effects [16]. Yet, we believe that whenever possible initial evaluation should include a health assessment of the perpetrator and treatment of any conditions which may contribute to the abusive behaviour. This may be possible specifically in the context of EAN occurring in family settings where the family physician cares for several members of the family but should be done discretely. When the perpetrator is also an older adult, he/she may have physical as well as mental health problems, occurring previously or arising at an older age, such as frontal lobe infarcts/injury, depression, dementia and substance abuse. These health issues may directly cause the abuse/neglect or indirectly contribute by decreasing the ability to function well enough as a caretaker for the older person (Table 18.7).

Relocation to nursing homes or to specialised shelter programs for elders, if available, should be considered whenever there is a need for providing security [5]. Nonetheless, it is important to note that EAN can occur also in such facilities [31, 41].

Important principles when managing EAN cases include a patient-centred approach, cultural sensitivity and adequate interventions for ethnic minorities—despite the lack of sufficient research on these topics [16].

(c) **Ethical and legal considerations**: It is believed that involving multidisciplinary teams is necessary both for evaluation and intervention in cases of elder abuse [5, 16, 28]. This may be limited by ethical and legal considerations. Specifically, every health professional should know whether the duty to report concerns only patients who are not legally competent or all cases of elder abuse; whether a suspicion of abuse is enough or there is a need for convincing evidence; whom to report to; and whether the reporter can remain anonymous or not. In the United States, for example, in most states there is a duty to report elder abuse to adult protective services whenever there is a reasonable suspicion, and most reports made by healthcare professionals cannot be anonymous [16].

Society should strive to protect the elderly while helping them maintain their autonomy, independence, culture and beliefs as well as their relationship with family whenever possible [6, 42]. Professionals should assume the ethical responsibility to protect elder abuse victims. Abuse, in principle, violates some ethical principles including autonomy, justice, beneficence and non-maleficence. Reporting violates the right to autonomy and confidentiality. In many EAN cases,

beneficence and non-maleficence should be prioritised, and reporting is ethically acceptable when potentially will lead to activation of protective systems to help the victim and enhance safety. One should always remember that when such a system does not exist, reporting may cause more harm than good, putting the patient at risk of exacerbation of abuse or neglect [42]. HCPs must also understand that they may face penalties, including jail time and fines, for not reporting suspected abuse. Failure to report is considered by some as negligence or malpractice [27].

(d) **Addressing barriers**: HCPs under-diagnose and under-report cases of elder abuse. For example, in one study of primary care physicians in Ohio, more than half of the respondents reported that they had never identified a case of elder mistreatment [43]. Physicians' barriers include lack of knowledge and confidence, personal and professional beliefs, time constraints, concern with effects on the patient-doctor relationship, etc. [43, 44]. The HCPs' dilemmas are even more complex in specific situations, e.g. when the victim does not want measures to be taken and when there are complex family contextual factors [45]. An encouraging finding, on the other hand, comes from a more recent study from Ireland. The GP responders in this study were willing to confront the issue of elder abuse and neglect, sometimes at the risk of personal harm, and 73% of them perceived that the GP's role is not simply to provide medical treatment but also to be a part of the intervention and solution in abuse cases [38].

All professionals involved, including HCPs should be aware and address possible patients' barriers to disclosure as well as to taking action once EAN was disclosed or established. These may include various forms of dependence (emotional, physical, instrumental, financial, etc.); lack of accessibility to and lack of trust in services; self-blame; ambivalence or wanting to avoid possible harm to the perpetrator; various cultural and religious issues; shame and stigma; etc. [46, 47]. Any discussion should be patient-centred, adapted to the patient's capabilities and culture.

18.6.8 Follow-Up

(a) **General follow-up**: The importance of follow-up in cases of suspected or established EAN should not be underestimated. It should address among other issues medical conditions, injuries, functional impairment and mental health. A practical way is using the problem list. The HCP should examine injuries' healing process and functional consequences, to ensure maximal recovery and functionality. It is pertinent to examine for possible new injuries as well. Pain should be assessed and addressed to ensure the patient's well-being. Further follow-up planning is indicated whenever physical, emotional or functional consequences persist [16].

In cases of sexual assault, patients should be followed up 2 weeks, 1 month, 3 and 6 months following the assault, including mental health and psychosocial support assessment. When clinical findings included STDs, compliance to preventive measures that were recommended and test results should be followed [37].

(b) **Follow-up on EAN**: Follow-up is necessary to monitor ongoing abuse or neglect [16]. HCPs can discuss it directly with the competent patient. If the

patient is incompetent, it is necessary to maintain ongoing contact with the relevant local services (e.g. APS, multidisciplinary team) as well as the legal guardian.

Close follow-up and a vigilant attitude may be considered when EAN was suspected but not proven or when there are relevant risk factors or "red flags".

When there are difficulties with follow-up, such as patients not showing up—the possibility of continued or worsening EAN should be considered, and actions should be taken accordingly. Follow-up by APS may sometimes be necessary to ensure medical treatment and follow-up [39].

18.7 Prevention of EAN

The MIPAA (Madrid International Plan of Action on Ageing) strongly recommended emphasising prevention and management through multi-sectoral, interdisciplinary community-based approaches to eliminate all forms of neglect, abuse and violence [31]. This is a complex task that requires the intervention of different professionals and agencies as well as a broad range of approaches. The WHO has recognised the need to establish a global strategy for the prevention of EAN improving cooperation between existing public health, social, medical and legal systems [31]. In this sense, it is important to point out the unique position of PHC professionals to detect EAN, raise awareness and promote effective interventions for this problem.

18.7.1 Types of Prevention and Their Aim

Based on the Cochrane reviewers' classification of levels of intervention [14], there are three fundamental types of preventive interventions, primary, secondary and tertiary prevention, as presented in Table 18.9. PHC teams and professionals could be involved at any of these levels.

Ayalon et al., in their systematic review and meta-analysis of interventions designed to prevent or stop elder abuse, identified three main categories of interventions:

1. Interventions designed to improve the ability of professionals
2. Interventions to detect or stop elder maltreatment that target older adults who experience elder maltreatment
3. Interventions that target caregivers who maltreat older adults

They concluded that currently, the most effective intervention was directly targeting physical restraint by long-term care facilities' paid carers (category 3 intervention) [48].

Another review indicates that community interventions focused on caretakers may have a protective effect against EAN. Such interventions include educational sessions provided by health professionals, trainings on coping skills for caretakers

Table 18.9 Type of preventive interventions

Type of prevention	Definition	Examples
Primary prevention	Interventions that prevent the abuse or neglect from occurring	• Health policies
		• Raising public awareness
		• Community interventions
		• General interventions for identification, reduction and treatment of risk factors, including:
		– Addressing possible caretaker burden
		– Advanced planning of care for an older person with a chronic condition that may worsen over time
		• Specific patient-/family-centred interventions: targeting the elderly, family members or caregivers
		• Encouraging research
		• Addressing ageism and advocacy for elders
		• Improving coordination of care
		• Training and education:
		– For caretakers
		– For HCPs
		– For various community services (social services, police, judicial system, etc.)
Secondary prevention	Actions aimed at preventing further abuse:	• Close monitoring of vulnerable older adults
	• Stopping abuse and escalating incidents	• Early EAN detection through screening or other tools
	• Improving patient's well-being	• Mandatory reporting
		• Protective service interventions
		• Helplines
		• Support groups
		• Temporary placement, housing, emergency shelters
		• Training and education: programmes targeted at health and social care professionals
		• Dealing with the perpetrator: medically, socially and legally as required
Tertiary prevention	Actions to manage the consequences after the abuse has occurred	• Treatment of medical and mental health conditions resulting from EAN
		• Social services, police, legal support
		• Rehabilitation
		• Long term multidisciplinary support and counselling
		• Training and education: programmes targeted at health and social care professionals

(e.g. problem-focused strategies) as well as classes on the impact and of caring for people with dementia [49]. Some of these interventions fit well within the scope of the PHC teams' work.

It is uncertain whether specific educational interventions improve the knowledge of health care professionals and caregivers about EAN. Furthermore, it remains to

be proved if such newly acquired knowledge actually leads to modification of professionals' and caretakers' behaviour resulting in a decrease of EAN [14].

Similarly, interventions such as supporting and educating EAN victims (category 2 interventions) appear to lead to more reporting. But it is unclear whether this indicates an actual increase in EAN cases or reflects only an increased awareness and inclination to report [14]. Nevertheless, there is evidence of moderate quality that shows teaching coping skills to family members caring for the elderly with dementia may possibly improve outcomes [50].

18.7.2 Screening as a Prevention Tool

The increased awareness of EAN has contributed to the development of screening protocols [51]; however, few of them have been accepted for extensive application in clinical settings. The variety of available tools reveals the urgent need to develop a reliable, practical and simple tool, easy and quick to use, with clear and appropriate wording, suitable for different contexts, with a high sensitivity rate [31].

The US Preventive Services Task Force (USPSTF) defines screening as the process of eliciting information about abusive experiences in a caring or family relationship from older or vulnerable adults who do not have complaints or obvious signs of abuse. Within such definition screening presents multiple goals as shown in Table 18.10 [52].

18.7.2.1 Screening Effectiveness and Employment

The effectiveness of EAN screening and its use in everyday practice are controversial. It is important to stress that screening refers to asymptomatic patients and in the context of EAN may be seen as older adults without obvious risk factors or "red flags" presented in Tables 18.7 and 18.9. The Canadian Task Force on Preventive Health Care, the United Kingdom National Screening Committee and the United States Preventive Services Task Force (USPSTF) do not recommend routine screening for EAN [53]. This is based on the lack of evidence that screening or early EAN detection reduces the exposure to abuse or its harmful consequences [54]. On the other hand, several associations such as the American College of Emergency Physicians, the American Medical Association and the National Gerontological Nursing Association do recommend routine EAN screening as there is a broad

Table 18.10 EAN screening

Screening definition	Screening goal
Process of eliciting information about abusive experiences in a caring or family relationship from older or vulnerable adults who do not have complaints or obvious signs of abuse (the US Preventive Services Task Force—USPSTF) [54]	• Identification of unrecognised EAN cases • Prevention of further and future abuse • Reduction of negative EAN health consequences [52]

agreement on encouraging and enhancing EAN prevention and early detection in order to reduce its potential negative impacts [52, 53].

18.7.2.2 Screening Tools

Among the existing validated screening tools, some can be suitable for clinical settings [53, 55]. They vary in length, type of abuse and psychometric appraisal, and they all represent useful tools to provide early identification and prevention.

The majority of screening tools include the direct questioning method used by clinicians to screen for abuse among the elderly in primary care or hospital settings [52]. Besides the EASI© tool (shown in Table 18.8), some other examples of open-ended questions that can reveal fear or any other potential indicators of abuse include [55]:

- “Is there anything going on at home that you would like to talk about?”
- “Has anyone touched you without your permission?”
- “Has anyone hurt, hit roughly or threatened you?”
- “Has anyone taken your personal possessions such as your money, car or valuables without your permission?”
- “Has anyone yelled or sworn at you?”
- “Has anyone made fun of you or hurt your feelings?”

It is important to emphasise that a positive screen for EAN does not indicate that abuse is taking place but that further information should be gathered [55]. In summary, HCPs should be aware of the high prevalence of EAN, educate themselves about elder abuse and consider actively searching and screening for EAN risk factors and “red flags”, especially in high-risk populations [16].

18.7.3 Prevention: The State of the Art

The global elderly population is increasing dramatically worldwide [56], from 900 million in 2015 to nearly 2 billion in 2050. A higher ratio of elders in the population probably will mean a heavier burden of care for the younger population. As a result of these processes, the incidence and prevalence of EAN are expected to increase significantly as well.

Such concerning figures urge an action on prevention. But unfortunately the most recent scientific reviews on the topic concluded that there is not enough evidence demonstrating the effectiveness of existing interventions to reduce the occurrence or recurrence of EAN [48, 50]. High-quality trials regarding EAN prevention are urgently needed, including those from low- and middle-income countries. These should address cost-effectiveness, implementation assessment and equity considerations [14, 50]. At the same time, urgent steps should be taken by policymakers around the globe targeting the population changes and risk factors for EAN comprehensively, from every possible aspect. Societal issues as poverty, equity, adequate

housing and health care as well as provision of adequate care for the elders and significant law enforcement for offenders are equally essential for a society striving to adequately control or abolish the sad phenomenon of EAN.

18.8 What's the Role of Family Physicians in Elder Abuse and Neglect?

Elder abuse and neglect are highly prevalent and significantly influence quality of life, morbidity and mortality of older adults. Family doctors should remain alert to major risk factors or "red flags". When suspicion arises, a proper evaluation should be done. This includes obtaining the bio-psycho-social history from the patient and/or caretakers and family; evaluating cognition, competence and functional ability; performing a comprehensive physical examination; and considering possible differential diagnoses. A home visit or additional studies may be necessary. The family doctor, who usually knows well the patient, family and community, is in a unique position to recommend whether the evaluation could be done in the ambulatory setting or whether prompt hospitalisation for further workup or protection is necessary. This decision should be guided by the perceived risks, as well as the patient's wish when competent. Whenever the patient is incompetent or dependent, the physician should act according to the local reporting laws. Family physicians can identify EAN early and activate multidisciplinary teams to prevent further abuse as well as its consequences. They have an invaluable role in an ongoing management, support and follow-up. Furthermore, by actively addressing caretaker burden, physicians and their teams can sometimes prevent abuse before it happens. To do so family doctors and primary healthcare teams should be properly trained on this topic. Training should address necessary knowledge and skills as well as possible barriers to EAN identification. Last but not least, physicians should not treat these cases alone! They should keep the updated contact information of relevant consultants and community services; they should actively consult multidisciplinary teams; they should make sure to care for themselves and seek support services to prevent secondary trauma.

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