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# Elder abuse identification and intervention.

## - a scoping review

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Introduction: The concept of elder abuse has been described in scientific journals dating back fifty years already. However, the emphasis on addressing elder abuse has only begun to gain real significance over the past twenty years, coinciding with the realisation that populations are aging rapidly but the knowledge, standard practice and best practices needed for safeguarding this vulnerable portion of the population are not sufficiently developed to meet the changing demographics. The aim of this scoping review is to identify areas needing development in relation to identification and intervention and increase awareness in healthcare professionals of the significance of comprehensively understanding elder abuse.

Methods: PubMed, CINAHL complete including Medline, Ovid Emcare & Ovid Nursing Databases were used for the literature search. Identifying the right sources was guided by the recommendations set out in JBI Manual for Evidence Synthesis 2020: search strategy for scoping reviews. A three-step search strategy was recommended. This search strategy was conducted by firstly making a pilot search, secondly the actual search through the analysis of the results using title, abstract, full-text and then thirdly examining the reference lists of all identified sources not just from the chosen articles to examine them for additional sources. This also led to a search for grey matter to attempt to close out any gaps in the search strategy which might have excluded relevant sources.

Results: Following a systematic search process, 13 studies were identified and included into this scoping review. This review had the data analysed using inductive content analysis. From this analysis the issues influencing identification and intervention emerged in the form of four themes: The need for improvements in identification and reporting; The need for research and valid tools; The need for the multidisciplinary collaboration and
The need for strengthening of standard practice, best practice, and legislation.

Conclusions: Elder abuse is rarely identified and weakly understood. Issues related to identification and intervention such as underreporting, lack of knowledge and training, lack of research, multidisciplinary collaboration and strengthening of legislation and practices must all be addressed and developed so as the health care professionals and allied health care providers designated to care for this vulnerable section of our society have the ability care for their clients in a safe and secure fashion.

Recommendations for future research: There is a dearth of empirical and evidence-based research on the topic of elder abuse. Without valid research there is no way to find answers to questions in an organised and systematic way that could inform practice and contribute to developing knowledge or improving existing knowledge in the field of elder abuse. The author recommends that more rigorous research to be conducted into elder abuse identification, reporting, interventions, and prevention, with the intention of providing valid information to inform best practice.




| Keywords | Elder abuse, identification, intervention |
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# 1 Introduction

In 2002 the World Health Organisation (WHO) adopted the definition of elder abuse based on the definition put forward in 1995 by the United Kingdom organisation, Action on Elder Abuse which stated that: 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 or violates their human and civil rights (WHO, 2002b). In 2015 the world report on aging and health published by the World Health Organisation reported that the absolute number of older people in populations was increasing dramatically and that it was estimated that the number of people over the age of 60 was expected to double by 2050, with over 30% of the many countries' population consisting of older people (WHO, 2015.) The concept of elder abuse has been described in scientific journals dating back fifty years already. However, the emphasis on addressing elder abuse has only begun to gain real significance over the past twenty years, coinciding with the realisation that populations are aging rapidly but the knowledge, standard practice and best practices needed for safeguarding this vulnerable portion of the population are not sufficiently developed to meet the changing demographics.

Development of curriculum level education pertaining to elder abuse, in-job training models, valid assessment tools, multidisciplinary collaboration and improvements to standard practice, best practices and legislation are all necessary to meet the complex challenge of tackling elder abuse. Elderly abuse cannot be tackled successfully if healthcare professionals lack the comprehensive knowledge to identify the abuse and the valid tools and systems to intervene when abuse is identified.

This thesis is a scoping literature review about elder abuse identification and intervention. It is well reported and easily observed that healthcare suffers from a lack of resources and with the population aging rapidly, the problems facing healthcare and health care professionals are likely to become more exacerbated. Elder abuse is an important public health problem, as it decreases quality of life, increases morbidity and mortality and the impact of negative physical and mental health issues (Ablofathi Momtaz, Hamid & Ibrahim 2013; Yaffe & Tazkarji 2012). The review will examine the phenomena of elder abuse and present current information available on identification and intervention in elder abuse in relation to healthcare professionals. The purpose of the

review is to identify areas needing development in relation to identification and intervention in elder abuse and to increase awareness in healthcare professionals of the significance of comprehensively understanding elder abuse.

# 2 Theoretical background

Defining the phenomenon of elder abuse is problematic as there has been no standard definition of the concept of elder abuse which is accepted by everyone (Gholipour, Khalili & Abbasian 2020). However, the definition of elder abuse as used by the WHO has become universally recognised since its introduction in 2002. This states that 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 or violates their human and civil rights (WHO, 2002b).

Theories attempt to inform understanding of social phenomena like elder abuse. Over the past several decades researchers, service providers and policy makers have suggested different models and theoretical frameworks to describe the phenomenon of elder abuse. It is commonly recognised that theories used to explain elder abuse have been adapted from other fields, such as intimate partner violence and child abuse (Gholipour et al. 2020). The current literature available on elder abuse suggests that the theoretical background of elder abuse could consist of theories in elder abuse, types of elder abuse and risk factors for elder abuse.

## 2.1 Theories in elder abuse

As mentioned earlier few theories have been specifically developed to address elder abuse. Theories that are used to inform understanding of elder abuse are adapted from other fields. These theories can be divided into two distinct categories, theories that are related to interpersonal relationships and theories related to societal and multisystem context (Mosqueda et al. 2016; O'Brien et al. 2015).

### 2.1.1 Interpersonal theories

Social exchange theory is rooted in the fields of economics and psychological and explains interactions between people as a process of negotiated exchanges. The social exchanges may include material goods for example money, housing/living arrangements, or non-material goods like approval within a relationship. If the cost of the relationship is higher than the rewards, and one party feels they are not getting fair return the likelihood of the aggrieved party causing harm to the other is potentiated (Mosqueda et al. 2016; O'Brien et al. 2015).

Social learning theory suggests that social behaviour is learned by observing and imitating the behaviours of others (modelling process). Thus, proposing that violence is a learned behaviour. Elder abuse may result from the perpetrator of the abuse using transferred behaviour which has been learned in an earlier context to resolve conflicts or obtain a desired outcome (Gholipour et al. 2020; Mosqueda et al. 2016; O'Brien et al. 2015).

Caregiver stress theory proposes that that elder abuse occurs when an adult caring for a vulnerable older adult is unable to adequately manage their responsibilities and become overwhelmed and frustrated leading to abuse (Mosqueda et al. 2016; O'Brien et al. 2015).

Dyadic discord theory (the background-situational theory) asserts that relationship discord results from a combination of contextual factors (for example a history of family violence can increase the level of tolerance for accepting that violence is a way to resolving conflicts) and situational factors (for example a lack of satisfaction in a relationship). This theory can be applied when the perpetrator of the abuse is the spouse or intimate partner of the victim (Mosqueda et al. 2016).

### 2.1.2 Societal and multisystem theories

Power and Control Theory, a feminist approach suggests that the perpetrator of abuse uses coercive tactics to gain and maintain power and control in the relationship. This theory often focuses on gender inequality. It considers the viewpoint and experiences of females as opposed to the traditional viewpoint of the male. Through the lens of the

female experience it attempts to highlight social problems, and issues that are otherwise overlooked or misidentified due to the historically male dominant perspective (Gholipour et al. 2020; Mosqueda et al. 2016; O'Brien et al. 2015).

Social Ecology Theory can be used as a framework for the organising of potential causes of elder abuse into groups. It examines interactions between the individual, relationships, community, and society and how these interactions influence well-being. Using this framework allows for the examination of elder abuse by considering the broader system (context) in which it occurs. The focus is on the interaction at four levels: *the microsystem,* which describes the relationship between the older person and individuals within their immediate settings such as their home or nursing home, family and social networks; *the mesosystem,* which describes the relationships between the micro settings that include the older person, such as institutions that provide services; *the exosystem,* which describes the social structures and systems that do not directly contain the older person, but which impact upon the immediate microsystem in which the older person is situated and can include health policy, social welfare system, adult protection services and finally *the macrosystem,* which focuses on the overarching beliefs and dominant social values around ageing, such as ageist attitudes towards older people (Mosqueda et al. 2016; O'Brien et al. 2015).

Symbolic interactionism theory assumes that people respond to elements of their environments according to the subjective meanings they attach to those elements, for example meanings can be created and modified through interaction involving symbolic communication with other people. So simply put, people in society understand their social worlds through communication - the way people react and view the world through their interactions with others. According to this theory, cultural values and expectations influence what is considered elder abuse. As an example, sending elderly individuals to nursing homes is considered a form of abuse in some cultures and it is unthinkable that the family would not take responsibility for the elder person, whereas other cultures would define sending the elderly individual to a nursing home as a sign of caring (Ablofathi Momtaz, Hamid & Ibrahim 2013; Gholipour et al. 2020).

## 2.2 Types of elder abuse

Elder abuse is any act that causes harm to an elderly person. It is more commonly perpetrated by someone know to the victim and in whom they trust. It is commonly accepted, and recognised worldwide that the types of elder abuse can be defined as those described by World Health Organization (2002a) and include:

- Physical abuse, which is the infliction of pain or injury, physical coercion, physical/chemical restraint. The physical abuse may include hitting, slapping, pushing, kicking, spitting, misuse of medication, restraint, or inappropriate sanctions.

- Psychological abuse including emotional abuse, is verbal abuse, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, isolation or withdrawal from services or supportive networks.

- Financial/material abuse, which is the illegal or improper exploitation and/or use of funds or resources. This can include theft, coercion, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, misuse of power of attorney or the misuse or misappropriation or property, possessions, or benefits.

- Sexual abuse, which is non-consensual sexual contact of any kind with an older person.

- Neglect/abandonment, which is the intentional or unintentional refusal or failure to fulfil a caretaking obligation. This can include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating, and failure to provide appropriate equipment.

During the investigation of the literature pertaining to the types of elder abuse some other types of abuse of interest was identified and included:

- Aggregate abuse which is an incorporation of some level of all types of abuse and mistreatment (Pillemer, Burnes, Riffin & Lachs 2015).

- Anticonstitutional abuse, which refers to violation of constitutionally guaranteed human rights. Examples are stealing of identity papers, coercion, or false pretence resulting in surrendering rights (Lacher, Wettstien, Senn, Rosemann & Hasler 2016).

## 2.3 Risk factors for elder abuse

There is no single factor which adequately explains why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. Violence is the result of the complex interplay of individual, relationship, social, cultural, and environmental factors. Applying the ecological model (see Figure 1) can help understand the multifaceted nature of violence. The model explores the relationship between individual and contextual factors and considers violence as the product of multiple levels of influence on behaviour. (WHO 2002a.)

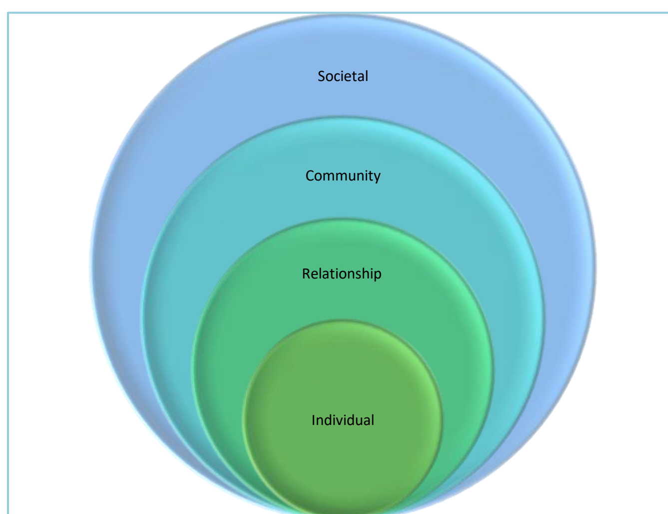



Figure 1 Ecological model for understanding violence as suggested by (Adapted from WHO 2002a)

The studies identified to inform the review about the background and theory of elder abuse have suggest that the risk factors discussed in this section are generally agreed upon to be those related to the victim and to the perpetrator at the individual and relationship levels of the ecological model. The studies also show that it is possible to categorise the likelihood (very likely, likely, and less likely) to which the specific factors predispose the victim to the possibility of being abused and similarly predisposes the perpetrator to the possibility of committing abuse. Also, through the ecological model for

understanding violence, risk factors for abuse at community and societal levels have been identified that put certain individuals at a considerable risk for abuse (Baker, Francis, Hairi, Othman & Choo 2016; Downes, Fealy, Phelan, Donnelly & Lafferty 2013; Lacher et al. 2016; Mosqueda et al. 2016; O'Brien et al. 2015; Pillemer et al. 2015).

### 2.3.1 Individual level risk factors for the victim

Functional dependence/ disability commonly occurs in older age, unfortunately this affects the ability to carry out activities of daily living (ADL). Elderly persons with functional dependency are very likely to suffer from abuse. Associated type of abuse: emotional and financial abuse (O'Brien et al. 2015; Pillemer et al. 2015).

Poor physical health usually manifests chronic health conditions like cardiovascular disease, diabetes, and obesity. Elderly persons with poor physical health are very likely to be subjected to abuse. Associated type of abuse: financial, emotional and neglect (Baker et al. 2016; O'Brien et el. 2015; Pillemer et al. 2015).

Cognitive impairment/dementia also occurs in older age but not exclusively and can be mild to severe, manifesting itself with problems remembering, concentrating, learning new things, and making decisions in relation to everyday life. Elderly persons with cognitive impairment/dementia are very likely to be subjected to abuse. Associated type of abuse: physical, sexual, verbal, and psychological (Downes et al. 2013; Pillemer et al. 2015).

Poor mental health affects a large proportion of the population. It can range from more common problems like anxiety or depression to more difficult problems such as bipolar and schizophrenia. It can be as debilitating as a physical illness and leave the sufferer unable to cope. Elderly persons suffering from poor mental health are very likely to be subjected to abuse. Associated type of abuse: depression or depressive symptoms have been associated emotional and physical abuse. (Pillemer et al. 2015.)

Low income describes those who earn less than or at least not very significantly more than the poverty level. Low income means less disposable income, difficulties paying bills and to low job security. Also, associations have been found between low income and violence and abuse, particularly regarding neglect and emotional abuse. Elderly

persons suffering from low income are very likely to be subjected to abuse. Associated type of abuse: financial, emotional, physical and neglect (O'Brien et al. 2015; Pillemer et al. 2015).

Gender the gender of older people specifically the female gender has been associated with an increased risk to being subjected to abuse. Gender is hierarchical therefore produces inequalities that intersect with other social and economic inequalities. In societies where women are viewed as subordinate to men, without power and control the risk is even greater. However, some studies suggest that that males are more vulnerable to abuse than females. Associated type of abuse: emotional and financial (Downes et el. 2013; O'Brien et al. 2015; Pillemer et al. 2015).

Age is a factor which has been associated with an increased risk to be subjected to abuse. Persons aged 65 years, and more are most often referred to being elderly. Aging can be viewed in many societies negatively and this leads to a devaluing of older people. As age increases so too does the likelihood for abuse. Associated types of abuse: emotional, physical, financial abuse, and neglect (O'Brien et al. 2015; Pillemer et al. 2015).

Financial dependence describes a relationship in which one of the partners if financially dependent on the other. This has been observed globally and, in this incidence, the elderly person who is financially dependent is likely to become subjected to abuse. Associated types of abuse: neglect (Downes et al. 2013; Pillemer et al. 2015).

Race/ethnicity of the elderly person influences the types of abuse likely to be inflicted. Findings suggest that specific racial/ethnic groups have divergent risk trends in relation to different types of elder abuse. Compared with Caucasians, African American elderly people are likely to have an increased risk of financial and psychological abuse. Aboriginal elderly people have an increased likelihood of being at higher risk of physical and sexual abuse. As a contrast Hispanic elderly people have shown lower risk of emotional abuse, financial abuse, and neglect. (Pillemer et al. 2015.)

### 2.3.2 Individual level risk factors for the perpetrator

Mental illness in the perpetrator is very likely to commit abusive behaviours. Poor psychological health, depressive symptoms, anxiety, burn out, lack of support, knowledge,

and adequate training on how to deal with challenging behaviours plus lower self-esteem was predictive of violent inclinations. Associated types of abuse: physical and verbal (Downes et el. 2013; O'Brien et al. 2015; Pillemer et al. 2015).

Substance abuse amongst perpetrators is reported to be common. Use of drugs and or alcohol made it very likely for the perpetrator to commit abuse or to engage in abusive behaviours. Associated types of abuse: verbal and financial (Pillemer et al. 2015).

Abuser dependency is where the perpetrator has co-dependency issues with their victim and are also dependent on their victims for financial help, housing, and/or other assistance. Associated types of abuse: aggregate (O'Brien et al. 2015; Pillemer et al. 2015).

### 2.3.3 Relationship level risk factors

Victim perpetrator relationship describes the relationship between the victim and the perpetrator be it the family system or relationship. The relationship can be dysfunctional in nature and have themes such as co-dependency, financial problems, and a history of violence in the context of the history of the relationship. The elderly person is also at higher risk when living with the care giver. Also, the abuse may vary according to abuse type and culture. In western countries the spouse or partner is the common perpetrator and likely to engage in abuse or abusive behaviours. Whereas in Asian countries children or children-in-law were likely to engage the abuse. Associated types of abuse: emotional and physical abuse (O'Brien et al. 2015; Pillemer et al.2015; Who 2002a).

Marital status has been associated with a likelihood for increased risk for abuse. Studies from the United States, Canada, and Europe indicate that being married is associated with aggregated elder abuse but with specific emphasis on emotional and physical abuse. In contrast to these, other studies from the United States, Europe, Mexico, and China have found that being single, separated/divorced, or widowed is associated with higher odds of aggregated elder abuse (Pillemer et al. 2015).

### 2.3.4 Community level risk factors

Geographic location of the elder person has been reported to have a likely associated with an increased risk of been subjected to abuse. Studies reported that individuals living in urban areas were at greater risk for elder abuse. Residing in a specific country may also be a risk factor for abuse. Social isolation emerges as a significant factor associated with geographical location. Isolation of older people can be both a cause and a consequence of abuse, they may also suffer from isolation because of physical or mental infirmities. Loss of friends and family members reduces the opportunities for social interaction (Pillemer et al 2015; WHO 2002a).

### 2.3.5 Societal level risk factors

Societal factors are considered important as risk factors for elder abuse in both developing and industrialized countries. A lack of empirical evidence makes identifying factors at societal level which may place individuals at higher risk for abuse difficult, however from the literature two possible factors are frequently cited.

Negative stereotypes on aging are frequently associated with elderly people. They are often depicted as being frail, weak, and dependent, making them appear less worthy and in many respects expendable, leaving them more susceptible to abuse by younger generations (Pillemer et al 2015; WHO 2002a).

Cultural norms and traditions – such as ageism, sexism, culture of violence leading to normalization of violence and further perpetuate violent behaviours toward older people (Pillemer et al 2015; WHO 2002a).

# 3 Purpose and aims

The purpose of this scoping review is to examine the phenomena of elder abuse and present current information available on identification and intervention in elder abuse in relation to healthcare professionals. The aim is to identify areas needing development in relation to identification and intervention and increase awareness in healthcare professionals of the significance of comprehensively understanding elder abuse.

The review question of the scoping review is: What does the current literature tell us about identification and intervention in elder abuse?

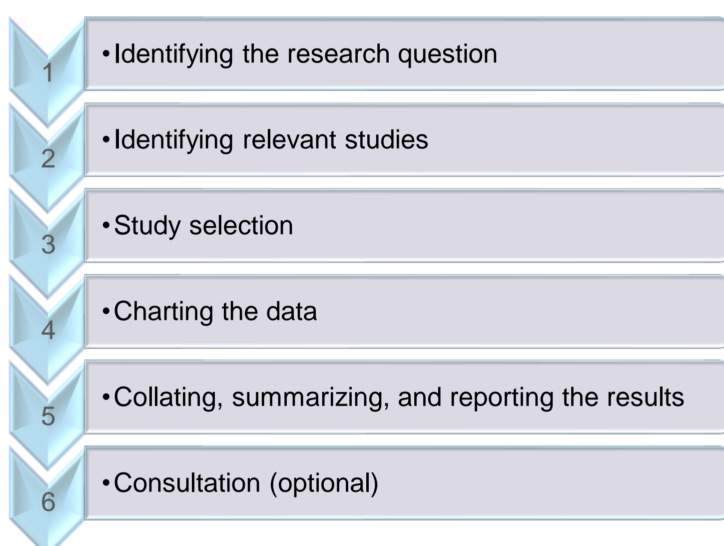
# 4 Research methods and data collection

This thesis is a scoping review. A scoping review can be conducted when there is a need to explore the breadth or extent of the literature, map and summarize the evidence, and inform future research. Scoping reviews are useful for examining emerging evidence when it is still unclear what other, more specific questions can be posed for evidence syntheses and valuably addressed. Conducting this kind of review is beneficial where there is interest in the identification and mapping of certain characteristics/concepts in sources of evidence and in reporting and discussion these characteristics/concepts (Peters et al. 2020). Elder abuse can be first identified in scientific literature several decades ago. The phenomenon has been globally acknowledged to be one of the greatest challenges to healthcare for future generations, as older people in populations are increasing dramatically with estimations that the number of people over the age of 60 will double by 2050, with estimates that 30% of some populations consisting of elderly people by then. Despite these facts there is a lack of curriculum level education pertaining to elder abuse, training models, valid assessment tools, standard practice, best practice, and legislation established to combat it. Combatting elderly abuse starts with being able to identify the abuse and then to be able to intervene, however it is commonly acknowledged that elder abuse goes woefully underreported. A scoping review is the appropriate choice for conducting this research into identification

and intervention in elder abuse, as it will help identify and map the concepts and characteristics, summarize the evidence, and perhaps inform future research concerning elder abuse identification and intervention.

A priori protocol must be developed before undertaking the scoping review. A scoping review protocol is important, as it pre-defines the objectives, methods, and reporting of the review and allows for transparency of the process. The protocol should detail the criteria that the reviewers intend to use to include and exclude sources of evidence and to identify what data is relevant, and how the data will be extracted and presented. The protocol provides the plan for the scoping review and is important in limiting the occurrence of reporting bias. Any deviations of the scoping review from the protocol should be clearly highlighted and explained in the scoping review (Peters et al. 2020). The protocol for this review adheres to JBI's scoping review framework, which was originally proposed by Arksey and O'Malley in 2005 in their paper Scoping studies: towards a methodological framework. This framework has been enhanced by several researchers later and these enhancements have been included in JBI's Manual for Evidence Synthesis (2020). However, for the purpose of this review the original version developed by Arksey and O'Malley was used. Table 1. The Arksey and O' Malley framework describes the framework and its steps.

Table 1. The Arksey and O'Malley Framework



Stage 1 of the framework: Identifying the research question

This is the starting point which is to identify the research question to be addressed as this guides the way that search strategies are built. Consider which aspects of the research question are particularly important, for example, the study population, interventions, or outcomes. Defining parameters, and considering the implications of adopting positions, is important at the outset of a scoping review. maintain a wide approach to generate breadth of coverage. Decisions about how to set parameters on large numbers of bibliographic references can be made once some sense of the volume and general scope of the field has been gained (Arksey & O'Malley 2005).

Stage 2 of the framework: Identifying Relevant Studies

The central purpose of the scoping review is to find and map as comprehensively as possible all research articles and reviews published and unpublished suitable for answering the central research question and that discuss the associated topic. For this to be achieved, a strategy that involves searching for research evidence via different sources: electronic databases, reference lists, hand-searching of key journals existing networks, relevant organizations and conference is recommended (Arksey & O'Malley 2005). It is agreed that the strength of a scoping review lies in its comprehensiveness and breadth. However, time, budget and personnel resources are potential limiting factors and decisions need to be made upfront about how these will impact the search (Levac, Colquhoun & O'Brien 2010).

Stage 3 of the framework: Study Selection

When identification of all the possible relevant studies is completed, then starts the process of screening and eliminating studies that are not suitable to be included into the review and do not address the central research/review question and select the ones that are suitable for inclusion. This is a laborious task which is assisted by defining and inclusion/exclusion criteria to ensure consistency in decision making. In the scoping review defining of the inclusion/exclusion criteria happen *post hoc* to the identification of the relevant studies. While reading through the literature, familiarity and understanding of the topic increases and the relevant studies reveal themselves (Arksey & O'Malley 2005). While Arksey and O'Malley (2005) do not indicate that a team approach is imperative, Levac, Colquhoun, and O'Brien (2010) suggest scoping studies involve multidisciplinary teams using a transparent and replicable process. This scoping review did not have the possibility to use a multidisciplinary team to complete the process.

## 4.1 Search strategy

Establishing a search strategy for literature review is imperative as to avoid biased conclusions that might occur during the search process. As suggested by Arksey and O'Malley (2005) the strategy should begin with identifying the research question to be addressed. For this to happen keywords must be identified and a formulation of the review question must be created. The "PCC" mnemonic is recommended as a guide to construct a clear and meaningful title for a scoping review and can also be used for creation of the review question. The PCC mnemonic stands for the Population, Concept, and Context. There is no need for explicit outcomes, interventions, or phenomena of interest to be stated for a scoping review; however, elements of each of these may be implicit in the concept under examination (Peters et al. 2020). The 'PICO' mnemonic was used in this thesis. The PICO mnemonic stands for Population, Intervention, Context and Outcome. PICO divides the review question into sections and identifies components or concepts in the question and brings focus to the question. It also defines the concepts that will be used to form the search terms when making the literature search.

The review question is: What does the current literature tell us about identification(I) and intervention(I) in elder abuse(P)? The key words were discovered from the PICO sections. These keywords and their synonyms were tested during a pilot search and most of the search terms were constructed based on these. Table 2. PICO and search terms. During the pilot search it was observed that according to the results, the context section would be regarded healthcare(C) and that outcomes (O) would be improvements. However, the review question was left unchanged at that point.

Table 2. PICO and search terms

| | |
|---|---|
| P | •Abused elder |
| I | •Identification, recognition, observing<br>•Intervention, intercede, mediate |
| C | •Healthcare, health care |
| O | •Improvements, recommendations |

### 4.1.1 Inclusion/ exclusion criteria

The “inclusion criteria” of the protocol details the basis on which sources will be considered for inclusion in the scoping review and should be clearly defined. These criteria provide a guide for the reader to clearly understand what is proposed by the reviewers and, more importantly, a guide for the reviewers themselves on which to base decisions about the sources to be included in the scoping review. There must be clear congruence between the tile, question/s, and inclusion criteria of a scoping review (Peters et al. 2020). As recommended by Arksey and O’Malley (2005) inclusion and exclusion criteria are to be defined in advance when planning the strategy. During the process of screening and eliminating studies that are were not suitable to be included into the review and that did not address the central research/review question the inclusion/exclusion criteria were modified slightly to ensure the quality and relevance of the studies chosen. The criteria for the studies chosen can be found in Figure 2. The eligibility criteria.

The inclusion criteria included studies written in English or Finnish, published not earlier than January 2010. The time limit to the date of publishment was justified as the purpose of the review was to present current information available on elder abuse identification and intervention. Studies needed to be quantitative and qualitative peer reviewed empirical studies, systematic, integrated, explorative, report reviews and non-randomized controlled pilot studies. Also included were, retrospective analyses, descriptive, cross-sectional studies plus books and editorials. Excluded from the review were conference proceedings, letters, and theses. The decision to exclude these was made as ample research studies were produced during the search process. To identify the most significant and relevant studies from a large body of literature the results from the PICO (see Table 2), guided all three chosen search terms: elder abuse, identification, and intervention had to be identified in the abstract for the study to be considered for the review. When screening the full text studies, studies that considered only one of the search terms were deemed admissible. However, if the studies treated search terms casually, they were excluded.

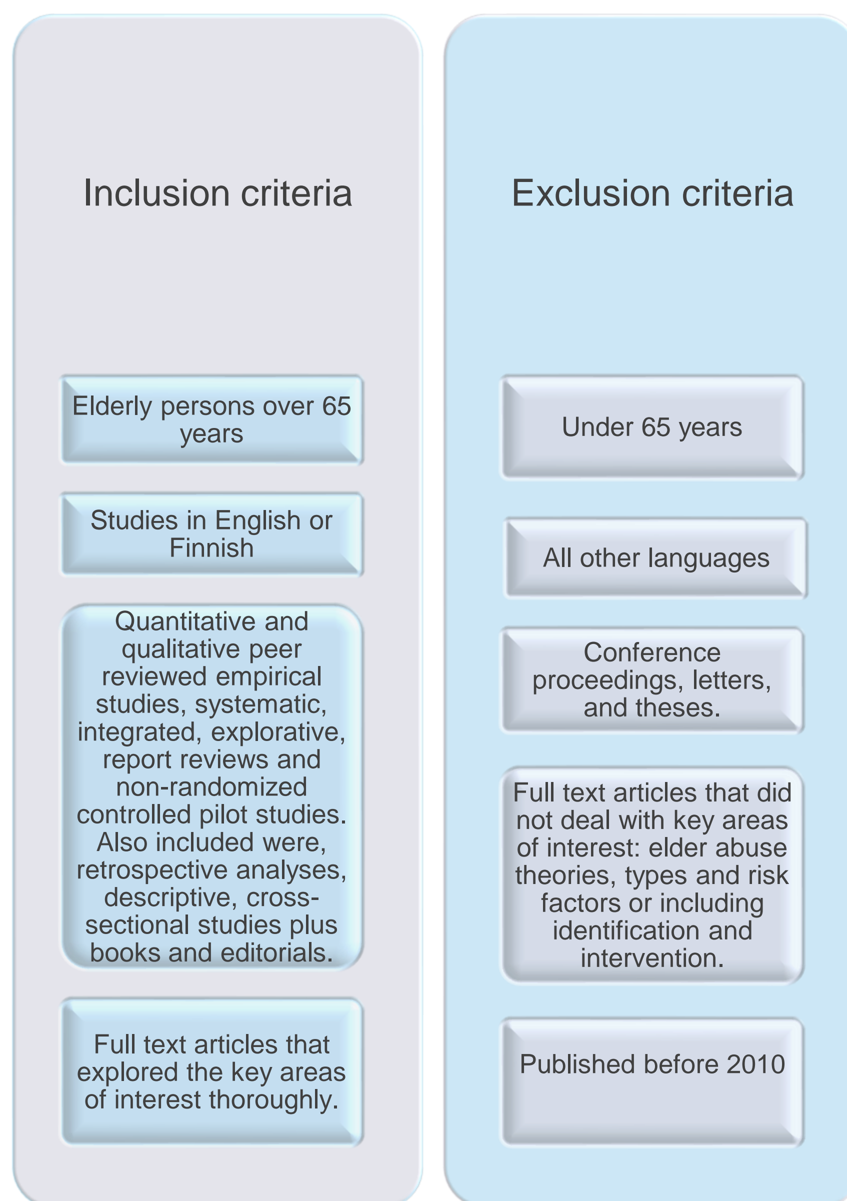



Figure 2. The eligibility criteria

### 4.1.2 Literature search and selection of studies

PubMed, CINAHL complete including Medline, Ovid Emcare & Ovid Nursing Databases were used for the literature search. Their selection was decided because of their appropriateness as they are the principal resources for literature in nursing and were relevant to the review question. Identifying the right sources was guided by the recommendations set out in JBI Manual for Evidence Synthesis 2020: search strategy for scoping reviews. A three-step search strategy was recommended. This search strategy was conducted by firstly making a pilot search, secondly the actual search through the

analysis of the results using title, abstract, full-text and then thirdly examining the reference lists of all identified sources not just from the chosen articles to examine them for additional sources. This also led to a search for grey matter to attempt to close out any gaps in the search strategy which might have excluded relevant sources. Every step of this process has been documented meticulously, duplicates were removed by the databases citation managers and by hand.

The pilot search was conducted in the above-mentioned databases in the Spring of 2022. This initial search was then followed by an analysis of the keywords and concepts in the title and abstract of retrieved papers. During the initial search it was observed that that hits using keywords “elder abuse” over “elderly abuse” was more likely to produce relevant studies. Earlier in the search strategy during the formulation of the review question through PICO the context and outcome sections of the were not concluded. During the initial search it became evident from the retrieved studies that the context was to be healthcare (C) and the outcome would be improvements (O), despite this revelation these findings were not entered into the keywords search terms. This was decided to keep the focus on the key components of the review question and because the databases used are principal resources for literature in nursing and influence results accordingly. Also, during this initial search it became evident that on certain databases using the keywords “identification” and “intervention” separately was not providing the most productive results, however using them together provided more. This conundrum led to a delay in the performing of the actual search. Help of a specialised librarian was used to rectify this problem. During the problem-solving session in Metropolia campus Myllypuro on the 1.6.2022 expert advice was given on how to tighten up the search word strings in the databases to give the best results, also it was advised to keep the search simple. The result of this intervention was positive and brought more reliability to the search of evidence.

The actual search was conducted in September 2022 using the same databases. The full search strings in the given databases are shown in Figure 3. Search strings in the databases.

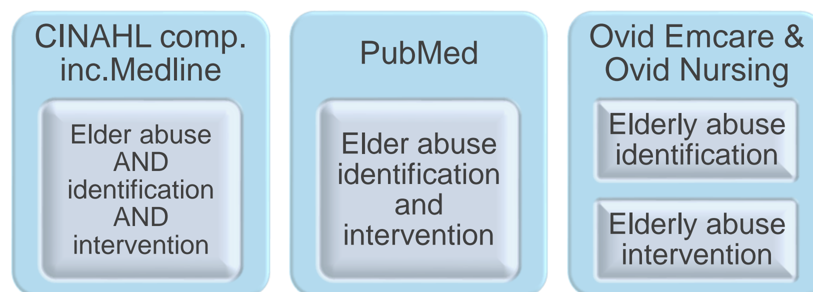



Figure 3. Search strings in the databases

The search strings were connected with the Boolean operator “AND” in all the data bases at first, however due to technicalities in the different databases this had to be rectified to produce reliable results. The difference in the search string keywords and search terms in the databases are recorded in Figure 3.

The actual search offered in total 1837 results across the three databases. The results of the search strategy are presented in the flow diagram in Figure 4. Studies identified from databases using inclusion criteria and search strings (n=1837) CINAHL comp. inc. Medline n=90, PubMed n=222, and Ovid Emcare & Ovid Nursing Database n=1525. Before proceeding duplicate records removed automatically (n =38) and the exclusion criteria employed. After this the remaining studies were screened by title and abstract, including possibility of full text availability. After this process the number of studies remaining was n=87, broken down in the databases as follows: CINAHL comp. inc. Medline n =20, PubMed (n=26) Ovid Emcare & Ovid Nursing n=41. From these studies it was observed that there were duplicate search results, which were removed manually n=22, also at this point the studies that were not open source were removed n= 12. So, in short studies assessed for overall eligibility after the studies that were not open source and duplicates were removed was n =53. After this, from the 53 studies remaining, assessment was made as to which of these studies would be suitable to be used as citing studies in the review background n=12 and which would be suitable for answering the review question n=13. Also, during the screening process reference lists of all identified studies not just the reference lists of the studies that were selected has been examined for so called grey literature. The results of this examination led to a total of 17 studies been identified in direct relation to background and the review question, all were used in this review.

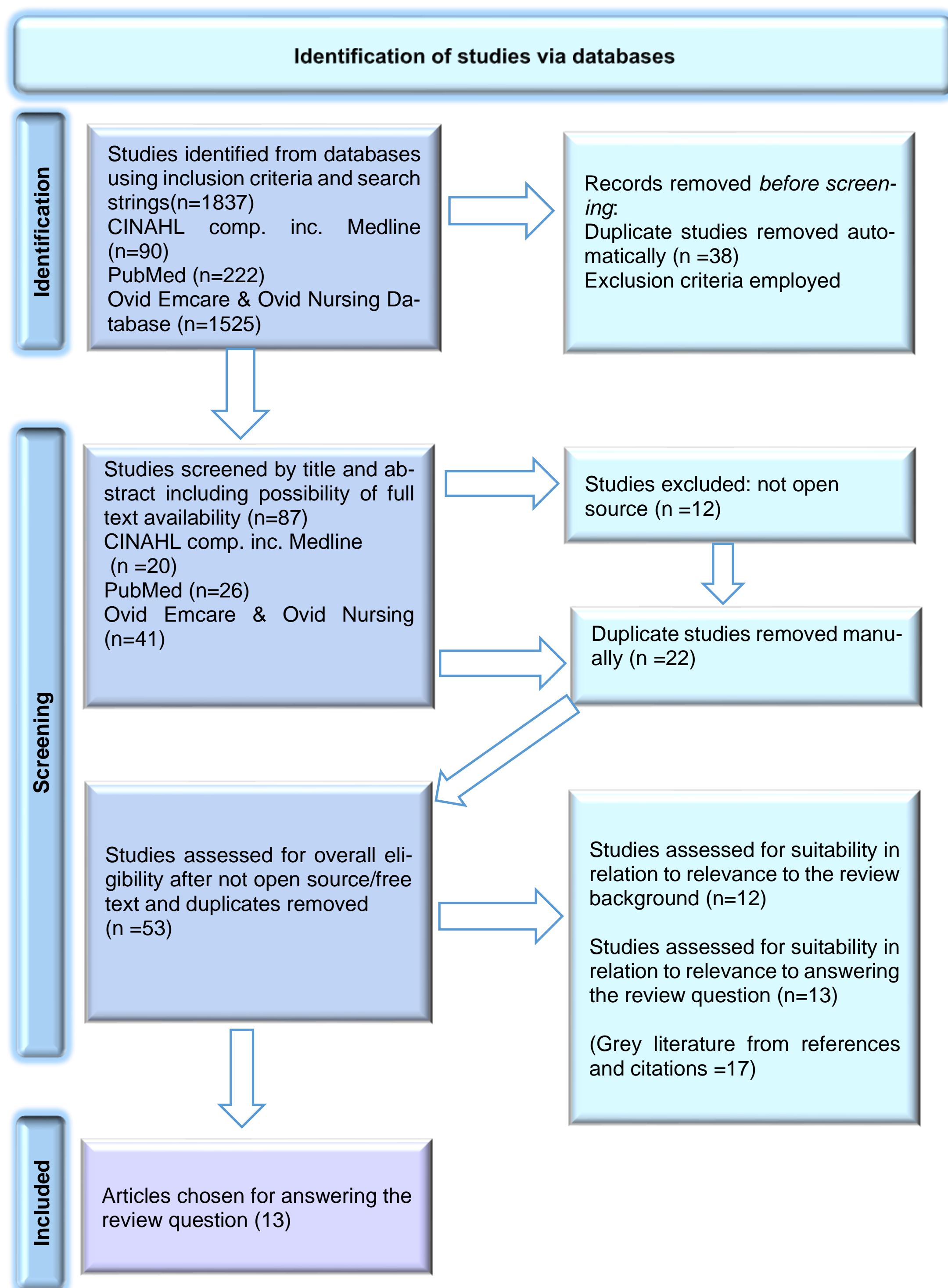



Figure 4. Flow diagram of search strategy

# 5 Data charting

This process provides the reader with a logical and descriptive summary of the results that aligns with the objective/s and question/s of the scoping review. A draft charting table or form should be developed and piloted at the protocol stage to record the key information of the source, such as author, reference, and results or findings relevant to the review question/s. This may be further refined at the review stage and the charting table updated accordingly. As reviewers chart each source, it may become apparent that additional unforeseen data (grey literature) can be usefully charted. Charting the results can therefore be an iterative process whereby the charting table is continually updated. The most important thing is authors are transparent and clear in their methods regarding what and how they have extracted data. (Peters et al.) The data charting system for this review can be found in Appendix 1. In this appendix the charting process for the articles chosen to answer the review question can be found and the articles that provided the information for the theoretical background of the review. The key information chosen to include in the chart were reference (authors), country, aims and purpose, design, data and methods, and main results of the study.

From the 13 studies that were chosen to answer the review question, seven of them were literature reviews, three were qualitative studies, there was one audit, one scoping review and one nonrandomized controlled pilot. All the studies were published between 2011 and 2022, six studies were published between 2011-2016 and seven articles were published between 2018-2022, which considering the review question, makes the evidence provided current. The studies emanated from North America, Europe, and Australia. North America including Canada producing (n=8), Europe including, Austria, Belgium, Finland, Ireland, Lithuania, Norway, Portugal, and Sweden producing(n=4) and Australia (n=1).

During the third step of the search strategy, all reference lists (not just the reference lists of the studies selected for the review) were examined to identify additional sources of information. This search provided a large array of grey literature that was used throughout the review. A summary of this information is provided in Appendix 2.

## 5.1 Critical Appraisal (Risk of Bias Assessment)

The JBI Manual for Evidence Synthesis 2020 suggests that though critical appraisal is not mandatory in a scoping review, reviewers may decide to assess and report the risk of bias depending on the purpose of the review. Also, if the reviewer does decide to perform a critical appraisal, a clear statement of how the critical appraisal was conducted should be documented and provide details of the items that were used to assess the included studies. The tools or instruments used should be appropriate for the review question asked and the type of research conducted. Assessment of the quality of the literature included in a review is regarded as essential (Peters et al. 2020). Performing a critical appraisal helps lay the foundations for the transparency of evidence synthesis (the information accumulated from a broad range of sources and disciplines to enlighten debate and decisions on specific issues), results and findings.

The thirteen studies chose to address the review question were evaluated by the critical appraisal tool proposed by Hawker, Payne, Kerr, Hardey, and Powell 2002. When this team developed their tool for critical appraisal, the necessity to create it, was born out of fact that at that time debates on how to grade/judge/assess studies that use qualitative methods or a combination of qualitative and quantitative methods had not led to a general consensus upon suitable methods for the assessing of the quality of qualitative research. This led to the development of a framework that could be used to assess the quality of diverse groups of empirical studies. Scoring systems from other assessment tools were gathered to form a scale/continuum. To ensure fairness and consistency the protocol was designed to be as explicit as possible. (Hawker, Payne, Kerr, Hardey, and Powell 2002.)

The tool includes nine four-point scale items: abstract and title, introduction and aims, method and data, sampling, data analysis, ethics and bias, results, transferability or generalizability, and implications and usefulness. Each item is rated with either 1 (very poor), 2 (poor), 3 (fair) or 4 (good) points which dictates that the minimum score of the tool is 9 and maximum is 36. The total calculated score and the total average scores of the individual items are then reported as very poor, poor, fair or good.

The average score of this review's thirteen studies was 31 out of the possible 36. This infers that the overall quality of the studies can be described to be fair to good. The total scores on each individual study spanned from the lowest which was 18 to 36 which was the highest, indication that the quality of the studies ranged from poor to good. The items which scored the highest average scores were abstract and title and data scoring

3,7 and 3,6 out of 4 respectively. The item which scored the lowest average score was ethics and bias scoring 2,7 out of 4. Method and data, sampling and implication and usefulness all scored 3,5 out of 4. Introduction and aims, results and transferability and generalizability scored 3,4 out of 4. The summery of this critical appraisal tool and its results presented in Table 3. Critical Appraisal Tool results

Table 3. Critical Appraisal Tool results

**Critical Appriasal Tool by Hawker et al. (2002)**

| Reference | 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Alt et al. 2011 | 4 | 3 | 3 | 4 | 3 | 1 | 3 | 3 | 3 | **27** |
| Cannell et al. 2016 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | **36** |
| Collins et al. 2020 | 4 | 3 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | **34** |
| Dominguez et al. 2020 | 3 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 3 | **18** |
| Downes et al. 2013 | 4 | 4 | 4 | 4 | 4 | 3 | 3 | 3 | 4 | **33** |
| Kayser et al. 2021 | 4 | 3 | 4 | 3 | 4 | 2 | 3 | 3 | 3 | **29** |
| Luoma et al. 2011 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | **36** |
| Myhre et al. 2020 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | **36** |
| Rosen et al. 2018 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | **35** |
| Rosen et al. 2019 | 3 | 4 | 4 | 4 | 4 | 2 | 3 | 3 | 3 | **30** |
| Simmons et al. 2022 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | **36** |
| Wang et al. 2015 | 3 | 3 | 3 | 4 | 4 | 3 | 3 | 3 | 3 | **29** |
| Yaffe & Tazkarji 2012 | 3 | 2 | 2 | 2 | 2 | 1 | 3 | 3 | 3 | **21** |
| **Average scores** | **3,7** | **3,4** | **3,5** | **3,5** | **3,6** | **2,7** | **3,4** | **3,4** | **3,5** | **31** |

**ITEMS**

1. Abstract and title
2. Introduction and aims
3. Method and data
4. Sampling
5. Data
6. Ethics and bias
7. Results
8. Transferability or generalizability
9. Implications and usefulness
10. Total

The tool of Hawker et al. (2002) includes nine four-point scale items (as mentioned above from 1-9). Every item is rated either 1 (very poor), 2 (poor), 3 (fair) or 4 (good) points which dictates that the minimum score of the tool is 9 and maximum is 36. The total calculated score of the studies and the total average scores of the individual items are then reported as very poor, poor, fair or good.

## 5.2 Data analysis

The way data is analysed in scoping reviews is largely dependent on the purpose of the review and the author's own judgement. Scoping reviews do not propose to synthesize the results/outcomes of included sources of evidence, as this is more appropriately done within the conduct of a systematic review. In some situations, scoping review authors may choose to extract results and descriptively (rather than analytically) map them. For example, a scoping review may extract the results, included sources and map these, but not attempt to assess certainty in these results or synthesize these in such a way as would be conducted in systematic reviews. For many scoping reviews, simple frequency counts of concepts, populations, characteristics, or other fields of data will be all that is required. However, other scoping review authors may choose to perform more in-depth analyses, such as descriptive qualitative content analysis, including basic coding of data. In terms of quantitative data, scoping review authors may choose to investigate the occurrence of concepts, characteristics, populations etc with more advanced methods than simple frequency counts. Whilst this in-depth type of analysis is not normally required in scoping reviews, in other scoping reviews (depending on the aim), review authors may consider some form of more advanced analysis depending on the nature and purpose of their review (Peters et al. 2020.)

This review had the data analysed using inductive content analysis as described by Erlingsson and Brysiewicz (2017). This process of analysis reduces the volume of text collected, identifies and groups categories together and seeks some understanding of it (Bengtsson 2016.) Through the understanding the text, the reviewer can then draw conclusions from it. An example of the results of this process are described in Figure 5. Inductive content analysis (Erlingsson & Brysiewicz 2017). The full description of the inductive analysis on the studies chosen to answer the review question can be found in Appendix 3.

As guided by Erlingsson and Brysiewicz 2017, the studies selected to address the review question were read and re-read to gain a sense of the whole, to gain a general understanding of what the chosen studies were really trying to convey. Information was recognised that addressed the review question. This information was then divided up into smaller parts, namely, into meaning units. Then these meaning units were condensed even further. While doing this, a conscientious effort was made to ensured that the core meaning was still retained. After the meaning units were condensed further,

they were be labelled by formulating codes and then those codes were grouped into categories. Subject to the aim and quality of the collected data of the studies, categories were chosen as the highest level of abstraction and for this review those categories went further and created themes. Intuition and reflective understanding were superimposed on this almost linear process and were used to guide the process when handling the data, assisting in the difficult job of balancing previous knowledge, personal assumptions, opinions, and personal beliefs, attempting not to let them unconsciously influence the analysis, while simultaneously, utilising pre-understanding to facilitate a deeper understanding of the data. It was observed that the process of identifying and condensing meaning units, coding, and categorising are not singular events, they are continuous processes of coding, categorising then returning to the original data to reflect on the initial analysis. This process was repeated until satisfaction was achieved with the length of meaning units, with the meaning units and codes remaining pertinent to each other, and with the codes still fitting into their assigned categories.

This content analysis process produced four themes and fifteen categories (see Figure 5. Inductive content analysis and example (Erlingsson & Brysiewicz 2017).

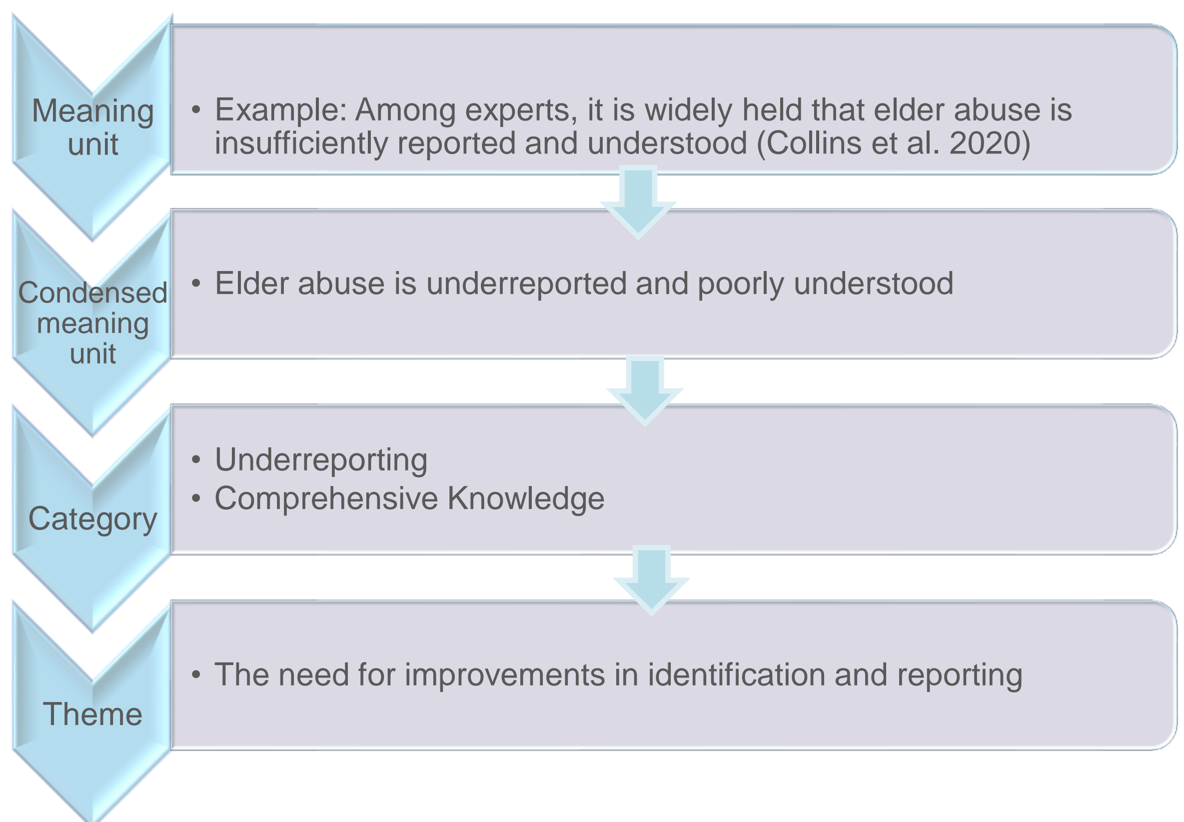



Figure 5. Inductive content analysis and example (Erlingsson & Brysiewicz 2017)

Categories were identified and themes formed rather fluidly while conducting the process of the content analysis. More significantly though, was that concrete themes emerged during the process which directly addressed the review question. These themes and categories will be presented in chapter 6.

# 6 Findings

During the content analysis specific themes and categories related to identification and intervention in elder abuse emerged. These evolved into four concrete themes and fifteen respective categories which are represented in Figure 6. Themes and Categories affecting identification and intervention of elder abuse. Under the theme The need for improvements in identification and reporting (the main theme), three categories were identified Reporting, Comprehensive knowledge, and Training. Under the theme The need for research and valid tools, four categories were identified, Research, Assessment, Confidence and Time. Under the theme The need for multidisciplinary collaboration, four categories were identified, Collaboration, Case management, Safety and Prevention. Under the final theme The need for strengthening of Standard practice, Best practice, and Legislation, four categories were identified, Standard practice, Best practice, Legislation and Legal advice. While for the purpose of this review the findings are charted out in themes and categories, all the themes and categories are intrinsically connected. Also worthy of mentioning is that while many of the findings are country specific, the findings have a high degree of transferability which allows the results to be applied to a wider geographical context. Also, this transferability applies to the healthcare professionals. Findings describe specific health care professionals, but the findings can be applied to all health care professionals (physicians, paramedics, emergency medical technicians, nurses, practical nurses, social workers, occupational therapists, and other allied health care professionals involved in care, care coordination and care management).

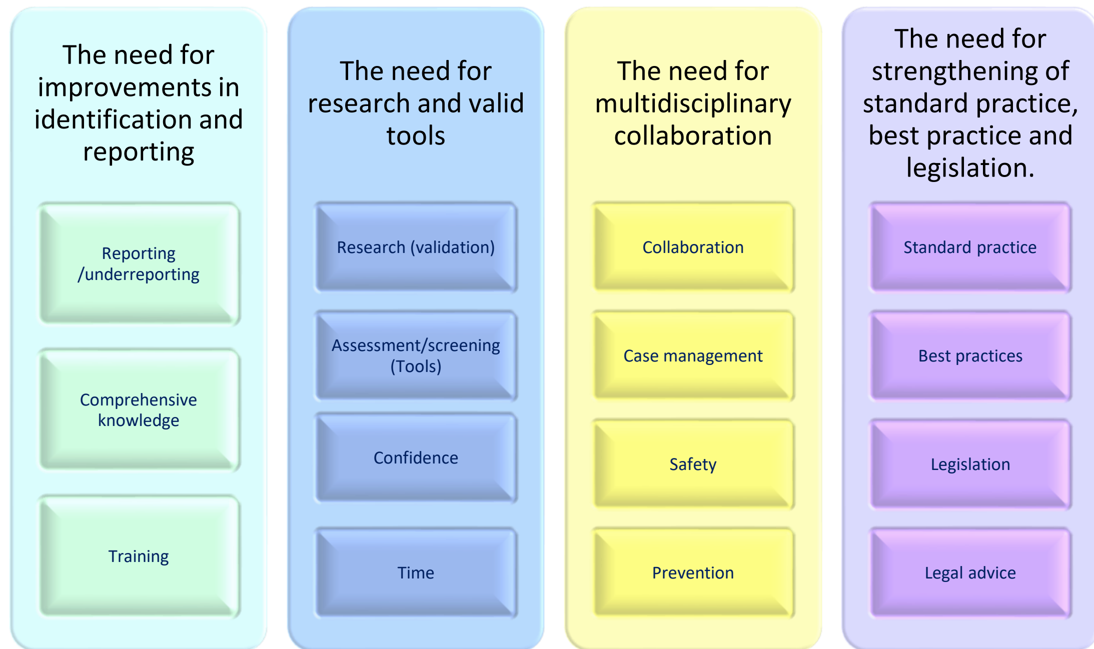



Figure 6 Content Analysis: Themes and Categories affecting identification and intervention of elder abuse.

## 6.1 The need for improvements in identification and reporting

Under the theme The need for improvements in identification and intervention, three categories were identified. These categories were Reporting /underreporting, Comprehensive knowledge, and Training. The Reporting Category discusses the prolific nature of underreporting and the barriers to reporting. The Comprehensive knowledge and Training Categories are represented under one sub-chapter. This decision was made as the two are so closely interconnected throughout the review studies. Comprehensive knowledge of elder abuse and training form the foundations upon which successful identification and intervention begins and potentiates improvements in reporting. The Comprehensive knowledge and Training category will discuss the need to raise awareness of addressing the complex phenomena of elder abuse through education (curriculum based) and educational training models aimed at improving the preparedness of healthcare professionals to care for elderly people subjected to abuse, specifically to enhance reporting propensity and the ability to manage the response.

### 6.1.1 Reporting/underreporting

The organisations and institutions that provide care for the elderly are in a unique position to observe, identify and intervene in elder abuse, however despite this elder abuse goes worryingly under identified and underreported. (Alt, Nguyen & Meurer 2011.) Reports have even gone as far as to suggest that the number of elderly persons experiencing abuse and the numbers actually reported do not correspond, and that for every one case of elder abuse identified 24 goes unreported. (Cannell, Jetelina, Zavadsky & Reingle Gonzalez 2016.) These discrepancies between the number of elderly people experiencing abuse and the reported numbers, give a false description of the situation and might lead to the understanding that a sturdy and systematic response to elder abuse is unnecessary (Kayser et al. 2021). Serious negative health consequences are associated with abuse; however, victims hesitate to report their situation and thus the majority of elder abuse cases go unreported. Health care professionals report that they reluctant to approach the topic of abuse and are usually unaware of the presence of elder abuse amongst their clients. They also describe a concern that they lack skills to manage cases of abuse or provide proper follow-up if cases presented themselves to them. This leads to unsafe environment for the client and the health care professionals responsible for their care. (Simmons, Motamedi, Ludvigsson & Swahnberg 2022.)

Suggestions of barriers to reporting by health care professionals in cases of elder abuse have been reported to be fear towards violating the elderly persons right to self-determination, anxiety about the possibility of negative outcomes for the victim if the abuse is reported and the case investigated, lack of confidence in skills related to correct identification of elder abuse and constraints of time when reporting is initiated. (Cannell et al. 2016.)

Actions that healthcare providers should engage in when they identify elder abuse will be influenced and guided by legislation of the country and jurisdiction where they are at work. Some states demand mandatory reporting of elder abuse. Unfortunately, even though there is the possibility to address elder abuse through the justice system, involvement remains low because victims are very reluctant to involve the legal authorities and because of the widescale problem of underreporting. (Dominguez, Valiquette, Storey & Glorney 2020.) Under-reporting is a cause of great concern due to the vulnerability of the elder population. Recognized risk factors such as poor physical health, cognitive impairment, and social isolation may impede vulnerable elderly people to identify that they are been abused and therefore report the abuse. Also, the victim might fear the repercussions from the perpetrator and decide to remain silent and allow

the abuse to continue. (Cannell et al. 2016.) Underreporting is also identified to be particularly high in abused elder women, as their behaviours towards self-reporting are poor. It has been reported that the overall majority (55.3%) of older women experiencing abuse did not divulge this abuse to anyone. The reason for this was that most of the victims trivialised the severity of the abuse and believed that discussing or reporting the abuse would not lead to any intervention or cessation of it. A lack of fundamental trust in the authority's ability to intervene and not wanting to involve outsiders in their situation were cited as reason for not reporting the abuse. In the cases where the victim reported the abuse it usually correlated to the severity of the violence and then was reported to a friend, family member or a health care professional int that order. Despite having reported the abuse only (51%) of the victims found it to be helpful. (Luoma et al. 2011.) Institutional underreporting also effects the overall national results on how many cases of elder abuse there actually are. Institutional underreporting can be discussed from two distinct viewpoints. One is underreporting by staff and the other is the client's reluctance or inability through cognitive impairment or fear of repercussions for self-reporting.  Institutions and organisations that provide residential care for elderly people must be aware of the difficult issues around elderly care like abuse and have the mission to provide a culture of safety in their institutions. The health care professionals in charge of leadership in residential homes or institutions have the goal ensure that a safety culture exists for staff and residents. The safety culture is created by the provision of quality, dignity, and respect for their clients and also for their staff. In such an environment elder abuse reporting could be potentiated (Myhre, Saga, Malmedal, Ostaszkiewicz & Nakrem 2020).

### 6.1.2 Comprehensive knowledge and Training

There is a systemic problem with inadequate knowledge among healthcare professionals and organisations on the topic of elder abuse. This lack of knowledge is a barrier to identification and intervention responses in elder abuse. Awareness and knowledge of elder abuse potentiates reporting activities. (Alt et al. 2011.) Elder abuse is poorly recognised so much so that abuse goes unrecognised even in individuals of high-risk (Collins et al. 2020). Health care professionals in the emergency department believed that elder abuse is regularly unrecognised because of a lack of routine assessment for it during the emergency department visit. Health care professionals and allied health care workers may not have sufficient experience to feel comfortable attempting to address

abuse often feeling unsure what constitutes abuse and in identifying appropriate responses. Health care professionals in any organisation or institution should be able to recognise from the client's perspective situations that are perceived as destructive and damaging for the client. However, it was found that in institutional care, health care professionals were uncertain about the identification of abuse in particular psychological abuse and caregiver abuse/neglect. There is a need for comprehensive knowledge and understanding of the phenomenon of elder abuse so as to effectively inform intervention and prevention strategies. The ambivalence towards elder abuse is partially explained by the health care professionals themselves as a lack of knowledge and training about elder abuse (Rosen et al. 2018; Kayser et al. 2021; Simmons et al. 2022; Myhre et al. 2020).

Situations where the risk of abuse is higher like that of cognitively impaired vulnerable older persons, where the victims may not be able to disclose the abuse, require high levels of comprehensive knowledge to utilise tools for screening, sensitive interviewing, and forensic biomarkers to detect the abuse. Without this knowledge and understanding the health care professional will be lacking skills imperative to recognise and intervene in a safe manner (Downes, Fealy, Phelan, Donnelly & Lafferty 2013; Dominguez et al. 2020).

Many organisations have recognised the need for comprehensive knowledge in addressing elder abuse and have thus initiated different types of educations and trainings to meet this challenge. These programs and educations are targeted primarily at health care professionals, students, and other allied health care providers. Educational programs the most commonly offered, as they are easier to implement and superimpose onto existing programs. Also, this method is less resource intensive than initiating new programs. (Rosen et al. 2019.) Training provided through didactic orientation along with face-to-face learning methods showed improvements in knowledge, reporting, and increased willingness to intervene. The overall improvements to confidence and increased efficacy persisted long after the educations. The likelihood of making reports of elder abuse was potentiated by the increase in knowledge. (Alt et al. 2011.) Other methods to increase knowledge and awareness have been described and initiated by social workers who offer a different perspective due to their own unique educational background. Through data derived from a 5-year audit they were able to influence and implement change and best practices. Elder abuse training sessions introduced staff to intervention planning, which included features such as the provision of information (crisis support call lines, legal support, and community-based support) and education

about the phenomena of elder abuse. Through this approach they were able to demonstrate an increase in awareness for elder abuse presentations and also improve knowledge around the topic which led to innovations in best practice, training, and research activities (Collins et al. 2020).

The outcomes of educational programs provided for health care professionals and allied health care providers demonstrate improvements in documentation of abuse and neglect assessment, and an increase in the ability to detect financial abuse in victims. (Rosen et al. 2019.) Also, improvements were reported in the ability to approach the subject of elder abuse with elderly clients, with significant increases in the frequency of asking questions about abuse from clients and significant increases in health care professionals' self-efficacy. These changes in knowledge and understanding also effected the significance in which elder abuse was held by the participants after the educations. The realisation through the educations at the prevalence of elder abuse and how under identified it is made a significant impact on the participants. Participants reported being more aware of the indications of abuse and were more willing ask questions about abuse and initiate interventions. (Simmons et al. 2022.)

Overall health care professionals who have received an education targeted an increasing their awareness of elder abuse reported that not only are such educations are imperative but also had led to improved practices in identification, intervention, and case management (Simmons et al.2022; Rosen et al.2018). This change was most likely brought about by a higher commitment to care for through an increased awareness of the issue. At this time the best intervention strategy for elder abuse would be the incorporation of elder abuse training into medical school curriculum. (Wang, Brisbin, Loo & Straus 2015.)

## 6.2 The need for research and valid tools

Under the theme The need for research and valid tools, four categories were identified. These Categories were Research, Assessment/screening, Confidence/safety, and Time. The Research Category discusses the need for rigorous research to evolve current information on elder abuse with verifiable evidence. The Assessment/screening

Category discusses the current evaluation processes and the need to develop universal, research informed, evidence based valid tools for use in assessing elder abuse. The Confidence Category discusses the lack of confidence in healthcare professionals when addressing cases of elder abuse. The Time Category discusses the perceived constrictions around time and how it effects elder abuse identification and intervention.

### 6.2.1 Research

In spite of being globally recognised as serious social problem elder abuse has not attracted the attention in research as other types of family violence have. Not only this, but the theme of elder abuse is not as evident with policy makers as it should be considering the serious impacts it has on the victim. Much of the research that exists does not include primary empirical based studies, the studies that do exist comprise primarily of descriptive, observational, and case studies, with no meta-analyses, and intervention trials, these lacking rigorous standards and the information provided is inadequate and inconsistent (Luoma et al. 2011; Yaffe & Tazkarji 2012). Responses are in need of reform. Vulnerable elderly people need organised and specialised responses to ensure their safety. Many countries have introduced strategies to encourage and guide service improvements and develop responses, however the lack of evidence-based research inhibits service providers from developing highly effective responses to elder abuse. (Collins et al. 2020.)

Using published literature as a guide to research and develop new program planning and curriculum continues to be a challenge. Articles do not give enough give enough details of their process for the programs to be duplicatable. Important details are omitted for the articles like barriers to implementation, requirement of attendance and even outcomes. Due to these omissions of information vital details like how best to motivating participants to learn and how to circumvent problems become impossible, inevitably this overall lack of transparency in the processes of studies relating to elder abuse weaken the validity of the information provided in the findings. (Alt et al. 2011.)

Many areas in elder abuse detection, intervention and management are in need of research and development to enhance their validity. The lack of research is viewed as a source of barriers to identification and intervention. These barriers include varied definitions of elder abuse, lack of reliable data on frequency, causes, and effective prevention. It is of vital importance that information with its foundations rooted in the best

available current research be made available to those in a position to prevent and manage elder abuse to ensure safe and effective intervention. (Alt et al. 2011.) Clinical manifestations of elder abuse so called forensic markers could be utilised for assisting with confirmation of elder abuse cases, in relation to medical and legal determinations of whether elder abuse has occurred. However, there is an absence of primary studies that report the prevalence of any symptoms or signs of elder abuse or report test characteristics of signs of elder abuse, thus weakening the validity of these clinical manifestations and their ability to be utilized in abuse detection. (Wang et al. 2015.)

Gaps in empirical literature exist around best practice for elder abuse case management. There is little research available to guide the health care professional when trying to engage with cognitive impaired elderly people in order to assess for abuse and facilitate disclosure (Dominguez et al. 2020). High-quality evidence-based research is needed develop effective interventions for elder abuse in cognitively impaired clients. Research which can effectively demonstrate the interventions that are effective in the prevention and management of elder abuse in cognitively impaired clients is sadly lacking. Development, implementation, and evaluation of interventions for cognitively impaired elderly people who are abused need to be reinforced scientifically. Also, systematic research must be conducted into the effectiveness of existing interventions that are in use. (Downes et al. 2013.)

The need for high-quality, rigorous, evidence-based research into elder abuse is a mentioned throughout all the studies. This research is needed to examine existing or newly developed interventions in elder abuse, to develop and validate detection tools, adopt data driven evidence-based approaches to improving knowledge, developing procedures, training, and processes. To guide health care professionals safely through the sometimes very challenging phenomena of elder abuse with all its facades and nuances to concrete patient orientated outcomes and reduce underreporting (Kayser et al. 2021; Cannell et al. 2016; Collins et al. 2020).

### 6.2.2 Assessment/screening (tools)

There is an urgent need for health care professionals to have evidence-based, universally applicable, research informed, tools for screening at their disposal to identify elder abuse. As emergency providers are often the first contact point for the victim with the authorities, it would be appropriate that they would have an evidence-based tool at

their disposal to identify elder abuse (Kayser et al. 2021). There is a strong belief that the provision of an appropriate screening tool would alleviate barriers to addressing abuse by Emergency Medical Technicians and thus increase the probability that they would report cases to Adult Protective Services. Adult Protective Services caseworkers also strongly supported the development of a screening tool believing it will improve the quality of data received from Emergency Medical Technicians. Research should seek to develop and validate a tool to enhance detection and reduce the underreporting of elder abuse using the health care professionals' contextual observations rather than systematic questionnaires. This tool will benefit the health care professionals and also allied health care providers engaged in elder management but most of all it will enhance the quality of the older persons life. (Cannell et al. 2016.)

Tools for screening are not always well described or usable. There exist differences and similarities between these tools, many are not designed to assess for abuse, they have been designed to assess for risk factors of a poor outcome for older adults presenting to the emergency department, this poor outcome risk factors might also be associated with abuse. Various constructs are presented in each tool, abuse, neglect, exploitation, and abandonment (EAI: Elder Assessment Instrument), mistreatment (ED-EMATS: Emergency Department Elder Mistreatment Assessment Tool for Social Workers), abuse that includes neglect (ED-Senior AID: Emergency Department Senior Abuse Identification), and vulnerability to adverse outcomes. Most of these tools rely on self-reporting from the clients which is unusable in cognitively impaired clients. (Kayser et al. 2016.) No screening tools have been validated for use in the emergency department, however tools that are useful for other forms of family violence have been utilized in the emergency department to improve elder abuse identification. (Rosen et al. 2018.) Clinical manifestations research and screening tools have the potential to improve elder abuse detection in the emergency department where the primary function of the providers is to stabilize the critical illness, rather than in detecting elder abuse (Rosen et el. 2018).

Social workers reported that, they used no standard screening or assessment tools when ascertaining the elderly clients for abuse. (Rosen et al. 2018). Assessment tools and routine screening for violence and abuse are needed by health care professional in all situations where they are working with elderly people, as part of good practice promoting identification and intervention in elder abuse. Not all screening tools are suitable, especially in persons who are cognitively impaired as most rely on self-reporting and the capability to comprehend the questions and respond to them. In the case that the elderly person is cognitively impaired, screening tools which rely on the health care

professionals' evaluation of abuse are more appropriate in trying to assess is the person abused (Luoma et al. 2011.) According to Wang et al. 2015, assessment of an elderly person suspected of being abused must begin with assessment of their capacity. Management strategies for elder abuse should be handled similarly to other medical treatment decisions with regard to capacity, namely whether the patient is able to understand and appreciate the consequences of the proposed treatment. (Wang et al. 2015.)

Despite growing calls for services around vulnerable elderly people to improve and for better screening of elderly persons, the validity and reliability of screening tools requires further evaluation. This evaluation should include investigations into potential harms, and patient-oriented outcomes. According to an independent group of experts in disease prevention and evidence-based medicine, who are tasked with the improvement of health through developing evidence-based recommendations for clinical preventive services, there is insufficient evidence to evaluate the benefits and harms of screening all elderly adults for abuse. Conclusions about recommendations about screening for the general elderly population were not made, however high-risk populations are more likely to be recommended to be screened despite the lack of evidence to support such an action (Wang et al. 2015; Collins et al. 2020; Kayser et al. 2021).

### 6.2.3 Confidence

Health care professionals dealing with elder abuse especially in the initial identification phase report low confidence due to anxiety related to perceived profound task of correct identification and reporting the abuse. Doubts as to whether their judgement is sufficient to make such a decision impedes them to actually report suspected cases on to the relative adult protection agencies. A person's self-efficacy is defined as their perceived ability to perform tasks and in theory the higher this efficacy is the more inclined the person is to perform the task to a high degree of success. Low levels of self-efficacy are commonly reported among health care professionals. In conjunction with this reported low self-efficacy there are reported anxieties due to time constrictions associated with a busy work environment, the lengthy process of reporting, the lack of comprehensive knowledge on the topic of elder abuse and being unsure of what constitutes abuse, placing the bar to approaching the topic with the possible victim too high. Also, there is a lack of reliable information, guidelines and institutional protocols for appropriate next steps being made available for the health care professionals who are in this

strategic and unique position to help. This lacking confidence also effects case management as health care professionals report insufficient skills to manage the case effectively, a fear that repercussions for the client and health care professional in the form of retaliation from the perpetrator and concern about negative reactions from the client. All these factors compound the lack of the feeling of lack confidence in healthcare professional tasked caring for cases of elder abuse. The health care professionals have expressed a need for support, as well as structured and concrete measures to offer the patient, as a means to lessen their insecurities and to provide the best possible care for victims. They have suggested that a screening tool that would assist with objectivity in the assessment stage and alleviate the anxiety felt. The creation of a user-friendly screening tool with a small number of items that strongly predict cases of elder abuse would impact uptake and use by health care professionals in many settings by supporting their decision-making confidence, thus enhance elder abuse and neglect detection and reporting rates (Alt et al. 2011; Cannell et al. 2016; Kayser et al. 2021; Simmons et al. 2022).

Many health care professionals reported low confidence in addressing elder abuse in relation to the barriers to identification and intervention, before being provided with educational training programs that were designed to enhance their comprehensive knowledge of addressing elder abuse. After the educations, there was reported higher self-assessed improvements in knowledge and perceived ability to manage and appropriately refer elder abuse cases was reported. This improved self-efficacy was reported even over a year after the education was provided. (Alt et al. 2011.)

### 6.2.4 Time

Health care professionals have busy schedules and a lack of resources, like low financial resources. Many reported believing that an abundance of cases of elder abuse go unidentified, while simultaneously reporting that the did not routinely assess for abuse. Organisational level pressures lead to staff prioritising their time, work, and tasks to meet certain criteria daily. This forced prioritization of time was generally accepted and furthermore situations defined as not been medical, physical or health related were given lower priority. These perceived constrictions to time effect the identification, intervention, and reporting of elder abuse negatively. This burden of time effects all aspects of some health care professional interactions with possible elder abuse victims. It was reported that though tools for screening to assist in identification were sought by health

care professionals, they felt that they had no time to conduct evaluations and that such tool were it to be introduced, the length of time taken to complete it would be an influencing factor in the tool's uptake by various departments and organisations (Rosen et al. 2018; Myhre et al. 2020).

Not only has screening for elder abuse been associated with perceived time constrictions so too is the feeling that the process after the identification will led to additional work like identifying the abuse, trying to solve, assessing the deeper effects the abuse has had on the victim and how prolonged was the abuse. The time used in association with investigation these were in turn perceived to hamper the health care professional's ability to care for the elderly persons present and pressing acute situation. Some health care professionals and case managers even went as far to say that they the felt that they might be questioned at an organisational level might for prioritizing the abuse-related problems if it took time away from their perceived medically related tasks.  It was also reported that in some organisations social workers had stumbled upon those cases of elder abuse, as staff had mitigated the suspicion of abuse and not made referrals due to the burden of time, lack of resources and the number of patients they were allocated. Psychiatrists reported that they were able to witness the burden of time in other health care professionals and how it leads to under identification of abuse when they were often able to identify subtle issues missed by the others because of their unique position to able to spend significant time with a patient and caregivers and to develop a therapeutic alliance (Cannell et al. 2016; Rosen et al. 2018; Myhre et al. 2020; Simmons et al. 2022).

## 6.3 The need for multidisciplinary collaboration

Under the theme The need for Multidisciplinary collaboration, four categories were identified. These Categories were, Collaboration, Case management, Safety and Prevention. The Collaboration Category discusses the need for the development of multidisciplinary teams to address elder abuse. The Case management Category discussed proficiency amongst healthcare professional in case management and the need for improvements. The Safety Category discusses the safety of the elder person during the process of identification and intervention from the perspective of the healthcare professionals as well as the client themselves. The Prevention Category discusses prevention of the continuation of the abuse (as opposed to prevention before the act).

### 6.3.1 Collaboration

It is commonly agreed among health care professional that there is need for multidisciplinary collaboration when responding to elder abuse. Most organisations have identified the importance and value of both working interdisciplinarity within departments and partnering with outside providers like emergency medical services and adult protection services. Once there is a suspicion of abuse, physicians and health care professionals are encouraged to consult with adult protection services and the police for assessment of and response to mistreatment of older adults. Adult Protective Services is charged with receiving and responding to reports of abuse and working closely with clients and a wide variety of allied professionals to maximize clients' safety and independence. This includes responsibilities for investigating any report of the abuse, neglect, or exploitation of an adult living with disability or an adult aged 65 or older, and if needed, provide services, and take steps to prevent further harm (Cannell et el. 2016; Rosen et al. 2019; Yaffe & Tazkarji 2012).

Social workers report concern that elder abuse is commonly missed during an emergency department visits because social work involvement in care was not routinely requested by the emergency department team caring for the client. Both social workers and the health care professional caring for the client in the emergency department expressed the belief a collaboration and the development of a department-based multidisciplinary response team would assist in assessing and caring for these patients, while helping ensure their safety. Many emergency departments have already begun this collaboration and recognized the value of social workers to the care team, particularly for elderly vulnerable persons, even going as far as providing the services around the clock. In addition to medical providers and social workers, other members of the emergency department team observe and interact with a patient during the visit and may contribute to identification of elder abuse, psychiatrists reported that they were often able to identify subtle issues missed by the medical team because of their ability to spend significant time with a patient (Rosen et al. 2018; Rosen et al. 2019).

Health care professionals are presented with unique challenges when an elderly person is cognitively impaired for example as a result of Alzheimer's disease or dementia. Observations of interaction between the elderly person and their caregiver, communication with family members or allied health care providers in order to establish caregiv-

ing patterns is vital. Assessing warning signs to determine if those signs can be attributed to abuse or the natural course of the cognitive impairment are pivotal to intervention. (Downes et al. 2013.) In cases like this such a task is too much for one person. A multidisciplinary team-based approach to identification of abuse, involving specialists outside of the disciplines medicine and social work are invaluable when the evidence maybe subtle or when the elder abuse is not immediately apparent. Such teams are of special importance when the client is unable to express coherently what is happening to them. In such cases, the need to obtain verifiable evidence is crucial. The best way to go about this is with consulting and collaborating with other more experienced co-workers and with relevant highly specialised professionals. An example of one such professional in this type of case could be the forensic nurses. This nurse is specialised in the techniques of gather clinical manifestations and understanding behavioural cues of elder abuse. Not only that but this nurse is very often knowledgeable in effective case management especially if mandatory reporting based on relevant legislation is required. Also, collaboration can define responsibilities and lead follow-up and case management (Dominguez et al. 2020; Rosen et al. 2018; Simmons et al. 2022).

Recognition for the need of a multidisciplinary consultation service has grown, as too has the understanding of its potential to impact care for elder abuse victims. Some multidisciplinary teams exist already. However, there is a need to develop this service to add to its validity and strengthen its incorporation into target departments and institutions. Trainings and educations enhance and encourage collaboration for example cross-discipline training, such as those that have been offered to social workers and the Alzheimer's Association, local professionals and community members dealing with cases of abuse can promote and enhance networks between organisations. Also, similar can be said for social and health care professionals' collaboration through education and training to potentiate the development of a joint understanding of the benefits of teamwork. (Alt et al. 2011.)

Through analysis of data interventions social workers at a hospital highlighted common care planning pathways that could be strengthened. Resources for managing complex elder abuse cases that required in depth assessment and complex care coordination were identified and developed in collaboration with health care and allied health care professionals. Also, they developed through collaboration the establishment of a health-justice partnership for timely, appropriate legal advice. These collaborative actions enhance patient safety. Policies, research, innovation, and intervention must be developed to tackle the phenomena of elder abuse. One way of accomplishing this is to

harness diverse perspectives, collaboration between health care professionals (physicians, nurses, mental health care providers, protective services), between organisations and associations, cross disciplinary trainings, multidisciplinary teams as well as patient-centred perspectives (Collins et al. 2020; Wang et al. 2015).

### 6.3.2 Case management

Case management involves a multidisciplinary protective intervention linking the victim with the essential resources and services. This is usually carried out by an elder person advocate who will liaises between the victim, the social and health professionals, and their allied health care providers. Health care professionals report doubt and a lack of confidence in their abilities to adequately carry out case management. Healthcare professionals reported insecurities due to lack of education pertaining to case management. Many expressed the desire for improvement in their case management skills as an alleviation to their anxieties. Not being able to present the elder persons who are being abused with a definite measure or solution can leave health care professionals with feelings of inadequacy. Some health care professionals have reported that their insecurities about how to manage the situation could influence them to avoid the subject all together and refrain from asking questions about abuse. (Simmons et al. 2022.) Educations to provide improvements in elder abuse knowledge for health care professionals have resulted in reported increases in perceived capabilities, improvements in case management behaviours, and reporting practices, and a decrease in perceived barriers to intervention. (Alt et al. 2011.)

A multidisciplinary intervention team would assist in case management by assessing and caring for these patients, while helping ensure their safety. A team will step in to care for cases that are estimated to be extremely time-consuming with identifying the problem, trying to solve the problem, attempting to estimate how prolonged the abuse has been plus ascertaining what the deeper effects of the abuse are. (Rosen et al. 2018.) Some organisations chose to elect one department to head the case management of elder abuse. In Canada the forensic nurse not only provides their specialisation for identification of the clinical manifestations of abuse, but also provides case management for high-risk elder persons suffering from neglect or abuse. The referrals come from emergency departments, hospitals and also from community. The nurse receives funding to provide crisis respite in emergency cases to enhance the case management and to offer the victim immediate safety. The nurse also liaises with the adult protection

services to facilitate engagement with victims, caregivers, and abusers. Case management interventions are driven by increasing safety and prevention of harm. These interventions often include victim-oriented support services, counselling, in-home services such as cleaning and personal care and caregiver-oriented support services such as in-home respite care and carer support groups, and referrals assessment teams for future care planning. (Dominguez et al. 2020; Collins et al. 2020). Social workers developed case management practices in a hospital environment by using data accumulated for a five-year audit to identify important resources that could be utilised and strengthened to better manage complicated cases of elder abuse. Complex cases included cases where there was a need for in-depth assessment and on-going planning. To enhance case management skills even further the social workers also addressed staff deficiencies in knowledge about elder by providing training and education. Also, improving already existing care planning pathways, referral pathways and developing care coordination teams enhanced case management and provided staff with key resources like legal support for clients (strengthened by collaboration with the legal offices), crisis support lines and community-based supports. (Collins et el. 2020.)

Also, for further consideration and investigation is the topic best practices around elder abuse case management from the perspective of the victim, how the victim experiences the process of identification and intervention, how victims seek the help they need (especially cognitively impaired elderly persons), what is helpful and not helpful in this process. Case management approaches that adapt the process and interventions to meet the needs and expectations of victims might be best. To date most of the empirical literature focus on the health care professional’s perspective, as opposed to the victims. Integration of the victim’s perspective is essential for future to develop appropriate interventions and enhance case management (Dominguez et al. 2020; Luoma et al. 2011). Recommended that developing existing interventions as well as involvement of multidisciplinary collaboration as opposed to developing new approaches and service would be beneficial a less resource intensive. Focus should be on interventions that already work in respond to the victim’s needs and the use of interventions successful in other areas of abuse and violence could be incorporated successfully into case management of elder abuse. (Luoma et al. 2011.)

### 6.3.3 Safety

Valid information and protocols must be available to those who are in positions to assist in the prevention and management of elder abuse, so that they can do their work in a safe and effective manner (Alt et al.2011). Health care professionals suffer moral anxiety caused by having to report and the consequences of doing. Not only are they concerned about negative effects on the vulnerable client also about violating the clients right to self-determination. Tools to assist with screening by providing an objective assessment of an elderly person suspected of being abused would enhance feelings of security when making challenging decisions like to whether to report a case to the adult protection services or not. (Cannell et al. 2016). Expectations placed on health care professionals are not always clearly defined. Some feel that it is their responsibility to investigate suspected on-going abuse, and to assist clients who were suffering from abuse. However, the extent of their professional responsibility needs to be clearly defined and explained. It needs to be clarified as to where their responsibilities toward the patient ends, and other health care professionals' and social welfare authorities' responsibilities started. (Simmons et al. 2022.) The feelings of apprehension and being unsafe are exacerbated when encountering cognitively impaired elderly clients. Interacting with cognitively impaired elderly persons suffering from Alzheimer's or dementia whom they suspect is being abused is already extra challenging, but when the situation requires disclosure and consent in order for the health care professional to safely intervene, the level of stress and anxiety is increased noticeably. This becomes even more difficult when consent is not granted by the elderly person, but intervention is warranted. Cognitive impairment challenges identified include, vague disclosures, no witnesses, a history provided by the suspected abuser, lack of communication or consent to share information between care providers, and the lack of staff awareness of indicators of abuse and risk factors. Healthcare professionals are faced with serious conundrums when caring for abused elderly people. The professional is bound by laws, advocacy, ethics and what is morally right but at the same time bound to respect the clients right to self-determination (Dominguez et al. 2020; Downes et al. 2013). These conflicted situations leave the health care professionals feeling unsure and unsafe as to how to proceed. Not only do health care professionals suffer from moral anxiety they also suffer from fear. Fear of retaliation from the perpetrator and concern about negative reactions from the clients are common among health care professionals. Also, uncertainty lies in how they should protect themselves and the client when trying to create privacy when having to addressing the subject of the suspected abuse. The lack of clarity about who has the responsibility to care for abused client insecurities created on

an organizational level. Due to these reasons health care professionals do not feel confident that the support systems can sufficiently meet the needs of elderly people subjected to abuse, not the protection of the health care professionals who have to address it. (Simmons et al. 2022.)

On an institutional level elder abuse is an overlooked patient safety issue. Many factors influence that it is overlooked, amongst others safety is one of them. The consequence of this is that nursing home residents are at risk of being harmed and distressed. Nursing home leaders are responsible for fostering a safe environment for their clients and staff. Recognising elder abuse and increasing awareness around the topic should be an activity of leaders. They also have a legal and moral obligation to ensure quality and safety standards thus creating a strong safety culture where staff and clients can operate with dignity, respect and without harm. Most health care professionals reported feeling unsafe in their work environment when it came to what constituted abuse and intervening in elder abuse and repercussions if reporting was to be initiated. There is lack knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes. (Myhre et al. 2020.)

Safety issues are reflected in victim responses also. Victims fear of consequences for reporting abuse or having their abuse reported to the relevant authorities. They harbour feelings of fear, humiliation, and shame, also fear of repercussions by the perpetrator and simultaneously worry for the outcomes for the perpetrator. Also, their negative expectations of support services derived through their own experience of the process (lack of effective access to and support from services and informal networks) can increase their feelings of unsafety. In order to ensure the safety of elderly people through coordinated and expert responses reforms have to be made to service protocols. Improvements to safety planning, strengthening of processes around identification and intervention, collaboration with multidisciplinary teams, access to timely legal advice, while paying attention to the independence and autonomy of the elder person throughout the process are concrete ways to increase safety for both health care professionals and elderly person who are suspected of being abused or abused (Collins et al. 2020; Dominguez et al. 2020).

### 6.3.4 Prevention

One of the core ethical principles in healthcare is non-maleficence which postulates that health care professionals should behave in a manner that causes no harm to be done to their clients even if that client would request this. It is the centre principle of health care services and should drive responsibility practices in leadership (Myhre et al. 2020). Most educational and training programs focused on intervening on existing mistreatment rather than prevention or identification and few if any studies mentioned pre-emptive actions that would use data about risk factors and frequency as a predicator to identifying elderly persons who could be vulnerable to victimization. Most studies discussed prevention in the context of it being an intervention after the abuse had been identified, or as a cessation of abuse. A recent systematic review of published programs internationally, found that 116 articles describing 115 elder-abuse programs focused on identification strategies of abuse or on interventions associated with existing abuse rather than pre-emptive measures. Despite the importance of prevention of elder abuse most global initiatives concentrate on identification and intervention (Collins et al. 2020; Dominguez et al. 2020).

Adult protective services have the responsibility of caring for vulnerable adults from the age of 65 and over, often the client arrives to their department through referral from the emergency department or some community-based or health care organisations. More often than not they are the sole intervention measure after the referral to them is made. They are able to provide services like counselling, crisis accommodation, legal support to the abuse victim and take steps to bring a cessation to the abuse and harm (Cannell et al. 2016; Rosen et al. 2019).

Pre-emptive measures like early detection of abusive behaviours including behaviours and actions that do not exactly meet abuse criteria or identification of predispositions for abuse like self-reported poor mental health and reports of feelings of loneliness being more likely to being exposed to violence and abuse, could be used to mark intervention points to de-escalate abusive behaviours and prevent situations developing into cases of abuse. For example, home care and respite care services would be considered pre-emptive preventative measures that could help prevent abuse and increasing the elderly persons independence and autonomy by the initiation of through of support services. Also, reducing caregiver isolation and strengthening social support for care givers could be effective in reducing abuse of not only cognitively impaired elderly persons but vulnerable elderly persons in general. Factors which influence the lack of pre-emptive prevention measures for elder abuse being developed are, inconsistencies

in what constitutes elder abuse, causes of abuse, lack of research and valid data on the prevalence of elder abuse and the diverse definitions of elder abuse. The phenomena of elder abuse touches such a wide variety of professionals that identification, intervention and prevention can emanate from many different sources, making development of pre-emptive preventative measures and strategies more difficult to develop (Alt et al. 2011; Collins et al. 2020; Downes et al. 2013; Luoma et al. 2011). While little research is available that would verify which interventions would be most pertinent in the prevention of elder abuse, guidelines facilitating the health care professionals in prevention and intervention and in assessment of elder abuse especially in cognitively impaired elderly persons would be valued (Downes et al. 2013). Also, multidisciplinary collaboration to manage cases, facilitate interdisciplinary support, to address intervention, prevention of future harm and to solve complex cases of abuse, while adhering to legislation would be the most effect system to increase preventative actions (Dominguez et al. 2020).

## 6.4 The need to strengthen Standard practice, Best practice, and Legislation

Under the theme The need to strengthen Standard practice, Best practice, and Legislation, four categories were identified. These Categories were Standard practice, Best practice, Legislation and Legal advice. The Standard practice and Best practice Categories are represented under one sub-chapter, as too are the Legislation and Legal advice categories. This decision was made as they are so closely connected and referred to simultaneously throughout the studies. The Standard and Best practice Category discusses the need for strengthening of policies, procedures, protocols, and guidance, based on high-quality evidence to enhance patient outcomes. The Legislation and Legal Advice Category discuss the legislation around elder abuse, how it is understood, and how does it guide the process of identification and intervention. It also discusses the lack of clarity on how healthcare professionals’ access legal support for their clients and how they perceive legal support effects themselves (enhances feelings of security when reporting/intervening).

### 6.4.1 Standard and Best practice

In order to improve identification and intervention in elder abuse there is a need for improvements in standard practice and best practice. There is a dearth of protocols to guide health care professionals in detection, management, and prevention of elder abuse. With elder abuse being so under recognised the ability to develop best practices and interventions around the topic is very challenging (Alt et al. 2011; Kayser et al. 2021). Health care professionals report that they are often unsure what actually constitutes abuse and have conflicts about reporting. Also there exists a lack of clarity on who is responsible for the care of the victims of elder abuse, to what extent their responsibilities span and clarification as to when their responsibilities toward the patient would end and other health care professionals' such as the intervention team or adult protection services responsibilities begin. Having knowledge or definitions of their area of responsibility is important to the healthcare professionals. Unintentionally stepping outside of one's area through undefined boundaries made health care professionals feel like they might be admonished over neglecting their medical based tasks because they had been focusing too much on the management of the problems surrounding the abused elderly person. (Simmons et al. 2022.) Identification of elder abuse is challenging as signs and symptoms are sometimes at best unclear. The information in guidelines leave some health care professional with a conundrum as guidelines do not always specify should screening be performed routinely amongst elderly clients, despite this health care professionals are presented frequently with cases that suggest that there is a possibility the elder person has been abused (Yaffe & Tazkarji 2012). Health care professionals should be provided with not only education but also with training on standard practice and best practice to heighten their awareness and knowledge about policies, protocols and guidelines pertaining to elder abuse identification and intervention. It has been reported that health care professionals who have reported low self-efficacy benefited from such trainings greatly and this had positive outcomes on elder abuse, identification, intervention, and prevention. (Alt et al. 2011.)

Almost every country where institutional care exists abuse of elderly clients has been reported. Many countries are making slow work of developing legislation to support regulation of such institutions and of addressing elder abuse overall. However, there are exceptions, in 1997 in Australia the Age Car Act was passed this act made it mandatory to report physical and sexual abuse in residential care a nationwide mandate (Collins et al. 2020). In institutional settings the care leaders hold the responsibility of creating a safe environment for both clients and staff. This responsibility should be guided by organisational level standard practices. In most countries there are existing

regulatory boards who have the duty of overseeing that legislations and standard practice are enforced in these institutions to ensure quality and safety. These types of regulatory boards should work with the care managers in these institutions to guarantee a safety culture is created through adhering to the standard practice and legislations that govern them, however this is not always the case. It has been reported that care managers failed to detect and therefore intervene in situations that caused harm to clients and staff. Failures to address the problems were cited as been lack of knowledge into what exactly constitutes an abuse situation, how to address elder abuse, a lack of clear definition of responsibility, a lack of strategies and a lack of authority. These reported failures can be linked to a lack of organisational level support and guidance. In conjunction with this lack of organisational standard practice and best practices there exists an area of conflict for the care managers in the form of health care policies from the governing organisations that clearly outlines mandates focus on coast efficiency. This conflict between focusing on the safety of the clients and staff contrasting with the emphasis on cost efficiency creates situations where prioritising on lowering costs lowers the limit as to what is perceived as been quality and safety. (Myhre et al. 2020.)

In complex cases of elder abuse, especially those involving cognitively impaired elderly persons, where assessment of capacity should be established and where disclosure and consent are necessary, the need for best practice development to safely guide identification, intervention and cessation are imperative. Also, multidisciplinary collaboration consisting of social and legal services should be encouraged to develop practices and policies for the protection of the vulnerable elderly people from the various types of abuse e.g., financial abuse. (Downes et al. 2013; Dominguez et al. 2020).

Furthermore, to highlight the important role of collaboration and innovation in the development of standard practice and best practice and the recognition that elder abuse is encountered by many sources. A government-based drive which aimed to promote the development of polices and practice, self-determination principles, informed choice, and autonomy for elderly persons, funded social workers in a hospital environment who performed a 5-year audit. The data that was collected was used to shape organisational protocol, identify resources for managing complex cases of abuse, provide pertinent education and training for staff, strengthen internal as well as external pathways leading to strong reinforcement of the network not just within the organisation but also in the community supporting abused elderly people and strengthening staff confidence in tackling complex abuse cases. It was also identified that there were secondary benefits to such work increase in research activities and development of collaboration link-

ing internal and external organisations strengthening support networks in the community also. The most important benefit was creation of new and strengthening of existing service protocols best practices to facilitate the identification and care of elder abuse. (Collins et al. 2020.)

As elder abuse is a violation of human rights and given its prolific nature plus those factors such as agism, social isolation and obsoletion increase elderly persons vulnerability to abuse, policies must be aimed at tackling such factors. Along with development of policies, guidelines and valid tools for assessment and screening of abuse, the perspective of the elderly people must be taken into account when developing strategies around elder abuse. (Luoma et al. 2011.)

### 6.4.2 Legislation and Legal advice

Standard practice and best practices have very often relied on organisational driven changes focused on service improvements and improvements of existing resources as opposed to legislation driven mandates to address elder abuse. However, in recent years changes within policy makers have been developing. Adult safe-guarding legislations have been introduced to many countries like Australia, Canada, and America. Mandatory reporting of elder abuse and statutory defined accountability and responsibility in regard to responding to reports of elder abuse, legal tribunals to address issues of capacity, guardianship, administration of estates, establishment of a safety plan which acts as a client-centred action plan designed to protect the client from abuse and promote autonomous decision making while respecting their clients right to self-determination. (Collins et al. 2020.)

However, it is still and issue that many countries do not have coordinated services dedicated to elder abuse. It has even been reported that victims have received services from adult protection/safeguarding organizations that also serve perpetrators of abuse. Elder abuse cases could be addressed within the criminal justice system, however due to the fact that elder abuse is woefully underreported and also because victims are not keen to take this pathway due to a lack of faith in the judicial system and the perceived distress that will be endured during the process this service is not commonly utilised. Despite this, intervention strategies are still victim focused and services for perpetrators are usually only extended to caregivers. The actions of the health care professional will

be heavily influenced by the laws and legislations governing the jurisdiction of the country where they work. (Dominguez et al. 2020.)

Though developments have been made there is still need for further research and improvements to be made in honing the policies and guidelines formed from these legislations. For example, laws that govern reporting can be very diverse in the content, change according to county, territory, change according to is the client living at home or at a residential institution, they are also reported to be challenging to categorises and understand leading them to be open to interpretation. Not only this but it also has to be taken into account when reporting the professional standards of the health care professional and policies on an organisational level which might contra interdict the governing laws. For example, in Canada where many territories have mandatory reporting laws, however there is no case law for addressing a physicians' failure to report suspected cases of elder abuse.  Many countries have mandatory reporting in almost every state and though their intention is to protect vulnerable elderly people the overall impact of mandatory reporting has yet to be fully researched (Dominguez et al. 2020; Kayser et al. 2021; Wang et al. 2015; Yaffe & Tazkarji 2012).

# 7 Discussion

The initial goal to performing this scoping review was to review current literature on the topic of elder abuse identification and intervention. To investigate the phenomena of elder abuse and present current information available on identification and intervention in elder abuse in relation to healthcare professionals. Also, to identify areas needing development in relation to identification and intervention in elder abuse and to increase awareness in healthcare professionals of the significance of comprehensively understanding elder abuse. The review was undertaken without bias as to what the findings would reveal, it was conducted in the genuine spirit to reveal what current literature tells us about identification and intervention of elder abuse. The findings of the review showed that there are reoccurring themes throughout the studies reviewed in relation to intervention and intervention in elder abuse. The themes were a need for improvements in identification and reporting; a need for research and validation of tools; a need multidisciplinary collaboration; and a need for strengthening of standard practice, best practice, and legislation. Every theme had their own identifiable categories that needed development in order to positively influence the related theme. Positive influence on

themes through development of the identified categories potentiate increases in elder abuse identification, intervention, and reporting.

## 7.1 Main Findings.

The main findings of the review are that there is a serious issue with *underreporting* of elder abuse. That despite the global acknowledgement of the importance of recognising and addressing the phenomena of elder abuse, little has been done to rigorously address it. The elderly portion of the most countries population will have increased to 30% by the year 2050 (WHO, 2015.) The phenomenon of elder abuse was already identified in scientific literature almost 50 years ago, and yet the problem still goes under recognised and underreported. Some figures even go as far as to indicate that for every case reported of elder abuse 24 go unreported (Cannell et al. 2016.) Elder abuse has serious negative health repercussions for the elder person. Despite the fact that health care professionals are in a unique position to observe, identify and intervene in elder abuse they have reported a reluctance to do so (Alt et al. 2011; Simmons et al. 2022).

Several underlying reasons have been reported to be linked to this widespread lack of reporting. Fears of violating the elderly persons right to self-determination, anxiety about the possibility of negative outcomes for the victim if the abuse is reported and the case investigated. A lack of confidence in skills related to correct identification of elder abuse, skills to manage cases of abuse or provide proper follow-up when cases present themselves and constraints of time when reporting is initiated (Cannell et al. 2016; Simmons et al. 2022). Many countries demand mandatory reporting of elder abuse, and should the decisions be made to report, this reporting process will be influenced and guided by legislation of the country and jurisdiction where the health care professionals are at work. These guidelines and legislations are reported to be very difficult to navigate and also act as a barrier to reporting. (Dominguez et al. 2020.)

When referring to institutional underreporting (which effects the overall statistics of reported cases) there has been reported a lack of a strong safety culture in many institutions for both staff and clients. Clients fear repercussions from their perpetrators if the report is investigated. While staff felt that the work environment did not support reporting. Health care professionals reported that they lacked skills as to being able to recognise what constitutes abuse and felt pressure on an organisational level because of low

financial resource to be more efficient. This in turn lowered the emphasis on so called non-medical issues. The culture in the institutions accepted this outcome of organisational pressure and elder abuse remained overlooked as a result. (Myhre et al. 2020.)

There is also a serious issue with self-reporting, with many victims hesitating to report their situations and despite the possibility to involve the justice system, involvement remains low because victims are very reluctant to involve the legal authorities (Dominguez et al. 2020; Simmons et al. 2022). This can be attributed to by fear of repercussions from the perpetrator and the victim decides to remain silent and allow the abuse to continue. Also, barriers to self- reporting exist because elderly people do not fundamental trust in the authority's ability to intervene and because the victim does not wish to involve outsiders in their situation. Victims tend to trivialize the of the severity of the abuse so as to justify their decisions not to report (Cannell et al. 2016; Luoma et el. 2011). For cognitively impaired elderly persons self-reporting is less likely to be successful as their capacity for self-reporting is significantly diminished. Many assessment tools use both self-reporting in the form of direct questioning along with clinical observation and inspection for signs of abuse by the health care professional. These are not suitable for assessment of cognitively impaired clients (Kayser et al.2021; Downes et al. 2013.)

Many of the issues associated with underreporting can be addressed with an increase in awareness of elder abuse brought about by *comprehensive knowledge* and *training*.

Comprehensive knowledge and understanding of the phenomenon of elder abuse would effectively inform intervention and prevention strategies. The ambivalence towards elder abuse is partially explained by the health care professionals themselves as a lack of knowledge and training about elder abuse. This lack of knowledge in relations to elder abuse is a barrier to identification and intervention responses. (Alt et al. 2011.) Abuse is regularly unrecognised because of a lack of routine assessment for it during the emergency department visit. Health care professionals and allied health care workers cited not having sufficient experience or knowledge to feel comfortable when attempting to address abuse often feeling unsure what constitutes abuse and identifying appropriate responses (Rosen et al. 2018; Kayser et al. 2021; Simmons et al. 2022; Myhre et al. 2020). Identifying elder abuse requires high levels of comprehensive knowledge to be able to utilise tools, screen vulnerable sometimes capacity impaired elderly persons, use sensitive interviewing and identify forensic biomarkers to detect the abuse. Without this knowledge and understanding the health care professional will

be lacking skills imperative to recognise and intervene in a safe manner (Downes et al. 2013; Dominguez et al. 2020).

Knowledge and awareness can be improved through *trainings* and education. Programs and educations targeted primarily at health care professionals, students, and other allied health care providers are necessary. Educational programs are the most commonly offered forms of educations, as they are easier to implement and superimpose onto existing programs. This method is less resource intensive than initiating new programs. (Rosen et al. 2019.) Through these educations overall improvements to confidence and increased efficacy persisted long after the educations have been reported. Health care professionals demonstrated improvements in documentation of abuse and neglect assessment, and an increase in the ability to detect financial abuse in victims. (Rosen et al. 2019.) Making reports of elder abuse was potentiated by the increase in knowledge. (Alt et al. 2011.) During training sessions health care professionals were introduced to intervention planning, which included features such as the provision of information (crisis support call lines, legal support, and community-based support) and education about the phenomena of elder abuse. Through this approach health care professionals were able to demonstrate an increase in awareness for elder abuse presentations and also improve knowledge around the topic which led to innovations in best practice, training, and research activities (Collins et al. 2020). Participants who have received an education targeted an increasing their awareness of elder abuse reported that not only are such educations are imperative but also had led to improved practices in identification, intervention, case management and a higher commitment to care for through an increased awareness of the issue. (Simmons et al. 2022.) At this time the best intervention strategy for elder abuse would be the incorporation of elder abuse training into medical school curriculum (Simmons et al. 2022; Wang et al. 2015; Rosen et al. 2018).

Improvements in knowledge and training cannot be developed about without *research*. Research into evidence-based practices, providing knowledge that is grounded in scientific research, using best available evidence, clinical expertise, patient-centred values, and experiences to guide practice, management and policy making in relation to elder abuse is imperative. This research must also include development and validation of assessment tools for use by health care professionals in elder abuse identification. At this time the research that exists does not include primary empirical based studies. The body of research comprises primarily of descriptive, observational, and case studies, with no meta-analyses, and intervention trials, they are lacking rigorous standards

and the information provided is inadequate and inconsistent. (Luoma et al. 2011; Yaffe & Tazkarji 2012).

Vulnerable elderly people need organised and specialised responses to ensure their safety. Elder abuse detection, intervention and management are in need of research and development to enhance their validity. Many countries have introduced strategies to encourage and guide service improvements and develop responses, but the lack of evidence-based research inhibits service providers from developing highly effective responses to elder abuse. Issues like lack of transparency in the processes, lack of reliable data on frequency, causes, and effective prevention in studies relating to elder abuse weaken the validity of the information provided in the findings. It is of vital importance that information with its foundations rooted in the best available current research be made available to those in a position to prevent and manage elder abuse to ensure safe and effective intervention (Alt et al. 2011; Collins et al. 2020.) High-quality evidence-based research is needed develop effective interventions for elder abuse in cognitively impaired clients. Research which can effectively demonstrate the interventions that are effective in the prevention and management of elder abuse in cognitively impaired clients is sadly lacking. Development, implementation, and evaluation of interventions for cognitively impaired elderly people who are abused need to be reinforced scientifically. Also, systematic research must be conducted into the effectiveness of existing interventions that are in use. (Downes et al. 2013.)

Many innovative methods are being researched and developed to add validity to the science of detecting elder abuse. Clinical manifestations of elder abuse so called forensic markers could be utilised for assisting with confirmation of elder abuse cases, in relation to medical and legal determinations of whether elder abuse has occurred. However, there is an absence of primary studies that report the prevalence of any symptoms or signs of elder abuse or report test characteristics of signs of elder abuse, thus weakening the validity of these clinical manifestations and their ability to be utilized in abuse detection. (Wang et al. 2015.)

As can be seen research and development are needed to strengthen many areas in elder abuse, from processes relation to identification to the processes relating to intervention and many other related issues like *tools* for assessment and prevention.

Health care professionals need evidence-based, universal, research informed, tools for screening at their disposal to identify elder abuse. As emergency providers are often the first contact point for the victim with the authorities, it would be appropriate that they

would have an evidence-based tool at their disposal to identify elder abuse (Kayser et al. 2021). There is a strong belief that the provision of an appropriate screening tool would alleviate barriers to addressing abuse increase the probability that elder abuse would actually be reported. Research should seek to develop and validate a tool to enhance detection and reduce the underreporting of elder abuse using the health care professionals' contextual observations rather than systematic questionnaires. This tool will benefit the health care professionals and also allied health care providers engaged in elder management but most of all it will enhance the quality of the older persons life. (Cannell et al. 2016.)

Surprisingly, it has been reported by social workers that they used no standard screening or assessment tools when ascertaining the elderly clients for abuse. (Rosen et al. 2018). Assessment tools and routine screening for violence and abuse are needed by health care professional in all situations where they are working with elderly people, as part of best practice, promoting identification and intervention in elder abuse. Of course, not all screening tools are suitable, for example in use with persons who are cognitively impaired. Most of the assessment tools rely on self-reporting and the capability to comprehend the questions and respond to them. Firstly, and foremostly there must be an evaluation made to ascertain the capacity of the elderly person. In such cases screening tools which rely on the health care professionals' evaluation of abuse are more appropriate in trying to assess is the person abused. Management strategies for elder abuse should be handled similarly to other medical treatment decisions with regard to capacity, namely whether the patient is able to understand and appreciate the consequences of the proposed treatment (Luoma et al. 2011; Wang et al. 2015). Despite growing calls for services around vulnerable elderly people to improve and for better screening of elderly persons, the validity and reliability of screening tools requires further evaluation. Despite analysis by and independent board of specialists, conclusions about recommendations about screening for the general elderly population have not made, however high-risk populations are more likely to be recommended to be screened despite the lack of evidence to support such an action (Wang et al. 2015; Collins et al. 2020; Kayser et al. 2021).

The lack of evidence-based research to guide practice, the absence of validated screening and assessment methods, compounded by the lack of knowledge all have a negative impact on the *confidence* of the health care professionals working closely with this vulnerable section of society.

Low levels of self-efficacy are commonly reported among health care professionals. The lack of comprehensive knowledge on the topic of elder abuse and being unsure of what constitutes abuse, places the bar to approaching the topic with the possible victim too high. There is a lack of reliable information, guidelines and institutional protocols for appropriate next steps being made available for the health care professionals when presented with cases of abuse. Insufficient skills to manage the case effectively, a fear that repercussions for the client and health care professional in the form of retaliation from the perpetrator and concern about negative reactions from the client for initiating the investigation. All these factors compound the feeling of low confidence in healthcare professional when tasked with caring for cases of elder abuse. The health care professionals have expressed a need for support, as well as structured and concrete measures to offer the patient, as a means to lessen their insecurities and to provide the best possible care for victims. (Alt et al. 2011; Cannell et al. 2016; Kayser et al. 2021; Simmons et al. 2022). Support can be provided through education. There was reported higher self-assessed improvements in knowledge and perceived ability to manage and appropriately refer elder abuse cases was reported. This improved self-efficacy was reported over a year after the education was provided. (Alt et al. 2011.)

The perceived burden of *time* has ramifications on the identification and intervention of elder abuse. Health care professionals have busy schedules and more often than not lack of resources, like financial resources. Many reported believing that an abundance of cases of elder abuse go unidentified, while simultaneously reporting that the did not routinely assess for abuse. Reasons for not doing were reported to be amongst others the perceived constrictions of time that would have to be used to initiate and investigation into the possible abuse. Others identified the organisations emphasis of efficiency in the face of low finances, leading to prioritising of work and that any tasks that were not perceived as medical related were perceived to be poor prioritising of time and resources, inevitable lowering the priority of addressing elder abuse. Psychiatrists reported that they were able to witness the burden of time in other health care professionals and how it leads to under identification of abuse when they were often able to identify subtle issues missed by the others because of their unique position to able to spend significant time with a patient and caregivers and to develop a therapeutic alliance (Cannell et al. 2016; Rosen et al. 2018; Myhre et al. 2020; Simmons et al. 2022).

The perceived burden of time and also to some extent lack of confidence reported by health care professionals could be alleviated significantly by multidisciplinary *collaboration*. Sharing time consuming complex cases of abuse with a group of specialists not only reinforces and strengthens cross-disciplinary relations, but it also increases the

overall confidence of the health care professionals involved in the management of the case and decreased the perceived burden associate with not having enough time to take care of the task at hand. It was generally agreed that there is need for multidisciplinary collaboration when responding to elder abuse. Most organisations place value and significance of interdisciplinarity collaboration within departments and partnering with outside providers like emergency medical services and adult protection services. Social services work closely with clients and liaise with wide variety of allied professionals to maximize clients' safety and independence. Their mission is to investigate the reported abuse and if needed, provide services, and take steps to prevent further harm (Cannell et el. 2016; Rosen et al. 2019; Yaffe & Tazkarji 2012). The social services also collaborate with the emergency department and other departments where the first report of the suspected abuse has emerged from. It is recognised that other members of the emergency department team observe and interact with a patient during the visit and may contribute to identification of elder abuse, because of their own unique relationship and interaction with the clients. (Rosen et al. 2018; Rosen et al. 2019.) Health care professionals are very often in a position to observe interactions between the elderly person and their caregiver, communication with family members or allied health care providers in order to establish caregiving patterns is vital. Assessing warning signs to determine if those signs can be attributed to abuse or the natural course of the cognitive impairment are pivotal to intervention. (Downes et al. 2013.) Involving specialists outside of the disciplines medicine and social work are invaluable when the evidence of the abuse maybe subtle or when the elder abuse is not immediately apparent. Such persons are of special importance when the client is unable to express coherently what is happening to them. In such cases, the need to obtain verifiable evidence is crucial. Forensic nurses are very often knowledgeable in effective case management especially if mandatory reporting based on relevant legislation is required. Also, collaboration can define responsibilities and lead follow-up and case management (Dominguez et al. 2020; Rosen et al. 2018; Simmons et al. 2022).

An important platform to which collaboration can be fostered is during cross-discipline trainings and educations, for example collaboration between social workers and the Alzheimer's Associations, local professionals and community members dealing with cases of abuse can promote and enhance networks between organisations. Also, similar can be said for social and health care professionals' collaboration through education and training to potentiate the development of a joint understanding of the benefits of teamwork. (Alt et al. 2011.) Harnessing diverse perspectives and collaboration between health care professionals (physicians, nurses, mental health care providers, protective services), organisations and associations, cross disciplinary trainings, as well as

patient-centred perspectives is essential in the development of multidisciplinary collaboration (Collins et al. 2020; Wang et al. 2015).

The development of multidisciplinary networks and teams through collaboration have positive outcomes on *case management*. Case management is an area frequently reported to provide challenges to health care professionals and a barrier to elder abuse reporting and intervention.

Case management involves a multidisciplinary protective intervention linking the victim with the essential resources and services. This is usually carried out by an elder person advocate who will liaises between the victim, the social and health professionals, and their allied health care providers. Health care professionals report doubt, insecurities due to a lack of knowledge and a lack of confidence in their abilities to adequately carry out case management. Many expressed the desire for improvement in their case management skills as an alleviation to their anxieties. Not being able to present the elder persons who are being abused with a definite measure or solution can leave health care professionals with feelings of inadequacy. Some health care professionals have reported that their insecurities about how to manage the situation could influence them to avoid the subject all together and refrain from asking questions about abuse. (Simmons et al. 2022.)

Case management approaches that adapt the process and interventions to meet the needs and expectations of victims might be best. Integration of the victim’s perspective is essential for future to develop appropriate interventions and enhance case management. Recommendations that developing existing interventions as well as involvement of multidisciplinary collaboration as opposed to developing new approaches and service would be beneficial a less resource intensive. Focus should be on interventions that already work in respond to the victim’s needs and the use of interventions successful in other areas of abuse and violence could be incorporated successfully into case management of elder abuse. (Dominguez et al. 2020; Luoma et al. 2011).

Case management can be led by a multidisciplinary team who assess and care for these patients, while helping ensure their safety by implementation of interventions. The team will step in to care for cases that are estimated to be extremely time-consuming with identifying the problem, trying to solve the problem, attempting to estimate how prolonged the abuse has been plus ascertaining what the deeper effects of the abuse are. Interventions include victim-oriented support services, counselling, in-home services such as cleaning and personal care and caregiver-oriented support services such

as in-home respite care and carer support groups, and referrals assessment teams for future care planning. (Dominguez et al. 2020; Collins et al. 2020; Rosen et al. 2018). Enhancement of case management skills include addressed staff deficiencies in knowledge about elder by providing training and education. Improving already existing care planning pathways, referral pathways and developing care coordination teams enhanced case management and provided staff with key resources like legal support for clients (strengthened by collaboration with the legal offices), crisis support lines and community-based supports. (Collins et el. 2020.)

A lack of knowledge, research, development of multidisciplinary collaboration and the improvements to case management have negative effects on security and feelings of *safety* in health care professionals.

Healthcare professionals are faced with serious conundrums when caring for abused elderly people. The professional is bound by laws, advocacy, ethics and what is morally right but at the same time bound to respect the clients right to self-determination (Dominguez et al. 2020; Downes et al. 2013). Valid information and protocols must be available to those who are in positions to assist in the prevention and management of elder abuse, so that they can do their conduct their safely and effectively. Organisations have a legal and moral obligation to ensure quality and safety standards thus creating a strong safety culture where staff and clients can operate with dignity, respect and without harm. Most health care professionals reported feeling unsafe in their work environment when it came to what constituted abuse and intervening in elder abuse. (Alt et al.2011; Myhre et al. 2020). Conflicted situations leave the health care professionals feeling unsure and unsafe as to how to proceed. Not only do health care professionals suffer from moral anxiety they also suffer from fear. Fear of retaliation from the perpetrator, concern about negative reactions from the clients and about violating the clients right to self-determination are common among health care professionals. Also, uncertainty lies in how they should protect themselves and the client when trying to create privacy when having to addressing the subject of the suspected abuse. The lack of clarity about who has the responsibility to care for abused client insecurities created on an organizational level. Due to these reasons health care professionals feel unsafe and do not feel confident that the support systems can sufficiently meet the needs of elderly people subjected to abuse, nor the protection of the health care professionals who have to address it (Cannell et al. 2016; Simmons et al. 2022).

Feelings of apprehension and being unsafe are particularly exacerbated when encountering cognitively impaired elderly clients. Interacting with cognitively impaired elderly

persons suffering from Alzheimer's or dementia whom they suspect is being abused is already extra challenging, but when the situation requires disclosure and consent in order for the health care professional to safely intervene, the level of stress and anxiety is increased noticeably (Dominguez et al. 2020; Downes et al. 2013).

The issue of safety is reflected in victim responses also. Victims fear of consequences for reporting abuse or having their abuse reported to the relevant authorities. They harbour feelings of fear, humiliation, and shame, also fear of repercussions by the perpetrator and simultaneously worry for the outcomes for the perpetrator. Also, their negative expectations of support services derived through their own experience of the process (lack of effective access to and support from services and informal networks) can increase their feelings of unsafety. (Collins et al. 2020; Dominguez et al. 2020).

There is a need to address the issue of health care professionals' safety issues and also those experienced by the clients. The way this is to be most likely achieved is improvements in the above-mentioned findings, such as improvements in knowledge and training, advances in research and validation of assessment tools, development of multidisciplinary collaboration to strengthen cross-disciplinary knowledge and strengthen case management. These developments will in turn potentiate reporting and inevitable *prevention*.

One of the core ethical principles in healthcare is non-maleficence which postulates that health care professionals should behave in a manner that causes no harm to be done to their clients even if that client would request this. It is the centre principle of health care services and should drive responsibility practices in leadership (Myhre et al. 2020). Most studies focus discussed prevention in the context of it being identification strategies of abuse or on interventions associated with existing abuse rather than preemptive measures. This intervention occurs after the report has been made to the social services and the investigation begins. More often than not this is the sole intervention measure after the referral to them is made. Social service or multidisciplinary teams are able to provide services like counselling, crisis accommodation, legal support to the abuse victim and take steps to bring a cessation to the abuse and harm (Cannell et al. 2016; Collins et al. 2020; Dominguez et al. 2020; Rosen et al. 2019).

More research into the pre-emptive prevention should be conducted. Identification of precursor factors that increase the likely hood of the elderly person being exposed to abuse should be made. Early detection of abusive behaviours including behaviours and actions that do not exactly meet abuse criteria or identification of predispositions for

abuse like self-reported poor mental health and reports of feelings of loneliness being more likely to being exposed to violence and abuse, could be used to mark intervention points to de-escalate abusive behaviours and prevent situations developing into cases of abuse. (Downes et al. 2013). Factors which influence the lack of pre-emptive prevention measures for elder abuse being developed are, inconsistencies in what constitutes elder abuse, causes of abuse, lack of research and valid data on the prevalence of elder abuse and the diverse definitions of elder abuse. The phenomena of elder abuse touches such a wide variety of professionals that identification, intervention and prevention can emanate from many different sources, making development of pre-emptive preventative measures and strategies more difficult to develop (Alt et al. 2011; Collins et al. 2020; Luoma et al. 2011).That is why multidisciplinary collaboration is to be harnessed to manage cases, facilitate interdisciplinary support, to address intervention, solve complex cases of abuse, develop pre-emptive prevention measures, while adhering to legislation and in so doing increase preventative actions (Dominguez et al. 2020).

In order for all the findings mentioned above to be realised they must be firstly and foremostly be guided by *standard practice, best practice,* and *legislation.*

There is a need for improvements in standard practice and best practice. There is a dearth of protocols to guide health care professionals in detection, management, and prevention of elder abuse. In order for appropriate responses to be made by those in a position to assist, information that is verified and clear protocols have to be available. With elder abuse being so under recognised the ability to develop best practices and interventions around the topic is very challenging. Most health care professionals report a lack of comprehensive knowledge to allow them to address elder abuse and effective manner (Alt et al. 2011; Kayser et al. 2021). Lack of knowledge in relation to what constitutes abuse, what are interventions, conflicts relating to reporting and responsibility parameters are common issues. (Simmons et al. 2022) Guidelines do not always provide clarity to these problems. For example, information in guidelines do not always specify should assessment screening be performed routinely amongst elderly clients, despite this health care professionals are presented frequently with cases that suggest that there is a possibility the elder person has been abused (Yaffe & Tazkarji 2012). Cognitively impaired elderly persons, where assessment of capacity should be established and where disclosure and consent are necessary, need best practice development to safely guide identification, intervention, and cessation. (Downes et al. 2013; Dominguez et al. 2020).

Almost every country where institutional care exists abuse of elderly clients has been reported. Regulatory boards have the duty of overseeing that legislations and standard practice are enforced in these institutions and to ensure quality and safety. Regulatory boards should work with the care managers in these institutions to guarantee a culture of safety is created through adhering to the standard practice and legislations that govern them, however this is not always the case. It has been reported that care managers failed to detect and therefore intervene in situations that caused harm to clients and staff. Failures to address the problems were cited as been lack of knowledge into what constitutes an abuse situation, how to address elder abuse, a lack of clear definition of responsibility, a lack of strategies and a lack of authority. (Myhre et al. 2020.)

In an attempt to encourage innovation, government-based drives which aim to promote the development of polices and practice, self-determination principles, informed choice, and autonomy for elderly persons have been conducted. These types of drives have been successful at shaping organisational protocol, identify resources for managing complex cases of abuse, provide pertinent education and training for staff, strengthen internal as well as external pathways leading to strong reinforcement of the network not just within the organisation but also in the community supporting abused elderly people and strengthening staff confidence in tackling complex abuse cases. Along with development of policies, guidelines and valid tools for assessment and screening of abuse, the perspective of the vulnerable elderly person must be taken into account when developing strategies around elder abuse (Collins et al.2020; Luoma et al. 2011).

Many countries are making slow work of developing legislation to support regulation of institutions and of addressing elder abuse overall. However, some countries have made *legislation* to address institutional abuse like Australia, where it was made mandatory to report physical and sexual abuse in residential care a nationwide mandate. (Collins et al. 2020.)

Standard practice and best practices have very often relied on organisational driven changes focused on service improvements and improvements of existing resources as opposed to legislation driven mandates to address elder abuse. However, in recent years changes within policy makers have been developing. Adult safe-guarding legislations have been introduced to many countries like Australia, Canada, and America. Mandatory reporting of elder abuse and statutory defined accountability and responsibility in regard to responding to reports of elder abuse, legal tribunals to address issues of capacity, guardianship, administration of estates, establishment of a safety plan which acts as a client-centred action plan designed to protect the client from abuse and

promote autonomous decision making while respecting their clients right to self-determination. (Collins et al. 2020.) The actions of the health care professional will be heavily influenced by the laws and legislations governing the jurisdiction of the country where they work. (Dominguez et al. 2020.)

Some honing of these the policies and guidelines formed from these legislations is still required. Laws that govern reporting can be very diverse in the content, change according to county, territory, change according to is the client living at home or at a residential institution, they are also challenging to categorises and understand, leading them to be open to interpretation. In addition to the professional standards of the health care professional, policies on an organisational level might contradict the governing laws. Many countries have mandatory reporting in almost every state and though their intention is to protect vulnerable elderly people the overall impact of mandatory reporting has yet to be fully researched (Dominguez et al. 2020; Kayser et al. 2021; Wang et al. 2015; Yaffe & Tazkarji 2012).

## 7.2 Limitations of the Study

Scoping reviews are subject to the limitations of any review, relevant sources of information may be omitted, and the review is dependent on information on the review question being available (Peters et al. 2020).

Scoping reviews do not, for example, appraise the quality of evidence in the primary research reports in any formal sense. The quantity of data generated can be considerable. Scoping reviews have inherent limitations because the focus is to provide breadth rather than depth of information in a particular topic. Scoping studies provide a narrative or descriptive account of available research. Many of these difficulties are addressed by systematic review methods that do require quality appraisal, thereby (mostly) reducing the quantity of studies included in the review and placing an emphasis on synthesizing data. It would be wrong to view the scoping study method as an easy option simply because hard questions about quality appraisal and synthesis are avoided. Conducting a scoping study requires reviewers to have high degrees of analytic skill in order to develop frameworks through which large numbers of studies can be described. (Arksey & O'Malley 2005.) This chapter will examine what factors in making this scoping review may cause it to have limitations and bias results.

This review was planned meticulously, and careful attention was paid to the implementation of the review strategy. The methodical framework suggested by Arksey & O'Malley 2005 was followed stringently. The review question was created methodically. The designs of the search strategy and the eligibility criteria were created to support the review question. Search for the studies was conducted in diligent manner while attempting to avoid bias during the process of study selection. Despite the fact the quality appraisal is not stipulatory in scoping reviews, to give credibility to the findings a quality appraisal of the studies was carried out. The critical appraisal tool described by Hawker et. al 2002 was used to assess the quality of the selected studies. The quality appraisal was carried out by one individual, and this could be suggested to affect the reliability of the review. Grey literature was included in the search of the studies and through this extra pertinent information was revealed and included in the review. This review was undertaken by one author, a fact which may have limited the search of the studies, as a lack of peers assessing the studies is associated with a risk for bias. No previous experience was had by the author on conducting a scoping review. According to Arksey & O'Malley 2005 conducting a scoping study requires reviewers to have high degrees of analytic skill in order to develop frameworks through which large numbers of studies can be described. Assistance was sought by a professional librarian who assisted with database selection, search word strings and management of search results in databases, bringing credibility to the search process conducted. The pilot search was conducted in the Spring of 2022. This initial search was then followed by an analysis of the keywords and concepts in the title and abstract of retrieved papers. During the initial search it was observed that that hits using keywords “elder abuse” over “elderly abuse” was more likely to produce relevant studies. Also, during the screening process reference lists of all identified studies not just the reference lists of the studies that were selected has been examined for so called grey literature. The results of this examination led to a total of 17 studies been identified in direct relation to background and the review question, all were used in this review. Selected studies for the review were either literature reviews, qualitative studies, one audit, scoping reviews, or nonrandomized controlled pilots. All the studies were published between 2011 and 2022, which considering the review question, makes the evidence provided from the studies current. The review was conducted over a very short period of time, using open-source available studies. This may have impacted on the overall quality of the review.

### 7.3 Ethical questions

The review followed the responsible conduct of research as set out by the Finnish Advisory Board on Research Integrity (2012). The research process was conducted diligently, charting, analysis, and reporting of the results were conducted with integrity, and transparency. A rigorous system of referencing was adopted in accordance with the referencing guidelines of Metropolia University of Applied Sciences. The system created reliability, retrievability and comparability in relation to this review and differentiated the review studies authors texts from the author of this review.

Turnit's plagiarism detection system has been used to verify the originality of this review. It was not relevant to apply for a separate permission for the research as a scoping review is a review of already published literature. No funding was sourced for this review nor has there been other relevant interests involved in the creation of this scoping review.

## 8 Conclusions

Elder abuse is a phenomenon that we cannot afford to ignore. It is a destination that we can all arrive at as aging is a natural part of the human condition. With prevalence rates hard to predict due to the extent of underreporting, we cannot say with certainty that in will not affect one of us or someone we know some day. The scoping review revealed that elder abuse is rarely identified and weakly understood. This is the first stumbling block because if it is rarely identified then the other processes associated with identification cannot happen. Without identification there can be no intervention, no reporting, and no prevention. This lack of identification means that there are false perceptions around the actual prevalence of elder abuse, and this might give the impression that more robust measures are unnecessary to combat it. During the search process for review studies, it was noted that there was very little quality research conducted into elder abuse and even less when specifically referring to identification and intervention. However, despite this the 13 review studies chosen did have commonalities and through the analysis of these commonalities themes and categories emerged and answers to the review question formed.

In order to safeguard our future and those of our fellow humans, we must start to develop better legislation, protocols, guidelines, and cultures of safety to help protect our

elderly. These developments must take into consideration the right to self-determination and use the target population perspective where possible in the development process. Issues related to underreporting, lack of research, multidisciplinary collaboration and strengthening of legislation and practices must all be addressed and developed so as the health care professionals and allied health care providers designated to care for this vulnerable section of our society have the ability care for their clients in a safe and secure fashion.

Barriers to reporting must be identified and addressed. Knowledge and awareness need to be increased through curriculum-based education, supported by in-job training and educational programs. Increased knowledge about topic of elder abuse will enhance identification and reporting of abuse. The lack of research needs to be addressed seriously, there is an absence of valid research on the topic of elder abuse. Without valid research there is no way to find answers to questions in an organised and systematic way that could inform practice and contribute to developing knowledge or improving existing in the realm of elder abuse. Research must also be used to validate and develop relevant assessment and screening tools. The emphasis on the value of multidisciplinary collaboration and its potential wide-reaching influence along with its potential to innovate must be recognised, developed, and implemented.

Finally elder abuse is an infringement of human rights, and it is not endemic. As a global initiative, policy makers have to make legislative reforms, foster international agreements that are developed to guide polices, which can in turn be adapted and made suitable for legislation on a national level, eventually permeating down to an organisational level, guiding protocols and guidelines on a grass roots level. To safeguard elderly people and those who care for them.

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## Data Charting

### Data charting

**Background, Theories, Types and Risk factors for Elder Abuse**

| Reference | Country | Aims and purpose | Design | Data and methods | Main results |
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| Abolfathi Momtaz et al.(2013) Theories and measures of elder abuse | Malaysia | This paper has two aims, to provide an overview of the aetiological theories and measures of elder abuse.Also to discusses the most commonly used measures of elder abuse, in order to train health and social-care providers and researchers about selecting and using existing elder abuse measurement instruments | Literature review | All relevant literature (released up to August 2012) was searched based on key words pertinent to the development and validation of instruments that measure elder abuse. Out of the articles, the instrument's purpose and content; the instrument's development and scoring; and the instrument's reliability and validity was then extracted and described. | Based on the reviewed theories, several factors including caregiver stress (situational theory; stratification theory), dependency (social exchange theory), negative attitude (political economic theory), environmental stress (role accumulation theory), learnt abusive behaviour (social learning theory), caregiver pathology (psychopathology of the caregiver theory), and spousal domestic abuse (feminist theory) cause elder abuse. Additionally, according to symbolic interactionism theory, cultural values and expectations influence what behaviour is considered abusive. It was concluded that elder abuse is a multifactorial and complex problem. Also that no single theory can comprehensively explain all causes of elder abuse. In the matter of the existing instruments it showed that many different screening and assessment tools have been developed to identify elders who are at risk for or are victims of abuse, it found that in elder abuse studies it is important to be aware of the instrument's purpose and reliability and validity for the population studied.These instruments may not be appropriate cross-culturally. |
| Baker et al. (2016) Interventions for preventing abuse in the elderly | Australia Malaysia | To assess the effectiveness of primary, secondary and tertiary intervention programmes used to reduceor prevent abuse of the elderly in their own home, in organisational or institutional and community settings. The secondary objective was to investigate whether intervention effects are modified by types of abuse, types of participants, setting of intervention, or the cognitive status of older people | Literature review | 19 databases were searched (AgeLine, CINAHL, Psycinfo, MEDLINE, Embase, Proquest Central, Social Services Abstracts, ASSIA, Sociological Abstracts, ProQuest Dissertations & Theses Global, Web of Science, LILACS, EPPI, InfoBase, CENTRAL, HMIC, Opengrey and Zetoc) on 12 platforms, including multidisciplinary disciplines covering medical, health, social sciences, social services, legal, finance and education. Also related organisational websites were browsed, authors of relevant articles contacted and reference lists checked. Two review authors independently extracted data and assessed the studies' risk of bias. Studies were categorised as: 1) education on elder abuse, 2) programmes to reduce factors influencing elder abuse, 3) specific policies for elder abuse, 4) legislation on elder abuse, 5)programmes to increase detection rate on elder abuse, 6) programmes targeted to victims of elder abuse, and 7)rehabilitation programmes for perpetratorsof elder abuse. All studies were assessed for study methodology, interventiontype, setting,targetedaudience, intervention components and intervention intensity. | Reviews:Out of the seven met the criteria for inclusion in this review; five of were described as 'randomised trials'. These seven studies investigated the efficacy of interventions aimed at decreasing the occurrence or recurrence of elder abuse by acting on mechanisms believed to be capable of moderating long-term outcomes. Five of the studies sought to modify the behaviour of carers, family members, other service providers, or victims of abuse through the provision of a variety of programmes, some evidence to suggest that the interventions were able to improve knowledge and attitudes relevant to elder abuse; however their ability to change the occurrence or recurrence of elder abuse is uncertain. Educational interventions: Educational interventions provided the largest body of evidence in this review, focusing primarily on healthcare professionals. Most educational interventions focused primarily on healthcare professionals. There is some limited evidence to suggest that educational interventions improve knowledge and attitudes towards elder abuse among healthcare professionals. There is no evidence to suggest if educational interventions prevent elder abuse or reduce recurrent elder abuse. |

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| Botngård et el. (2021) Factors associated with staff-to-resident abuse in Norwegian nursing homes: across-sectional exploratory study | Norway | To explore individual, relational, and institutional characteristics associated with perpetrated staff-to-resident abuse in nursing homes, using a multilevel hierarchical approach | A cross-sectional exploratory study | A cross-sectional exploratory study of nursing home staff in Norway, where the nursing homes were randomly selected from the Central Register of Establishments and Enterprises. Collection of the data was completed between October 2018 and January 2019. STROBE guidelines for cross-sectional studies was used for reporting. 3693 nursing staff (response rate 60.1%) in 100 randomly selected nursing homes in Norway. Characteristics of nursing staff, their relationship with residents, and institutional features associated with three types of abuse: psychological abuse, physical abuse, and neglect was explored. A survey questionnaire used was specifically developed for this study and included different measurement instruments for the dependent and independent variables. Data were analysed with the software package Stata 16.1. | Several predictors of staff-to-resident abuse on different levels of the ecological model were found, which underlines the importance of using a multifaceted approach to identify risk factors of elder abuse in nursing homes. Various factors in the ecological model increase the likelihood of staff perpetrating psychological abuse, physical abuse, and neglect. The predictors most strongly found to be associated with all three types of abuse were 1) being a registered nurse/social educator or licensed practical nurse, 2) reporting symptoms of psychological distress, 3) considering leaving the job, 4) reporting poor attitudes towards persons with dementia, 5) and experiencing care-related conflicts and resident aggression. Other predictors were poor quality of childhood (neglect) and lack of support from a manager (psychological abuse). Understanding the complexity of elder abuse and identifying predictors of staff-to-resident abuse may contribute to the reduction and prevention of abuse, and we believe this study provides evidence that may have some implications for education, nursing home care, and future research. | |
| Bows & Penhale(2018) Elder Abuse and Social Work: Research, Theory and Practice | UK | To examine the international development of research, theory, policy and practice in relation to elder abuse and domestic violence affecting older populations. | Editorial | The review did not have a description and methods. However, references from recent studies from the fields of Geriatrics, Public health, Elder Abuse and Neglect, Geriatric Psychiatry and Neurology were used thoroughlt to present and justify the findings. | The editorial showcases the range of current research, policy and practice developments in the area of elder abuse/domestic violence. Developing good practice needs to include developing knowledge and understanding about what sorts of interventions are most appropriate for specific types of abuse, together with a thorough evaluative framework for interventions, including those that are designed and targeted to prevent abuse, and based on public-health frameworks. It focus on extending knowledge and understanding, as well as the evidence base that is needed to further develop much-needed responses and interventions in this area, aims to provide a useful check of the current state of play in elder-abuse research and practice as well as a resource for all those in volved in work to counter all forms of elder mistreatment. | |

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| Dominguez et al. (2022) Elder Abuse Vulnerability and Risk Factors: Is Financial Abuse Different From Other Subtypes? | UK | This study investigated EA by comparing cases involving financial abuse only, financial abuse that co-occurs with other abuse types (i.e., physical, psychological, sexual, and neglect), and EA that is not financial in nature. Specifically, this study aimed to understand whether these abuse types were characterized by a different:<br>1. Frequency of victim vulnerability and perpetrator risk factors;<br>2. Nature of victim vulnerability and perpetrator risk factors;<br>3. Victim–perpetrator relationship (family vs nonfamily). | A cross-sectional quantitative analysis | A cross-sectional quantitative analysis of secondary data (N = 1,238),The data were anonymized cases obtained from the charity Age UK's helpline that were previously flagged as EA cases by the helpline staff over a period of 3 years (April 2014–March 2017).Each case included a description of the concerns reported by the enquirer and recorded by Age UK staff. This case description generally encompassed details about the individuals involved in the case (i.e., alleged victim and perpetrator), their characteristics, the victim–perpetrator relationship, and the abusive situation (e.g., a description of the type of abuse and abusive behaviors).Two of the authors developed a data collection tool to gather information on the variables of interest (described in "Materials") prior to the start of the coding process. These variables related to four main areas: sample characteristics, relationship between the victim and perpetrator, vulnerability and risk factors, and abuse type(s).A coding scheme was developed to gather the data needed for the purposes of this study. The coding scheme recorded primarily nominal variables, some of them with categories (e.g., victim's relationship with the perpetrator) but most coded dichotomously as present or absent (e.g., physical health problems). | Findings indicate that financial abuse, occurring in isolation, is distinct from other EA types. Specifically, there were more vulnerability and risk factors in cases of non-FA and FAco-occurring when compared with FAonly. this study's findings are consistent with previous research that has found that victim–perpetrator relationship is associated with abuse type. In this case, family members were more likely to perpetrate EA that was not financial or financial abuse co-occurring with other abuse types. Risk assessment and future research should consider financial abuse separately to other EA forms. | |
| Gholipour et al. (2020) Definitions and Theories of Elder Abuse | Iran | To provide definitions and theories of elder abuse | Literature review | The review did not have a description and methods. However, references from recent studies from the fields of Geriatrics, Public health, Geriatric Psychiatry and Neurology were used thoroughlt to present and justify the findings. | Even though no standard definition of the concept of elder abuse which is accepted by everyone because the current definitions have been often presented according to the specific views and professional needs of researchers, the review did provide definitions and theories of elder abuse. | |

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| Koga et al. (2020) Elder Abuse and Social Capital in Older Adults: The Japan Gerontological Evaluation Study | Japan | To clarify the prevalence of and the factors associated with elder abuse among independent older adults in Japan. | Retrospective observational study | Data were derived from the Japan Gerontological Evaluation Study (JAGES). These self-report data were collected from 26,229 people aged 65 years or older living in 28 municipal ities in 2013. The types of elder abuse and factors associated with them were examined using logistic regression analysis. | The prevalence of elder abuse among the sample was 12.3% (11.1% in males and 13.3 in females). In the entire sample, physical, psychological, and financial abuses were reported to be 1.26, 11.12, and 1.45%, respectively. Factorsassociated with increased odds of experiencing abuse were being a woman, living with family members, having poor self-rated health, and having mild or severe depression. By contrast, age ≥85 years, being widowed, or unmarried, and having a positive view of community trust were associated with a lower risk of experiencing abuse. | |
| Lacher et al. (2016) Types of abuse and risk factors associated with elder abuse | Switzerland | To assess the frequency of the various types of abuse in victims suffering from elder abuse in the northern part of Switzerland, and the associated risk factors for both victims and perpetrators. Also to compare the prevalence of risk factors associated with abuse (wilful infliction of damage) to the prevalence of those associated with neglect (active or passive). | Retrospective analyses | Retrospective analyses of 903 dossiers created at an Independent Complaints Authority for Old Age in the Canton of Zurich, Switzerland. Bi- and multivariate analysis were used to identify abuse and neglect determinants. | **Prevalence of associated risk factors related to the victims**: the most common risk factors related to the victims were need of support (73%), need of care (59%) and dementia (41%). **Prevalence of associated risk factors related to the perpetrators:** The most common risk factors related to the perpetrators were being overburdened with the situation and cohabiting with the victim (33% each). **Comparison of associated risk factors and characteristics in abuse and neglect :** Three risk factors were associated with a significantly lower risk for abuse than for neglect: need of support, need of care, and dementia of the victim. In contrast, the factors significantly associated with a higher risk for suffering abuse than neglect were positive history of violence of the victim, cohabitation of the victim and perpetrator, overburdening of the perpetrator, dependency on the victim by the perpetrator, or psychiatric disease other than addiction disease or dementia of the perpetrator. | |
| Mosqueda et al. (2016) The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment | USA | In this paper presents a new intervention model the Abuse Intervention Model (AIM), to examine the multidimensional and complex relationships between risk factors to be used to study and intervene in elder mistreatment. | Literature review | The review did not have a description and methods. However, references from recent studies from the fields of Geriatrics, Public health, Elder Abuse and Neglect, Geriatric Psychiatry and Neurology were used thoroughlt to present and justify the findings. | The review presented new model, the Abuse Intervention Model (AIM), and it examined the multidimensional and complex relationships between risk factors informed by theories of elder mistreatment. It also showed through case studies how this intervention tool is applicable. | |

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| O'Brien et al. (2015) ELDER ABUSE CONTEXT AND THEORY Finland, Ireland, Italy and Romania | Finland, Ireland, Italy and Romania | The aim of the book is to set the context and inform the development of an educational tool ,the Respect to Prevent – Education and Training Handbook. It provides an overview of elder abuse from the perspective of the four countries. It explores theories associated with elder abuse and how they inform policy and responses within the four countries. | Literature review/ | The review did not have a description and methods. However, references from recent studies from the fields of Geriatrics, Public health, Elder Abuse and Neglect, Geriatric Psychiatry and Neurology were used thoroughlt to present and justify the findings. | The book reviewed the definitions and typologies of elder abuse suggesting that there similarities among different countries in how elder abuse is understood, also acknowledging there were also differences. Showing that elder abuse is understood within a health and social care framework. The book suggested best ways of addressing elder abuse, is to ascertain causal factors. The book showed that different theories place the older person at risk. It clearly defines these theories and factors and also suggests and explaine a framework for intervention. | |
| Orfila et al. (2018) Family caregiver mistreatment of the elderly: prevalence of risk and associated factors | Spain | To estimate the prevalence of risk of abuse against community-residing elderly with moderate to severe dependency whose caregivers are relatives. Also to describe the association between such a risk and socio-demographic variables, cognitive and dependency state of the victim, and the scale of the caregiver's anxiety, depression, and burden | Cross-sectional study | Participants were caregivers and their dependent care recipients (N = 829). Home interviews included the Caregiver Abuse Screen (CASE); self-reported abuse from care recipient; activities of daily living and cognitive state of the carerecipient; anxiety and depression in caregivers and Caregiver Burden Scale. The relationship prior to the dependency, positive aspects of caregiving, and social support for the caregiver were also assessed. Multivariate analysis was performed using logistic regression with risk of abuse as dependent variable. | It was found that risk factors in family caregivers (that are preventable to an extent), namely: anxiety and feelings of burden, can lead to a high prevalence of risk of abuse among family caregivers. Caregivers were mainly women (82.8%) with a mean age of 63.3 years. Caregivers and care recipients lived in the same household in 87.4% of cases, and 86.6% had enjoyed a good previous relationship. Care recipients were women (65.6%), with a mean age of 84.2 years, and 64.2% had moderate to severe cognitive impairment. CASE demonstrated a prevalence of 33.4% (95% CI: 30.3-36.7) of abuse risk by the caregiver. It was found to be essential to become aware of these risk factors and their causes to intervene and help primary as well secondary prevention. | |
| Park, EO (2018) Most prevalent type of elder abuse and its correlation with elder depression | S. Korea | To identify the most prevalent type of elder abuse in S. Korea. Also it examined which type of elder abuse most affected elder depression and then discussed social countermeasures toward the prevalent types of elder abuse | Descriptive study | Data was collected via a convenience sampling method. Seventy-seven study participants were 60 years old or above and did not have mental disabilities or depression disorder. Five different types of elder abuse (verbal, emotional, physical, financial, and neglect) were measured along with their depressive symptoms. Descriptive statistics were used to determine the most prevalent type of elder abuse in S. Korea. Also, bivariate correlation and multiple regression were utilized to understand the relationship between types of elder abuse and elder depression. | Among the five types of elder abuse, verbal, emotional, and neglect abuse were more prevalent than physical and financial abuse. According to the bivariate analysis, emotional abuse and verbal abuse were signifi cantly related with elder depression. | |

**Articles chosen for answering the review question**

| Reference | Country | Aims and purpose | Design | Data and methods | Main results |
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| Alt et al. (2011) The Effectiveness of Educational Programs to Improve Recognition and Reporting of Elder Abuse and Neglect: A Systematic Review of the Literature | USA | To synthesizes the current literature on educational interventions aimed at promoting the recognition of, and response to, situations of elder abuse and neglect. The aims being are: 1. To describe the educational interventions designed to improve recognition and reporting of elder abuse and neglect and cite evidence of effectiveness 2. To identify the success-predicting characteristics of these programs that can be used to inform the development of educational modules for professionals 3. To analyze the content of current literature and summarize program descriptions for readers hoping to replicate successful models | Literature review | A comprehensive literature search was performed to identify all evaluation studies of educational interventions for health care professionals, first responders, and aging service providers aimed at increasing the recognition of, or response to, elder abuse and neglect. Descriptive methods were used to summarize the literature content. Study results are described qualitatively because of the wide variation in methods,target audiences, and forms of evaluation. Out of the search 14 articles were included, 10 focused specifically on elder abuse prevention, while four described broader training programs that included an elder abuse component. | Training programs that utilize patient cases and hands-on active learning with real or standardized patients appear to result in improvedknowledge and perceived ability to manage and appropriately refer elder abuse cases. Participation in a case-based didactic training program resulted in higher self-assessed knowledge and confidence in recognizing and reporting elder abuse, which persisted one year following training. Change in knowledge was measured by a test which showed a significant increase in correctly marked answers of 40% on the pretest to 83% following training. Overall it was found that even though programs were each unique in their methodology of information dissemination most intervention sare aimed at increasing participant awareness and knowledge of elder abuse with the overall objective of increasing elder abuse reporting. Interactive teaching techniques seem to be most impactful, particularly if opportunities for discussion and feedback are provided. |
| Cannell et al. (2016) Towards the development of a screening tool to enhance the detection of elder abuse and neglect by emergency medical technicians (EMTs): a qualitative study | USA | To identify the most salient indicators of elder abuse and neglect for potential inclusion on a screening tool | Qualitative study | Qualitative data were collected from 23 EMTs and Adult Protective Services (APS) caseworkers that participated in one of five semi-structured focus groups. Focus group data were iteratively coded by two coders using inductive thematic identification and data reduction | EMTs and APS caseworks identified eight domains of items that might be included on a screening tool: (1)exterior home condition; (2) interior living conditions; (3) social support; (4) medical history; (5) caregiving quality; (6)physical condition of the older adult; (7) older adult's behavior; and, (8) EMTs instincts. The screening tool should be based on observable cues in the physical or social environment, be very brief, easily integrated into electronic charting systems, and provide a decision rule for reporting guidance to optimize utility for EMTs in the field. EMTs should always be trained to use their own judgement and report elder abuse when suspected, regardless of any risk score. |

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| Collins et al. (2020) Elder Abuse Identification by an Australian Health Service: A Five-Year, Social-Work Audit | Australia | To examine VOP (Vulnerable Older People) presentations to SVHM (St Vincent's Hospital Melbourne) and address the following questions:(1) What are the demographics and risk factors for the VOP and the alleged perpetrators? (2) What are the main interventions provided by health professionals? (3) What are the implications of the findings for the health service in terms of elder-abuse policy, practice, service provision, training, and research? | Audit | Exploratory study which used a retrospective clinical data mining (CDM) approach to examine all VOP alerts over a five-year period in total, the sample contained 466 episodes of care. Data from each yearly audit were collated confidentially, put into a spreadsheet and analysed quantitatively. | The findings highlighted key characteristics of the vulnerable older persons, the perpetrators, their social contexts, and interventions undertaken, clarifying a range of vulnerability and risk factors in the sample. Half were aged 80 years and over; two thirds lived with the person of concern; two thirds were from culturally and linguistically diverse backgrounds, and a third had cognitive impairment. A high proportion were assessed as being at moderate to high levels of risk, requiring urgent to prompt intervention. The findings show how social workers engaged in data collection and analysis were able to inform their practice within a health-care setting and contributed to service evaluation and improvements. This study not only offers social work but also other health professionals a snapshot of patients experiencing elder abuse who present in a hospital setting. It highlighted the type and pattern of abuse occurring so that elder abuse is no longer a hidden problem within the health service. The study was able to inform practice with VOPs at SVHM by improving knowledge about elder-abuse presentations to SVHM, as well as the barriers and facilitators of organisational processes and practices in responding to elder abuse. The study identified some of the key characteristics of patients presenting to SVHM who were experiencing elder abuse, and of the POC (Person of Concern). The importance of Information provision and education featured in intervention planning,highlighting the need to ensure key SVHM staff were aware of resources, such as crisis support lines, legal options and community supports, through elder abuse training sessions. | |
| Dominguez et al. (2020) Elder Abuse Detection and Intervention: Challenges for Professionals and Strategiesfor Engagement From a Canadian Specialist Service | Canada | To discuss (a) existing research findings relevant to each of the four EA presentation types, including the identification of the unique challenges that they present, and (b) how forensic nurses and other providers should respond in these different situations. | Literature review | The review did not have a description and methods. However, references from recent studies from the fields of Geriatrics, Public health, Geriatric Psychiatry, Forensic Nursing and Neurology were used thoroughlt to present and justify the findings. | Four potential presentation types were identified based on the victim's mental capacity and disclosure of EA. A guidance for detection and intervention efforts by healthcare providers. The actions healthcare providers take when they identify EA will vary depending on the laws and regulations of the country and jurisdiction where they work. Specific presentation depends on whether the victim has the capacity to understand and appreciate decisions related to their health, personal care, or finances and whether they can or want to make a disclosure of abuse. Also gave considerations for Providers in Working With Potential Elder Abuse (EA) Victim Presentations. | |

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| Downes et al. (2013) Abuse of Older People with Dementia | Ireland | The aim was to collate, analyse and summarise published literature on abuse of community-dwelling older people with dementia, in order to inform future research in this area. The objectives of the review were to identify published evidence relating to: the prevalence and risk factors for the abuse and neglect of older people with dementia, on the characteristics of perpetrators who abuse older people with dementia, the means of recognising abuse and neglect of older people with dementia, and to identify the strategies for preventing and managing cases of abuse of older people with dementia. | Literature review | A comprehensive search of peer-reviewed published works indexed in the databases Cochrane, Medline, PsychInfo, PubMed and CINAHL was conducted. This was supplemented by a search of Google Scholar in order to identify relevant grey literature on the topic. The search strategy yielded an initial total of approximately 500 titles. Following screening of the abstracts, report summaries and full papers, 43 items were deemed relevant for inclusion in the review. Relevant data from included studies were extracted according to a standard template in order to facilitate the description and synthesis of the main body of literature on elder abuse of people with dementia. The data extracted included methodological details, such as the study design and the sample characteristics as well as findings on the nature and prevalence of elder abuse of people with dementia, and the risk factors and correlates related to the abuse of older people with dementia. | **Abuse of community-dwelling older people with dementia:**the literature relating to elder abuse of community-dwelling older people with dementia remains sparse. Although some studies have advanced the knowledge of abuse in people with dementia, there is a considerable gap in knowledge related to elder abuse in this cohort of at-risk older people. In the matter of the objectives**: prevalence and risk factors for the abuse and neglect of older people with dementia**: abuse is substantially higher when compared to the rates of elder abuse reported for the general population of community-dwelling older people also the higher prevalence rates of abuse among older people with dementia indicate that dementia is itself a substantial risk factor for elder abuse also early stages of cognitive disorder, undiagnosed cognitive impairment for example behavioural disturbances and functional impairment may be a particular source of tension between an older person and their caregiver. **Characteristics of perpetrators who abuse older people with dementia:**no clear profile of the characteristics of a typical perpetrator of elder abuse of people with dementia emerged from the literature. Socio-demographic factors related to gender, age, education, and the relationship between caregiver and care-recipient are not sufficiently consistent to enable the building a clear perpetrator profile. Nevertheless, the literature does indicate that a perpetrator of abuse will typically have experienced abusive or disruptive behaviour in their role as carer and may have a history of conflict with their care-recipient**. Recognising abuse and neglect of older people with dementia:** Identifying elder abuse is challenging for many reasons, including the tendency for perpetrators to abuse privately and also because the signs of elder abuse are not easily distinct from the signs associated with morbidity in older age or those resulting from self-neglecting behaviours also. Detecting abuse of older people with dementia is even more challenging due to the presence of cognitive impairment as those affected may be unable to articulate what is happening to them or to substantiate suspicions of abuse. Also found was that healthcare professionals' assessment of abuse, may be more advantageous than other methods where direct questioning of the older person with dementia is not possible. **Finally identifying the strategies for preventing and managing cases of abuse of older people with dementia:** firstly findings reaffirmed the lack of high quality evidence based research needed to inform the design of effective interventions for elder abuse. There is very little research evidence to demonstrate the types of interventions that are effective in preventing and managing elder abuse, either with reference to older people in general or specifically in relation to older people with dementia. | |

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| Kayser et al. (2021) Research priorities for elder abuse screening and intervention: A Geriatric Emergency Care Applied Research (GEAR) network scoping review and consensus statement. | USA | To (1) conducted a scoping review of the current literature on the identification of and interventions to address elder abuse among patients receiving care in emergency departments and (2) used the review to prioritize research questions for knowledge development. | Scoping Review | Two questions guided the scoping review: What is the effect of universal emergency department screening compared to targeted screening or usual practice on cases of elder abuse identified, safety outcomes, and health care utilization?; and What is the safety, health, legal, and psychosocial impact of emergency department-based interventions vs. usual care for patients experiencing elder abuse? Five article databases were used. Additional material was located through reference lists of identified publications, PsychInfo, and Google Scholar. The results were discussed in a consensus conference; and stakeholders voted to prioritize research questions. No studies were identified that directly addressed the first question regarding assessment strategies, but four instruments used for elder abuse screening in the emergency department were identified. For the second question, we located six articles on interventions for elder abuse in the emergency department; however, none directly addressed the question of comparative effectiveness. Based on these findings, GEAR participants identified five questions as priorities for future research – two related to screening, two related to intervention, and one encompassed both. | Research to identify best practices for elder abuse assessment and intervention in emergency departments is still needed. Although there are practical and ethical challenges, rigorous experimental studies are needed. | |
| Luoma et al. (2011) Prevalence study of violence and abuse against older women. Results of a multi-cultural survey in Austria, Belgium, Finland, Lithuania, and Portugal (European report of the AVOW project) | Austria, Belgium, Finland, Lithuania, and Portugal | Objective of the AVOW study was to contribute to the development of preventive measures and the protection of victims of violence and abuse among older women. | Literature review | A literature review was initially carried out of the European literature asking certain before agreed upon questions that covered existing methodologies in prevalence studies of violence and abuse against older people or women. The results of this literature research served as the main background for the development of a quantitative survey instrument. | The study assessed the prevalence rates of abuse and violence against older women covering six different types of mistreatment: neglect, emotional, financial, physical, sexual abuse, and violation of personal rights. It also included information concerning patterns of abuse, encompassing data about severity of abuse, and the co incidence of different types of abuse. In addition, it identified the perpetrators, which included only persons known to the older women, such as family members, friends, acquaintances, neighbours, or care workers. Furthermore the risk factors for abuse were assessed, from a socio-ecological framework perspective, relating the overall abuse and its severity with both individual and social factors. The report also includes information regarding the psychological and emotional consequences of abuse and help-seeking behaviour of the mistreated older women. Finally the subjective well being and quality of life of older women are evaluated and their association with abuse considered. | |

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| Myhre et al. (2020) Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect | Norway | To explore nursing home leaders' perceptions of elder abuse and neglect. | A qualitative study | Six focus group interviews with 28 nursing home leaders in the role of care managers was conducted. Nursing home leaders' perceptions of different types of abuse within different situations were explored. The constant comparative method was used to analyse the data. | Results of this study indicate that elder abuse and neglect are an overlooked patient safety issue. Resident-to-resident aggression appeared to be so commonplace that care leaders perceived it as normal and had no strategy for handling.  Relatives with abusive behaviour visiting nursing homes residents was described as difficult and something that should be kept between the resident and the relatives. Staff-to-resident abuse was considered to be difficult to talk about and viewed as not being in accordance with the leaders' trust in their employees. Findings in the study show that care managers lack awareness of elder abuse and neglect, and that elder abuse is an overlooked patient safety issue. The consequence is that nursing home residents are at risk of being harmed and distressed. Care managers lack knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes. | |
| Rosen et al. (2018) Emergency Department Provider Perspectives on Elder Abuse and Development of a Novel ED-Based Multi-Disciplinary Intervention Team | USA | To improve understanding of both current practice surrounding elder abuse identification and the potential for a multi-disciplinary team intervention. | A qualitative study | A qualitative study utilizing focus groups with practicing ED providers from multiple disciplines. To conduct these focus groups,  a semi-structured topic guide was developed with two sections. The first section, which was based partly on an existing instruments and the second explored participants' perspective on the proposed multi-disciplinary intervention. Both sections had guiding questions. The focus group guide was piloted for content and comprehension and modified based on suggestions made. Consolidated Criteria for Reporting Qualitative Research to guide collection, analysis, and reporting. Focus groups were conducted from January-May, 2016 in ED offices. Each focus group was moderated by one or two of the authors. The purpose of the research and the members of the research team including their backgrounds were introduced in detailed and standard fashion before the commencement of each focus group. Focus group transcripts were reviewed in detail and discussed by the investigative team. | **Existing instruments:** Overall the results found that social workers did in fact try to identify cases of elder abuse/mistreatment however not using not use any standard screening or assessment tool. Other health care professionals in the ED reported that they did not routinely assess for elder mistreatment and they commonly missed it, citing lack of knowledge or training, reliance on history from family or caregivers or distrust of history from older adults, sympathy with caregivers, lack of time to conduct an evaluation, concern that identifying elder abuse would lead to additional work, and absence of a standardized response. **Participants' perspective on the proposed multi-disciplinary intervention:** ED medical providers and social workers both reported believing strongly that an ED-based multi-disciplinary response / intervention team would assist in assessing and caring for these patients, while helping ensure their safety. ED medical providers, social workers, and other disciplines identified 21 key recommendations to consider when developing the ED-based multi-disciplinary team. In **additional education and quality improvement focused on elder abuse and neglect,were thought to be an important step. Several screening tools exist but none had been validated in an ED setting, however anation wide screening tool was attempting to be developed.** | |

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| Rosen et al. (2019) Review of Programs to Combat Elder Mistreatment: Focus on Hospitals & Level of Resources Needed | USA | To conduct a more comprehensive examination of programs to improve elder mistreatment identification, intervention, or prevention, including those that had not undergone evaluation. | Literature review | Systematic literature review was made to identify programs combatting elder mistreatment. A comprehensive search strategy was developed to identify peer-reviewed publications about programs combatting elder mistreatment. Searches were run on April 19, 2017 in a broad range of databases. From each article was abstracted, a brief description of the program, its focus(es) (identification, intervention, prevention), type(s) of mistreatment targeted, target population(s), setting(s) where professionals were based, setting(s) where services were provided, and whether an acute care hospital was involved . When we identified multiple articles describing a single program, we examined all articles together rather than each separately. Each study's quality by assessing the presence of well-established study design limitations, based in part on the SQUIRE (Standards for QUality Improvement Reporting Excellence) guidelines for quality improvement. | 115 programs were identified. , 43% of programs focused on improving prevention, 50% on identification, and 95% on intervention, with 66% having multiple focuses. The most common program types were: educational (53%), multi-disciplinary team (MDT) (21%), psycho-education /therapy / counseling (15%), and legal services / support (8%), with 20% of programs having components in multiple categories. 57% reported an attempt to evaluate program impact, but only two programs43–47 (2%) were evaluated using a higher tier quality study design and 6 programs48–55 (5%) using a middle tier quality study design. Of those with a high quality study design, both were psychoeducational / therapeutic / counseling, one for older adults, and the other for informal/family caregivers. The START program (STrAtegies for RelaTives)43–45 reduced anxiety and depression among caregivers but did not reduce abusive behavior or improve quality of life for older adults. Most only showed modest short-term impact. **An educational program for mental health** and home care professionals demonstrated improvement in documentation of abuse and neglect risk assessment, and an educational program for social and health care professionals showed an increased ability to detect financial elder abuse in case scenarios. | |
| Simmons et al. (2022) Testing an educational intervention to improve health care providers' preparedness to care for victims of elder abuse: a mixed method pilot study | Sweden | To perform initial testing of an educational model aiming at improving health care providers' preparedness to care for older adults subjected to abuse. We used a mixed method approach to investigate:1) How health care providers perceived the education and how it infuenced a) their propensity to ask older patients questions about abuse and b) their perceived ability to manage the response. 2) Health care providers' personal and organizational a) sense of responsibility to identify victims, b) barriers and facilitators towards asking questions about elder abuse and managing the response, and how those were afected by the education. | A non-randomized controlled pilot study | A cohort pilot study an educational model concerning elder abuse, targeting health care providers. A mixed method convergent parallel design was used, i.e. both quantitative and qualitative data were used and they were collected at the same time and given the same importance in analysis. In the convergent parallel design, quantitative and qualitative data are collected and analysed separately. Tereafter an interpretation was conducted regarding how the two data sets converge, diverge and relate to each other. In accordance with this the quantitative and qualitative data is be presented separately in the methods and results sections, while interpreting and relating the data together in the discussion. | The reported frequency of asking older patients questions about abuse increased in the intervention group, but not the control group, post-intervention. Potential mediators for the improvement were an increased awareness of elder abuse and higher self-efficacy for asking questions about elder abuse. Participants also reported a higher perceived ability to manage cases of elder abuse, even though uncertainties concerning how to provide the best possible care remained. The qualitative interviews indicated that learning from each other in group discussions and forum theatre likely was an important contributor to the positive results. In a nut shell educational model may be effective in improving health care providers' preparedness to care for older adults subjected to abuse. However, uncertainties about how to handle elder abuse cases remained post-intervention. | |

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| Wang et al. (2015) Elder abuse: an approach to identification, assessment and intervention | Canada | Aims to update that earlier systematic review; discusses definitions, risk factors, clinical manifestations and recommendations for screening for elder abuse; and to offer an approach for clinicians to consider when assessing older adults at risk for abuse | Literature review | Systematic review: MEDLINE, Embase, CINAHL and PsycINFO databases were searched from the earliest date available to August 30, 2013, using a variety of search terms, including "elderly," "abuse" and "mistreatment". Primary research articles and relevant review articles were retireved, and the reference lists of pertinent articles were reviewed. A systematic review was performed of interventions for the management of elder abuse, the focus of the article, according to the same search strategy. | Updates previous review on the discussion of definitions, risk factors, clinical manifestations and recommendations for screening for elder abuse; and offers an approach for clinicians to consider when assessing older adults at risk for abuse. Findings on the definition of **Elder abuse**: concept of elder abuse is not consistently defined across jurisdictions in Canada. But through the systematic review drew the widely agreed upon definition and outlined the commonly agreed typs of abuse. **Risk factors:** the review defined the commonly agreed risk factors and also clinical maifestations**.** Recommendations for **screening** and **an approach** for clinicians to considering adults for risk of abuse: The review found that There is insufficient evidence to recommend screening all older people for elder abuse and insufficient evidence to recommend any one intervention. Evidence suggested that , physicians still need to address this relatively common health issue, to be be aware of potential risk factors and clinical manifestations of elder abuse. An advocacy approach for suspected elder abuse is recommended. The review suggested that The best intervention strategy at this time appears to be education targeted at increasing awareness of<br>elder abuse among health care professionals. | |
| Yaffe & Tazkarji (2012) Understanding elder abuse in family practice | Canada | To discuss what constitutes elder abuse, why family physicians should be aware of it, what signs and symptoms might suggest mistreatment of older adults, how the Elder Abuse Suspicion Index might help in identification of abuse, and what options exist for responding to suspicions of abuse. | Literature review | MEDLINE, PsycINFO, and Social Work Abstracts were searched for publications in English or French, from 1970 to 2011, using the terms elder abuse, elder neglect, elder mistreatment, seniors, older adults, violence, identification, detection tools, and signs and symptoms. Relevant publications were reviewed. | Family physicians are well placed to identify mistreatment of seniors, their actual rates of reporting abuse are lower than those in other professions. This might be improved by an understanding of the range of acts that constitute elder abuse and what signs and symptoms seen in the office might suggest abuse. Detection might be enhanced by use of a short validated. Physicians working with older adults need to be aware of and sensitive to the signs of elder abuse. The Elder Abuse Suspicion Index is a validated tool for use by family physicians to help identify such abuse. Once there is a suspicion of abuse, physicians are encouraged to consult with adult protection or social services or with police officers trained in assessment of and response to mistreatment of older adults. tool, such as the Elder Abuse Suspicion Index. | |

# Grey Literature

| Search engine Google Scholar, Google and ResearchGate. | Results | Saved as | Saved | Date |
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| **Search string : elder abuse** | | | | |
| | Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies | Reference from the WHO Abuse of older people. Accessed 10.9.2022 | | PubMed 15.9.2022 |
| | Abuse of Older People with Dementia | https://www.safeguardingireland.org/wp-content/uploads/2020/02/Abuse_OP_Dementia_Review-2013.pdf | | Google search accessed 15.9.2022 |
| | Elder Abuse Context Theory | https://www.lenus.ie/bitstream/handle/10147/617710/Bookletstage.pdf?sequence=1 | | ResearchGate accessed 15.9.2022 |
| | | https://www.age-platform.eu/publications/elder-abuse-context-and-theory-finland-ireland-italy-and-romania | | |
| | Prevalence study of violence and abuse against older women. Results of a multi-cultural survey in Austria, Belgium, Finland, Lithuania, and Portugal (European report of the AVOW project) | | | ResearchGate accessed 15.9.2022 |
| | Working Group on Elder Abuse | https://www.lenus.ie/handle/10147/46362 | | Google accessed 15.9.2022 |
| | Abuse of older people | https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people | | Google search accessed 10.9.2022 |
| | World report on ageing and health 2015 | https://www.who.int/publications/i/item/9789241565042 | | Google search accessed 10.9.2022 |
| | Missing voices: views on older persons on elder abuse | https://www.who.int/publications/i/item/missing-voices-views-of-older-persons-on-elder-abuse | | Google search accessed 10.9.2022 |
| | World report on violence and health | https://www.who.int/publications/i/item/9241545615 | | Google search accessed 10.9.2022 |

| **Search string : leglislation and policies that influence legal direction on elder abuse.** | | | | | |
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| | European Charter of rights and responsibilities of older people in need of long-termcare and assistance | https://www.age-platform.eu/publications/eu-charter-rights-and-responsibilities-older-people-need-long-term-care-and-assistance | | Google accessed 10.9.2022 | |
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| | Elder Abuse in Europe<br>Background and Position Paper | http://www.combatingelderabuse.eu | | Google accessed 10.9.2022 | |
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| | Elder abuse and neglect in the European Union UN Open-ended Working Group on Ageing | https://www.age-platform.eu/un-open-ended-working-group-ageing-oewg | | Google accessed 10.9.2022 | |
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| | GREEN PAPER ON AGEING Fostering solidarity and responsibility between generations | https://epale.ec.europa.eu/en/resource-centre/content/green-paper-ageing-fostering-solidarity-and-responsibility-between | | Google accessed 10.9.2022 | |
| | | | | | |
| | Tackling abuse of older people: five priorities for the United Nations Decade of Healthy Ageing (2021–2030). | https://www.who.int/publications/i/item/9789240052550 | | Google accessed 10.9.2022 | |
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| | The European Pillar of Social Rights Action Plan | https://ec.europa.eu/info/publications/european-pillar-social-rights-action-plan_en | | Google accessed 10.9.2022 | |
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**Search string : scoping studies, scoping reviews**

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| | Scoping Studies: Towards a Methodological Framework | | | Google accessed 6.6.2022. Free text from Semantic Scholar at full pdf text link, 6.6.2022. | |
| | Scoping studies: advancing the methodology | | | Google accessed 6.6.2022. Free text from PubMed at full text link, 6.6.2022. | |
| | JBI Manual for Evidence Synthesis. Chapter 11: Scoping Reviews (2020 version). | https://jbi-global-wiki.refined.site/space/MANUAL | | Google accessed 6.6.2022 | |

**Search string : content analysis, critical assessment, PICO and PRISMA.**

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| | How to plan and perform a qualitative study using content analysis. | | | Google accessed 1.10.2022. Free text from ScienceDirect at full pdf link 1.10.2022 | |
| | A hands-on guide to doing content analysis. | | | Google accessed 1.10.2022. Full free text at PubMed Central 1.10.2022. | |
| | Appraising the evidence: reviewing disparate data systematically | | | Google accessed 11.9.2022. Full free text at ResearchGate 15.9.2022 | |
| | Prisma Transparent Reporting of Systematic reviews and Meta-Analyses. | https://prisma-statement.org/prismastatement/flowdiagram.aspx | | Google accessed 23.5.2022 | |
| | Evidence-based Nursing Practice: Seven Steps to the Perfect PICO Search. | https://www.ebsco.com/blogs/health-notes/seven-steps-perfect-pico-search | | Google accessed 1.4.2022 | |

## Inductive Content Analysis

**Data Analysis according to the inductive content analysis and the analysis process described by Erlingsson and Brysiewicz (2017)**

*Review question: What does the current literature tell us about elder abuse and identification and intervention?*

| *Steps* | 1 | 2 | 3 | 4 | → | 5 | → | 6 | → | 7 | |
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| Data analysis process | Reviews are read and re-read individually. | Meaning units (Condensations). Keeping your research aim and question clearly in focus, divide up the text into meaning units. | Located meaning units are then condensed further while keeping the central meaning intact. | Condensed meaning units. The condensation should be a shortened version of the same text in the meaning unit that still conveys the essential message of the meaning unit. | | Codes. In this step codes are developed that are descriptive labels for the condensed meaning units. Codes concisely describe the condensed meaning unit and are tools to help researchers reflect on the data in new ways. Codes make it easier to identify connections between meaning units | | Catagories. In this step codes are sorted into categories that answer the questions who, what, when or where? One does this by comparing codes and appraising them to determine which codes seem tobelong together, thereby forming a category. | | Themes. A theme can be seen as expressing an underlying meaning, i.e., latent content, found in two or more categories. Themes are expressing data on an interpretative (latent) level. A theme answers questions such as why, how, in what way, or by what means? | |
| Alt et al. (2011) The Effectiveness of Educational Programs to Improve Recognition and Reporting of Elder Abuse and Neglect: A Systematic Review of the Literature | | Elder abuse is underrecognized and underreported. Elder abuse will increase as the aging population steadily grows in size. Improvements needed in recognition and reporting practices. The professionals and institutions that provide medical care have a unique position elders to detect, manage, and report elder abuse. Barriers: Inadequate knowledge, a lack of institutional policies in place to facilitate appropriate responses. Reliable information and policies must be made available to those who are in positions to aid in the prevention and management of elder abuse, so that they are able to intervene in a safe and effective manner. | | Under recognised and under reported. Improvements needed in recognition, reporting,knowledge, policies, tools to facilitate appropriate response, prevention and management in a safe manner. | | Lack of education/knowledge; Inablitlty to identify EA; Underreporting; Screening tools; Appropriate response; Policies and guidelines; Safe management. | | Underreporting; Lack of knowledge; Assessment/screening; Research; Confidence; Collaboration; Prevention. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |
| Cannell et al. (2016) Towards the development of a screening tool to enhance the detection of elder abuse and neglect by emergency medical technicians (EMTs): a qualitative study | | Primary challenge is under-detection and underreporting of EA occurrence. The HCP unique position to identify and intervene. Necessity to develop a screening tool to enhance elder abuse and neglect detection and reporting rates. Time constraints for reporting.To identify most salient t indicators of EA that might be included on a screening tool. Screening tool would alleviate the moral anxiety currently faced when making a "judgment call" to report (or not report) a potential caseof EA. Evidence that EMTs/HCPs do, in fact, regularly interact with older adults who are living with risk factors for abuse, and that they desire a screening tool to help them overcome current barriers to reporting. HCPs report low confidence regarding the abitlity to correctly identify potential EA. | | Under recognized and under reported. Imporvements needed/desired in recognition and reporting. Knowledge/education about how to recognise EA. Consensus that a valid tool is needed to support confidence to report EA. Time burden of reporting. | | Lack of education/knowledge; underreporting; Lack of valid tools; Lack of confidence in responding; Lack of safety when reporting; Lack of time for reporting. | | Underreporting; Lack of Knowledge; Assessment/screening; Confidence; Safety; Time. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; | |

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| Collins et al. (2020) Elder Abuse Identification by an Australian Health Service: A Five-Year, Social-Work Audit | | Elder abuse is insufficiently reported and understood.In spite of its recognition as a serious social problem, research into elder abuse is relatively scarce compared to other family violence studies. Elder-abuse programs, focus on interventions regarding existing abuse rather than prevention or identification strategies. Hospitals play an important role as individuals experiencing elder abuse are more likely to be identified while an inpatient or being cared for by a hospital community team, but unfortunatly hospitals ( and the HCPs within ) fail to identify high-risk individuals because elder abuse is still poorly recognised. Growing calls for services to better screen and respond to older persons experiencing abuse, potentially through the use of targeted screening tools . However, the use of screening tools requires further evaluation and validity to be highly reliable. Acknowledgement of better understanding of the problem, need for development and better understanding of current policies and how they influence the current environment. This article looks into identifying interventions provided by health professionals and implications of the findings for the health service in terms of elder-abuse policy, practice, service provision, training, and research. | | Reporting of EA insuffient. Defrciencies in information and education in intervention planning. Staff were unaware of indicators of elder abuse, of resources, such as crisis support lines, legal options and community supports. Provision of training sessions led to improvements. Need to promote the importance sensitive inquiry approach. Collaboration between HCP institutions and justice departments. | | Underreporting; Lack of comprehensive knowledge; Lack of valid tools for screening; Standard practice and Policies; Collaboration. | | Lack of knowledge; Underreporting; Assessment/screening; Collaboration; standard practice and policies; Legal support. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |
| Dominguez et al. (2020) Elder Abuse Detection and Intervention: Challenges for Professionals and Strategies for Engagement From a Canadian Specialist Service | | Importance of healthcare providers as detectors of abuse and disclosure recipients, however actions healthcare providers should take when they identify EA will vary depending on the laws and regulations of the country and jurisdiction where they work. It is essential to have knowledge about possible indicators of EA to enhance detection, relatively little has been written about how health care providers can facilitate disclosure if they suspect abuse or how to engage victims in intervention efforts. The importnce of the role of the HCP by securing engagement and impacting the vicitms attitude towards help. HC Providers can identify abuse by utilizing indicator-based screening tools. Multidisciplinary approach to intervention and prevention of future harm, which systematically considers risk factors will be most effective in managing cases and may include mandatory reporting based on relevant legislation. | | Importance of the HCP in reporting/identification and intervention.Essential to have knowledge of indicators.Tools for better identification/screening. Training, skills in detection and case management. Multidisciplinary teams. Guidance for detection and intervention efforts by healthcare providers. | | Knowledge about indicators; Enhance dectection; Need for Tools; Case management skills especially when victims are cognatively impaired); Multidisciplinary collaboration; policies. | | Intervention; Laws; Leglislation; Lack of comprehensive knowledge; Collabotation; Case management; Safety; | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

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| Downes et al. (2013) Abuse of Older People with Dementia | | Health and social care professionals have a critical role in preventing and intervening in elder abuse. Health professionals need to be equipped with both the knowledge and the tools to recognise the warning signs of abuse in this group. Multiagency collaboration in the management of elder abuse. Ethical considerations. guidelines to support healthcare professionals when assessing capacity in older people with dementia would facilitate healthcare professionals in their role in elder abuse prevention and intervention. Development of best practice approaches to detecting, preventing and managing abuse of older people with dementia and for informing future research. Identification of EA difficult e.g. Perpetrators abuse privately, signs of elder abuse are not easily distinct from the signs associated with morbidity in older age or those resulting from self-neglecting behaviours. Elder abuse can go undetected by health and social care professionals if they erroneously assume that indicators of abuse and neglect are as a result of degenerative ageing processe Screening for elder abuse has been identified as good practice as it promotes the detection of abuse and facilitates early intervention. Multidisciplinary assessment may be conducted in cases of suspected abuse in order to assess warning signs to determine if they are indicative of abuse or attributable to the natural course of a disease. | | HCP critical role in intervention and prevention, they also need to be equipped with knowledge and tools. Management involves multiagency/multidisciplinary. Guidelines needed to better support assessment and development of best practices approaches to detecting,preventing and managing EA. | | Comprehensive Knowledge; ScreeningTools;Multidisciplinary Collaboration; Guidelines; Best practice,policies,protocols, guidelines. | | Comprehensive Knowledge; Assessment/screening; Research; Collaboration;Case management; Best practices. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |
| Kayser et al. (2021) Research priorities for elder abuse screening and intervention: A Geriatric Emergency Care Applied Research (GEAR) network scoping review and consensus statement. | | Hospitals, the availability of consulting services or ancillary professionals like social workers, HCP, emergency departments are strongly positioned to screen and intervene. Unique opertunity to identify and intervene. EMS/HCP report little training regarding recognition of elder abuse. Low rates of elder abuse identification may also create the false perception that a robust, standardized response is not needed. Highlighted the value of both working interdisciplinarity within the emergency department and partnering with outside providers like EMS and APS. Further work to establish instrument utility of these tools that includes investigations of provider acceptability, potential harms, and patient-centric outcomes in the clinical setting are needed. Lacking time and sufficient experience and knowledge bring reluctance to address possible abuse cases. Ethical issues: Identification and discussion of abuse may make a situation acutely worse or potentially expose patients to new risks. No clear guidelines.Screening approaches and interventions for elder abuse. Low rates of recognition, little knowledge can be built around best practices and effective interventions. Screening and intervention..multidisciplinary teams ..recommendations exist...no clear guidelines. | | Unique position for screening and intervention. Underidentified and underreported. Lack of training, comprehensive knowledge and time. Standardized response/ best practices/guidelines/protocols needed to strenghten responses. Desire for valid tools. | | Underreporting; Knowledge/education; Time;Tools; Guidelines; Protocols; Best practice; Multidisciplinary collaboration. | | Underreporting; Comprehensive knowledge; Time;Prevention; Research; Assessment/screening; Collaboration; Case management; Best practices; Standard practice. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

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| Luoma et al. (2011) Prevalence study of violence and abuse against older women. Results of a multi-cultural survey in Austria, Belgium, Finland, Lithuania, and Portugal (European report of the AVOW project) | | Lack of reporting, women thought the incident was too trivial to report or discuss or considered that nobody could do anything about the situation. Growing again population in Europe.Despite the growing concern about elder abuse, the topic has not yet emerged as a major theme in research.Research about where, when and how often elder abuse occurs is generally inadequate and inconsistent, or even non-existent. The study's overall objective was to develope preventive measures and the protection of victims of violence and abuse among older women. Percieved density levels of violence correlated to self-reporting levels. Reluctancy to report according to the level of abuse experienced...might indicate the knowledge about abuse is low or at least somewhat lacking significance. Psychological and emotional consequences of abuse and help-seeking behaviours. High levels of knowledge are needed for an in-depth understanding of violence against older women/elderly people. Research, policies and intervention strategies should be developed and devised that consider the number of dimensions and multiple layers of the phenomenon. Diverse and interdisciplinary perspectives as well as the central perspective of the victims. The development of guidelines, risk mapping tools, and screening instruments can facilitate co-ordinated action against the abuse of older women/people. A need for further examintion of Intervention and identification and best practices to improve intervention strategies. Development of Case management approaches. Multidisciplinary organisations working together to bring together their knowledge and expertise | | Lack of reporting. Reluctance of reoprting due to density levels of violence experienced. Lack of valid research. High levels of knowledge needed for indept understanding. Research, policies and intervention strategies should be developed. Multidisciplinary collaboration. The development of guidelines, risk mapping tools, and screening instruments can facilitate co-ordinated action against the abuse of older women/people. Examination of existing interventions, identification methods and best practices needed. Development of case mamagement approaches. | | Underreporting; Knowledge/ awareness; Tools; Policies; Case management development; Multidisciplinary collaboration develope co-ordinated action; Development of best practices. | | Underreporting; Comprehensive knowledge; Research; Assessment/screening; Best practices; Standard practice; Collaboration. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

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| Myhre et al. (2020) Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect | | Prevention of harm is a core principle in health care services. Knowledge about nursing home leaders' perceptions of elder abuse and neglect is of particular interest since their understanding of the phenomenon will affect what they signal to staff as important to report and how they investigate adverse events to ensure residents' safety. However, underreporting of abuse and neglect is a significant problem. Elder abuse in residential care found that staff were often uncertain about how to identify abuse,especially psychological abuse and caregiver abuse and neglect. Leaders understanding of the phenomenon will affect what they signal to staff as important to report and what they investigate to create a safe and healthy environment. Study found that there exists an overall lack of awareness of elder abuse and its harm among care managers. Also found was a lack of knowledge or experience in identifying and intervening in EA. There was a lack of knowing what to do and when and how to interfere in EA, especially when the resident has dementia or another form of cognitive impairment. Reported lack of strategy and authority. No knowledge or guidelines to intervene. Ability to defining abuse was blurred. Nursing care home policies provide some limited guidelines. Being aware of the abuse but still acting against the moral right due to outside influencers like time restrictions and staff resources. Care managers' lack of awareness in identifying and following up on abuse. Knowledge about their empirical understanding of the phenomenon is important to form more effective intervention and prevention strategies. The present study shows an ambiguity in the nursing home leaders' examples of abuse and neglect. | | Despite management being regulated perceptions of EA and understanding of the phenomenon by HCP are poor. Lack of knowledge affects the work environment and this lack of knowledge under signals to staff the improtance of identifying and report cases of abuse. Thus EA is underreported. Study found and overall lack of understanding of the subtleties in EA, identifying,intervening and how and when to intefere. Lack of strategy and authority also and policies for best practices. An overall ambiguity when it comes to EA where best practice is influenced by alack time and resource, and not intefering in EA justified through these. Health care policies that mandate efficiency, cost saving, and nursing home care managers' focus on prioritising contribute to lowering the limit for what is perceived as quality and safety, resulting in low quality and unsafe environment as the norm and accepted in nursing homes. | | Underreporting; Knowledge/education; Policies; Case management improvement; Best practices; Safe and healthy enviornment for reporting guided by leadership; Lack of time. | | Underreporting; Comprehensive knowledge; Best practices; Standard practice; Safety; Time. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for development of best practices, standard practice and legislation. | |
| Rosen et al. (2018) Emergency Department Provider Perspectives on Elder Abuse and Development of a Novel ED-Based Multi-Disciplinary Intervention Team | | Contact ( in this study the emergency department) with HCP provides a unique opportunity to identify EA. Despite this, emergency providers rarely recognize or report it. The study describes the development of the design of an ED-based multidisciplinary consultation service to improve identification and provide comprehensive medical and forensic assessment and treatment for potential victims. EA is underreported, some of the reasons for this underreporting suggested for this by this study's focus groups (and by current literature) include lack of knowledge or training, no time to conduct an evaluation, concern that identifying elder abuse would lead to additional work, and absence of a standardized response and uncertaintly when been with involvement in the legal system. HCP in direct contact position with elderly persons hold an important potential with the opportunity to identify elder mistreatment and initiate intervention, as this may be the only time a vulnerable, isolated older adult leaves his/her home. There has been a strong recognition of the importance of multidisciplinary team work and a desire for the strenghtening of such collaborations. All those involved in the study's focus groups ( which consisted of a wide range of HCP and related workers) reoprted a lack of acking knowledge about identification and structured tools to guide assessment also reported was a lack or absence of standardized protocols and in fact many reported using no tools or standard screening. | | Despite being in a unique position for identification and intervention HCP reported underreporting of EA and gave the barriers to identification and intervention. Lack of knowledge, education needs to provided at a cirriculum level, lack of time for evaluation, guidelines, training/educations should include focus on legal resources and reporting requirements, standardized protocols, a need for mutlidisciplinary teams to be developed to share knowledge and experience and to strenghten development of guidelines and proceedures in identification and intervention in EA. Also the study revealed a need for international recognition of the phenomena, validation of screening tools and more research into specialized into forensic patterns of abuse int EA. | | Underreporting; Knowledge/ education; Lack of time; Protocols; Guidelines; Standard practice; Legal resources; Mutlidisciplinary teams. | | Underreporting; Comprehensive knowledge; Assessment/screening; Time;Training; Collaboration; Case management;Standard practice; Best practices; Legal support. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

| Rosen et al. (2019) Review of Programs to Combat Elder Mistreatment: Focus on Hospitals & Level of Resources Needed | | This study was a systematic review to examine programs to improve elder mistreatment identification, intervention, or prevention, including those that had not undergone evaluation. Programs to combat elder mistreatment have been developed and implemented, with the majority focusing on education and multidisciplinary team development, however few are of high-quality study design, despite this drawback many programs are transferrable to low-resource environments. Again mentions the unique moment where a HCP meets a vulnerable elder person where identification and intervention is at its most possible. The desire of this study was to identify the existing programs and to improve elder mistreatment identification, intervention, and prevention with a focus on programs that integrate acute care hospitals and may be implemented in low-resource environments. The study's findings supports that idea that better knowledge/education, multidisciplinary team work and legal support/ understanding are the popular themes in identification and intervention of EA. Educational program for mental health and home care professionals demonstrated improvement in documentation of abuse and neglect risk assessment, and an educational program for social and health care professionals showed an increased ability to detect financial elder abuse in case scenarios. So supporting the understanding that proper education/knowledge can lead to an increase in reporting EA. Multidisciplinary teams and collaboration led to integrated multiple strategies which have the potential for greater impact. | | There are many educational programs implemented that concentrate on the identification, intervention and prevention (less focused on) depite this the EA is underreported and infrequently detected despite HCPs unique position to identify and intervene. The desire of this study was to identify the existing programs and to improve elder mistreatment identification, intervention, and prevention with a focus on programs that integrate acute care hospitals and may be implemented in low-resource environments. Knowledge/education, multidisciplinary team work and legal support/ understanding are the popular themes in identification and intervention of EA. The study shows that education/knowledge can lead to an increase in reporting EA. Multidisciplinary teams and collaboration led to integrated multiple strategies which have the potential for greater impact. | | Underreporting; knowledge; educational programmes (training); tools; Multidisciplinary collaborating teams developing best practices; legal support. | | Underreporting; Comprehensive knowledge; Training; Assessment/screening; Research; Collaboration; Legal support. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |
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| Simmons et al. (2022) Testing an educational intervention to improve health care providers' preparedness to care for victims of elder abuse: a mixed method pilot study | | The study mentions that the health care system plays an important role in detecting and reporting cases of elder abuse, however, health care providers are often unaware that their patients are sufering from elder abuse and are often unsure how to manage cases. A lack of education/knowledge about EA leads to cases going undetected and also leads to underreporting. Lack od time was also mentioned as a barrier to intervention. The study is a pilot study which performed initial testing of an educational model (which tested the efectiveness of a comprehensive one-day course about elder abuse, combining theory, group discussions and forum theatre) aiming at improving health care providers' preparedness to care for older adults subjected to abuse, or more specifcally their self-reported propensity to ask older patients questions about abuse and perceived ability to manage the response. The authors had conducted an earlier study that only half of personnel at an acute internal medicine and geriatrics clinic in Sweden had ever talked about abuse with an older patient and half of respondents were rather or very concerned about not being able to give victims a proper follow-up. A similar lack of awareness and knowledge about elder abuse has been found among health care providers in other studies, both in Sweden and internationally. Also fear of reporting cases because of a lack of confidence in their knowledge, repercussions by the perpetrator and confidence in case management, uncertainty about who has responsibility and a lack of confidence in the support systems for the elder person and the HCPs (legal). One factor found to be associated with improved recognition and management of elder abuse is having received education about elder abuse, which is also often sought after by care providers. The pilot was able to show that through the educational model that educational intervention increases HCP ability to approach the subject of EA with elderly clients. | | The study highlighted the barriers to detection, reporting and intervention in EA. It also identifies and descrides and educational model aimed at improving HCPs preparedness to care for vistims of EA. A lack of knowledge/education, in identifying EA, the theories of EA and how to intervene are all concerns for HCP, also a lack of confidence in case management because of a lack of clear protocols for managing the cases. The results of the educational model showed that educational intervention increases HCP ability to approach the subject of EA with elderly clients and led to an increase in self-efficacy. Knowledge both general and comprehensive leads to awareness thus leading to the subject becoming more important. | | Underreporting; lack of knowledge ( general and comprehensive); Time; Case management; Protocols; Best practice; Multidisciplinary teams. | | Underreporting; Comprehensive knowledge; Training; Assessment/screening; Safety; Confidence; Case management; Collaboration; Best practices; Standard practice. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

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| Wang et al. (2015) Elder abuse: an approach to identification, assessment and intervention | | This is a systematic review discussing definitions, risk factors, clinical manifestations and recommendations for screening for elder abuse; and offers an approach for clinicians/HCPs to consider when assessing older adults at risk for abuse. As populations age, it is becoming increasingly necessary for physicians to identify, assess and initiate management of elder abuse. However despite the introducation of legislation for the protection of elderly there is a substantial discrepancy between prevalence estimates of elder abuse and the number of cases reported to police-under reporting. There is insufficient evidence to recommend screening all older people for elder abuse and insufficient evidence to recommend any one intervention. HCP have a unique position in initiating indentification and intervention in EA. Knowledge about EA and the clinical manifestation of it. Tools for assesment are in need however an overall lack of statistically measurable outcomes to justify/validate any one instrument, with the exception of the Elder Abuse Suspicion Index, none of these instruments has been validated in the primary care setting. The study discussed possible the most promising model is that of multidisciplinary teams that include physicians, nurses, mental health care providers, protective services and professionals within the justice system. The article suggests how to assess a client suspected of being a victim of EA, first step would be to assess ' assessment of capacity' of the client. Also suggestions for management strategies to be approached in elder abuse similarly to other medical treatment decisions with regard to capacity, namely whether the patient is able to understand and appreciate the consequences of the proposed treatment. Also collaboration with multidisiplinary teams for optimal continuation of care. Suggestions were made that there would be considerations about liaising with the legal services in matters of cases where the elderly victim is deemed incapable. The conclusion was that the best intervention strategy at this time appears to be education targeted at increasing awareness of elder abuse among health care professionals, analogous to the incorporation of child abuse training into the medical school curriculum. | | The review discusses in a way the framework for approaches to elder abuse and suggests what should be taken into consideration when addressing it. Deapite development of legislation into the protection of the elderly EA still remains underrepported and under indentified. Not enough emphasise has been placed on the the development of valid assessment tools, creation of multidisicplinary collaborative teams and comprehensive education for HCP in EA. Assessment of the vicitm, thoughtful case management, legal support and best practices should all be developed to create more efficient identification and intervention actions from HCP. | | Underreporting; Knowledge/education; Need for research; Valid tools; Multidisciplinary teams; Standard practice and best practices;Standardized assessment; Legal intervention. Case management and legal support. | | Underreporting; Comprehensive knowledge; Research; Assessment/screening; Safety; Collaboration; Case management; Standard practice; Best practices, Legal support. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |
| Yaffe & Tazkarji (2012) Understanding elder abuse in family practice | | This short clinical review discussed what constitutes elder abuse, why family physicians/HCPs should be aware of it, what signs and symptoms might suggest mistreatment of older adults, how the Elder Abuse Suspicion Index might help in identification of abuse, and what options exist for responding to suspicions of abuse. HCPs in this case family physicians are well placed to identify mistreatment of seniors, however the actual rates of reporting abuse by family physicians (transferrable to HCPs in general) are lower than those in other professions. Improvements could be in by an understanding of the range of acts that constitute elder abuse and what signs and symptoms seen in the office/work environment might suggest abuse. Detection might be enhanced by use of a short validated tool, such as the Elder Abuse Suspicion Index. The authors suggest the importance of the HCP initial identification of the EA, suggesting further more that once suspicion of abuse is raised, most communities have (multidisciplinary teams) social service or law enforcement providers available to do additional assessments and interventions. | | EA is underreported. HCPs/physicians have a unique position for identification and initiating interventions. Comprehensive knowledge about EA is needed for identification of physical (identify the clinical manifestations through forensic based identification) and psychological (signs and symptoms) EA. Mandatory reporting laws guiding reporting are not always available. Guidelines do not agree about whether physicians should screen for mistreatment of older adults. Nonetheless, physicians are confronted with situations that arouse suspicions of such abuse. Tools such as the EASI are useful, simple, fast, a convenient means of learning about the scope of elder abuse and its implications have been described (validity). | | Underreporting; Education/knowledge; Guidelines for best practice; Standard practice; Laws; Tools; Multidisciplinary teams; Legal intervention. | | Underreporting; Comprehensive knowledge; Assessment/ screening; Standard practice ; Best practices; Case management; Collaboration; Legal support. | | Necessity for improvements in identification and reporting; Necessity for research and valid tools; Necessity for the creation of multidisciplinary teams; Necessity for development of best practices, standard practice and legislation. | |

## Themes and Categories

| | The need for improvements in identification and reporting | The need for research and valid tools | The need for multidisciplinary collaboration | The need for strengthening of standard practice, best practice, and legislation. |
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| Themes | | | | |
| Categories | Reporting (barriers to)/underreporting | Research (validation) | Collaboration | Standard practice |
| | Comprehensive knowledge (education/curriculum based) | Assessment/screening | Case management | Best practices |
| | Training | Confidence/safety | Safety/security | Legislation |
| | | Time | Prevention | Legal advice |