ELDER ABUSE: IDENTIFICATION AND SCREENING

CONTENTS

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Disclaimer: This document is a general guide, to be followed subject to the clinician's judgment and person's preference, choices and decisions in each individual case. The guideline is designed to provide information to assist decision making and is based on the best evidence available at the time of development of this publication.

1. Key Messages

- Elder abuse refers to any intentional or unintentional behaviour pattern (action or inaction) that results in psychological, financial, physical or social harm to a person aged over 65 years, or 45 years for Aboriginal and Torres Strait Islander peoples. In Aboriginal and Torres Strait Islander people the term “elder abuse “ may need to be replaced with “abuse of older persons”.
- Elder abuse leads to poor health outcomes, including distress, morbidity and mortality.
- There are several types of elder abuse including neglect and emotional/psychological, physical, social, sexual and financial abuse. Abuse types may occur in isolation or co-exist. Psychological abuse is the most common type of abuse in older people with dementia.
- Older person risk factors for abuse include cognitive impairment (e.g. dementia), behavioural problems (e.g. BPSD), functional dependency and poor health/frailty. These risk factors are common in older people with dementia living at home or in residential aged care (RAC).
- Abuser risk factors for elder abuse include caregiver burden and stress, negative care-giving motivation factors and psychiatric/psychological problems. A trusted person who is close to and relied upon by the older person is typically the abuser (e.g. the older person’s own children).
- Relationship risk factors for elder abuse include family disharmony, conflicted relationships and family violence history.
- Environment risk factors include living in a rural or remote community and low social support.
- GPs and practice nurses have a key role in reducing the risk of elder abuse, monitoring for signs of abuse and responding when suspected or identified. Safe, respectful and inclusive care of older people with dementia includes sensitive assessment of and person-centred response to suspected abuse and elder abuse.

- There is no gold standard method for identifying elder abuse and little validation of screening questionnaires for use with older people who have dementia. However, screening methods, including signs and symptoms and common risk factors for abuse, can assist GPs/practice nurses to broach the topic of personal safety and assess for abuse risks and harm. Importantly, as dementia impacts on cognitive function and many methods rely on the older person's ability to recount experiences, more reliance may be needed on identifying signs of abuse and risks factors.
- Older person factors may make identification of abuse more problematic. For example, through denial or sense of shame/embarrassment, concerns about punishment by the abuser for disclosure, fears about losing their carer or concerns about repercussions from breaking family solidarity.
- Risks for elder abuse should be managed proactively with the older person and carer as part of a comprehensive care plan. Information about options should be provided. Care and prevention should be tailored to the specific needs and circumstances of the older person and carers, including the older persons stage of dementia. Evidence based guidance for dementia care and carer support should be followed and revised as circumstances and needs change over time.
- GPs and practice nurses should thoroughly and clearly document assessed risks, and signs/symptoms of elder abuse.
- As the reporting of elder abuse is not mandatory in Australia, except in relation to specific offences occurring within Commonwealth-funded aged care facilities (physical and sexual assault), the decision to voluntarily report abuse and intervene should prioritise, where possible, the expressed wishes of the older person. Alternatively, an uninvolved substitute decision maker.
- Australian laws provide the legal framework for reporting crimes that occur as elder abuse (e.g. physical and sexual abuse). With the consent of the person or substitute decision maker, the police should also be notified where there is an immediate risk of physical harm or serious risk of damage to property. State and territory policies detail voluntary reporting frameworks and agencies for other types of elder abuse.

2. Practice Points – What can I do?

a) Underlying principles of care where there is suspected or elder abuse

- Recognise the impact of dementia on the older person, their carer, family relationships, living and economic circumstances.
- Recognise and respect the decision-making and privacy rights of the person with dementia.
- Aim to maximise the older person's quality of life and safety over the duration of their condition and across care environments. Regularly communicate with the older person and their carers about the demands of caring, the older person's needs and the problems/stressors they both encounter. Assess coping. Encourage timely use of support services and respite.
- Minimise the potential for elder abuse by knowing and assessing for risk factors and signs/symptoms of abuse.
- Recognise that older people and health care professionals may have difficulty raising, discussing and responding to elder abuse.
- Recognise that elder abuse is a serious circumstance for the older person and that different types of abuse (see table below) may occur and change over time – in isolation or combination.

Type and definition	Examples
Emotional (or psychological or social) abuse Using threats, humiliation or intimidation which causes mental anguish, fear, shame or isolation.	• Verbal abuse, harassment or bullying • Threats of physical harm or institutionalisation • Withdrawing emotional support. • Preventing contact with family and friends
Physical abuse Causing physical pain or injury	• Pushing, shoving, slapping, kicking or burning. • Restraining with rope or ties or locking in a room. • Using chemical restraints such as alcohol, medications or poisons.
Sexual abuse Any unwanted sexual contact or activity or	• Inappropriate touching • Sexual harassment • Sexual assault

Type and definition	Examples
Financial or material abuse Using someone's assets illegally or improperly.	• Using credit cards without the person's permission. • Moving into the older person's home, but not for the benefit of the older person. • Stealing goods, whether expensive items or basic necessities.
Neglect Failing to provide the basic necessities of life.	• Not giving the person adequate food, clothing, shelter, medical or dental care. • Receiving the Carers' Allowance and not providing the care required

Adapted from Kurrle and Naughtin [1], Australian Law Reform Commission (ALRC) [2]

- Recognise the important role of GPs and practice nurses in preventing, recognising and responding to elder abuse risks, suspected elder abuse and abuse, including in RACs.

b) Assessing for elder abuse risk and prevention strategies where the person has dementia

- Assess degree of abuse risk considering older person, abuser, relationship and environmental factors detailed in the following table.

Risk factors for elder abuse	
Elder person factors	• Cognitive impairment • Behavioural problems • Psychiatric illness or psychological problems • Functional dependency • Poor physical health or frailty • Low income or wealth • Trauma or past abuse • Ethnicity • Low literacy levels or a lack of awareness of rights.
Perpetrator factors	• Caregiver burden or stress • If carers have a negative motivation for providing care (e.g. there are no other carers available or suitable) • Psychiatric illness or psychological problems (including anxiety, depression and anger). • Having a strong sense of entitlement towards the older person's property
Relationship factors	• Family disharmony • History of family violence • Poor or conflictual relationships

Risk factors for elder abuse	
Environmental factors	• Low social support • Living with others (except for financial abuse) • Living with adult dependents with a disability or health issue • Living in a rural or remote community

Adapted from Johannesen and LoGiudice [3], Bagshaw, Wendt [4], Camden, Livingston [5], Cooper, Selwood [6], Macneil, Kosberg [7], Seniors Rights Victoria [8]

- The mitigation of risk factors (e.g. carer burden) should be included as prevention strategies in care plans for people with dementia and their carers. Information about options should be provided. Enhance support for the older person and their carer by referral to community support services. These services are also important for monitoring and support older people at risk of abuse; for example, implement, maintain or enhanced home services where possible. Refer carers to support and respite services, including Dementia Support Australia (https://www.dementia.com.au/) where there are problems in coping with behavioural and psychological symptoms of dementia (BPSD). Substance abuse or a gambling addiction in the carer may also be a factor contributing to the abusive behaviour, in which case organising the appropriate support services for the abuser may be warranted.[8, 9]
- Prevention strategies require systematic review and adjustment as the older person's circumstances change and their dementia progresses over time. Many people at risk of abuse, are actually abused.

c) Assessing the person who has dementia for elder abuse

- The use of screening tools to identify abuse in people living with dementia can be difficult in the case of dementia. The EASI © has been validated in early dementia.[10] GPs should therefore assess for the signs of abuse, and evaluate risk factors (see above) to identify suspected abuse and abuse in the case of dementia.
- Whilst the signs of abuse might not be visible or conclusive[11] the GP should assess the older person for the presence of possible signs and symptoms of elder abuse (see table below). Where the possibility of abuse is suspected the GP should utilise time during consultation with the older person and carer to

observe the emotional reactions and body language of the older person and the suspected abuser. A detailed picture may not be possible during one consultation, but rather built over a sequence of planned visits with the older person. Time alone with the older person may be needed in order to assess for some signs and symptoms of abuse and risk factors.

Possible signs and symptoms of elder abuse	
Emotional (or psychological or social) abuse	Unexplained passivity or withdrawal. Reduced social contact. Anger, depression or unexplained weight loss. A carer who answers for the person with dementia or obstructs a private consultation with the person. Regular requests for sedatives.
Physical abuse	Unexplained bruises, welts, lacerations, sprains or fractures. Unexplained changes in behaviour possibly due to overmedication or undermedication. Unexplained physical pain. Withdrawal, anxiety or depressed mood.
Sexual abuse	Bruising, inflammation, tenderness or abrasions to the genital area.
Financial or material abuse	Unexplained anxiety, avoidance, social withdrawal or depression. Lack of money to purchase food or medication. Improperly attired for the weather. Reluctance or guilt about identifying their abuser.
Neglect	Poor mobility Decubitus ulcers or pressure sores Poor hygiene or body odour Frequent infections or unexplained medical conditions. Unexplained weight loss, anxiety or depressed mood.

Adapted from Yaffe and Tazkarji [12]

- Consider the influence of barriers to the older person disclosing abuse e.g. fear, shame or concerns about discovery. People living with dementia who depend on a caregiver might be particularly reluctant to disclose abuse for fear of the loss of support.[13] People with dementia may have difficulties discussing their feelings or remembering instances of abuse.
- Consider who may be a potential abuser. In an RAC, “the abuser may be another resident (sometimes with dementia), a staff member (including volunteers), visitors or family members”.[14(p76)]

- Where abuse is suspected the GP should collect a detailed medical history which includes psychosocial and cultural information, document relevant findings from physical examinations (including photos of injuries where relevant), document observations of the person's behaviour including body language and interactions with carers/family/RAC staff members, order laboratory and imaging tests as appropriate, devise plans with the patient to enable support, education, and follow-up, implement patient safety plans and monitor ongoing abuse.[15, 16]
- The reporting of elder abuse is not mandatory in Australia, except in relation to specific offences occurring within Commonwealth-funded aged care facilities.[1, 17] The decision to voluntarily report abuse and intervene should therefore prioritise the expressed wishes of the older person.[8] Taking this stance also respects the older person's privacy. However, if the person with dementia does not have the capacity to make decisions/engage in supported decision-making, the GP should consult the older person's substitute decision maker (SDM). If the SDM is the suspected abuser or if there is no clear indication of the existence of an SDM, the GP should contact the public guardian, public advocate or appropriate body in their own state or territory if it is considered necessary or desirable to safeguard the person with dementia's wellbeing. Further information can be obtained by contacting the relevant state and territory helplines below.

State and Territory Contact Information

Information and support contacts for people suffering from abuse		
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	(02) 6205 3535
New South Wales	NSW Elder Abuse Helpline	1800 628 221
Northern Territory	Elder Abuse Information Line	1800 037 072
Queensland	Elder Abuse Prevention Unit	1300 651 192
South Australia	SA Elder Abuse Prevention Phone Line	1800 372 310
Tasmania	Tasmanian Elder Abuse Helpline	1800 441 169
Victoria	Seniors Rights Victoria	1300 368 821
Western Australia	Advocare Inc	1300 724 679 (Perth) 1800 655 566 (Rural)

Different reporting mechanisms should be used depending upon each older person's specific circumstances (e.g. abuse type, location and abuser).

- Cases of a criminal nature (e.g. physical or sexual assault) - If there is an immediate risk of physical harm, or there is suspicion that the abuse is of a criminal nature, the GP should notify the police. Extra care to document injuries should be taken in case of criminal abuse cases.[8]
- Cases relating to professional malpractice - suspicions of abuse by providers of health services, such as GPs, nurses and allied health professionals should be notified to the Australian Health Practitioners Regulation Agency (AHPRA), including professional malpractice cases relating to RACs (www.ahpra.gov.au).
- Cases requiring guardianship intervention - if the case relates to an older adult who has lost capacity to make decisions (for example, due to dementia) the matter should be referred to the Guardianship authority (or your state equivalent) for investigation or advocacy (refer to Table 19 in Chapter 13 of the RACGP White Book https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book)
- Making a complaint about aged care services - anyone can make a complaint about aged care in Australia by discussing issues directly with a service provider or by contacting the Aged Care Quality and Safety Commission. Most complaints can be addressed quickly by discussing the issue(s) with the aged care service provider, in person or over the phone. If this is not possible, you can contact the Commission via https://www.agedcarequality.gov.au/

3. Literature Review

a) Definition and terminology

In Australia the term ‘elder abuse’ has been used by the medical and allied health professions as “any pattern of behaviour which causes physical, psychological, financial or social harm to an older person”.[1, p.112] Internationally the most common definition of 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”.[18] Such abuse can be either deliberate or unintentional.[8]

The terms ‘elder mistreatment’ and ‘elder maltreatment’ are often used interchangeably with ‘elder abuse’. However, definitions of elder abuse are also often used inconsistently among scientific and practice communities and in addition there is often only limited consensus between health professionals, carers and older people about what constitutes abuse.[15, 19-21] Moreover, there are also discrepancies between studies in the definition of ‘elder’ with some studies using over 60 years of age as the criterion, whereas others are setting the cut-off at 65 years or even higher.[21] In Australia, 65 years and above is the accepted standard with 45 years and above for Aboriginal and Torres Strait Islander people.[17]

Elder abuse is associated with significant negative health outcomes, including distress, morbidity and mortality.[9, 15]

b) Elder abuse types

There are several different types of elder abuse. [1, 8, 9, 15, 22]

Emotional (or psychological) abuse

Emotional abuse involves the use of threats, humiliation or harassment causing the older person to experience distress and negative feelings (i.e. shame, stress, hopelessness, anxiety). Examples include:

- pressuring, bullying, belittling;
- name-calling; and
- threatening to harm the person, other people or pets.

Physical abuse

Physical abuse involves inflicting physical pain or injury on an older person. Examples include:

- pushing, shoving, slapping, biting, kicking, burning;
- rough handling;
- restraining with rope, belts, ties or locking the person in a room, building or yard;
- using chemical restraints such as alcohol, medications, household chemicals or poisons (a blood test would be required); and
- holding a pillow over a person's head.

Social abuse

Social abuse involves restricting an older person's social life. Examples include:

- preventing contact with family and friends;
- withholding mail;
- not allowing phone calls or listening in to calls; and
- preventing involvement in religious or cultural practices.

Sexual abuse

Sexual abuse refers to sexual activity or touching to which the older person has not consented. Examples include:

- non-consensual sexual contact, language or behaviour;
- inappropriate touching;
- sexual assault;
- rough or inappropriate cleaning or treatment of an older person's genital area; and
- viewing sexually explicit material or making sexually explicit phone calls in the presence of an older person without their consent.

Financial abuse

Financial abuse involves using the older person's assets (i.e. money, property) illegally or improperly. Examples include:

- moving into the home of an older person without their consent and failing to contribute to household costs;
- forcing, coercing or misleading an older person into signing paperwork concerning loans, property, wills or powers of attorney;
- using powers of attorney to manage an older person's finances inappropriately;
- stealing goods, whether expensive jewellery, electronic equipment or basic necessities such as blankets and food;
- using bank or credit cards without the person's permission; and
- promising to care for someone in exchange for their financial help, then not providing the care.

Neglect

Neglect refers to when someone fails to provide the basic necessities of life for an older person. This can either be intentional or unintentional. Examples include:

- not giving the person the care they need such as adequate food, medical care, warmth or dental care; and
- receiving the Carers' Allowance and not providing the care required.

c) Prevalence of elder abuse

There have been no detailed studies of prevalence rates in Australia, but rough Australian estimates suggest a prevalence of 0.5 to 5 percent of people aged over 65 years.[1, 23, 24]

The National Elder Mistreatment Study conducted on over 60-year-olds in the United States found that, in the year preceding the study, 4.6 percent of respondents had experienced emotional abuse, 1.6 percent physical abuse, 0.6 percent sexual abuse, 5.1 percent potential neglect, and 5.2 percent financial abuse by a family member. In total 11.4 percent of respondents reported having experienced at least one form of

abuse.[20] Similarly in a representative study, Burnes, Pillemer [25] found a past-year prevalence of 1.9 percent for emotional abuse, 1.8 percent for physical abuse and 1.8% for neglect, with an aggregate prevalence of 4.6 percent. In a systematic review, Cooper, Selwood [26] found that 6 percent of older people in general population studies reported significant abuse in the last month and that nearly a quarter of older people dependent on carers reported significant psychological abuse. Moreover, a third of family carers reported having committed significant abuse. In another international systematic review, psychological abuse was identified as the most prevalent form of abuse.[21] In Australia, financial abuse is often reported to be the most common form of abuse experienced by older Australians.[4, 27]

Elder abuse is more common in persons with cognitive impairment and hence is an issue of concern when treating people with dementia. Dong, Chen [13] found in a literature review that psychological abuse was the most widespread form of abuse among older adults with dementia, comprising an estimated 27.9 percent to 62.3 percent of cases. Physical abuse was found to affect 3.5 percent to 23.1 percent of elderly persons living with dementia. In one study of persons living with dementia, Wiglesworth, Mosqueda [28] found that 47.3 percent of participants had experienced abuse. In another study, Cooper, Selwood [29] found that most family carers reported some abusive behaviour and a third reported significant abusive behaviour towards persons living with dementia.

Variations in estimates are thought to be the result of difficulties in identification of abuse and how it is defined. [15]

d) Abusers

Abuse is typically carried out by someone close to an older person and whom that older person relies on and trusts (e.g. children, grandchildren, partner, other family members, friends or neighbours).[9, 21] Research in Western Australia shows that the perpetrators of abuse of older people are most likely to be the victims' own children.[30]

e) The role of GPs in recognising and responding to elder abuse

GPs and practice nurses are well-positioned to detect signs of elder abuse as they usually have regular contact with their older patients. For socially isolated older people, visiting the general practice may be the only social interaction they have

outside their home.[31] Therefore, GPs have a key role in recognising, assessing and managing cases of elder abuse.[14] Initially the older person should be assessed to determine if there are immediate risks to their health and safety (e.g. physical violence or restricted access to mediations vital to their health).[32]

f) Screening and identification

Whilst it is everybody's responsibility to recognise and effectively respond to elder abuse,[33] under-detection has become a serious issue.[34] Difficulties in identifying elder abuse contribute to this issue. and include older person:

- denial, sense of humiliation, shame or embarrassment;
- concerns about abuser punishments or retaliation;
- concerns about losing their care provider;
- fear about breaking family solidarity; and
- pre-existing medical and social issues, [10]

Identification can be compromised where the older person discloses circumstances that are abusive but fail to label their experience as abuse (e.g. pressure from an adult son for money).[32] Further, the older person may be unwilling to repeat their concerns to more than one health or legal professional and those living in small rural or remote communities may be less willing to disclose abuse, fearing discovery.[33]

There is no single gold standard test to identify abuse. Numerous methods and tools have been employed in various studies.[21] These different ways to screen and identify abuse can assist GPs to talk about elder abuse with older people[32] and can be divided into: direct questioning tools; identifying signs and symptoms of abuse; and evaluating risk of abuse indicators. Each of these approaches has different strengths and limitations and as such, some studies argue that all three approaches should be used together to identify abuse.[11, 35] Whilst these tools exist the Services Task Force (USPSTF) found that screening practices for elder abuse were limited due to the wide array of screening methods and tools, the varying definitions of elder abuse and uncertainty about whom to screen and what to do if abuse is detected.[36]

Identification of abuse of people living with dementia can be hampered by the limitations of direct questioning tools and the potential unreliability of information given. Most screening tools (including the EASI © described below) rely on the person recounting abusive experiences and risk factors, and have therefore not been

validated for people living with dementia.[28, 35, 37] It is hence recommended to first screen for cognitive impairment before using direct questioning tools (i.e. the EASI ©[10]).[16] Moreover, people living with dementia who depend on a caregiver might be particularly reluctant to disclose abuse for fear of the loss of support,[13] and might also have difficulties discussing their feelings or remembering instances of abuse.[13, 15, 38] Where cognitive impairment exists, the clinician may have to rely on identification approaches such as signs of abuse, or on the evaluation of risk factors to identify abuse.

Direct questioning tools

Yaffe, Wolfson [10] developed the Elder Abuse Suspicion Index © (EASI) in order to help GPs identify cases of abuse. The EASI © has been included by the Royal Australian College of General Practitioners (RACGP) in its White Book, *Abuse and Violence: Working with our patients in general practice* https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book[14] and has been evaluated internationally by the World Health Organisation.[31] It is important to note, however, that the EASI © is intended for cognitively intact individuals and might therefore only be used for cases where the older person displays no or very mild cognitive impairment.[10, 12, 31, 35] A copy of the EASI © tool can be found in Appendix 1.

Signs and symptoms of abuse

Apart from self-disclosure and asking the older person directly, abuse can also be identified by concentrating on identifying the signs and symptoms of abuse.[9] Where abuse is suspected or concern has been raised with the GP, consultation time with the older person and the suspected abuser can be used to observe emotional reactions and body language of the older person and the suspected abuser and interactions between the two. Where the older person resides in RAC, possible abusers include other residents (with/without dementia), staff members/volunteers, visitors or family members.[14]

Possible signs and symptoms of elder abuse are provided in the table below. GPs should be aware that these signs of abuse might not be visible or conclusive.[11]

Possible signs and symptoms of elder abuse	
Emotional (or psychological) or social abuse	• Unexplained passivity or withdrawal. • Reduced social contact. • Anger, depression or unexplained weight loss. • A carer who answers for the person with dementia or obstructs a private consultation with the person with dementia. • Regular requests for sedatives.
Physical abuse	• Unexplained bruises, welts, lacerations, sprains or fractures. • Unexplained changes in behaviour possibly due to overmedication or undermedication. • Unexplained physical pain. • Withdrawal, anxiety or depressed mood.
Sexual abuse	• Bruising, inflammation, tenderness or abrasions to the genital area.
Financial or material abuse	• Unexplained anxiety, avoidance, social withdrawal or depression. • Lack of money to purchase food or medication. • Improperly attired for the weather. • Reluctance or guilt about identifying their abuser.
Neglect	• Poor mobility • Decubitus ulcers or pressure sores • Poor hygiene or body odour • Frequent infections or unexplained medical conditions. • Unexplained weight loss, anxiety or depressed mood.

Adapted from Yaffe and Tazkarji [12]

Risk of abuse indicators

Studies have shown that many people at risk of abuse are abused.[15, 26] For example, the National Elder Mistreatment Study conducted on participants over 60 years of age in the United States found that low social support and a previous traumatic event were the most consistent correlates across all abuse types. Participants with little social support were over three times more likely to experience abuse than those receiving high levels of social support.[20]

Therefore, the presence of risk indicators might be used as a first step for intervention and preventive strategies.[15, 26]

Risk factors for elder abuse are detailed in the table below however it is important to note that cognitive impairment has consistently been identified as an important risk factor for elder abuse. As such, persons living with dementia are at higher risk of elder abuse. Persons living with dementia are not only more vulnerable to abuse, but

might also have difficulties discussing their feelings or remembering instances of abuse.[13, 15, 38] It is also important to note that caregiver burden or stress has been identified as a risk factor for abuse and that the inability to cope with a person's needs might lead to abusive behaviour.[3, 38, 39] One study by Camden, Livingston [5] also found that carers who had a negative motivation for providing care (e.g. no other carers available or suitable) ended up being more abusive than carers who had more positive motivations to become carers (e.g. close relationship with the care recipient). Another study by Cooper, Selwood [6] found that family carers who were more anxious and depressed were more likely to report being abusive. However, in another study anger was found to be the most important factor for elder abuse and that anxiety did not predict abusive behaviour if anger was absent.[7]

Risk factors for elder abuse	
Older person factors	• Cognitive impairment • Behavioural problems • Psychiatric illness or psychological problems • Functional dependency • Poor physical health or frailty • Low income or wealth • Trauma or past abuse • Ethnicity • Low literacy levels or a lack of awareness of rights.
Perpetrator factors	• Caregiver burden or stress • If carers have a negative motivation for providing care (e.g. there are no other carers available or suitable) • Psychiatric illness or psychological problems (including anxiety, depression and anger). • Having a strong sense of entitlement towards the older person's property
Relationship factors	• Family disharmony • History of family violence • Poor or conflictual relationships
Environmental factors	• Low social support • Living with others (except for financial abuse) • Living with adult dependents with a disability or health issue • Living in a rural or remote community

Adapted from Johannesen and LoGiudice [3], Bagshaw, Wendt [4], Camden, Livingston [5], Cooper, Selwood [6], Macneil, Kosberg [7], Seniors Rights Victoria [8]

g) Improving the safety of older people at risk of elder abuse/experiencing abuse

Older people at risk of elder abuse or experiencing abuse should be provided with information about options to address the issues they face.[32] These options should be considered in the context of the severity of the risk they face.[32] The initiation, maintenance or enhancement of home-based services to support and monitor the older person at risk is advocated.[8] In addition, factors contributing to or causing the abuse can be addressed. Abuse might be due to carer burden or inability to cope with a person's needs.[3, 38, 39] In these cases, abuse might be addressed by organising support services for the carer.[40] For example, carers who are having difficulties coping with the behavioural and psychological symptoms of dementia can be referred to Dementia Support Australia (https://www.dementia.com.au/). Substance abuse or a gambling addiction may also be a factor contributing to the abusive behaviour, in which case organising the appropriate support services for the abuser may be warranted.[8, 9]

Barriers to reporting and intervention

Reporting and intervening in elder abuse can often be difficult. In a national online survey of 228 chief executive officers and 214 aged care service providers, Adams, Bagshaw [27] found that although service providers were well placed to identify financial abuse, successful intervention was often hampered due to detection difficulties, the need to secure older person consent to intervene, concerns about the withdrawal of care by the abuser and insufficient resourcing to cope the complex nature of the problem.[27] Similarly, Cairns and Vreugdenhil [41] note that important issues for frontline practitioners when working with older abuse victims are questions around self-determination, capacity and duty of care. Additionally, the Australian Law Reform Commission (ALRC) has identified that a barrier to reporting can arise from health professionals' concerns that disclosure of information about abuse to another provider or government agency constitutes a breach of privacy legislation.[33]

The National Elder Mistreatment Study found that of the respondents who had experienced some form of abuse, only a minority of cases had been reported to the police: 7.9 percent of emotional abuse, 31 percent of physical abuse and 16 percent of sexual abuse cases.[20] It is estimated that 80 percent of abuse cases are not reported to authorities.[9] While GPs are best positioned to identify and report abuse,

they may lack the training to screen for abuse or might be reluctant to be involved in the legal consequences.[22, 42] However, there has been scant research on the best form of intervention for elder abuse.[13, 43, 44]

Further information can be obtained by contacting the relevant state/territory helplines listed earlier in this chapter.

Reporting and documenting elder abuse or suspected elder abuse

The reporting of elder abuse is not mandatory in Australia, except in relation to specific offences occurring within Commonwealth-funded aged care facilities.[1, 17] Consequently, the decision to report abuse and intervene should reflect the expressed wishes of the older person.[8]

A range of reporting mechanisms can however be utilised is situations where the GP wishes to voluntarily report abuse or suspected abuse.[14] Different mechanisms may be more appropriate depending on the type of abuse, the older person's relationship with the abuser and their location. Options for different types of abuse/circumstances include:

- guardianship intervention – if the older person has lost their capacity to make decisions (e.g. due to dementia) the GP should notify the Public Guardian (or the state/territory equivalent) for investigation or advocacy. Australian state and territory policies pertaining to elder abuse usually discuss older person "empowerment or the right to self-determination".[24, p.117] The standard response in all jurisdictions for elder abuse victims with cognitive decline is the appointment of a substitute decision maker (e.g. through a guardianship application to a state or territory tribunal).[24] The RACGP recommends initially checking the older person's clinical record for details of existing substitute decision makers.[14] Where the documented person is the suspected abuser or where no substitute decision maker is known, and the GP considers action is needed/desirable for the older person's safety and wellbeing, the GP should contact their state/territory public guardian, public advocate or other appropriate body.[14]
- criminal – where the GP suspects that a crime has occurred, or if the older person/others requires protection, the GP should notify the police; Some forms of abuse are criminal acts (e.g. physical or sexual abuse). Alleged

criminal activity should be reported to the police if there is sufficient evidence (e.g. the guardian has reported the abuse) and permission has been given by the appropriate person. Police should also always be involved in an emergency where there is an immediate risk of physical harm or serious damage to property. Extra care should be taken to document injuries in criminal abuse cases.[8] Chesterman [24] also argues that it should be made clear to victims that crimes should be treated as such and to encourage victims to report abuse to the police. However, if a victim does not wish to report a crime to the police, this wish should be respected if the older person demonstrates insight and have freely made that decision; and

- professional malpractice – where the GP suspects that an abuser is a provider of health care (e.g. GP, nurse, allied health care professional) the Australian Health Practitioners Regulation Agency (AHPRA) should be notified. AHPRA should be contacted in professional malpractice cases relating to RAC (www.ahpra.gov.au).
- Aged care services - the Aged Care Quality and Safety Commission should be contacted regarding cases of known or suspected abuse occurring within a residential aged care facility (https://www.agedcarequality.gov.au/).
- All reported or suspected cases of elder abuse need to be clearly and comprehensively documented.[14] Health record/RAC progress note documentation should include photos of injuries and quotations from the older person and relevant others. Where the suspected abuser is a RAC staff member the GP should document details of the abuse in the patient file at the medical practice.

It is important to collect and document a complete medical history.[16] Specifically, Dong [15] suggests health professionals should :

- collect detailed histories, including psychosocial and cultural aspects;
- document findings from physical examinations which might show elder abuse;
- document observations of the person with dementia's behaviour (i.e. reactions to questions, family conflicts);
- order laboratory and imaging tests as appropriate;

- devise person-centred plans to provide support, education, and follow-up; and
- monitor ongoing abuse.[15]

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Appendix 1 – Elder Abuse Suspicion Index © (EASI)

EASI Questions Questions1-5 asked of patient; question 6 answered by doctor (Within the last 12 months…)			
Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

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"The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2 to 6 may establish concern. The EASI was validated* for use by family practitioners of cognitively intact seniors seen in ambulatory settings." [45(p1)].

Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI)©. J Elder Abuse Neglect. 2008;20(3):276-300.

Appendix 2 – Extract from NHMRC guidelines

The following recommendations for…and evidence strength/quality definitions have been extracted from Clinical Practice Guidelines and Principles of Care for People with Dementia.[46]

Recommendations

Number	Detailed Recommendation
61 PP	As people with dementia are vulnerable to abuse and neglect, all health and aged care staff supporting people with dementia should receive information and training about how to prevent and manage suspected abuse.

46(p.XI)

Definitions of types of recommendations

Evidence-based recommendation (EBR) - Recommendation formulated after a systematic review of the evidence, with supporting references provided.

Consensus based recommendation (CBR) - Recommendation formulated in the absence of quality evidence, when a systematic review of the evidence has failed to identify any quality studies meeting the inclusion criteria for that clinical question.

Practice point (PP) - A recommendation that is outside the scope of the search strategy for the systematic evidence review and is based on expert opinion.

Definitions of GRADE ratings of the quality of the evidence

High - Further research is very unlikely to change our confidence in the estimate of effect.

Moderate - Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low - Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very Low - Any estimate of effect is very uncertain. [46(pp.IV)]

Appendix 3 – Evidence summary for elder abuse information

Evidence summary for literature reviews

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Abbey (2009) **USA**	Non-systematic review/overview of elder abuse and neglect	NA (50 references)	NA	NA	"The complex phenomenon of elder abuse and neglect requires collaboration of home care professionals with other disciplines, including social services, law enforcement, and legal support. Identification can be challenging, but the prevalence suggests that routine screening may be advisable. Knowing and working effectively with local resources is important. ''Protecting older people, assisting in creative interventions and developing needed services is a shared professional responsibility.'"	1 NA 2 NA 3 CA 4 CA 5 NA 6 NA 7 N 8 CA 9 NA 10 NA 11 N
Burnett, Achenbaum & Murphy (2014) **USA**	Non-systematic review/overview of prevention and early identification of elder abuse	NA (52 references)	NA	NA	- "Early identification and prevention of elder abuse requires challenging ageist perceptions. - Increasing public awareness and health professional training is needed to differentiate abuse in older adults from "normal" aging. _ More research is needed to identify characteristics that increase the risk of elder abuse and subsequent studies to inform best practices for reducing harmful outcomes. _ Concise assessments can be used effectively during brief clinical visits with older adults to identify risk factors and indicators of abuse."	1 NA 2 NA 3 CA 4 CA 5 NA 6 NA 7 N 8 CA 9 NA 10 NA 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Chesterman (2016) **Australia**	Non-systematic review/opinion on future needs for elder abuse policies in Australia	NA (39 references)	NA	NA	"Elder abuse is acknowledged to be a significant social problem in Australia, but Australia's elder abuse responses have significant limitations. These responses, as evidenced by state and territory elder abuse strategies, voice important principles and typically seek to improve the knowledge of service providers, potential victims, and the general public about elder abuse. But they tend only to identify and draw upon existing service and community care responses in their attempts to address elder abuse. This article provides a policy analysis of existing elder abuse response strategies and argues that reforms are needed to ensure that the strategies: prioritise the wishes and wellbeing of the person in question; identify and empower lead agencies; and drive collaborative responses."	1 NA 2 NA 3 Y 4 Y 5 NA 6 NA 7 N 8 NA 9 NA 10 NA 11 N
Cohen (2011) **Israel**	Non-systematic review of screening tools for the identification of elder abuse.	NA (69 references)	NA	NA	"Elder abuse prevalence rates are under-estimated in the literature, and many abuse victims fail to receive the professional help that could improve their quality of life. A number of structured and validated tools can be used to identify abuse victims. Three types of tools are discussed: direct questioning, inspecting for signs of abuse, and evaluating for risk factors for abuse. An integrative model that encompasses the 3 screening modes is described. Considerations regarding special populations and cultural aspects should be incorporated into the screening process."	1 NA 2 NA 3 CA 4 CA 5 Y 6 Y 7 Y 8 Y 9 NA 10 NA 11 Y

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Cooper, Selwood & Livingston (2008) **UK**	Systematic review of the prevalence of elder abuse and neglect	N=49. "We searched databases [Allied and Complementary Medicine (1985–); British Nursing Index (1994–); CINAHL (1982–); EMBASE (1974–); MEDLINE (1950–); PsycINFO (1806–)] up to October 2006. We used the keywords: *incidence* or *prevalence, elder abuse; elder* and *abuse; potentially harmful behavio(u)r* of *carer* or *caregiver; abuse* and *nursing home and residential home* or *care home*. We searched references of all included papers and review articles."	We included primary research reporting the incidence or prevalence of elder abuse. We excluded reports of lifetime abuse (which could, for example, include child abuse); routine service data; dissertations and meeting abstracts.	NA	"forty-nine studies met our inclusion criteria, of which only seven used measures for which reliability and validity had been assessed. In the general population studies, 6% of older people reported significant abuse in the last month and 5.6% of couples reported physical violence in their relationship in the last year. In studies using valid instruments involving vulnerable elders, nearly a quarter reported significant levels of psychological abuse. Five per cent of family caregivers reported physical abuse towards care recipients with dementia in a year, and a third reported any significant abuse. Sixteen per cent of care home staff admitted significant psychological abuse. Rates of abuse recorded using objective measures (5%) or reported to home management or adult protective services (APS) (1–2%) were low."	1 Y 2 Y 3 Y 4 N 5 Y 6 Y 7 Y 8 Y 9 Y 10 N 11 Y
Daly, Merchant, Jogerst (2011) **USA**	Systematic review of elder abuse research	N=590. "Sixteen health care and criminal justice literature databases were searched."" The databases were searched using combinations of the following keywords: abuse, aged, elder, elder abuse, neglect, and exploitation. In addition, two other mechanisms were used to retrieve the elder abuse research: a manual search of the reference list of publications dated prior to 1990 and a reference search of elder abuse reviews or annotations."	"Elder abuse research publication inclusion criteria were English-language articles reporting completed research on abuse of people aged 55 years and older from any country."	NA	"Publications were reviewed by at least two independent readers who graded each from A (evidence of well-designed meta-analysis) to D (evidence from expert opinion or multiple case reports) on the quality of the evidence gained from the research. Of 6,676 titles identified in the search, 1,700 publications met inclusion criteria; omitting duplicates, 590 publications were annotated and graded."	1 Y 2 Y 3 Y 4 Y 5 CA 6 CA 7 Y 8 Y 9 Y 10 N 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Dong (2015) **USA**	Systematic review of elder abuse and implications for practice	N=30 for prevalence studies, n=35 for risk factor studies, n=20 for outcome studies. "The global literature in PubMed, MEDLINE, PsycINFO, BIOSIS, Science Direct, and Cochrane Central was searched. Search terms included elder abuse, elder mistreatment, elder maltreatment, prevalence, incidence, risk factors, protective factors, outcomes, and consequences."	Studies that existed only as abstracts, case series, or case reports or recruited individuals younger than 60; qualitative studies; and non- English publications were excluded.	NA	"This review highlights the epidemiology of elder abuse and the complexities of research and practice. National longitudinal research is needed to better define the incidence, risk and protective factors, and consequences of elder abuse in diverse racial and ethnic populations. Health professionals should consider integrating routine screening of elder abuse in clinical practice, especially in high-risk populations. Patient-centered and culturally appropriate treatment and prevention strategies should be instituted to protect vulnerable populations. Although vast gaps remain in the field of elder abuse, unified and coordinated efforts at the national level must continue to preserve and protect the human rights of vulnerable aging populations.	1 Y 2 CA 3 Y 4 CA 5 Y 6 Y 7 Y 8 Y 9 Y 10 N 11 Y
Dong, Chen & Simon (2014) **USA**	Non-Systematic review of the research and health policy of elder abuse and dementia.	N=28. "We searched the literature in the PubMed, MEDLINE, and PsycINFO databases. Information about US federal policies, state regulations, and programs targeting abuse in older adults with dementia was retrieved online. The search terms were elder abuse, elder mistreatment, elder self-neglect, financial exploitation, dementia, Alzheimer's disease, cognitive impairment, cognitive decline, and public policy. Because most state adult protective services agencies define self-neglect as a form of elder abuse, we included studies that examined elder self-neglect among adults with dementia."	Limited to studies published in English, excluded studies that existed only as abstracts and case reports published before 1990.	NA	"We found that psychological abuse was the most common form of abuse among older adults, with estimates of its prevalence ranging from 27.9 percent to 62.3 percent. Physical abuse was estimated to affect 3.5–23.1 percent of older adults with dementia. We also found that many older adults experienced multiple forms of abuse simultaneously, and the risk of mortality from abuse and self-neglect may be higher in older adults with greater levels of cognitive impairment. We summarize programs and policies related to the abuse of older adults with dementia, including adult protective services, mandatory elder abuse reporting, and the Long-Term Care Ombudsman Program. We also summarize aspects of the National Alzheimer's Project Act, the Older Americans Act, and the Elder Justice Act."	1 Y 2 Y 3 Y 4 CA 5 CA 6 CA 7 CA 8 CA 9 Y 10 N 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Hoover & Polson (2014) **USA**	Non-systematic review/overview of assessment and intervention of elder abuse	NA (35 references)	NA	NA	"Elder mistreatment includes intentional or neglectful acts by a caregiver or trusted person that harm a vulnerable older person. It can occur in a variety of settings. One out of 10 older adults experiences some form of abuse or neglect by a caregiver each year, and the incidence is expected to increase. Although the U.S. Preventive Services Task Force found insufficient evidence that screening for elder abuse reduces harm, physicians in most states have professional and legal obligations to appropriately diagnose, report, and refer persons who have been abused. Screening or systematic inquiry can detect abuse. A detailed medical evaluation of patients suspected of being abused is necessary because medical and psychiatric conditions can mimic abuse. Signs of abuse may include specific patterns of injury. Interviewing patients and caregivers separately is helpful. Evaluation for possible abuse should include assessment of cognitive function. The Elder Abuse Suspicion Index is validated to screen for abuse in cognitively intact patients. A more detailed two-step process is used to screen patients with cognitive impairment."	1 NA 2 NA 3 CA 4 CA 5 NA 6 NA 7 N 8 CA 9 NA 10 NA 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Johannesen & LoGiudice (2013) **Australia**	Systematic review of risk factors of elder abuse in community-dwelling elders	N=49. Search was undertaken using the MEDLINE, CINAHL, EMBASE and PsycINFO databases for articles published in English up to March 2011, to identify original studies with statistically significant risk factors for abuse in community-dwelling elders.	Articles published in English up to March 2011. Exclusion criteria: • Studies which did not meet the selection criteria • Studies which did not compare groups of abused and non-abused elders. • Studies concerning self-neglect • Studies involving participants under 55 years old	NA	"Forty-nine studies met the inclusion criteria, with 13 risk factors being reproducible across a range of settings in high-quality studies. These concerned the elder person (cognitive impairment, behavioural problems, psychiatric illness or psychological problems, functional dependency, poor physical health or frailty, low income or wealth, trauma or past abuse and ethnicity), perpetrator (caregiver burden or stress, and psychiatric illness or psychological problems), relationship (family disharmony, poor or conflictual relationships) and environment (low social support and living with others except for financial abuse)."	1 Y 2 N 3 Y 4 CA 5 CA 6 CA 7 CA 8 CA 9 Y 10 Y 11 Y
Kurrle & Naughtin (2008) **Australia**	Non-systematic review of elder abuse and neglect in Australia	NA (24 references)	NA	NA	"Only relatively recently has the issue of elder abuse come to prominence in Australia. Until the late 1980s it was a hidden problem with little knowledge of its presence. Attention was drawn to elder abuse after the publication of a number of reports and research projects, allowing the development of responses at national and state levels. This paper gives an overview of the development of elder abuse as a social, legal and medical issue in Australia, and describes the diverse range of responses from the national, state and territory governments."	1 NA 2 NA 3 CA 4 CA 5 NA 6 NA 7 NA 8 CA 9 NA 10 NA 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Moyer & U. S. Preventive Services Task Force (2013) **USA**	Systematic evidence review/Overview of screening for intimate partner violence and abuse of elderly and vulnerable adults	"In updating its 2004 recommendation, the USPSTF commissioned a systematic evidence review on screening women for IPV and elderly and vulnerable adults for abuse and neglect. This review examined the accuracy of 14 screening tools for identifying IPV. Published literature on randomized, controlled trials and other systematic reviews were searched for evidence on the benefits and harms of screening adult women of childbearing age and elderly and vulnerable adults."	CA	CA	"The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement)."	1 CA 2 CA 3 CA 4 CA 5 CA 6 CA 7 CA 8 CA 9 CA 10 CA 11 Y
Ploeg et al. (2009) **Canada**	Systematic review of interventions for elder abuse	N=8. Searched Ageline, CINAHL, EMBASE, MEDLINE, PsycINFO, PubMed, Sociological Abstracts, and Social Science Abstracts from the start date of each database to February 2008 using appropriate database-specific subject headings and keywords such as "elder abuse" and "elder neglect."	Studies were eligible if they (a) included a limited or no intervention comparison group or if they (b) compared two or more interventions.	NA	"The purpose of this study was to use rigorous systematic review methods to summarize the effectiveness of interventions for elder abuse. Only eight studies met our inclusion criteria. Evidence regarding the recurrence of abuse following intervention was limited, but the interventions for which this outcome was reported failed to reduce, and may have even increased, the likelihood of recurrence. Elder abuse interventions had no significant effect on case resolution and at-risk caregiver outcomes, and had mixed results regarding professional knowledge and behavior related to elder abuse. The included studies had important methodological limitations that limit our ability to draw conclusions about the effectiveness of these interventions."	1 Y 2 Y 3 Y 4 Y 5 Y 6 Y 7 Y 8 Y 9 Y 10 N 11 N

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Sooryanarayana, Choo & Hairi (2013) **Malaysia**	Systematic review on the prevalence and measurement of elder abuse in the community	N=26. "Articles on elder abuse from 1990 to 2011 were reviewed. A total of 1,832 articles referring to elders residing at home either in their own or at relatives' houses were searched via CINAHL and MEDLINE electronic databases, in addition to a hand search of the latest articles in geriatric textbooks and screening references, choosing a total of 26 articles for review."	Exclusion: Reviews, non-English, editorials, seminars, reports, drug abuse, intimate partner violence, long-term care, dementia, substance abuse, child abuse, suicide, depression, mental illness, caregiver abuse, hospital-based studies Inclusion criteria : Primary research, year 1990 to 2011, elders aged 60 years and above, residing in own/relatives' houses	NA	"Highest prevalence was reported in developed countries, with Spain having 44.6% overall prevalence of suspicion of abuse and developing countries exhibiting lower estimates, from 13.5% to 28.8%. Physical abuse was among the least encountered, with psychological abuse and financial exploitation being the most common types of maltreatment reported. To date, there is no single gold standard test to ascertain abuse, with numerous tools and different methods employed in various studies, coupled with varying definitions of thresholds for age."	1 Y 2 Y 3 Y 4 Y 5 Y 6 Y 7 Y 8 Y 9 Y 10 N 11 Y

Reference Country	Study design/ Level of evidence	Sample characteristics (n=)	Intervention	Comparison	Results/findings	Quality appraisal*^
Yaffe & Tazkarji (2012) **Canada**	Non-systematic review/ Overview regarding understanding elder abuse in family practice	NA (34 references)	NA	NA	"Elder abuse is an important cause of morbidity and mortality in older adults. While 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 tool, such as the Elder Abuse Suspicion Index."	1 NA 2 NA 3 CA 4 CA 5 NA 6 NA 7 N 8 CA 9 NA 10 NA 11 Y

Notes: * Appraisal criteria from the AMSTAR measurement tool – Shea BJ, Grimshaw JM, Wells GA, Boers M, Andersson N, Hamel C, et al. Development of AMSTAR: a measurement tool to assess the methodological quality of systematic reviews. BMC Med Res Methodol. 2007;7(1):10.

Appraisal items:

1, 'A priori' design provided; 2, duplicate study selection and data extraction; 3, comprehensive literature search performed; 4, the status of publication (i.e. grey literature) used as an inclusion criterion; 5, a list of studies (included and excluded) provided; 6, characteristics of the included studies provided; 7, scientific quality of the included studies assessed and documented; 8, scientific quality of the included studies used appropriately in formulating conclusions; 9, methods used to combine the findings of studies appropriate; 10, likelihood of publication bias assessed; 11, conflict of interest stated.

Ratings:

Yes (Y); No (N); Can't answer (CA); Not applicable (NA)

Evidence summary for qualitative studies

Reference Country	Objective	Partic-ipants (n=)	Method	Findings	QATSDD score*	Paper No.*
Cairns & Vreugdenhil (2014) **Australia**	"To explore the experiences of frontline health and Welfare practitioners in working with older people experiencing abuse."	N=16	"In-depth interviews with 16 Tasmanian community-based health and welfare practitioners regarding their experiences of working in 49 recent cases of elder abuse. Interview transcripts were analysed using thematic analysis."	"All participants found working in cases of elder abuse challenging and the work itself was perceived as difficult, complex and at times dangerous. The cumulative effect of intimidating work contexts, practice dilemmas and a lack of support resulted in frustration and stress for many practitioners. Nevertheless, participants were committed to providing ongoing services and support for older people experiencing abuse."	48%	1
Du Mont et al. (2015) **Canada**	"We have undertaken a multi-phase, multi-method program of research to develop, implement, and evaluate a comprehensive hospital-based nurse examiner elder abuse intervention that addresses the complex functional, social, forensic, and medical needs of older women and men. In this study, we determined the importance of possible participating professionals and respective roles and responsibilities within the intervention."	N=26	"Using a modified Delphi methodology, recommended professionals and their associated roles and responsibilities were generated from a systematic scoping review of relevant scholarly and grey literatures. These items were reviewed, new items added for review, and rated/re-rated for their importance to the intervention on a 5-point Likert scale by an expert panel during a one day in-person meeting. Items that did not achieve consensus were subsequently re-rated in an online survey."	"Twenty-two of 31 recommended professionals and 192 of 229 recommended roles and responsibilities rated were retained for our model elder abuse intervention. Retained professionals were: public guardian and trustee (mean rating = 4.88), geriatrician (4.87), police officer (4.87), GEM (geriatric emergency management) nurse (4.80), GEM social worker (4.78), community health worker (4.76), social worker/counsellor (4.74), family physician in community (4.71), paramedic (4.65), financial worker (4.59), lawyer (4.59), pharmacist (4.59), emergency physician (4.57), geriatric psychiatrist (4.33), occupational therapist (4.29), family physician in hospital (4.28), Crown prosecutor (4.24), neuropsychologist (4.24), bioethicist (4.18), caregiver advocate (4.18), victim support worker (4.18), and respite care worker (4.12)."	95%	2
Sandmoe, Kirkevold & Ballantyne (2011) **Australia & Norway**	"The aim of this study was to explore how nurses and care coordinators in community care in Norway and Australia experienced and handled cases of abused older clients, including the support they received in clinical interventions."	N=20	"Twenty participants, nurses, auxiliary nurses and care workers in Norway and Australia, were recruited by purposeful sampling. They participated in in-depth interviews."	"The similarity of the information given in the two countries was striking. The interventions differed based on the type and seriousness of the abuse and the client's cognitive capacity. Financial abuse was a more prominent issue in Australia than in Norway. The handling of neglect cases in both countries followed much the same pathway and the intervention usually involved long-lasting processes. The managers' support and the elder protective services were of great importance to the nurses."	60%	3

Quality Assessment Tool for Studies with Diverse Designs (QATSDD) scoring of qualitative studies

	Paper No:	1	2	3
No.	**Criteria (Scored 0-3)**			
1	Explicit theoretical framework	1	3	2
2	Statement of aims/objectives in main body of report	2	3	3
3	Clear description of research setting	2	3	2
4	Evidence of sample size considered in terms of analysis	0	2	0
5	Representative sample of target group of a reasonable size	2	3	2
6	Description of procedure for data collection	2	3	2
7	Rationale for choice of data collection tool(s)	2	3	2
8	Detailed recruitment data	2	2	2
9	Fit between stated research question and format and content of data collection tool e.g. interview schedule (**Qualitative only**)	2	3	2
10	Fit between research question and method of analysis	2	3	2
11	Good justification for analytic method selected	1	3	3
12	Assessment of reliability of analytic process (**Qualitative only**)	1	3	2
13	Evidence of user involvement in design	0	3	1
14	Strengths and limitations critically discussed	1	3	0
Total score (max 42):		20	40	25
Percentage:		48%	95%	60%

* Appraisal tool used - Sirriyeh, R., Lawton, R., Gardner, P., & Armitage, G. (2012). Reviewing studies with diverse designs: the development and evaluation of a new tool. Journal of Evaluation in Clinical Practice, 18(4), 746-752. doi:10.1111/j.1365-2753.2011.01662.x

Key to Papers:

1. Cairns J, Vreugdenhil A. Working at the frontline in cases of elder abuse: 'it keeps me awake at night'. Australas J Ageing. 2014;33(1):59-62.
2. Du Mont J, Kosa D, Macdonald S, Elliot S, Yaffe M. Determining possible professionals and respective roles and responsibilities for a model comprehensive elder abuse intervention: A Delphi consensus survey. PLoS One. 2015;10 (12) (no pagination)(e0140760).
3. Sandmoe A, Kirkevold M, Ballantyne A. Challenges in handling elder abuse in community care. An exploratory study among nurses and care coordinators in Norway and Australia. J Clin Nurs. 2011;20(23-24):3351-63.

Evidence summary for quantitative studies

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Acierno et al. (2010). **USA**	"We estimated prevalence and assessed correlates of emotional, physical, sexual, and financial mistreatment and potential neglect (defined as an identified need for assistance that no one was actively addressing) of adults aged 60 years or older in a randomly selected national sample."	N=5777	"We compiled a representative sample by random digit dialing across geographic strata. We used computer-assisted telephone interviewing to standardize collection of demographic, risk factor, and mistreatment data. We subjected prevalence estimates and mistreatment correlates to logistic regression."	"We analyzed data from 5777 respondents. One-year prevalence was 4.6% for emotional abuse, 1.6% for physical abuse, 0.6% for sexual abuse, 5.1% for potential neglect, and 5.2% for current financial abuse by a family member. One in 10 respondents reported emotional, physical, or sexual mistreatment or potential neglect in the past year. The most consistent correlates of mistreatment across abuse types were low social support and previous traumatic event exposure."	74%	1
Almogue et al. (2010) **Israel**	"Although physicians and nurses are best positioned to recognize and diagnose cases of elder abuse, the level of reporting these cases is much lower than its true incidence. Our aim was to assess and compare knowledge and attitudes of physicians and nurses toward this phenomenon."	N=157	"Two hundred and thirty-five nurses and physicians were asked to participate in the study. One hundred nurses and 57 physicians ultimately completed the questionnaires."	"The main finding was that participants had a low level of knowledge of elder abuse issues and the relevant laws and regulations […]. No significant differences were found in the physicians' knowledge according to medical specialty, hospital type, years in the profession and geriatric experience. Licensed practical nurses knew less than registered and academic nurses relating to the abuse issue and state reporting laws ($p = 0.003$ and 0.02, respectively). No significant differences relating to the knowledge of elder abuse were found between nurses and physicians nor between general and geriatric hospital employees. Both physicians and nurses tended to have neutral attitudes regarding this issue."	57%	2

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Bagshaw et al. (2013) **Australia**	"This paper presents findings from national online surveys that aimed to ascertain the concerns of older people and their family members regarding financial and property matters as well as the knowledge and understandings of risk factors for financial abuse determined by service providers responding to older people."	N=214 + N=113	Examined the results of wo national online surveys. "The first, conducted in 2009, explored service providers' (n=214) knowledge and understandings of financial abuse of older people. The second, conducted in 2010, investigated older people's and their family members' (n=113) views and experiences of financial abuse."	"In our sample, service providers' knowledge of risk factors for financial abuse of older people mirrored the experiences of older people and their family members in Australia and also confirmed factors identified in the literature. However, our findings also showed that many older people were not mindful of the potential risks to their financial wellbeing, particularly when and if they experience diminished capacity. Therefore, service providers may find it difficult to engage them in preventative strategies."	52%	3
Beach et al. (2005) **USA**	"Caring for a sick or disabled relative has been linked to compromised caregiver health, and risk factors for negative caregiver outcomes have been studied extensively, but little attention has been given to care recipient and caregiver health as risk factors for potentially harmful behavior by informal caregivers. This article explores such risk factors."	N=265	"Self-reported care recipient demographics, cognitive status, need for care, and self-rated health; self-reported caregiver demographics, cognitive status, amount of care provided, self-rated health, physical symptoms, and depression. Care recipient reports of potentially harmful caregiver behavior, including screaming and yelling, insulting or swearing, threatening to send to a nursing home, and withholding food, were the main outcome variable."	"The following were significant risk factors for potentially harmful caregiver behavior: greater care recipient ADL/IADL needs (odds ratio (OR)51.12, 95% confidence interval (CI)51.03–1.22), spouse caregivers (vs others; OR58.00, 95% CI51.71–37.47), greater caregiver cognitive impairment (OR51.20, 95% CI51.04–1.38), more caregiver physical symptoms (OR51.07, 95% CI51.01–1.13), and caregivers at risk for clinical depression (OR53.47, 95% CI51.58–7.62).	71%	4
Burnes et al. (2015) **USA**	"To estimate past-year prevalence and identify risk and protective factors of elder emotional abuse, physical abuse, and neglect."	N=4,156	"The Conflict Tactics Scale was adapted to assess elder emotional and physical abuse. Elder neglect was evaluated according to failure of a responsible caregiver to meet an older adult's needs using the Duke Older Americans Resources and Services (OARS) scale. Caseness thresholds were based on mistreatment behaviour frequencies and elder perceptions of problem seriousness."	"Past-year prevalence of elder emotional abuse was 1.9%, of physical abuse was 1.8%, and of neglect was 1.8%, with an aggregate prevalence of 4.6%. Emotional and physical abuse were associated with being separated or divorced, living in a lower-income household, functional impairment, and younger age. Neglect was associated with poor health, being separated or divorced, living below the poverty line, and younger age. Neglect was less likely in older adults of Hispanic ethnicity."	86%	5

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Camden, Livingston, Cooper (2011) **UK**	"Using a representative secondary care survey for the first time, we explored family carers' reasons for providing care. We hypothesized that carers with a positive rather than negative motivation for caring would be less abusive towards the care recipient and more likely to be caring for someone still living at home a year later."	N=220	"We interviewed 220 consecutively referred dementia family/friend carers from UK Community Mental Health Teams. We asked non-spousal carers why they were the main carer. Our main outcomes were the revised Modified Conflict Tactics Scale scores, measuring abusive behavior by the carer, and admission of the person with dementia to a care home."	"Nineteen (17.1%) said they were the main carer due to the high quality of their relationship with the care recipient, their willingness to take on or their suitability for the carer role. A further 22 (19.8%) said they were the main carer due to other potential carers' negative relationship with the care recipient, unwillingness or lack of suitability for the role. Carers who gave the latter explanation tended to be more anxious at baseline ($F = 3.0$, $p = 0.055$), reported higher abusive behavior towards the care recipient a year later after controlling for sociodemographic variables ($t = 2.0$, $p = 0.05$), and their care recipient was more likely to be admitted to a care home in the following year (hazards ratio 9.9, $p = 0.040$)."	74%	6
Cohen (2013) **Israel**	"The aim of the paper is to describe a process of constructing and validating a three-dimensional screening tool for identification of abuse in older persons. It describes four studies that were conducted in the process of development and assessment of a three-dimensional screening tool for identification of abuse that consisted of direct questioning, identification of risk indicators and identification of signs of abuse."	N=108 + N=730 + N=1317 + N=71	"Questionnaires included the three-dimensional tool for identification of abuse, Expanded Indicators of Abuse (E-IOA), list of signs of abuse, direct questioning for disclosure of abuse, and personal, medical and functioning details."	"Discriminant function analyses (DFA) and receiver operating curve (ROC) analyses in each of the described steps showed good psychometric properties of the risk indicators. Regression analyses adjusted for sociodemographic and health variables showed that risk indicators significantly increased likelihood of abuse in individuals living in the community and in long-term care facilities. The three dimensions of identification of abuse were partially overlapped in their identification of different rates of abuse. In conclusion, the three-dimensional identification tool is efficient for identifying older adults experiencing abuse or at risk of abuse."	86%	7

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Cooper et al. (2010) **UK**	"To test our hypotheses that carers' reports of abusive behaviour would increase over time, and that change in abuse scores would be predicted by change in anxiety and depression scores."	N=131	"In total, 131 (71.6%) of the family/friend dementia carers consecutively recruited from new referrals to Essex and London community mental health teams who were interviewed at baseline, completed the revised Modified Conflict Tactics Scale to measure abuse 1 year later."	"Sixty-three (48.1%) of the carers reported any abusive behaviour at baseline compared with 81 (61.8%) a year later (w2 = 6.9, P = 0.009). An increase in abuse scores was predicted by an increase in anxiety and depressive symptoms (respectively b = 0.32, t = 3.9, P50.001 and b = 0.24, t = 2.9, P = 0.005), and by less domiciliary care at baseline (b = –0.18, t =72.2, P = 0.031)."	67%	8
Cooper et al. (2008) **UK**	"To investigate the acceptability and validity of the Modified Conflict Tactics Scale (MCTS) and abuse correlates."	N=86	"Eighty-six people with Alzheimer's disease and their family carers, originally recruited for a representative community study were interviewed. We asked carers about acceptability of the MCTS and investigated its validity by comparing scores to the Minimum Data Set (MDS) abuse screen (an objective measure) and testing hypotheses that MCTS score would correlate with the COPE dysfunctional coping scale but not carer education."	"Twenty-four (27.9%) were identified as abuse cases by interview. No care recipients (CRs) screened positive for abuse using the MDS screen. Seventy-two (83.7%) participants thought that the scale was acceptable, ten (11.6%) that it was neither acceptable nor unacceptable, and three (3.5%) that it was unacceptable. As hypothesised, MCTS scores correlated with dysfunctional coping scale score but not carer education."	62%	9
Cooper et al. (2009) **UK**	"To determine the prevalence of abusive behaviours by family carers of people with dementia."	N=220	**"Design** Representative cross sectional survey **Setting** Community mental health teams in Essex and London. **Participants** 220 family carers of people newly referred to secondary psychiatric services with dementia who were living at home. **Main outcome measure** Psychological and physical abuse (revised modified conflict tactics scale)."	"115 (52%, 95% confidence interval 46% to 59%) carers reported some abusive behaviour and 74 (34%, 27% to 40%) reported important levels of abuse. Verbal abuse was most commonly reported. Only three (1.4%) carers reported occasional physical abuse."	69%	10

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Cooper et al. (2010) **UK**	"Although dementia and elder abuse prevention are political priorities, there are no evidence-based interventions to reduce abuse by family carers. We have limited understanding of why some family carers, but not others in similar circumstances, behave abusively. We aimed to test our hypothesis, that more anxious dementia carers report more abusive behaviours, and dysfunctional coping strategies and carer burden mediate this relationship."	N=220	"We interviewed 220 family/friend dementia carers from Essex and London Community Mental Health Teams. We used the revised Modified Conflict Tactics Scale to measure abuse."	"More anxious and depressed carers reported more abuse; this relationship was mediated by using dysfunctional coping strategies and higher burden. Abuse was predicted by: spending more hours caring, experiencing more abusive behaviour from care recipients and higher burden."	71%	11
Hempton et al. (2011) **Australia**	"To explore the perceptions of family carers, older people and health professionals in Australia about what constitutes elder abuse."	N=120 (health professional), n=361 (older people), n=89 (carer)	"The Caregiving Scenario Questionnaire (CSQ) was disseminated to health professionals from two metropolitan hospitals, older volunteers and carers of older people with dementia recruited for other studies."	"One hundred and twenty health professionals, 361 older people and 89 carers returned the surveys. x2 analyses indicated that significantly more health professionals than older people identified locking someone in the house alone all day (x2 (2)¼10.20, p¼0.006, Cramer's V¼0.14), restraining someone in a chair (x2 (2)¼19.984, p¼0.0005, Cramer's V¼0.19) and hiding medication in food (x2 (2)¼8.72, p¼0.013, Cramer's V¼0.13) as abusive. There were no significant differences between healthy volunteer older people and carers in their perceptions of elder abuse. A significant minority (40.8%) of health professionals and over 50% of carers did not identify locking the care recipient alone in the house all day as abusive."	71%	12

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Macneil et al. (2010) **USA**	"Caregivers feeling stress and experiencing mental health problems can be at risk for engaging in abusive acts against elderly care recipients. Potentially harmful behavior (PHB) was used as a measure of caregivers' engagement in, or fear of engagement in, behavior that places dependent care recipients at risk of physical and/or psychological maltreatment and may be seen as an antecedent of, or a proxy for, identifiably abusive behavior. The study examined the ability of anger to mediate and moderate the relations of depression, resentment, and anxiety with PBH."	N=417	"Data are from the first wave of the second Family Relationships in Late Life study of caregivers of community dwelling elderly care recipients with whom they coreside. Caregivers (*N* = 417) completed face-to-face interviews."	"Anger was found to mediate the relation between anxiety and PHB. Anger both mediates and moderates the relations of both depression and resentment with PHB in a dynamic way such that the mediating effect of anger increases substantially with increased scores on both depression and resentment."	81%	13
Morris et al. (1997) **Australia, Canada, Czech Republic, Japan, USA**	To describe the results of an international trial of the home care version of the MDS assessment and problem identification system (the MDS-HC), including reliability estimates, a comparison of MDS-HC reliabilities with reliabilities of the same items in the MDS 2.0 nursing home assessment instrument, and an examination of the types of problems found in home care clients using the MDS-HC.	N=241	"Independent, dual assessment of clients of homecare agencies by trained clinicians using a draft of the MDSHC, with additional descriptive data regarding problem profiles for home care clients." "The array of MDS-HC assessment items included measures in the following areas: personal items, cognitive patterns, communication/hearing, vision, mood and behavior, social functioning, informal support services, physical functioning, continence, disease diagnoses, health conditions and preventive health measures, nutrition/ hydration, dental status, skin condition, environmental assessment, service utilization, and medications.	Forty-seven percent of the functional, health status, social environment, and service items in the MDS-HC were taken from the MDS 2.0 for nursing homes. For this item set, it is estimated that the average weighted Kappa is .74 for the MDS-HC and .75 for the MDS 2.0. Similarly, high reliability values were found for items newly introduced in the MDS-HC (weighted Kappa = .70). Descriptive findings also characterize the problems of home care clients, with subanalyses within cognitive performance levels.	83%	14

Reference Country	Objective	Participants (n=)	Method	Results/findings	QATSDD*	Paper No.*
Wiglesworth et al. (2010) **USA**	"To investigate characteristics of people with dementia and their caregivers (CGs) that are associated with mistreatment in order to inform clinicians about screening for mistreatment."	N=129	"A convenience sample of CG–care recipient (CR) dyads were assessed for literature-supported factors associated with mistreatment, and evidence of mistreatment for the prior year was collected. An expert panel considered the evidence and decided on occurrences of psychological abuse, physical abuse, and neglect based on criteria adopted before data collection."	"Mistreatment was detected in 47.3%. Variables associated with different kinds and combinations of mistreatment types included the CG's anxiety, depressive symptoms, social contacts, perceived burden, emotional status, and role limitations due to emotional problems and the CR's psychological aggression and physical assault behaviors. The combination of CR's physical assault and psychological aggression provided the best sensitivity (75.4%) and specificity (70.6%) for elder mistreatment as defined by the expert panel. This finding has potential to be useful as a clinical screen for detecting mistreatment."	88%	15

Note: * Sirriyeh R, Lawton R, Gardner P, Armitage G. Reviewing studies with diverse designs: the development and evaluation of a new tool. J Eval Clin Pract. 2012;18(4):746-52.. See QATSDD scoring of quantitative studies for details below.

QATSDD scoring of quantitative studies

Paper No:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
No.	**Criteria (Scored 0-3)**															
1	Explicit theoretical framework	3	2	2	2	3	2	3	2	2	2	2	2	3	3	3
2	Statement of aims/objectives in main body of report	3	3	3	3	2	2	3	2	3	1	2	3	2	2	3
3	Clear description of research setting	3	1	2	3	3	2	3	3	2	2	2	2	3	3	3
4	Evidence of sample size considered in terms of analysis	3	2	1	1	3	3	2	0	1	3	3	2	3	2	2
5	Representative sample of target group of a reasonable size	3	1	2	2	3	3	3	2	1	3	3	2	3	2	2
6	Description of procedure for data collection	2	2	2	3	3	2	2	3	2	2	2	2	2	3	3
7	Rationale for choice of data collection tool(s)	2	2	1	3	3	2	3	2	2	2	2	3	2	3	3
8	Detailed recruitment data	3	1	1	3	3	2	2	2	2	2	2	2	3	2	2
9	Statistical assessment of reliability and validity of measurement tool(s) (**Quantitative only**)	0	1	0	1	1	2	2	2	2	2	2	2	2	3	2
10	Fit between stated research question and method of data collection (**Quantitative only**)	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3
11	Fit between research question and method of analysis	3	3	2	2	3	3	3	3	3	2	2	3	3	3	3
12	Good justification for analytic method selected	2	1	1	2	3	3	2	2	2	2	2	2	2	2	3
13	Evidence of user involvement in design	0	1	0	1	1	1	2	1	1	1	1	2	1	2	3
14	Strengths and limitations critically discussed	2	2	3	2	2	1	3	1	0	2	2	0	2	2	2
Total score (max 42):		31	24	22	30	36	31	36	28	26	29	30	30	34	35	37
Percentage:		74	57	52	71	86	74	86	67	62	69	71	71	81	83	88

Key to papers: Evidence summary for quantitative studies

1. Acierno R, Hernandez MA, Amstadter AB, Resnick HS, Steve K, Muzzy W, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The national elder mistreatment study. Am J Public Health. 2010;100(2):292-7.
2. Almogue A, Weiss A, Marcus E, Beloosesky Y. Attitudes and knowledge of medical and nursing staff toward elder abuse. Arch Gerontol Geriatr. 2010;51(1):86-91.
3. Bagshaw D, Wendt S, Zannettino L, Adams V. Financial abuse of older people by family members: Views and experiences of older Australians and their family members. Aust Social Work. 2013;66(1):86-103.
4. Beach SR, Schulz R, Williamson GM, Miller LS, Weiner MF, Lance CE. Risk factors for potentially harmful informal caregiver behavior. J Am Geriatr Soc. 2005;53(2):255-61 7p.
5. Burnes D, Pillemer K, Caccamise PL, Mason A, Henderson CR, Jr., Berman J, et al. Prevalence of and risk factors for elder abuse and neglect in the community: A population-based study. J Am Geriatr Soc. 2015;63(9):1906-12.
6. Camden A, Livingston G, Cooper C. Reasons why family members become carers and the outcome for the person with dementia: results from the CARD study. Int Psychogeriatr. 2011;23(9):1442-50.
7. Cohen M. The process of validation of a three-dimensional model for the identification of abuse in older adults. Arch Gerontol Geriatr. 2013;57(3):243-9.
8. Cooper C, Blanchard M, Selwood A, Walker Z, Livingston G. Family carers' distress and abusive behaviour: longitudinal study. Br J Psychiatry. 2010;196(6):480-5.
9. Cooper C, Manela M, Katona C, Livingston G. Screening for elder abuse in dementia in the LASER-AD study: prevalence, correlates and validation of instruments. Int J Geriatr Psychiatry. 2008;23(3):283-8.
10. Cooper C, Selwood A, Blanchard M, Walker Z, Blizard R, Livingston G. Abuse of people with dementia by family carers: representative cross sectional survey. BMJ. 2009;338:b155.
11. Cooper C, Selwood A, Blanchard M, Walker Z, Blizard R, Livingston G. The determinants of family carers' abusive behaviour to people with dementia: results of the CARD study. J Affect Disord. 2010;121(1-2):136-42.
12. Hempton C, Dow B, Cortes-Simonet EN, Ellis K, Koch S, LoGiudice D, et al. Contrasting perceptions of health professionals and older people in Australia: what constitutes elder abuse? Int J Geriatr Psychiatry. 2011;26(5):466-72.
13. Macneil G, Kosberg JI, Durkin DW, Dooley WK, Decoster J, Williamson GM. Caregiver mental health and potentially harmful caregiving behavior: the central role of caregiver anger. Gerontologist. 2010;50(1):76-86.
14. Morris JN, Fries BE, Steel K, Ikegami N, Bernabei R, Carpenter GI, et al. Comprehensive clinical assessment in community setting: Applicability of the MDS-HC. J Am Geriatr Soc. 1997;45(8):1017-24.
15. Wiglesworth A, Mosqueda L, Mulnard R, Liao S, Gibbs L, Fitzgerald W. Screening for abuse and neglect of people with dementia. J Am Geriatr Soc. 2010;58(3):493-500.

Evidence summary for mixed method studies

Reference Country	Objective	Participants (n=)	Methods	Results/ Findings	QATSDD score*	Paper No.*
Adams et al. (2014) **Australia**	Explore the awareness and prevalence of financial abuse identified by aged care service providers in Australia and explore limitations to identifying financial abuse.	N=442	"This article draws on two national online surveys conducted between February and April 2010: one for chief executive officers (CEOs) of organizations providing services to older people and their families, and the other for service providers working in those organizations. Following approval from the University of South Australia's Human Research Ethics Committee, the surveys were conducted online using *SurveyMonkey*, a mixed methods instrument for collecting both quantitative and qualitative data."	"National online surveys of 228 chief executive officers and 214 aged care service providers found that, while they were well placed to recognize financial abuse, it was often difficult to intervene successfully. Problems providers encountered included difficulties in detecting abuse, the need for consent before they could take action, the risk that the abusive family member would withdraw the client from the service, and a lack of resources to deal with the complexities inherent in situations of financial abuse."	71%	1
Yaffe et al. (2009) **Canada**	"This study aimed to develop and validate a brief tool for physician use to improve suspicion about the presence or absence of elder abuse."	N=31 (doctors, nurses, social workers in focus groups); n=953 (seniors)	"A literature review on elder abuse, obstacles to its identification, limitations of detection tools, and characteristics of screeners employed by physicians were used to generate elder abuse detection questions for critique by 31 doctors, nurses, and social workers in focus groups. Six resulting questions became the Elder Abuse Suspicion Index (EASI) administered by 104 family doctors to 953 cognitively intact seniors in ambulatory-care settings. Findings were compared to a recognized, detailed elder abuse Social Work Evaluation (SWE) later administered to participants by social workers blinded to the results of the EASI."	"The EASI had an estimated sensitivity and specificity of 0.47 and 0.75, usually took less than 2 minutes to ask, and 97.2% of doctors felt it would have some or big practice impact. This research is a first phase in the development and validation of a user-friendly tool that might sensitize physicians to elder abuse and promote referrals of possible victims for in-depth assessment by specialized professionals."	96%	2

See Evidence appraisal for mixed method for appraisal criteria

QATSDD scoring of mixed method articles

	Paper No:	1	2
No.	**Criteria (Scored 0-3)**		
1	Explicit theoretical framework	2	3
	Statement of aims/objectives in main body of report	1	3
3	Clear description of research setting	3	3
4	Evidence of sample size considered in terms of analysis	2	2
5	Representative sample of target group of a reasonable size	2	2
6	Description of procedure for data collection	3	3
7	Rationale for choice of data collection tool(s)	3	3
8	Detailed recruitment data	3	3
9	Statistical assessment of reliability and validity of measurement tool(s) (**Quantitative only**)	0	3
10	Fit between stated research question and method of data collection (**Quantitative only**)	3	3
11	Fit between stated research question and format and content of data collection tool e.g. interview schedule (**Qualitative only**)	3	3
12	Fit between research question and method of analysis	3	3
13	Good justification for analytic method selected	3	3
14	Assessment of reliability of analytic process (**Qualitative only**)	1	3
15	Evidence of user involvement in design	0	3
16	Strengths and limitations critically discussed	2	3
Total score (max 48):		34	46
Percentage:		71%	96%

Key to papers

1. Adams VM, Bagshaw D, Wendt S, Zannettino L. Financial abuse of older people by a family member: a difficult terrain for service providers in Australia. J Elder Abuse Neglect. 2014;26(3):270-90.
2. Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI)©. J Elder Abuse Neglect. 2008;20(3):276-300.

Grey literature appraisal

Instrument: AACODS	Reference: Clare M, Black Blundell B, Clare J. Examination of the extent of elder abuse in Western Australia: A qualitative and quantitative investigation of existing agency policy, service responses and recorded data. Crime Research Centre. The University of Western Australia; 2011.	YES	NO	?
Authority	*Identifying who is responsible for the intellectual content.*			
	Individual author:			
	• Associated with a reputable organisation?	x		
	• Professional qualifications or considerable experience?	x		
	• Produced/published other work (grey/black) in the field?	x		
	• Recognised expert, identified in other sources?	x		
	• Cited by others? (use Google Scholar as a quick check)	x		
	• Higher degree student under “expert” supervision?			NA
	Organisation or group:			
	• Is the organisation reputable? (e.g. W.H.O)	x		
	• Is the organisation an authority in the field?	x		
	In all cases:			
	• Does the item have a detailed reference list or bibliography?	x		
Accuracy	• Does the item have a clearly stated aim or brief?	x		
	• Is so, is this met?	x		
	• Does it have a stated methodology?	x		
	• If so, is it adhered to?	x		
	• Has it been peer-reviewed?			x
	• Has it been edited by a reputable authority?	x		
	• Supported by authoritative, documented references or credible sources?	x		
	• Is it representative of work in the field?	x		
	• If No, is it a valid counterbalance?			NA
	• Is any data collection explicit and appropriate for the research?	x		
	• If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	x		
Coverage	*All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey.*			
	• Are any limits clearly stated?	x		
Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged.			
	• Opinion, expert or otherwise, is still opinion: is the author’s standpoint clear?	x		
	• Does the work seem to be balanced in presentation?	x		
Date	*For the item to inform your research, it needs to have a date that confirms relevance*			
	• Does the item have a clearly stated date related to content? No easily discernible date is a strong concern.	x		
	• If no date is given, but can be closely ascertained, is there a valid reason for its absence?			NA
	• Check the bibliography: have key contemporary material been included?	x		
Significance	*This is a value judgment of the item, in the context of the relevant research area*			
	• Is the item meaningful? (this incorporates feasibility, utility and relevance)?	x		
	• Does it add context?	x		
	• Does it enrich or add something unique to the research?	x		
	• Does it strengthen or refute a current position?	x		
	• Would the research area be lesser without it?	x		
	• Is it integral, representative, typical?	x		
	• Does it have impact? (in the sense of influencing the work or behaviour of others)	x		

Appraisal instrument: Tyndall J. Authority, accuracy, coverage, objectivity, date and significance scale (AACODS) 2010 [Available from: https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/3326/AACODS_Checklist.pdf;jsessionid=2EB4A7A580B36D6D06FFD6428FB02920?sequence=4.

Grey literature appraisal

Instrument: AACODS	Reference: Lowndes G, Darzins P, Wainer J, Owada K, Mihaljcic T. Financial abuse of elders: a review of the evidence. Protecting elders' assets study. Melbourne Monash University; 2009.	YES	NO	?
Authority	*Identifying who is responsible for the intellectual content.*			
	Individual author:			
	• Associated with a reputable organisation?	x		
	• Professional qualifications or considerable experience?	x		
	• Produced/published other work (grey/black) in the field?	x		
	• Recognised expert, identified in other sources?	x		
	• Cited by others? (use Google Scholar as a quick check)	x		
	• Higher degree student under "expert" supervision?			NA
	Organisation or group:			
	• Is the organisation reputable? (e.g. W.H.O)	x		
	• Is the organisation an authority in the field?	x		
	In all cases:			
	• Does the item have a detailed reference list or bibliography?	x		
Accuracy	• Does the item have a clearly stated aim or brief?	x		
	• Is so, is this met?	x		
	• Does it have a stated methodology?	x		
	• If so, is it adhered to?	x		
	• Has it been peer-reviewed?			x
	• Has it been edited by a reputable authority?	x		
	• Supported by authoritative, documented references or credible sources?	x		
	• Is it representative of work in the field?	x		
	• If No, is it a valid counterbalance?			NA
	• Is any data collection explicit and appropriate for the research?	x		
	• If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	x		
Coverage	*All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey.*			
	• Are any limits clearly stated?	x		
Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged.			
	• Opinion, expert or otherwise, is still opinion: is the author's standpoint clear?	x		
	• Does the work seem to be balanced in presentation?	x		
Date	*For the item to inform your research, it needs to have a date that confirms relevance*	x		
	• Does the item have a clearly stated date related to content? No easily discernible date is a strong concern.			NA
	• If no date is given, but can be closely ascertained, is there a valid reason for its absence?	x		
	• Check the bibliography: have key contemporary material been included?			
Significance	*This is a value judgment of the item, in the context of the relevant research area*			
	• Is the item meaningful? (this incorporates feasibility, utility and relevance)?	x		
	• Does it add context?	x		
	• Does it enrich or add something unique to the research?	x		
	• Does it strengthen or refute a current position?	x		
	• Would the research area be lesser without it?	x		
	• Is it integral, representative, typical?	x		
	• Does it have impact? (in the sense of influencing the work or behaviour of others)	x		

Appraisal instrument: Tyndall J. Authority, accuracy, coverage, objectivity, date and significance scale (AACODS) 2010 [Available from: https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/3326/AACODS_Checklist.pdf;jsessionid=2EB4A7A580B36D6D06FFD6428FB02920?sequence=4

Grey literature appraisal

Instrument: AACODS	Reference: RACGP. Abuse and violence: Working with our patients in general practice (White Book). Melbourne: The Royal Australian College of General Practitioners 2014 [cited 2016 September 16].	YES	NO	?
Authority	*Identifying who is responsible for the intellectual content.*			
	Individual author:			
	• Associated with a reputable organisation?	x		
	• Professional qualifications or considerable experience?	x		
	• Produced/published other work (grey/black) in the field?	x		
	• Recognised expert, identified in other sources?	x		
	• Cited by others? (use Google Scholar as a quick check)	x		
	• Higher degree student under “expert” supervision?			NA
	Organisation or group:			
	• Is the organisation reputable? (e.g. W.H.O)	x		
	• Is the organisation an authority in the field?	x		
	In all cases:			
	• Does the item have a detailed reference list or bibliography?	x		
Accuracy	• Does the item have a clearly stated aim or brief?	x		
	• Is so, is this met?	x		
	• Does it have a stated methodology?	x		
	• If so, is it adhered to?	x		
	• Has it been peer-reviewed?	x		
	• Has it been edited by a reputable authority?	x		
	• Supported by authoritative, documented references or credible sources?	x		
	• Is it representative of work in the field?	x		
	• If No, is it a valid counterbalance?			NA
	• Is any data collection explicit and appropriate for the research?	x		
	• If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	x		
Coverage	*All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey.*			
	• Are any limits clearly stated?	x		
Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged.			
	• Opinion, expert or otherwise, is still opinion: is the author’s standpoint clear?	x		
	• Does the work seem to be balanced in presentation?	x		
Date	*For the item to inform your research, it needs to have a date that confirms relevance*	x		
	• Does the item have a clearly stated date related to content? No easily discernible date is a strong concern.			NA
	• If no date is given, but can be closely ascertained, is there a valid reason for its absence?	x		
	• Check the bibliography: have key contemporary material been included?			
Significance	*This is a value judgment of the item, in the context of the relevant research area*			
	• Is the item meaningful? (this incorporates feasibility, utility and relevance)?	x		
	• Does it add context?	x		
	• Does it enrich or add something unique to the research?	x		
	• Does it strengthen or refute a current position?	x		
	• Would the research area be lesser without it?	x		
	• Is it integral, representative, typical?	x		
	• Does it have impact? (in the sense of influencing the work or behaviour of others)	x		

Appraisal instrument: Tyndall J. Authority, accuracy, coverage, objectivity, date and significance scale (AACODS) 2010 [Available from: https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/3326/AACODS_Checklist.pdf;jsessionid=2EB4A7A580B36D6D06FFD6428FB02920?sequence=4

Grey literature appraisal

Instrument: AACODS	Reference: World Health Organization. A global response to elder abuse and neglect: Building primary health care capacity to deal with the problem worldwide. Main report. Geneva: WHO; 2008 [cited 2016 September 16].	YES	NO	?
Authority	*Identifying who is responsible for the intellectual content.*			
	Individual author:			
	• Associated with a reputable organisation?	x		
	• Professional qualifications or considerable experience?	x		
	• Produced/published other work (grey/black) in the field?	x		
	• Recognised expert, identified in other sources?	x		
	• Cited by others? (use Google Scholar as a quick check)	x		
	• Higher degree student under "expert" supervision?			NA
	Organisation or group:			
	• Is the organisation reputable? (e.g. W.H.O)	x		
	• Is the organisation an authority in the field?	x		
	In all cases:			
	• Does the item have a detailed reference list or bibliography?	x		
Accuracy	• Does the item have a clearly stated aim or brief?	x		
	• Is so, is this met?	x		
	• Does it have a stated methodology?	x		
	• If so, is it adhered to?	x		
	• Has it been peer-reviewed?	x		
	• Has it been edited by a reputable authority?	x		
	• Supported by authoritative, documented references or credible sources?	x		
	• Is it representative of work in the field?	x		
	• If No, is it a valid counterbalance?			NA
	• Is any data collection explicit and appropriate for the research?	x		
	• If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	x		
Coverage	*All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey.*			
	• Are any limits clearly stated?	x		
Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged.			
	• Opinion, expert or otherwise, is still opinion: is the author's standpoint clear?	x		
	• Does the work seem to be balanced in presentation?	x		
Date	*For the item to inform your research, it needs to have a date that confirms relevance*			
	• Does the item have a clearly stated date related to content? No easily discernible date is a strong concern.	x		
	• If no date is given, but can be closely ascertained, is there a valid reason for its absence?			NA
	• Check the bibliography: have key contemporary material been included?	x		
Significance	*This is a value judgment of the item, in the context of the relevant research area*			
	• Is the item meaningful? (this incorporates feasibility, utility and relevance)?	x		
	• Does it add context?	x		
	• Does it enrich or add something unique to the research?	x		
	• Does it strengthen or refute a current position?	x		
	• Would the research area be lesser without it?	x		
	• Is it integral, representative, typical?	x		
	• Does it have impact? (in the sense of influencing the work or behaviour of others)	x		

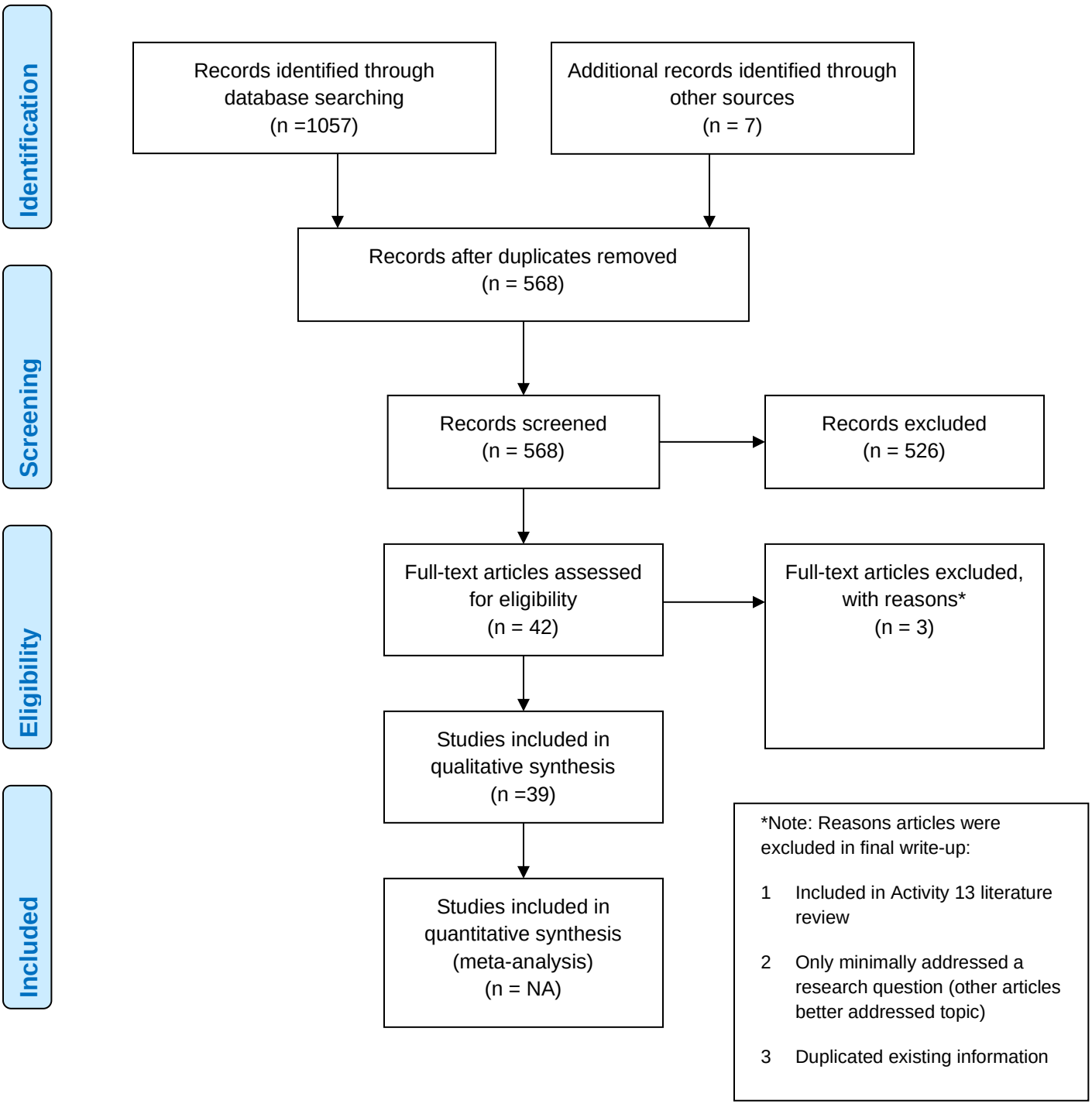
Appraisal instrument: Tyndall J. Authority, accuracy, coverage, objectivity, date and significance scale (AACODS) 2010 [Available from: https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/3326/AACODS_Checklist.pdf;jsessionid=2EB4A7A580B36D6D06FFD6428FB02920?sequence=4

Search strategy summary

Searches	Results	Abstracts			
		Medline	Embase	PychINFO	PHCRIS
1	(general practitioner or primary care physician or family physician).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	22639	91678	4800	
2	(primary health care or general practice or family medicine or family practice).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	148115	155705	22214	
3	1 or 2 GP context	15995	222330	25309	
4	dementia.mp. or Delirium, Dementia, Amnestic, Cognitive Disorders/ or Frontotemporal Dementia/ or AIDS Dementia Complex/ or Dementia, Vascular/ or Dementia/ or Dementia, Multi-Infarct/ *(Medline)* HIV associated dementia/ or semantic dementia/ or dementia assessment/ or "mixed depression and dementia"/ or Pick presenile dementia/ or dementia/ or senile dementia/ or multiinfarct dementia/ or frontal variant frontotemporal dementia/ or Cornell Scale for Depression in Dementia/ or Clinical Dementia Rating/ or dementia.mp. or presenile dementia/ or frontotemporal dementia/ *(Embase)* Vascular Dementia/ or Dementia/ or Semantic Dementia/ or AIDS Dementia Complex/ or Presenile Dementia/ or dementia.mp. or Dementia with Lewy Bodies/ or Senile Dementia/ (PsychINFO)	84924	143615	56227	
5	Alzheimer Disease/ or Alzheimer$.mp (Medline) Alzheimer$.mp. or Alzheimer disease/ (Embase) Alzheimer's Disease/ or Alzheimer$.mp (PsychINFO)	107283	176289	49340	
6	4 or 5 Dementia	160224	262421	81996	
7	elder abuse/ or elder abuse.mp. or elder mistreatment.mp.	2195	1700	1639	213
8	(recogni* or identif*).mp.	2518099	3617025	594152	
9	3 and 7 GP + elder abuse context	65	65	23	
10	6 and 7 Dementia + elder abuse context	161	178	132	
11	7 and 8 elder abuse + identifying context	547	570	518	
12	9 or 10 or 11	704	717	627	
13	Limit 12 to (abstracts and English language and humans/human and yr="2008 -Current")	310	393	292	62

PRISMA 2009 Flow Diagram for:

Recognising Abuse



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.