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Interventions for preventing abuse in the elderly

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1 | BACKGROUND

Elder abuse is a global problem with an estimated 10% of older people experiencing some form of abuse although many cases remain unreported and/or not referred to social services. As such, the true extent of elder abuse is relatively unknown, and this poses significant challenges given recent demographic changes with people living longer. Maltreatment of older people, commonly referred to as elder abuse, is multidimensional and includes psychological, physical, sexual abuse, neglect and financial exploitation.

Elder abuse exists within a socio-ecological context with influences at the level of the individual, families, communities and society. The complex interplay between factors influencing elder abuse is challenging. Elder abuse may involve one or more types of abuse and may occur as a single or repeated act. A confounding problem is that those who carry out the abuse are often someone the older person knows well, such as partners, family members and friends. It may also be carried out by service providers who older people rely on in institutional and health care settings. In institutions or health care settings, elder abuse is most likely if staff lack education and training and/or there are inadequate resources to meet the care and support needs of older people.

The outcomes from elder abuse are numerous and may result in poorer health, physical injuries, psychological morbidity and premature death. Due to the significant morbidity and premature mortality which may result from elder abuse, the physical, psychosocial and economic costs of elder abuse are considerable.

Primary, secondly and tertiary interventions exist to address elder abuse. However, it is unclear what are the most effective interventions to prevent or reduce elder abuse across the diversity of settings. Given the wide range of possible elder abuse interventions and the lack of population knowledge about these, it is important to assess their possible benefits, effectiveness and any implications.

2 | OBJECTIVES

The overall aim was to establish the effectiveness of primary, secondary and tertiary intervention programmes to prevent and/or reduce the occurrence of elder abuse in any setting (organizational, institutional and/or community settings).

A further objective was to identify whether the interventions' effects were modified by types of abuse, types of participants, setting of intervention or cognitive status of older people (Baker, Francis, Hairi, Othman, & Choo, 2016).

Participants in randomized controlled trials, cluster-randomized trials, and quasi-RCTs, before-and-after studies, and interrupted time series were older people (age over 60) and those who care for them. Studies eligible for inclusion included methods of preventing or reducing re-occurrence of elder abuse and required to have a minimum of 12 weeks of follow up.

2.1 | Intervention/methods

Elder abuse interventions were classified as any strategies intended to avoid potential abuse or its re-occurrence in home, communities

and institutions. Examples of these interventions included those designed to improve the quality of care and living situations of older people and those designed to improve long-term care. Interventions included those which sought to increase detection of abuse, raised awareness of elder abuse amongst the public and professionals, provided victim support and delivered training for care providers.

The researchers also sought to determine whether programmes of a greater intensity were more effective.

3 | RESULTS

Seven studies, four from the United States, one from Taiwan and two from the United Kingdom (all classed as high income countries) were included. A total of 1942 older participants and 740 other people (e.g., family carers and staff) were involved.

Three studies focussed on education and prevention interventions for health care professionals and caregivers. One study aimed to improve the mental health of carers in order to reduce abuse in persons with dementia, and one study focussed on the detection of abuse compared with a control arm focused on preventing elder abuse. One offered a psychosocial group intervention to support victims of abuse and one examined a multi-agency/public health approach.

There was some evidence of increased knowledge and improved attitudes to elder abuse; however, results were mixed, whether these strategies were successful in detecting and preventing elder abuse. Overall, there was uncertainty as to the effectiveness of these interventions in reducing the occurrence or recurrence of elder abuse due to the heterogeneity in the settings, measures and effects reported in the seven included studies. The teaching of coping skills appeared helpful to reduce anxiety and depression of family member carers, although it was unknown whether this led to less abuse. Interventions targeting re-occurrence may possibly result in a detrimental effect. Of the four interventions deemed as higher intensity, only one low quality study showed some effect.

4 | CONCLUSIONS

Review authors were unable to draw any firm conclusions as to the effects of elder abuse interventions on any of the main outcomes compared with control/standard care. The seven studies were of low methodological quality with only one study judged to have no domains at low risk of bias. Although raising awareness of elder abuse, it is unclear if educational interventions can aid detection and prevent elder abuse. Blending education and support for victims may improve reporting but the evidence was equivocal.

The reviewers identified some potential for service planning interventions to improve awareness of the need for meticulous assessment and documentation of elder abuse. Teaching coping skills to family members of the elderly with dementia is a promising approach. Programmes need to be carefully evaluated, as there is a risk for inadvertent harm. The present evidence does not support the approach of simply doing more of a program, or more in combination.

More research is required as the current evidence base offers little guidance for nurses as to the best approaches to prevent and detect elder abuse. The review identified forthcoming research, but even so, given the breadth of the definition of elder-abuse and possible strategies, the evidence remains scarce.

4.1 | Implications for practice

Elder abuse is a societal problem which can take various forms, may be carried out by those whom older people are reliant on and can be invisible. The findings of this review suggest that education interventions may improve attitudes to elder abuse but there is little evidence that such interventions have a positive impact on the prevention or reduction of elder abuse. A significant challenge for nurses is that elder abuse may be carried out by people well known to the older person or colleagues. Therefore, nurses need to be alert to the possibilities of elder abuse and have a duty of care to investigate if they have concerns.

Nurses in the community or institutional care provide care for older people. They are therefore well placed to be alert to the possibility of elder abuse. Building a relationship with the older person and their family alongside impeccable assessment is important.

Given education and training has been shown to change attitudes such training is important and staff need to be aware of policies around elder abuse. From an organizational perspective, the knowledge that the pressures of inadequate resources also positively correlate with an increase in elder abuse should be considered in the management of organizational risk. Given that family members often struggle with caring for elderly people with dementia, teaching coping skills appears a promising approach.

Each situation should be evaluated to ensure that the actions are not resulting in detrimental effects. Furthermore, this review highlights the need to consider not only the responsibilities of individuals and organizations but also that of wider society in preventing and tackling the issue of elder abuse. In the absence of robust research evidence, it is recommended that primary, secondary and tertiary interventions continue to be funded, provided and engaged with in order that they may be fully evaluated.

Catriona Kennedy PhD, BA (Hons), Dip Nurs. RN, DN, PG Cert RNT, QNIS Professor of Community Nursing, A member of Cochrane Nursing Care (CNC)
Jill Will BN (Hons) Adult Nursing, MSc (ANP), PG Cert LTA, FHEA, Lecturer in Adult Nursing

School of Nursing and Midwifery, Robert Gordon University, Aberdeen, UK

Correspondence
Catriona Kennedy, School of Nursing and Midwifery, Robert Gordon University, Garthdee Road, Aberdeen AB10 7QG, UK.
Email: c.m.kennedy1@rgu.ac.uk

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