CHAPTER 5

Abuse of the elderly

Background

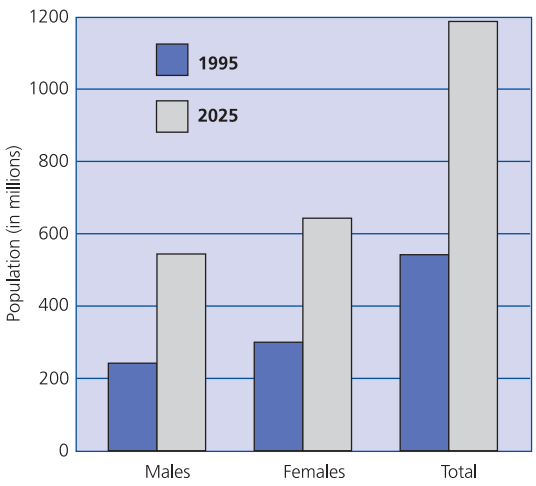
The abuse of older people by family members dates back to ancient times. Until the advent of initiatives to address child abuse and domestic violence in the last quarter of the 20th century, it remained a private matter, hidden from public view. Initially seen as a social welfare issue and subsequently a problem of ageing, abuse of the elderly, like other forms of family violence, has developed into a public health and criminal justice concern. These two fields – public health and criminal justice – have therefore dictated to a large extent how abuse of the elderly is viewed, how it is analysed, and how it is dealt with. This chapter focuses on abuse of older people by family members or others known to them, either in their homes or in residential or other institutional settings. It does not cover other types of violence that may be directed at older people, such as violence by strangers, street crime, gang warfare or military conflict.

Mistreatment of older people – referred to as "elder abuse" – was first described in British scientific journals in 1975 under the term "granny battering" (*1, 2*). As a social and political issue, though, it was the United States Congress that first seized on the problem, followed later by researchers and practitioners. During the 1980s scientific research and government actions were reported from Australia, Canada, China (Hong Kong SAR), Norway, Sweden and the United States, and in the following decade from Argentina, Brazil, Chile, India, Israel, Japan, South Africa, the United Kingdom and other European countries. Although elder abuse was first identified in developed countries, where most of the existing research has been conducted, anecdotal evidence and other reports from some developing countries have shown that it is a universal phenomenon. That elder abuse is being taken far more seriously now reflects the growing worldwide concern about human rights and gender equality, as well as about domestic violence and population ageing.

Where "older age" begins is not precisely defined, which makes comparisons between studies and between countries difficult. In Western societies, the onset of older age is usually considered to coincide with the age of retirement, at 60 or 65 years of age. In most developing countries, however, this socially constructed concept based on retirement age has little significance. Of more significance in these countries are the roles assigned to people in their lifetime. Old age is thus regarded as that time of life when people, because of physical decline, can no longer carry out their family or work roles.

Concern over the mistreatment of older people has been heightened by the realization that in the coming decades, in both developed and developing countries, there will be a dramatic increase in the population in the older age segment – what in French is termed *"le troisième âge"* (the third age). It is predicted that by the year 2025, the global population of those aged 60 years and older will more than double, from 542 million in 1995 to about 1.2 billion (see Figure 5.1). The total number of older people living in developing countries will also more than double by 2025, reaching 850 million (*3*) – 12% of the overall population of the developing world – though in some countries, including Colombia, Indonesia, Kenya and Thailand, the increase is expected to be more than fourfold. Throughout the world, 1 million people

FIGURE 5.1
Projected growth in the global population aged 60 years and older, 1995–2025



Source: United Nations Population Division, 2002.

reach the age of 60 years every month, 80% of whom are in the developing world.

Women outlive men in nearly all countries of the world, rich and poor (*3*). This gender gap is, however, considerably narrower in developing countries, mainly because of higher rates of maternal mortality and, in recent years, also because of the AIDS epidemic.

These demographic changes are taking place in developing countries alongside increasing mobility and changing family structures. Industrialization is eroding long-standing patterns of interdependence between the generations of a family, often resulting in material and emotional hardship for the elderly. The family and community networks in many developing countries that had formerly provided support to the older generation have been weakened, and often destroyed, by rapid social and economic change. The AIDS pandemic is also significantly affecting the lives of older people. In many parts of sub-Saharan Africa, for instance, children are being orphaned in large numbers as their parents die from the disease. Older people who had anticipated support from their children in old age are finding themselves to be the main caregivers and without a family to help them in the future.

Only 30% of the world's elderly are covered by pension schemes. In Eastern Europe and the countries of the former Soviet Union, for instance, as a result of the changes from planned to market economies, many older people have been left without a retirement income and the health and welfare services that were provided by the former communist regimes. In the economies of both developed and developing countries, structural inequalities have often been the cause among the general population of low wages, high unemployment, poor health services, lack of educational opportunities and discrimination against women – all of which have tended to make the elderly poorer and more vulnerable.

Older people in developing countries still face a significant risk from communicable diseases. As life expectancy increases in these countries, the elderly will be subject to the same long-term, largely incurable and often disabling diseases associated with old age that are currently most prevalent in developed countries. They will also face environmental dangers and the likelihood of violence in their societies. Nevertheless, advances in medical science and in social welfare will ensure that many older people will enjoy longer periods of disability-free old age. Diseases will be avoided or their impact lessened through better health care strategies. The resulting large number of older people will be a boon for society, constituting a great reservoir of experience and knowledge.

How is elder abuse defined?

It is generally agreed that abuse of older people is either an act of commission or of omission (in which case it is usually described as ''neglect''), and that it may be either intentional or unintentional. The abuse may be of a physical nature, it may be psychological (involving emotional or verbal aggression), or it may involve financial or other material maltreatment. Regardless of the type of abuse, it will certainly result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person (*4*). Whether the behaviour is termed abusive, neglectful or exploitative will probably depend on how frequently the mistreatment occurs, its duration, severity and consequences, and above all, the cultural context. Among the Navajo people in the United States, for instance, what had appeared to an outside researcher to be economic exploitation by family members was regarded instead by the tribal elders concerned as their cultural duty, and indeed privilege, to share material belongings with their families (*5*). Other Indian tribes in the United States viewed elder abuse as a community problem rather than an individual one (*6*).

The definition developed by Action on Elder Abuse in the United Kingdom (*7*) and adopted by the International Network for the Prevention of Elder Abuse states that: ''Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older

person.'' Such abuse is generally divided into the following categories:

- Physical abuse – the infliction of pain or injury, physical coercion, or physical or drug-induced restraint.
- Psychological or emotional abuse – the infliction of mental anguish.
- Financial or material abuse – the illegal or improper exploitation or use of funds or resources of the older person.
- Sexual abuse – non-consensual sexual contact of any kind with the older person.
- Neglect – the refusal or failure to fulfil a caregiving obligation. This may or may not involve a conscious and intentional attempt to inflict physical or emotional distress on the older person.

This definition of elder abuse has been heavily influenced by the work done in Canada, the United Kingdom and the United States. Studies conducted in China (Hong Kong SAR), Finland, Greece, India, Ireland, Israel, Norway, Poland and South Africa have approached the topic in distinctly different ways (*8*). Norwegian researchers, for instance, identified abuse with a ''triangle of violence'' that includes a victim, a perpetrator and others, who – directly or indirectly – observe the principal players. In countries such as China, that emphasize harmony and respect within society, neglecting the care of an older person is considered an act of elder abuse. If family members fail to fulfil their kinship obligations to provide food and housing, this also constitutes neglect.

Traditional societies

Many traditional societies of the past considered family harmony to be an important factor governing family relationships. This reverence for the family was reinforced by philosophical traditions and public policy. In Chinese society, it was embedded in a value system that stressed ''filial piety''. Mistreatment of older people was unrecognized and certainly unreported. These traditions are still influential today. Studies in the United States of attitudes towards elder abuse revealed that citizens of Korean origin believed in the primacy of family harmony over individual well-being as a yardstick for determining whether a particular behaviour was regarded as abusive or not (*9*). Similarly, people of Japanese origin considered the ''group'' to be paramount, and that an individual's well-being should be sacrificed for the good of the group (*10*).

Displacing older people as heads of households and depriving them of their autonomy in the name of affection are cultural norms even in countries where the family is the central institution and the sense of filial obligation is strong (*11*). Such infantilization and overprotection can leave the older person isolated, depressed and demoralized, and can be considered a form of abuse. In some traditional societies, older widows are abandoned and their property seized. Mourning rites of passage for widows in parts of Africa and India include practices that elsewhere would certainly be considered cruel, for example sexual violence, forced levirate marriages (where a man is obliged by custom to marry the childless widow of his brother) and expulsion from their homes (*12*). In some places, accusations of witchcraft, often connected with unexplained events in the local community, such as a death or crop failure, are directed at isolated, older women (*13*). In sub-Saharan Africa, accusations of the practice of witchcraft have driven many older women from their homes and their communities to live in poverty in urban areas. In the United Republic of Tanzania, an estimated 500 older women accused of witchcraft are murdered every year (*14*). These acts of violence have become firmly entrenched as social customs and may not be considered locally as ''elder abuse'' (see Box 5.1).

A workshop on elder abuse held in South Africa in 1992 drew a distinction between *mistreatment* (such as verbal abuse, passive and active neglect, financial exploitation and overmedication) and *abuse* (including physical, psychological and sexual violence, and theft) (*8*). Since then, focus groups have been held with older people recruited from three historically ''black'' townships in South Africa to determine the level of knowledge and understanding of elder abuse within these communities. In addition to the typical Western schema that

comprises physical, verbal, financial and sexual abuse, and neglect, the participants wished to add to the definition:

— loss of respect for elders, which was equated with neglect;
— accusations of witchcraft;
— abuse by systems (mistreatment at health clinics and by bureaucratic bodies).

The focus groups produced the following definitions (*15*):

- Physical abuse – beating and physical manhandling.

BOX 5.1

Witchcraft: the threat of violence in the United Republic of Tanzania

In the United Republic of Tanzania, some 500 older women are murdered each year following accusations against them of witchcraft. The problem is particularly serious in Sukumaland in the north of the country. Large numbers of older women are driven from their homes and communities in fear of being accused of witchcraft, and end up living destitute in urban areas.

Belief in witchcraft has existed in Sukumaland for centuries, though the violence surrounding it has increased sharply in recent years. This may in part be due to increased poverty caused by too many people living off too little land, as well as an overall lack of education. As poor and uneducated people try to explain the misfortunes that befall them — illness and death, crop failures and dried-up wells — they search for a scapegoat, and witchcraft appears to explain events they cannot otherwise understand or control.

Men are sometimes accused of witchcraft, though the low status of women in society means that women are overwhelmingly the main target. Among some of the particular ways in this region in which women are accused of witchcraft are the following:

- *Land disputes* are a common underlying cause of violence against widows. According to inheritance laws, widows may continue to live on their husbands' land, without owning the property. When they die, the land becomes the property of their husbands' sons. Accusations of witchcraft are thus used to get rid of widows living on the land as tenants, and blocking the inheritance of others.
- *Traditional healers* are frequently urged by family members or neighbours to make accusations of witchcraft against women. One young boy killed his mother after a traditional healer told him that she was the cause of his problems.
- *Myths* about the physical appearance of witches — that they have red eyes, for instance — also often give rise to accusations of witchcraft. The eyes of many older women are red from a lifetime of cooking over smoky stoves, or from medical conditions such as conjunctivitis.

Community leaders in Sukumaland are calling for a strong lead from the Government. One was quoted as saying: "It is a question of educating the people. In other areas of the country where people are better educated, we don't face this problem."

Until recently, the Government was reluctant to acknowledge that belief in witchcraft still existed. Now the subject is being widely discussed and officially condemned. In 1999, the Tanzanian Government made witchcraft the theme for International Women's Day.

A local nongovernmental organization and HelpAge International are also taking measures to improve the security of older women in the United Republic of Tanzania. They aim to change attitudes and beliefs surrounding witchcraft and to address some of the practical matters, such as poverty and poor housing, that have helped to keep such beliefs alive.

Source: reproduced from reference *14* with the permission of the publisher.

- Emotional and verbal abuse – discrimination on the basis of age, insults and hurtful words, denigration, intimidation, false accusations, psychological pain and distress.
- Financial abuse – extortion and control of pension money, theft of property, and exploitation of older people to force them to care for grandchildren.
- Sexual abuse – incest, rape and other types of sexual coercion.
- Neglect – loss of respect for elders, withholding of affection, and lack of interest in the older person's well-being.
- Accusations of witchcraft – stigmatization and ostracization.
- Abuse by systems – the dehumanizing treatment older people are liable to suffer at health clinics and pension offices, and marginalization by the government.

These definitions, produced by the participants and classified by the researchers, were the result of an initial effort in South Africa to obtain information on elder abuse directly from older people. They are also the first attempt to classify elder abuse in a developing country, building on the Western model but bringing in factors that are relevant to the indigenous population.

The extent of the problem

Domestic settings

With most developing nations only recently becoming aware of the problem, information on the frequency of elder abuse has relied on five surveys conducted in the past decade in five developed countries (*16–20*). The results show a rate of abuse of 4–6% among older people if physical, psychological and financial abuse, and neglect are all included. One difficulty in making comparisons between studies is the variation in their time frames. The studies conducted in Canada, the Netherlands and the United States refer to the ''preceding year''. The study in Finland investigated abuse since the ''age of retirement'', while the study in Great Britain examined cases from ''the past few years''. The first set of studies (from Canada, the Netherlands and the United States) found no significant difference in prevalence rates of abuse by age or by sex, the study in Finland found a higher proportion of female victims (7.0%) than male victims (2.5%), while no breakdown by age or sex was given in the British study. Because of the differences in the methodology used in the five surveys and the relatively small numbers of victims, further comparative analysis is not justified.

A recent survey of family violence in Canada found that 7% of older people had experienced some form of emotional abuse, 1% financial abuse, and 1% physical abuse or sexual assault, at the hands of children, caregivers or partners during the previous 5 years (*21*). Men (9%) were more likely than women (6%) to report suffering emotional or financial abuse. Because of differences in the survey questions and time frame, these findings cannot be compared with the earlier study in Canada which had found a much smaller proportion of emotional abuse (1.4%) and a larger rate of financial abuse (2.5%) (*17*).

Institutional settings

A quarter of a century ago, the proportion of older people living in institutions in developed countries had reached an estimated 9% (*22*). Since that time, there has been a shift in emphasis towards care in the community and the use of less restrictive residential settings. Current rates of use of nursing homes are in the range of 4–7% in countries such as Canada (6.8%), Israel (4.4%), South Africa (4.5%) and the United States (4%). In most African countries, older people can be found in long-stay hospital wards, homes for the destitute and disabled, and – in some sub-Saharan countries – in witches' camps. Social, economic and cultural changes taking place in some of the developing societies will leave families less able to care for their frail relatives and thus portend an increasing demand for institutional care. In China, the expectation of institutional care for older people is becoming the norm. In Taiwan, China, institutional care has rapidly overtaken family care for the elderly (AY Kwan, unpublished data, 2000).

In Latin America, the rates of institutionalization of older people range from 1% to 4%. Institutional care is no longer considered unacceptable for an older person but is seen as an alternative for families. The government-sponsored *asilos*, large institutions resembling the early English workhouses, have been converted into smaller facilities with professional staff from many disciplines. Other homes are operated by religious communities of immigrant origin. Figures for rates of institutionalization are not available in the countries of the former Eastern European bloc, because the authorities at the time did not allow publication of such information.

Despite the fact that a vast literature exists on the quality of care in institutional settings, and that cases of elder abuse have been well documented in reports of governmental inquiries, ethnographic studies and personal histories, there are no national data on the prevalence or incidence of abuse available, but only local data from smaller-scale studies. A survey of nursing-home personnel in one state of the United States disclosed that 36% of the nursing and general staff reported having witnessed at least one incident of physical abuse by other staff members in the preceding year, while 10% admitted having committed at least one act of physical abuse themselves. At least one incident of psychological abuse against a resident had been observed by 81% of the sample in the preceding year, and 40% admitted to having also committed such an act (*23*). The findings suggest that mistreatment of older residents in institutions may be even more extensive than generally believed.

The likely rates of elder abuse both in the community and in institutional settings may be greater than the general statistics collected by countries on violent acts would indicate. Some of the disparity stems from the fact that elder abuse had gone unrecognized until the 1970s. Deaths of older people, both in institutional settings and the community, have often been attributed to natural, accidental or undetermined causes when in fact they were the consequences of abusive or neglectful behaviour.

What are the risk factors for elder abuse?

Most of the early work on abuse of the elderly was limited to domestic settings and carried out in developed countries. In seeking explanations for elder abuse, researchers drew from the literature in the fields of psychology, sociology, gerontology and the study of family violence. To accommodate the complexity of elder abuse and the many factors associated with it, researchers have turned to the ecological model, which was first applied to the study of child abuse and neglect (*24*) and has been applied more recently to elder abuse (*25, 26*). The ecological model can take into account the interactions that take place across a number of systems. As described in Chapter 1, the model consists of a nested hierarchy of four levels of the environment: individual, relationship, community and society.

Individual factors

Early researchers in the field played down individual personality disturbances as causal agents of family violence in favour of social and cultural factors (*27*). More recently, though, research on family violence has shown that abusers who are physically aggressive are more likely to have personality disorders and alcohol-related problems than the general population (*28*). Similarly, studies restricted to violence against older people in domestic settings have found that aggressors are more likely to have mental health and substance abuse problems than family members or caregivers who are not violent or otherwise abusive (*29–31*).

Cognitive and physical impairments of the abused older person were strongly identified in the early studies as risk factors for abuse. However, a later study of a range of cases from a social service agency revealed that the older people who had been mistreated were not more debilitated than their non-abused peers and may even have been less so, particularly in cases of physical and verbal abuse (*32*). In other studies, a comparison of samples of patients with Alzheimer disease showed that the degree of impairment was not a risk factor for being abused (*33, 34*). However, among cases of abuse reported to the authorities, those involving the very

old and the most impaired generally constitute a large proportion.

Gender has been proposed by some as a defining factor in elder abuse on the grounds that older women may have been subject to oppression and economically disadvantaged all of their lives (*35*). However, according to community-based prevalence studies, it appears that older men are at risk of abuse by spouses, adult children and other relatives in about the same proportions as women (*16, 17*).

Although the income of the older person was not a significant factor in a study of the prevalence of elder abuse in the United States, financial difficulties on the part of the abuser did appear to be an important risk factor. Sometimes this was related to an adult child's substance abuse problem, leading him or her to extort money, possibly a pension cheque, from the older person. Resentment by family members at having to spend money on the care of the older person may also have played a part in abuse of this nature.

Relationship factors

In the early theoretical models, the level of stress of caregivers was seen as a risk factor that linked elder abuse with care of an elderly relative (*36, 37*). While the popular image of abuse depicts a dependent victim and an overstressed caregiver, there is growing evidence that neither of these factors properly accounts for cases of abuse. Although researchers do not deny the component of stress, they tend now to look at it in a wider context in which the quality of the overall relationship is a causal factor (*30, 34, 38*). Some of the studies involving caregiver stress, Alzheimer disease and elder abuse suggest that the nature of the relationship between the caregiver and the care recipient before abuse begins may be an important predictor of abuse (*34, 39, 40*). Today, therefore, the belief is that stress may be a contributing factor in cases of abuse but does not by itself account for the phenomenon.

Work with patients with dementia has shown that violent acts carried out by a care recipient can act as ''triggers'' for reciprocal violence by the caregiver (*41*). It may be that the violence is a result of the interplay of several factors, including stress, the relationship between the carer and the care recipient, the existence of disruptive behaviour and aggression by the care recipient, and depression in the caregiver (*42*).

Living arrangements, particularly overcrowded conditions and a lack of privacy, have been associated with conflict within families. Although abuse can occur when the abuser and the older person suffering abuse live apart, the older person is more at risk when living with the caregiver.

The early theories on the subject also sought to associate dependency with increased risk of abuse. At first the emphasis focused on the dependency of the victim on the caregiver or abuser, though later case work identified abusers who were dependent on the older person – usually adult children dependent on elderly parents for housing and financial assistance (*32*). In some of these cases a ''web of interdependency'' was evident – a strong emotional attachment between the abused and abuser that often hindered efforts at intervention.

Community and societal factors

In almost all studies of risk factors, the community factor of social isolation emerges as a significant one in elder mistreatment (*17, 29, 43, 44*). As with battered women, isolation of older people can be both a cause and a consequence of abuse. Many older people are isolated because of physical or mental infirmities. Furthermore, loss of friends and family members reduces the opportunities for social interaction.

Although there is as yet little solid empirical evidence, societal factors are currently considered important as risk factors for elder abuse in both developing and industrialized countries; in the past the emphasis was generally on individual or interpersonal attributes as potential causal factors for elder abuse. Cultural norms and traditions – such as ageism, sexism and a culture of violence – are also now recognized as playing an important underlying role. Older people are often depicted as being frail, weak and dependent, something that has made them appear less worthy of government

investment or even of family care than other groups, and has presented them as ready targets for exploitation.

As regards sub-Saharan Africa in particular, societal and community factors include (*12*):

— the systems of patrilineal and matrilineal inheritance and land rights, affecting the distribution of power;
— the way societies view the role of women;
— the erosion of the close bonds between generations of a family, caused by rural–urban migration and the growth in formal education;
— the loss, through modernization, of the traditional domestic, ritual and family arbitration roles of older people.

According to the focus group study in South Africa mentioned earlier, much of the abuse – and particularly domestic violence – occurred as a result of social disorder, exacerbated by crime, alcohol and drugs. Similar conclusions came from an exercise conducted by seven male community leaders of the Tamaho squatter camp in Katlehong, South Africa (*15*). Drawing a link between poverty and violence, they described how dysfunctional family life, a lack of money for essentials, and a lack of education and job opportunities have all contributed to a life of crime, drug peddling and prostitution by young people. In this society, older people are viewed as targets for abuse and exploitation, their vulnerability being a result of poverty distinguished by a lack of pension support and job opportunities, poor hygiene, disease and malnutrition.

The political transformations within post-communist Eastern Europe have also produced conditions heightening the risk of elder abuse. The factors suggested there as having affected the overall health and psychosocial well-being of people, particularly the elderly, whose vulnerability to mistreatment has thereby increased, include:

— the growing pauperization of significant parts of society;
— high unemployment;
— a lack of stability and social security;
— the outward expression of aggressiveness, especially among the young.

In Chinese societies several reasons have been suggested (*45*) for the mistreatment of older people, including:

— a lack of respect by the younger generation;
— tension between traditional and new family structures;
— restructuring of the basic support networks for the elderly;
— migration of young couples to new towns, leaving elderly parents in deteriorating residential areas within town centres.

Studies on elder abuse have tended to focus on interpersonal and family problems. However, an integrated model encompassing individual, interpersonal, community and societal perspectives is more appropriate, and reduces some of the bias evident in the earlier studies. Such a model takes into account the difficulties faced by older people, especially older women. These people often live in poverty, without the basic necessities of life and without family support – factors that increase their risk of abuse, neglect and exploitation.

The consequences of elder abuse

For older people, the consequences of abuse can be especially serious. Older people are physically weaker and more vulnerable than younger adults, their bones are more brittle and convalescence takes longer. Even a relatively minor injury can cause serious and permanent damage. Many older people survive on limited incomes, so that the loss of even a small sum of money can have a significant impact. They may be isolated, lonely or troubled by illness, in which case they are more vulnerable as targets for fraudulent schemes.

Domestic settings

Very few empirical studies have been conducted to determine the consequences of mistreatment, even though clinical and case study reports about the severe emotional distress experienced by mistreated older people are plentiful. There is some evidence from studies in developed countries to show that a higher proportion of abused elderly people suffer

from depression or psychological distress than do their non-abused peers (*31, 46, 47*). Since these studies were cross-sectional in design, it is not possible to tell whether the condition existed before or was a consequence of the mistreatment. Other symptoms that have been proposed as being associated with cases of abuse include feelings of helplessness, alienation, guilt, shame, fear, anxiety, denial and post-traumatic stress (*48, 49*). Emotional effects were also cited by the participants in the focus group study in South Africa, along with health problems and, in the words of one participant, ''illness of the heart'' (*15*).

In a seminal study in New Haven, CT, United States, data from a comprehensive annual health and welfare study of a representative sample of 2812 older people were merged with the database of the local agency concerned with adult abuse for each year over a 9-year period (*50*). Information for the health survey was recorded by nurses, who saw the older people at a hospital for the first year's data collection and every third year after that. In the intervening years, data were updated by telephone. Information about abuse and neglect was obtained by case workers using existing protocols after investigating claims of mistreatment, usually by a home visit. The merged database allowed the researchers to identify those people from the sample who were confirmed during the 9-year survey as having experienced physical abuse or neglect. Mortality rates were then calculated, beginning with the first year of the survey and for 12 years thereafter, both for those who had been abused or neglected as well as for the non-abused group. When mortality rates for the two groups were compared, 13 years after the study began, 40% of the group where no abuse or neglect had been reported were still alive, compared with 9% of those who had been physically abused or neglected. After controlling for all possible factors that might affect mortality (for example, age, sex, income, functional and cognitive conditions, diagnosis and degree of social support) and finding no significant relationships in these additional factors, the researchers concluded that mistreatment causes extreme interpersonal stress that may confer an additional risk of death.

Institutions

Mistreatment of older people has been identified in facilities for continuing care (such as nursing homes, residential care, hospitals and day care facilities) in almost every country where such institutions exist. Various people may be responsible for the abuse: a paid member of the staff, another resident, a voluntary visitor, or relatives or friends. An abusive or neglectful relationship between the older person and their caregiver at home may not necessarily end once the older person has entered institutional care; the abuse may sometimes continue in a new setting.

A distinction must be made between individual acts of abuse or neglect in institutional settings and institutionalized abuse – where the prevailing regime of the institution itself is abusive or negligent. In practice, though, it is often difficult to say whether the reasons for abuse or neglect found in an institutional setting have been caused by individual acts or through institutional failings, since the two are frequently found together.

The spectrum of abuse and neglect within institutions spans a considerable range (*51*), and may be related to any of the following:

- The provision of care – for example, resistance to changes in geriatric medicine, erosion of individuality in the care, inadequate nutrition and deficient nursing care (such as lack of attention to pressure sores).
- Problems with staffing – for example, work-related stress and staff burnout, poor physical working conditions, insufficient training and psychological problems among staff.
- Difficulties in staff–resident interactions – for example, poor communication, aggressiveness on the part of residents and cultural differences.
- Environment – for example, a lack of basic privacy, dilapidated facilities, the use of restraints, inadequate sensory stimulation, and a proneness to accidents within the institution.

- Organizational policies – for example, those that operate for the benefit of the institution, giving residents few choices over daily living; bureaucratic or unsympathetic attitudes towards residents; staff shortages or high staff turnover; fraud involving residents' possessions or money; and lack of a residents' council or residents' family council.

Anecdotal evidence from India suggests that institutional abuse is often perpetuated by staff through a system of unquestioning regimentation – in the name of discipline or imposed protective care – and exploitation of the dependence of the older people, and is aggravated by a lack of professionally trained management.

With the present state of knowledge, it is impossible to know how pervasive such conditions are. The leading ten deficiencies, cited in broad categories by the United States Government in its 1997 survey of 15 000 nursing homes (*52*), were:

1. Food preparation (21.8%).
2. Comprehensive assessment – a documented assessment of all care needs, including medical, nursing and social care (17.3%).
3. Comprehensive care plans – usually in the form of a document specifying the day-to-day care needs of an individual and stating who is responsible for delivering them, with comments on progress and changes required (17.1%).
4. Accidents (16.6%).
5. Pressure sores (16.1%).
6. Quality of care (14.4%).
7. Physical restraints (13.3%).
8. Housekeeping (13.3%).
9. Lack of dignity (13.2%).
10. Accident prevention (11.9%).

Abuse and neglect can occur in many types of institution, including those that seem to provide high-quality care to patients. A key finding from an examination of inquiries into scandals in residential care suggested that an acceptable or good regime of care could be transformed into an abusive one relatively easily and quickly, with little detectable change in the outward situation (*53*).

What can be done to prevent elder abuse?

The impact that physical and psychological violence have on the health of an older person is exacerbated by the ageing process and diseases of old age. It is more difficult for the elderly to leave an abusive relationship or to make correct decisions because of the physical and cognitive impairments that usually come with old age. In some places, kinship obligations and the use of the extended family network to resolve difficulties may also lessen the ability of older people, particularly women, to escape from dangerous situations. Often, the abuser may be the abused person's only source of companionship. Because of these and other considerations, preventing elder abuse presents a whole host of problems for practitioners. In most cases, the greatest dilemma is how to balance the older person's right to self-determination with the need to take action to end the abuse.

Responses at national level

Efforts to galvanize social action against elder abuse at a national level and to develop legislation and other policy initiatives are at varying stages of development around the world. Some authors (*54, 55*) have used Blumer's model (*56*) of social problems to describe the stages of the process:

— emergence of a problem;
— legitimization of the problem;
— mobilization of action;
— formulation of an official plan;
— implementation of the plan.

The United States is furthest advanced in terms of a national-level response, with a fully developed system for reporting and treating cases of elder abuse. This system operates at the state level, the federal government's involvement being limited to supporting the National Center on Elder Abuse, which gives technical assistance and a small amount of funding to the states for their elder abuse prevention services. A focus at national level is also provided by the National Committee for the Prevention of Elder Abuse, a non-profit organization formed in 1988, and the National Association

of State Adult Protective Services Administrators, established in 1989.

In Australia and Canada, some provinces or states have set up systems to deal with cases of elder abuse, but no official federal policy has been announced. New Zealand has established a series of pilot projects throughout the country. All three of these countries have national groups. The New Zealand National Elder Abuse and Neglect Advisory Council was formed in the early 1990s to provide a national perspective on strategies for the care and protection of older people. The Australian Network for the Prevention of Elder Abuse was set up in 1998, as a point of contact and information-sharing for those working with older people in abusive situations. In 1999, the Canadian Network for the Prevention of Elder Abuse was created with similar aims – to find ways to develop policies, programmes and services to eliminate elder abuse.

In the United Kingdom, Action on Elder Abuse, a national nongovernmental organization, has helped focus government attention on the abuse of older people, giving rise to policy documents from the Department of Health and the Social Services Inspectorate. Norway leads among the Scandinavian countries, having obtained parliamentary approval for a service project in Oslo and a resource centre for information and research on violence, the latter largely as a result of action by campaigners against elder abuse. Other European countries – including France, Germany, Italy and Poland – are at the ''legitimization'' stage of Blumer's model. Activities for the prevention of elder abuse in these countries are limited mainly to individual researchers and to some local programmes.

The Latin American Committee for the Prevention of Elder Abuse has actively campaigned to draw attention to the problem of abuse of the elderly within Latin American and Caribbean countries, and it offers training at regional and national meetings. For some countries – including Cuba, Peru, Uruguay and Venezuela – awareness of the problem is still emerging, and activities consist mainly of meetings of professionals and research studies. Other countries in the region, such as Argentina, Brazil and Chile, have moved on to legitimization and action.

In Buenos Aires, Argentina, the organization ''Proteger'', dealing exclusively with elder abuse cases, was established in 1998 as one of the programmes of the Department for the Promotion of Social Welfare and Old Age. Professionals and other workers in this programme receive a 6-month training in gerontology, focusing mainly on the prevention of violence and intervention in cases of elder abuse. Proteger also runs a free telephone helpline.

In Brazil, official support for training on elder abuse has been provided by the Ministry of Justice, Health and Welfare. In Chile, as a result of the work of the Interministerial Commission for the Prevention of Intrafamiliar Violence, a law against violence in the family was passed in 1994 (*57*). The law covered all acts of family violence, including those directed at the elderly.

In Asia, studies by researchers in China (Hong Kong SAR), India, Japan and the Republic of Korea have drawn attention to the problem of elder abuse, but no official action, in terms of policies or programme development, has followed so far.

Reports about elder abuse in South Africa first surfaced in 1981. In 1994 a preventive programme on institutional abuse was established jointly by the state and private sector (*58*). Activists working to prevent elder abuse strongly promoted the idea of a national strategy on elder abuse, which the government is now considering, and pushed for the inclusion of elder abuse in the final declaration of the Southern African Development Community Conference on the Prevention of Violence Against Women, held in Maseru, Lesotho, in December 2000. The Nigerian Coalition on Prevention of Elder Abuse brings together all agencies and groups working with and for the elderly. For many other African nations, efforts to deal with elder abuse are overshadowed by other seemingly more pressing concerns – such as conflicts, poverty and debt.

With a rapid expansion of activities worldwide on elder abuse, the International Network for the Prevention of Elder Abuse (INPEA) was formed in 1997, with representation from all six continents.

INPEA's aims are to: increase public awareness; promote education and training; campaign on behalf of abused and neglected older people; and promote research into the causes, consequences, treatment and prevention of elder abuse. During INPEA's early stage of development, workshops have been the main medium of training, and have been conducted at professional meetings in Australia, Brazil, Canada, Cuba, the United Kingdom and the United States. A quarterly newsletter and a web site have been set up. INPEA was also the inspiration for both the Australian and the Canadian networks.

Local responses

Most of the programmes set up to tackle the problem of abuse of the elderly are found in high-income countries. They are generally conducted under the auspices of the social services, health care or legal systems or in conjunction with programmes to combat family violence. Although elder abuse has been proven to exist in several low-income or middle-income countries, few specific programmes have been established. In these countries, cases of elder abuse are generally handled by governmental or nongovernmental social service agencies, even though the staff of such agencies might not always be knowledgeable about the subject. Costa Rica, where there is a strong local programme in place, is an exception (*11*). In some countries, there are no social services or health care systems to deal with elder abuse.

Social services

In general, countries that deliver services to abused, neglected or exploited older people have done so through the existing health and social services network. Such cases frequently involve medical, legal, ethical, psychological, financial, law enforcement and environmental issues. Guidelines and protocols have been developed to help case workers and special training is usually available to them. Care is generally planned by consulting teams drawn from a wide range of disciplines. Typically, these services operate in close collaboration with task forces, usually representing statutory bodies and voluntary, private and charitable organizations, that offer consultation services, provide training, develop model legislation and identify weak points in the system. Telephone helplines to receive reports of mistreatment are often a feature of such systems (*59, 60*) and are currently operating in the United Kingdom and in local communities in France, Germany and Japan (see Box 5.2). Only the United States and a number of Canadian provinces have created a system solely for handling reports of adult mistreatment. In these adult protection services, as they are known, the case workers investigate and assess cases, develop plans for appropriate care and monitor the cases until they can be handed over to existing social service agencies for the elderly.

There is a growing interest in providing services for victims of elder abuse along the lines of those developed for battered women. Emergency shelters and support groups specifically aimed at older abused people are relatively new. They provide an environment where victims of abuse can share experiences, develop the psychological strength to cope with their fears, self-doubt, stress and anxiety, and raise their self-esteem. One example of how the domestic violence model has been adapted for elder abuse is the programme set up by the Finnish Federation of Mother and Child Homes and Shelters in collaboration with a local nursing home and the Finnish health care system. This project provides emergency shelter beds in the nursing home, a telephone helpline offering advice and an opportunity for older people to talk about their problems, and a biweekly victim support group meeting. Other such emergency shelters exist in Canada, Germany, Japan and the United States.

In low-income countries lacking the social service infrastructure to undertake these types of programmes, local projects can be established to help older people plan programmes and develop their own services, as well as to campaign for change. Such activities will also give the older people strength and self-esteem. In Guatemala, for instance, blind older people who had been ejected from their homes by their families formed their own committee, created a safe house for themselves, and set up local handicraft and other

BOX 5.2

The Japan Elder Abuse Prevention Centre

In 1993, the Society for the Study of Elder Abuse (SSEA) in Japan, an independent group consisting largely of social workers and academics, carried out a national survey of community care centres. Their study confirmed the existence of elder abuse in Japan. Based on the results, SSEA decided that a telephone counselling service, similar to that run in the United Kingdom by Action on Elder Abuse, was the best way to confront the problem of elder abuse (*60*).

With financial help from a national nongovernmental organization, the Japan Elder Abuse Prevention Centre was set up in 1996 as a non-profit body, offering a volunteer-operated telephone counselling service known simply as *Helpline*. One of the SSEA's members, a director of a nursing home, made a room available in the nursing home for use as an office and provided other help. The counselling service was advertised in newspapers, support centres and other agencies.

Helpline now offers a wide range of information as well as legal counselling to anyone — including health care and welfare professionals — with a problem related to elder abuse.

Initially, *Helpline* counsellors were all members of the SSEA, but three outside volunteers were subsequently added to the staff. On any particular day, one or two counsellors are in attendance. Extensive training is given to new counsellors, and all counsellors attend monthly meetings at the SSEA, to exchange information on elder abuse and review their case studies. Outside professionals may be called in, if required, to help deal with special cases.

Helpline is exclusively a telephone service. If a caller needs counselling in person, rather than by telephone, their case is handed over to a local home service support centre. Privacy, confidentiality and the anonymity of the callers are key concerns of *Helpline.*

income-generating projects to help fund the safe house (*61*).

Health care

In some Latin American and European countries, as well as in Australia, the medical profession has played a leading role in raising public concern about elder abuse. In other countries, including Canada and the United States, physicians have lagged many years behind the social work and nursing professions. Few intervention programmes for abused older people are housed in hospital settings. Where these do exist, they are usually consultation teams who are on call in the event a suspected case of abuse is reported. Those involved in the provision of health care have an important role to play in programmes that screen for and detect abuse.

While it may be thought that doctors are best placed to notice cases of abuse – partly because of the trust that most elderly people have in them – many doctors do not diagnose abuse because it is not part of their formal or professional training and hence does not feature in their list of differential diagnoses.

In emergency rooms, too, it would seem, scant attention is usually paid to the special needs of elderly people. Health care professionals often feel more comfortable dealing with younger people than they do with elderly ones, and the concerns of older patients are frequently ignored. Most emergency departments do not use protocols to detect and deal with elder abuse, and rarely attempt to address the mental health or behavioural signs of elder abuse, such as depression, attempted suicide, or drug or alcohol abuse (*62*).

There should be an investigation of a patient's condition for possible abuse (*63, 64*) if a doctor or other health care worker notices any of the following signs:

— delays between injuries or illness and seeking medical attention;

— implausible or vague explanations for injuries or ill-health, from either the patient or his or her caregiver;
— differing case histories from the patient and the caregiver;
— frequent visits to emergency departments because a chronic condition has worsened, despite a care plan and resources to deal with this in the home;
— functionally impaired older patients who arrive without their main caregivers;
— laboratory findings that are inconsistent with the history provided.

When conducting an examination (*65*), the doctor or health care worker should:

— interview the patient alone, asking directly about possible physical violence, restraints or neglect;
— interview the suspected abuser alone;
— pay close attention to the relationship between, and the behaviour of, the patient and his or her suspected abuser;
— conduct a comprehensive geriatric assessment of the patient, including medical, functional, cognitive and social factors;
— document the patient's social networks, both formal and informal.

Table 5.1 contains a list of indicators that may serve as a useful guide if mistreatment is suspected. The presence of any indicator in this table, though, should not be taken as proof that abuse has actually taken place.

Legal action

Despite a growing interest in the problem, most countries have not introduced specific legislation on elder abuse. Particular aspects of abuse are usually covered either by criminal law, or by laws dealing with civil rights, property rights, family violence or mental health. Specific and comprehensive legislation on the abuse of older people would imply a much stronger commitment to eradicating the problem. However, even where such laws exist, cases of elder abuse have only rarely been prosecuted. This is principally because older people are usually reluctant – or unable – to press charges against family members, because older people are often regarded as being unreliable witnesses, or because of the inherently hidden nature of elder abuse. As long as elder abuse is viewed solely as a caregiver issue, legal action is not likely to be an effective measure.

Only the Atlantic provinces of Canada, Israel, and a number of states in the United States have legislation for the mandatory reporting of abuse of the elderly. In the United States, 43 states require professionals and others working with older people to report possible cases of elder abuse to a state-designated agency, should they have ''reason to believe'' that abuse, neglect or exploitation has taken place. The first of these states passed its legislation in 1976, and the most recent in 1999. The Canadian province of Newfoundland passed its adult protection law as early as 1973, with the last of the four Atlantic provinces, Prince Edward Island, following in 1988. Israel's law dates from 1989. As with child abuse reporting laws, all these laws on elder abuse were introduced to prevent evidence of abuse from going unnoticed. Mandatory reporting was considered a valuable tool, particularly in situations where victims were unable to report and professionals were reluctant to refer cases. While research on the impact of existing mandatory reporting does not as yet provide a conclusive answer, the indications are that whether a case is reported or not has less to do with legal requirements than with other organizational, ethical, cultural and professional factors (*66*).

Education and public awareness campaigns

Education and public awareness campaigns have been vital for informing people in industrialized countries about elder abuse. Education involves not only teaching new information but also changing attitudes and behaviour, and is thus a fundamental preventive strategy. It can be conducted in a wide variety of ways – for instance, in training sessions, seminars, continuing educational programmes, workshops, and scientific meetings and conferences. Those targeted will include not only practitioners in the various relevant disciplines – from medicine, mental health and nursing to social

TABLE 5.1
Indicators of elder abuse

Indicators relating to the elderly person				Indicators relating to the caregiver
Physical	Behavioural and emotional	Sexual	Financial	
• Complaints of being physically assaulted • Unexplained falls and injuries • Burns and bruises in unusual places or of an unusual type • Cuts, finger marks or other evidence of physical restraint • Excessive repeat prescriptions or under-usage of medication • Malnourishment or dehydration without an illness-related cause • Evidence of inadequate care or poor standards of hygiene • Person seeks medical attention from a variety of doctors or medical centres	• Change in eating pattern or sleep problems • Fear, confusion or air of resignation • Passivity, withdrawal or increasing depression • Helplessness, hopelessness or anxiety • Contradictory statements or other ambivalence not resulting from mental confusion • Reluctance to talk openly • Avoidance of physical, eye or verbal contact with caregiver • Older person is isolated by others	• Complaints of being sexually assaulted • Sexual behaviour that is out of keeping with the older person's usual relationships and previous personality • Unexplained changes in behaviour, such as aggression, withdrawal or self-mutilation • Frequent complaints of abdominal pain, or unexplained vaginal or anal bleeding • Recurrent genital infections, or bruises around the breasts or genital area • Torn, stained or bloody underclothes	• Withdrawals of money that are erratic, or not typical of the older person • Withdrawals of money that are inconsistent with the older person's means • Changing a will or property title to leave house or assets to "new friends or relatives" • Property is missing • Older person "can't find" jewellery or personal belongings • Suspicious activity on credit card account • Lack of amenities, when the older person could afford them • Untreated medical or mental health problems • Level of care is not commensurate with the older person's income or assets	• Caregiver appears tired or stressed • Caregiver seems excessively concerned or unconcerned • Caregiver blames the older person for acts such as incontinence • Caregiver behaves aggressively • Caregiver treats the older person like a child or in a dehumanized way • Caregiver has a history of substance abuse or abusing others • Caregiver does not want the older person to be interviewed alone • Caregiver responds defensively when questioned; may be hostile or evasive • Caregiver has been providing care to the older person for a long period of time

work, criminal justice and religion – but also researchers, educators, policy-makers and decision-makers. A typical basic syllabus suitable for most disciplines includes an introduction to the topic of elder abuse, consideration of the signs and symptoms of abuse, and details of local organizations that can provide assistance. More specialized training courses will concentrate on developing skills in interviewing, assessment of abuse cases, and planning care programmes. Even more advanced teaching from specialists in the field is needed to cover ethical and legal matters. Courses in how to work with other professionals and in multidisciplinary teams have also become part of advanced training curricula on elder abuse.

Public education and awareness raising are equally important elements in preventing abuse and neglect. As in public education on child abuse and intimate partner violence, the aim is to inform the general public about the various types of abuse, how to identify the signs and where help can be obtained. People who come into frequent contact with the elderly are a particular target for such education. Apart from family members and friends,

they include postal workers, bank tellers, and electricity and gas meter readers. Educational programmes aimed at older people themselves are usually more successful if the information on abuse is woven into wider topics such as successful ageing or health care. Organizations for the elderly, community centres, day-care programmes, schools (see Box 5.3), and self-help and support groups can all help this educational effort.

The media are a powerful tool for raising public awareness. More positive images and a greater prominence for older people in the media can work towards changing attitudes and reducing the stereotyping that exists around the elderly. The participants in the focus group study in South Africa stressed the importance of the media in raising public awareness (*15*), suggesting that awareness of the problem of elder abuse should also be promoted through community workshops with government involvement. In other developing countries with limited resources, local associations can provide basic education along with health care.

To date, few intervention programmes have been evaluated and it is therefore not possible to say which approaches have had the most success. Efforts to assess the effectiveness of various projects have been hindered by a lack of common definitions, a variety of theoretical explanations, a low level of interest on the part of the scientific community and a lack of funding for rigorous studies to be conducted.

A literature review of studies on elder abuse interventions found that 117 such studies had been published, in English, between 1989 and 1998 (G. Bolen, J. Ploeg & B. Hutchinson, unpublished data, 1999). Not one of them, however, included a comparison group or met standard criteria for a valid evaluation study. Based on these findings, the authors of the review felt that there was insufficient evidence in favour of any specific intervention. Six of the studies reviewed were singled out as most closely meeting the necessary criteria, but they too contained serious methodological weaknesses. Among these six studies, the proportion of cases

BOX 5.3

A Canadian school curriculum to prevent elder abuse

A nongovernmental organization, Health Canada, has developed a two-part educational project on elder abuse for children and young people. The project is intended to make children aware of and sensitive to old age and what it entails, and to create opportunities for young people to foster relationships across the generations. In so doing, it is hoped that children and young people will develop greater respect for the elderly and will be much less inclined, now and in the future, to mistreat them.

The first part of the project is an interactive story-telling kit for children aged 3–7 years, involving games and stories. While not directly addressing the subject of elder abuse, the kit provides positive images of old age. It has also proved effective with older children with a limited knowledge of English.

A formal school curriculum is at the core of the second part of the project, developed after extensive consultations with a range of people — including teachers, youth workers, religious leaders, health care providers, young people, those working with the elderly and older people themselves. The curriculum — appropriate mainly for adolescents — aims to change the deeply-rooted negative attitudes in society about older people and ageing, and to reduce the level of elder abuse.

Also in Canada, schools in Ontario have included the topic of conflict resolution in their curricula, and teachers there have found that a discussion of elder abuse can easily be introduced in this subject.

successfully resolved following a particular intervention ranged from 22% to 75%.

Recommendations

Although abuse of the elderly by family members, caregivers and others is better understood today than it was 25 years ago, a firmer base of knowledge is needed for policy, planning and programming purposes. Many aspects of the problem remain unknown, including its causes and consequences, and even the extent to which it occurs. Research on the effectiveness of interventions has to date yielded almost no useful or reliable results.

Perhaps the most insidious form of abuse against the elderly lies in the negative attitudes towards, and stereotypes of, older people and the process of ageing itself, attitudes that are reflected in the frequent glorification of youth. As long as older people are devalued and marginalized by society, they will suffer from loss of self-identity and remain highly susceptible to discrimination and all forms of abuse.

Among the priorities for confronting and eradicating the problem of elder abuse are:

— greater knowledge about the problem;
— stronger laws and policies;
— more effective prevention strategies.

Greater knowledge

Better knowledge about elder abuse is a top priority worldwide. In 1990 the Council of Europe convened a broad-ranging conference on the subject that looked at definitions, statistics, laws and policies, prevention and treatment, as well as the available sources of information on elder abuse (*67*). A global working group on elder abuse should be set up to deal with all these subjects. Among other things, such a body could bring together and standardize global statistics, and work out the requirements for a common data-reporting form. The precise role of different cultures in elder abuse should also be researched and better explained.

Research leading to effective interventions is urgently needed. Studies should be conducted to ascertain how older people can play a greater part in designing and participating in prevention programmes, something that has already been started in Canada. This could be particularly relevant in developing countries, where involving older people in the design and implementation of programmes can help raise awareness about their rights, address the problems related to social exclusion and help to empower them (*3*).

More rigorous standards are needed in scientific research on elder abuse. Too much past research has involved small samples and weak methodology, sometimes producing conflicting results. Some studies have shown that the mental state of the abuser and substance abuse are risk factors, but exactly how these factors contribute to abuse or neglect in some cases but not in others has not been investigated. Further work is also needed to resolve the currently contradictory data about cognitive and physical impairment in older people as risk factors for abuse.

Causes of abuse

More research is needed on the role of stress among caregivers, originally considered a primary cause of elder abuse. With the increasing prevalence of Alzheimer disease worldwide and the greater level of abusive behaviour found in families where a family member suffers from the disease, more attention should be given to the relationship between the caregiver and the care recipient. While it may be obvious that social isolation or lack of support can contribute to abuse or neglect, the sufferers of abuse in these situations are generally unwilling to join programmes that encourage social interaction, such as centres for the elderly or day-care activities. Research on who these victims are and on their situations might produce better solutions.

The role of ageism – discrimination against and stigmatization of older people – as a possible cause of elder abuse has yet to be properly investigated, although some specialists in the field have suggested that the marginalization of the elderly is a contributory factor. Cross-cultural studies would probably be helpful in understanding this effect.

Clearly there are certain social and cultural factors in some developing countries that are directly linked to abuse, such as a belief in witchcraft and the abandonment of widows. Other practices, which are also often quoted as being important causal factors, need to be examined, since there has been no research to confirm the claims.

Other cultural and socioeconomic factors, such as poverty, modernization and inheritance systems, may be indirect causes of abuse. The use of the ecological model to explain elder abuse is still new and more research is needed on the factors operating at different levels of the model.

Impact of abuse

The aspect of elder abuse that has perhaps received least attention is the impact on the older person. Longitudinal studies that track both abused and non-abused people over a long period of time should therefore form part of the research agenda. In particular, few studies have looked at the psychological impact on an abused person. Except for depression, little is known about the emotional damage caused to the victims.

Evaluation of interventions

A variety of interventions have been developed, including interventions related to mandatory reporting, protective service units, social service protocols, emergency shelters, support and self-help groups, and consultation teams. Very few of these, however, have been evaluated using an experimental or quasi-experimental research design, and evaluative research of a high standard is urgently required. Unfortunately, the topic of elder abuse has not attracted the attention of many established researchers, whose expertise is nonetheless much needed. A greater investment of resources in studies on elder abuse would encourage such research.

Stronger laws

Basic rights

The human rights of older people must be guaranteed worldwide. To this end:

- Existing laws on domestic or intrafamily violence should be extended to include older people as a group.
- Relevant existing criminal and civil laws should explicitly cover the abuse, neglect and exploitation of older people.
- Governments should introduce new laws specifically to protect older people.

Abusive traditions

Many existing traditions are abusive towards older women, including belief in witchcraft and the practice of abandoning widows. Ending these customs will require a high degree of collaboration among many groups, probably over a long period of time. To help this process:

- Advocacy groups, consisting of older people as well as younger people, should be formed at local, provincial and national levels to campaign for change.
- Governmental health and welfare programmes should actively seek to mitigate the negative impact that many modernization processes and the consequent changes in family structure have on older people.
- National governments should establish an adequate pension system, in all countries where it does not exist.

More effective prevention strategies

At the most basic level, greater importance must be attached to primary prevention. This requires building a society in which older people are allowed to live out their lives in dignity, adequately provided with the necessities of life and with genuine opportunities for self-fulfilment. For those societies overwhelmed by poverty, the challenge is enormous.

Prevention starts with awareness. One important way to raise awareness – both among the public and concerned professionals – is through education and training. Those providing health care and social services at all levels, both in the community and in institutional settings, should receive basic training on the detection of elder abuse. The media are a second powerful tool for raising awareness of the

problem and its possible solutions, among the general public as well as the authorities.

Programmes, in which older people themselves play a leading role, for preventing abuse of the elderly in their homes include:

— recruiting and training older people to serve as visitors or companions to other older people who are isolated;
— creating support groups for victims of elder abuse;
— setting up community programmes to stimulate social interaction and participation among the elderly;
— building social networks of older people in villages, neighbourhoods or housing units;
— working with older people to create ''self-help'' programmes that enable them to be productive.

Preventing elder abuse by helping abusers, particularly adult children, to resolve their own problems is a difficult task. Measures that may be useful include:

— offering services for the treatment of mental health problems and substance abuse;
— making jobs and education available;
— finding new ways of resolving conflict, especially where the traditional role of older people in conflict resolution has been eroded.

Much can also be done to prevent abuse of the elderly in institutional settings. Measures that may be useful include:

— the development and implementation of comprehensive care plans;
— training for staff;
— policies and programmes to address work-related stress among staff;
— the development of policies and programmes to improve the physical and social environment of the institution.

Conclusion

The problem of elder abuse cannot be properly solved if the essential needs of older people – for food, shelter, security and access to health care – are not met. The nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where anti-ageing attitudes are discouraged, where older people are given the right to live in dignity – free of abuse and exploitation – and are given opportunities to participate fully in educational, cultural, spiritual and economic activities (*3*).

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