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Violence in Older Adults: Scope, Impact, Challenges, and Strategies for Prevention

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Abstract

Although often perceived to be a problem of the young, violence commonly affects older adults, a rapidly growing segment of the population. Violence can be directed toward older adults (elder abuse and intimate partner violence), self-directed (suicide), or perpetrated by older adults against others (intimate partner violence and violence in dementia). Across forms of violence, firearm access increases lethality, and veterans may be a particularly high-risk population. The forms of violence in older adults have some common risk factors (such as medical or psychiatric illness) and common challenges for prevention (such as balancing autonomy and well-being in vulnerable adults). The integration of prevention strategies across the life span, disciplines, and types of violence offers promise for promoting older adult health and well-being. Looking forward, key areas for attention will include raising awareness about these topics and prioritizing funding for the implementation and evaluation of violence-prevention interventions in health care settings and the community.

Violence is often perceived to be a problem of the young, but it persists into later life and has a major impact on older adults. The anticipated explosive growth of the US population ages sixty-five and older, which is expected to double to eighty-three million by 2050,[1] will increase the urgency of addressing this problem. Unfortunately, violence in older adults has received little attention to date from researchers; policy makers; or providers in the fields of social services, medicine, or criminal justice.

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Violence takes three main forms in older adults: violence directed toward older adults (physical or sexual elder abuse or intimate partner violence [IPV]), self-directed violence (suicide or nonfatal self-harm), and violence perpetrated by older adults against others. In this article, we summarize the available data on each of these forms of violence, including risk factors and challenges—as well as strategies for preventing and responding to violence.

Forms Of Violence

Violence Toward Older Adults

Although older adults report violent victimization at lower rates than other populations do,[2] perpetrators may target older adults because of their perceived vulnerability or lower likelihood of reporting. While violence may be perpetrated by strangers, a substantial portion is physical or sexual elder abuse, in which the perpetrator is a known person in a position of trust.[3–5] Based on law enforcement data, 50 percent of older victims of violent crime were assaulted by a family member.[6] This violence includes abuse of a dependent older adult by a caregiver as well as incidents involving an independent older adult.

IPV is also an important type of violence toward older adults, although it may also be categorized as elder abuse (albeit with a partner as the perpetrator).[7] As is the case with younger adults, it most commonly involves a female victim and a spouse or partner as the perpetrator. Though many older adult IPV victims have suffered for decades in abusive relationships, others experience it for the first time in later life.[8] This can occur either from a new partner or from a long-term partner in the context of cognitive impairment (in either partner) or stress related to caregiving. In some cases, the abuse is mutual, with both the partner delivering care and the partner receiving care acting violently toward one another. Recent research from seven US states emphasizes the lethality of IPV among older adults: 23 percent of all women killed by their partners were ages fifty and older, and 31 percent of homicides among women ages sixty-five and older were IPV-related.[9]

Self-Directed Violence

In the US, suicide rates are much higher than homicide rates among older adults (exhibit 1). Women's suicide rates peak in midlife, whereas men's suicide rates continue to a peak in old old age at a rate that is 3.6 times greater than the age-adjusted overall rate for men and women combined.[10] Older adults are more likely than younger adults to use firearms (versus other methods) in suicide attempts: In 2017, 70 percent of suicides were by firearm among people ages 65 and older, versus 46 percent among those ages 15–64.[10] Older adults are also more likely than younger people to live alone and are therefore less likely to be found in sufficient time to be rescued after a suicide attempt.[11] These characteristics, combined with reduced physical resilience to survive an attempt, lead to higher fatality rates in suicide attempts in later life. Whereas there are approximately 200 suicide attempts per suicide death in adolescents, that ratio drops to 29:1 for people ages 35–59 and 8:1 for those ages 60 and older.[12] The large baby-boom cohort now entering older adulthood has carried a higher risk for suicide across the life course than preceding birth cohorts have.[13] These combined factors suggest that absolute numbers of completed suicides among older adults will increase dramatically in coming decades.

Violence Perpetrated By Older Adults Against Others

Older adults are more often victims than perpetrators of violence, but it is important to recognize two main scenarios in which they might inflict harm on others. The first is IPV—which, as discussed above, can continue into or begin in later life. The second is violence perpetrated toward relatives or others by people with dementia, defined as brain diseases causing long-term, gradual decreases in cognition and memory (Alzheimer disease is the most common type of dementia). Dementia is often accompanied by anxiety, delusions, and paranoia, all of which can lead to behavioral changes and potentially violent outbursts.[14] The estimated rates of perpetrating physical violence at least once during the course of their illness hover around 24 percent among people with dementia but range from 18 percent to 64 percent depending on the study, population, and definition of violence.[14–16] Approximately 20 percent of home-based dementia caregivers experience violence or aggression, which may be associated with subsequent placement of the person with dementia in a long-term care facility.[14] Of note, while much public attention is focused on mass shootings, it appears that these are not commonly perpetrated by older adults: There were 160 incidents in the period 2009–17 in which the shooters' ages were known, and all but three of the shooters were younger than age sixty.[17]

Prevalence, Risk Factors, And Challenges For Identification, Intervention, And Prevention

Exhibit 2 shows the prevalence, and online appendix exhibit 1[18] shows the risk factors, of each of these forms of violence based on best available evidence. Notable similarities in risk factors exist across forms of violence, including cognitive impairment, medical illness, functional disability or dependence, psychiatric illness, substance misuse, low socioeconomic status, and social isolation or low social support.[4,10,19–21] Yet there are also differences in risk factors across types of violence. For example, males are at higher risk than females for self-directed violence and violence perpetration, while females are at higher risk than males for IPV victimization. These differences can inform prevention and intervention efforts, but additional research is needed to understand which factors pose the greatest magnitude of risk for various types of violence.

Key challenges related to identification, intervention, and prevention for older adult violence are shown in online appendix exhibit 1.[18] Identification of at-risk older adults is a challenge for all types, as older adults may not report victimization or threats that they have experienced and community workers and health care providers may not be familiar with warning signs. Intervention and prevention efforts must balance the competing goals of autonomy and protection. For example, thoughts of death are normative in later life but overlap with thoughts of suicide. Intervening to prevent suicide in an older person who wishes for an early death may unjustifiably restrict the person's autonomy or may be appropriately lifesaving, and distinguishing between the two can be difficult, even for experts.

Special Topics

Firearm Access

An estimated 35 percent of all adults ages sixty and older own a gun, and another 14 percent live in a household with someone who does. These rates are higher than those among the total US adult population (23 percent own a firearm and another 12 percent are nonowners living in a household with a firearm).[22] Across ages, personal protection is the most commonly cited primary reason for firearm ownership.[23]

Firearm access can increase the risk of serious injury or death because of the high lethality of firearms compared to other weapons. For example, among all forms of suicide, approximately 83 percent of attempts with firearms result in death, versus 61 percent by hanging and 1.5 percent by medication overdose.[24] Higher rates of firearm access among older adults, especially men, may contribute to higher suicide rates in this age group. Whereas firearms are the means used in approximately 50 percent of US suicides overall, they are the means used in 72 percent of suicides in late life.[10,11] Ninety-one percent of firearm deaths among older adults are due to suicide.[10]

Veterans

While any older adult can experience violence, the US veteran population is a high-risk group that deserves focused attention. According to the 2017 American Community Survey, 18 percent of the US population ages sixty-five and older are veterans, which makes this a large group of older adults with shared experiences and risk factors.[25] Adults ages sixty and older account for 55 percent of veterans,[26] and in the coming decades this proportion is expected to grow among the general veteran population,[1,26] particularly among those receiving care from the Veterans Health Administration (VHA).[27]

In 2014, veterans accounted for 8.5 percent of the US population but 18 percent of all deaths from suicide among US adults.[28] In the same year, approximately 65 percent of all veterans who died from suicide were ages fifty and older.[28] Higher rates of firearm access among veterans than in the general population may contribute to the higher rates of suicide, and the majority of suicides by male veterans involved a firearm (66 percent compared to 56 percent in male nonveterans).[28] Population-based studies show that 45 percent of veterans own firearms,[29] and many own multiple guns: In a 2015 national survey, responding veterans reported having an average of 6.1 firearms at home. One-third reported that at least one gun was stored loaded and unlocked, and those with suicide risk factors were not more or less likely to store guns safely.[30]

Veterans may also be at elevated risk of being victims or perpetrators of violence involving other people[31] because of high rates of firearm ownership; multiple risk factors for experiencing elder abuse, including poor physical health, functional dependence, and social isolation;[31] and a high prevalence of past trauma and subsequent elevated rates of posttraumatic stress disorder and associated mental health conditions. While posttraumatic stress disorder is associated with subsequent aggressive and violent behaviors in younger veterans,[32] aging with the disorder may also increase veterans' risk of dementia,[33] with

concurrent disorder symptoms and cognitive impairment leading to potentially violent behavior.

Integrated Approach To Older Adult Violence Prevention

Ideally, violence prevention strategies would occur from the level of the individual and his or her relationships up to higher-level societal policies and structures. Strategies should incorporate principles of healthy aging by optimizing older adult physical, social, and mental health and enabling older adults to remain independent and engaged in their communities. Based on existing research and experience, we believe that integration of existing services and programs would also ideally occur across the life span, across types of violence, and across disciplines (exhibit 3).

First, programs to address violence should be integrated across the life span to include older adults. This would include violence prevention programs focused on risks present in both younger and older adults, such as mental health issues, heavy alcohol and illicit substance use, and homelessness. Hospital-based violence intervention programs typically focus on adolescents and young adults involved in violence, but these approaches could be extended to older groups. Outside of health care settings, existing domestic violence shelters and related services might be redesigned to serve older adults, especially those with functional or cognitive impairment. In cases of IPV in younger and middle-age adults, current practice among law enforcement and protective services involves checking for the presence of children in the home to assess for potential child abuse.[34] Similar screening of vulnerable older adults should also occur when household IPV or child abuse is detected, as optimal violence reduction addresses entire families in crisis. In addition to integrated services, programs targeted specifically to older adults should be encouraged and supported, as different populations may need different services.

Second, interventions to prevent one type of violence, such as suicide, should also address other forms, given common risk factors. As an example, an older man who is angry and depressed after his partner leaves him might be at risk of both suicide and partner homicide. At the level of community interventions, programs to decrease social isolation[35] could enhance mental health while possibly reducing the risk of all types of violence.

Third, integration should occur across multiple disciplines. Health care, social services, civil law, and criminal justice systems all offer different resources for prevention, identification, and intervention. While these systems are generally siloed, there are rare examples of integrated, multisector approaches. One example is multidisciplinary elder abuse teams or forensic centers that provide a streamlined and rapid response to complex cases referred by concerned health care providers or other professionals.[36]

A Path Forward: Key Areas For Action

Raising Awareness And Prioritizing Funding

Raising awareness among professionals and the public about the underrecognized and growing phenomenon of violence in older adults is a key action for policy makers and others

involved in the field. Examples of strategies to raise awareness include campaigns that focus on the prevalence and prevention of suicide in older adults as well as information about safe firearm storage. Elder justice was one of four focus topics of the 2015 White House Conference on Aging, which greatly raised the profile of this issue.[37] New York State amended its elder law ("Identifying and Reporting Self Neglect, Abuse, and Maltreatment in Healthcare Settings) in 2017 to require state agencies to give health care providers education and tools to use in screening older adults for the presence of elder abuse. In addition, many police departments[38] and prosecutorial offices[39] have developed units that focus exclusively on elder abuse.

Prioritizing funding for programmatic efforts and research is also critical. One large source of federal funds is the Crime Victims' Fund established by the Victims of Crime Act of 1984. With recent increases in VOCA funding, the Department of Justice has provided guidance on how VOCA funds could be used for older adult victims.[40] In the VHA, suicide prevention has been named a top clinical priority, with the 2020 budget proposing $222 million toward its suicide prevention program and the Office of Research Development in the Department of Veterans Affairs prioritizing applications for research grants focused on this topic.[41] The National Institutes of Health and foundations could similarly encourage innovative research in the area of violence in older adults by releasing specific requests for applications in this area.

Health Care Setting Interventions

Health care providers could play an important role in reducing violence in older adults through both identification and intervention. Providers should consider the potential for violence exposure when assessing an older adult patient, either through formal screening or the recognition of red flags. Identification provides the opportunity for appropriate interventions that may prevent bad outcomes. Such interventions include reporting potential cases of abuse or violence perpetration to the appropriate authorities, referring at-risk patients to other professionals, and connecting those patients to community services.

Evaluation by a health care provider might be the only occasion when a socially isolated older adult leaves his or her home. Primary care providers, whom older adults are much more likely to see than mental health professionals, have the opportunity to focus on optimizing independent function and quality of life while increasing social supports, reducing isolation, and enhancing engagement with family members and the community. Interventions affecting these types of issues could reduce the risk of all types of violence, given their common risk factors. These interventions could include referring a patient to a friendly visitor program or senior center, helping the patient enroll inMeals on Wheels and other home-based services, connecting the patient to a geriatric psychiatrist, and reporting concerns to adult protective services.

For suicide in particular, the effective recognition and aggressive treatment of mental illness in primary care is key. Up to three-quarters of older adults who die by suicide were seen in a primary care provider's office in the last month of life, and as many as one-third were seen in the last week.[42] Primary care–based integrated depression care management approaches such as the Improving Mood-Providing Access to Collaborative Treatment (IMPACT) model

have been shown to be effective in reducing suicidal ideation in later life.[43] Clinics that see high proportions of patients with dementia might stock and distribute gun locks, as many VHA geriatric clinics currently do, to help lower suicide risk and prevent violence perpetration. Primary care providers might also identify changes in behavior or new physical findings in patients that are suggestive of violent victimization.

Emergency departments (EDs) are another key setting, as older adult victims of violence and those with mental health or other crises are likely to visit EDs for acute care. ED providers already play an important role in the identification of and intervention for other types of violence, including child abuse[44] and IPV among younger adults.[45] They have an opportunity to address and possibly prevent violence in older adults through better screening and the adoption of emerging ED-based geriatric violence identification and intervention programs. One example is the Vulnerable Elder Protection Team, an innovative consultation service that focuses on improving the care of and ensuring safety for potential elder abuse victims identified in the ED.[46] First responders, including paramedics, police officers, and firefighters, can also play an important role, as they are typically the first medical providers to evaluate an older adult during an emergency—often in the patient's home.

Given the elevated risk of violence for US veterans and the VHA's position as the largest integrated health system in the US, the VHA has a unique responsibility for implementing innovative, cross-disciplinary, violence prevention programs—and an opportunity to do so. With its robust mental health and social services, the VHA could implement internal multidisciplinary teams to address elder abuse. To address the high prevalence of firearm ownership among veterans, VHA clinics that serve large numbers of older adults with dementia could implement routine screening for firearm ownership and safe storage and provide interventions (for example, storage devices) for harm reduction. As a federal agency, the VHA could partner with state and local programs (such as Medicaid, Area Agencies on Aging [discussed below], and adult protective services) to coordinate home care, transportation, and other services that maximize older veterans' ability to age well in the community. The VHA could also use its unique access to comprehensive national health care data to improve the understanding of risk factors for violence and subsequently preemptively offer services and interventions to people at increased risk.

Community Interventions

Interventions should not be based exclusively in health care systems. A cornerstone of healthy aging is enabling older adults to remain independent, active, and involved in their communities.[47] Community-based efforts to prevent violence support this mission and complement health care–based approaches. Area Agencies on Aging, which are funded by State Units on Aging using federal dollars, should be key players in such efforts. Although the area agencies vary in structure, size, and programming, collectively they are a national network of community-based services[48] that could allow for the dissemination of best practices for violence prevention. Peer companionship is one way through which Senior Corps volunteers (who are ages fifty-five and older) are linked with vulnerable elders to reduce social isolation and help with everyday tasks. Such programs can benefit the older adult who needs assistance[49] as well as the volunteer, since providing skills and services

might increase an older adult's sense of purpose and self-worth[50] and potentially reduce suicide risk. Other programs of the Area Agencies on Aging include training community gatekeepers—people whose routine activities bring them into frequent contact with older adults (such as postal or utility workers, retail store staff members, and pharmacists)—to identify people at risk of suicide or other forms of violence and refer them for mental health evaluation and treatment. Support programs for caregivers and family members might also prevent violence by reducing burnout and the associated risk of maltreatment.

Firearm-Specific Interventions

Firearm access can increase the likelihood of completed suicide or serious injury or death in the context of other risk factors for violence such as depression, posttraumatic stress disorder, or heavy alcohol use. Yet firearm ownership can also be a source of identity and pride, which highlights the challenge of balancing safety with autonomy. Voluntary collaborative efforts are an important approach in working to prevent older adult suicide or violence in the context of dementia. For example, "gun shop projects" provide suicide prevention information for distribution to firearm owners at firearm ranges and retailers.[51] Parallel efforts could similarly use trusted networks such as these to distribute information about safeguarding people with dementia and "family firearm agreements"[52] for advance planning about when and to whom people with dementia wish to transfer their firearms. Alzheimer San Diego[53] recently partnered with a local firearm retailer to develop a "gun safety checklist" and a program to distribute free gun locks to families caring for someone with dementia.

There are no broad policies or programs to remove firearms from people with cognitive impairment or dementia or to prevent the sale of firearms to such people. Cognitive impairment (except as adjudicated in a court ruling) is not listed as a disqualifier for firearm purchase on the federal background check form, and at the state level, as of early 2019 only Hawaii and Texas explicitly mentioned dementia in state laws related to firearm purchase or possession.[52] Laws known as extreme risk protection orders (or "red flag laws") have been passed or proposed in numerous states as a mechanism for law enforcement officials or family members to request the temporary confiscation of firearms from people who pose an imminent risk to themselves or others. While these policies have most often been debated in the context of preventing mass shootings or suicide, they have also been cited as a tool for use in situations when someone with dementia has access to a firearm.

Conclusion

Increasing the focus on violence in older adults, including raising awareness and prioritizing funding, is critical to addressing the underappreciated and rapidly growing problem of violence against and among older adults. Integrated approaches at multiple levels are needed to improve identification, intervention, and prevention among people at risk for perpetrating or becoming victims of violence. Attention to firearm access and other risks among vulnerable groups, including veterans, is important to reducing violence and associated harm among older adults.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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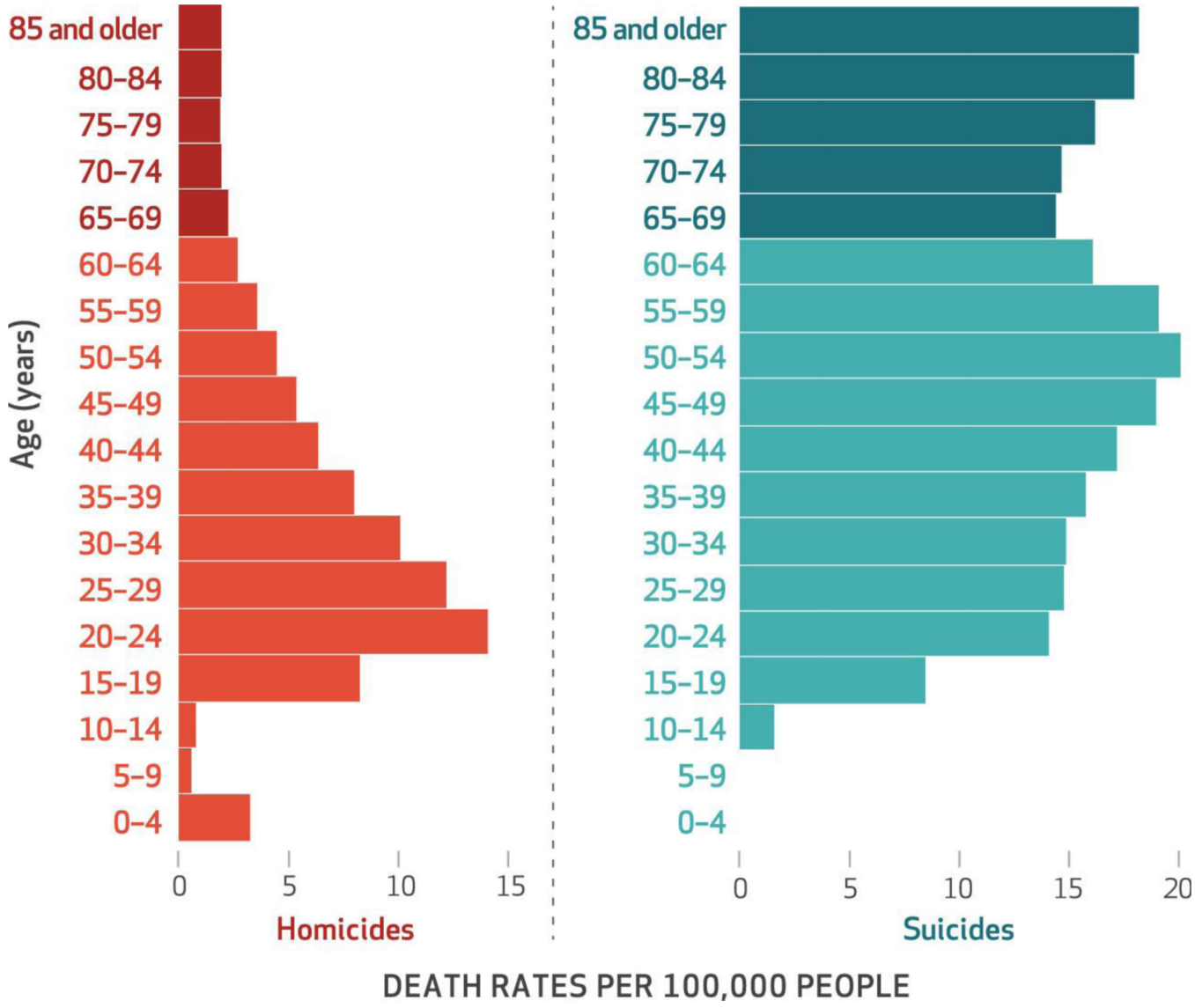

Exhibit 1:
Age-adjusted death rates per 100,000 people in the United States, 2007–17 SOURCE: Authors' analysis of data on the number of deaths from the National Vital Statistics System of the National Center for Health Statistics and of population estimates from the Census Bureau. NOTE: Homicides include deaths related to legal intervention (for example, police-involved shootings).

Exhibit 2:

Estimated annual prevalences per 1,000 people of key forms of violence involving older adults

Type of violence	Estimated prevalence
Violence toward older adults[a]	
Physical or sexual abuse	22
Intimate partner violence	17
Self-directed violence[b]	
Suicide (fatal)	0.17
Self-harm (nonfatal)	0.27
Violence perpetrated by older adults Against Others[c]	
Associated with dementia	9.7–−32.6

SOURCE Authors' analysis of available data:

[a]Based on cross-sectional population-based survey studies, although incidences of such violence may be underreported (see notes 4, 5, and 7 in text).

[b]Based on 2017 estimates of deaths from the National Vital Statistics System of the National Center for Health Statistics (NEISS All Injury Program) and of the population from the Census Bureau.(see note 10 in text).

[c]Estimates vary depending on study population and definition. The low estimate is based on the 16.4 percent incidence of "agitation/aggression" over eighteen months in a Cache County, Utah, study of participants with dementia (see note 16 in text).The high estimate is based on the unadjusted incidence of physical aggression per year among older adults with newly diagnosed dementia (see Kunik ME, Snow AL, Davila JA, Steele AB, Balasubramanyam V, Doody RS, et al. Causes of aggressive behavior in patients with dementia. J Clin Psychiatry. 2010;71[9]:1145–52). Both were adjusted using an estimated 8.8 percent prevalence of dementia among adults ages sixty-five and older (see Langa KM, Larson EB, Crimmins EM, Faul JD, Levine DA, Kabeto MU, et al. A comparison of the prevalence of dementia in the United States in 2000 and 2012. JAMA Intern Med. 2017;177(1):51–8).

Exhibit 3:

Multidomain integration of strategies to reduce violence among older adults

Domain of integration	Goal of integration	Examples
Across the life span	Include older adults as a population at risk; focus on entire family in crisis	Redesign domestic violence shelters and their services to serve older adults; use protocols to assess older adults and intervene for those who are at risk of violence because they live in a household with potential intimate partner violence among younger adults
Across forms of violence	Ensure that programs focusing on one form of violence in older adults also address other forms	Interventions to address social isolation
Across disciplines	Ensure integration between health care, mental health, social services, civil law, and criminal justice systems	Multidisciplinary teams or forensic centers to address elder abuse; family justice centers that integrate medical, psychiatric, and social management teams based in primary care

SOURCE Authors' analysis of existing models for different forms of violence.