Intimate Partner Violence and Elder Abuse in Later Life: Educational Brief

Intimate partner violence (IPV) and elder abuse represent significant public health concerns affecting millions of older adults every year. While there is currently insufficient evidence for universal screening of older adults for abuse, emerging evidence suggests that universal education approaches can support at-risk individuals and connect them with vital resources.[1] This brief explains the importance of developing effective IPV protocols that are specifically tailored to older patients served in health centers.

HEALTH PARTNERS ON IPV + EXPLOITATION

NATIONAL CENTER FOR EQUITABLE CARE FOR ELDERS

Introduction

Elder abuse encompasses multiple forms of harm, either intentional or not, including:[2]

- **financial exploitation**
- **abandonment/neglect**
- **emotional or psychological abuse**
- **physical abuse**
- **sexual abuse**

At least 1 in 10 community-dwelling older adults experience abuse annually, with rates significantly higher among those with cognitive concerns such as dementia or mild cognitive impairment.[3] The true prevalence of elder abuse is underestimated, with research suggesting only 1 in 24 cases comes to the attention of authorities, making elder abuse one of the most underreported public health concerns affecting individuals in later life.

IPV can encompass all categories of elder abuse, particularly when the intimate partner is also the caregiver. **This overlap underscores the importance of integrated approaches to screening and intervention.** Dependence on others as health and cognitive function declines can increase vulnerabilities to abuse.

The health consequences of IPV and elder abuse extend far beyond immediate physical injuries to include:[4]

- **increased rates of depression and anxiety**
- **social isolation**
- **cognitive decline**
- **UTIs and STIs**
- **frequent falls**
- **cardiovascular disease**
- **loss of independence, including nursing home placement**
- **premature mortality**

Several factors, individually or in combination, can increase the likelihood of IPV and its harmful effects among older adults:[5]

- **physical susceptibilities** such as decreased bone density, chronic conditions, and medication interactions that can amplify the severity of injuries
- **cognitive changes** including early stages of dementia that affect abuse recognition and help-seeking capacity

- **relational factors** such as decades-long partnerships with complex emotional dynamics, increased dependency on partners for care, and pressure to keep problems private
- **financial circumstances** including fixed incomes, shared assets accumulated over time, and economic abuse that threatens basic security

These intersecting factors create a distinct risk profile that can differ from the antecedents and effects of IPV in younger populations, suggesting the need for tailored screening and intervention approaches.

Current Recommendations for Preventative Care Screening

The U.S. Preventative Services Task Force (USPSTF), the body which reviews the published evidence to make recommendations for specific preventative care screening practices, updated their recommendations related to screening for IPV in 2025.[6] Although they concluded that the evidence supported screening and referral for women of reproductive age (B recommendation), they were unable to extend this recommendation to all older and vulnerable adults due to insufficient current evidence to assess the balance of benefits and harms of screening for abuse and neglect in this broader population (I statement). This recommendation is unchanged from the previous recommendation issued in 2018.

The American Academy of Neurology issued a position statement in 2012 on abuse and violence, recommending that physicians routinely screen all patients for past and ongoing violence, including "spousal abuse", with no recommended age or gender limits, integrating questions into the medical history.[7] Similarly, the American Medical Association recommends that physicians routinely inquire about any history of family violence (including child maltreatment, intimate partner violence, and elder abuse) in the context of care provision.[8] The American College of Obstetricians and Gynecologists published ACOG Committee Opinion 824 in 2021 recommending "screening of patients older than 60 years to help identify victims of abuse and provide them with appropriate medical and psychosocial care and referrals".[9]

Screening Approaches

Despite the current lack of sufficient evidence for a recommendation to routinely assess older adults for IPV in the absence of signs or symptoms, the USPSTF acknowledges that IPV impacts "millions of U.S. residents across the lifespan".[6] Considering the impact of such abuse, multiple professional organizations recommend addressing this issue in the context of routine primary care.

Lessons learned from the research and application of screening approaches in this and other populations include:

- **Conduct any assessment in a safe, confidential environment.**

  Older adults often present for care accompanied by a caregiver or family member. When clinically appropriate, the cognitively intact patient should be seen alone for at least part of the visit to provide an environment that is safe for discussion of, and intervention related to, potential abuse. For cognitively impaired patients, indirect methods such as caregiver surveys, healthcare provider directed screenings, reports from social services and physical findings may be useful in identifying victims/survivors of abuse.[10]

- **Be aware of and respond to clinical indicators of vulnerability to abuse.**

  Indicators include:

  - **history of IPV in the relationship**
  - **cognitive impairment**
  - **depression**
  - **alcohol or other substance misuse**
  - **isolation**
  - **lack of social support**
  - **functional impairment**
  - **poor physical health**
  - **observed or reported controlling behavior by the intimate partner**
  - **suicidal ideation**

Although multiple tools and approaches have been developed to detect elder abuse, to date there remains a lack of validated and reliable screening tools.[11] Evidence for the use of effective tools to detect and address IPV in other populations, such as reproductive-age women, has yet to be demonstrated in the older adult population.[10] It is unclear what clinical environment may be best for screening older adults for IPV, although lessons learned from both IPV screening in reproductive-age women and child abuse screening suggest that the emergency department and primary care visits may be appropriate environments for universal screening.[10]

Multiple professional organizations recommend that health professionals query all older adult patients regarding potential abuse as an integral part of obtaining a health history. Some key screening questions to consider include:

- **Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?**
- **Have you been upset because someone talked to you in a way that made you feel intimidated, shamed or threatened?**

- **Have you ever felt controlled or isolated by your partner?**
- **Has anyone made you afraid, touched you in ways that you did not want or hurt you physically?** [7, 12]

Considerations for Patient Communication

- Prioritize immediate physical safety and emotional security during conversations.
- Use non-judgmental, validating language that acknowledges the complexity of long-term relationships.
- Support their decision-making capacity while providing resources and referrals, including for safety planning.

Universal Education

Universal education about elder abuse for older adults and their caregivers has been identified as a promising practice.[13] Utilizing the CUES intervention, a brochure-based approach to universally incorporate relationship information, support and referral to resources regardless of whether there is an affirmative disclosure, has been shown to be effective in reproductive-age populations. Potential harms are minimized due to the focus on information and resource sharing rather than disclosure.

The Aging with Respect Safety Card tool complements the CUES intervention

Caregiver Support

A promising approach to reduce elder abuse is caregiver education and support. A recent pilot study which provided education and social support to caregivers, a third of whom were the spouse/partner, showed a significant decrease in mistreatment of dependent elders by their caregivers.[14] In a large study in Maine, an intervention to address and reduce elder abuse after a referral to Adult Protective Services was found to significantly reduce the likelihood of recurrence of abuse.

Known as the RISE *(Repair harm, Inspire change, Support connection, Empower choice)* Model, the intervention included goal setting, education, and support of client/victims and educational and social support of their alleged harmers.[15, 16] Further research is needed to create an evidence base for effective interventions, but these approaches demonstrate potential for reducing vulnerability to elder abuse.

Documentation

In 2020, HRSA introduced the Uniform Data System (UDS) data element where health centers (HCs) report data on experiences of IPV that are documented in the electronic health record (EHR). It is vital that HC staff consider the ways that EHRs and data sharing may decrease safety for survivors and take steps to ensure that patients who are surviving abuse are in control of their health information.

To view the related ICD-10 codes and an adaptable protocol on IPV/HT/E in English and Spanish, see here.

ICD-10 codes for UDS data collection of intimate partner violence:

- **T74.11** - Adult physical abuse, confirmed
- **T74.21** - Adult sexual abuse, confirmed
- **T74.31** - Adult psychological abuse, confirmed
- **Z69.11** - Encounter for mental health services for victim of spousal or partner abuse
- **Y07.0** - Spouse or partner, perpetrator of maltreatment and neglect

Model Protocol and OCHIN and eClinicalWorks Smart Tools

Updating your health IT platforms will rely on and work alongside your protocol for engaging patients around IPV/HT/E. To develop your HC's approach, adapt the Protocol for HRSA-supported Community Health Centers to Engage Patients through Universal Education Approaches on Exploitation (E), Human Trafficking (HT), Domestic Violence (DV) and Intimate Partner Violence (IPV). This protocol, available in English and Spanish, offers a model to enable HCs to implement CUES to provide survivor-centered care and formalize strategies to connect patients with community-based services.

Health Partners on IPV +Exploitation has worked with two common EHRs, eClinicalWorks and OCHIN Epic to create smart tools for CUES:

- **eClinicalWorks smart tool**
- **OCHIN internal website for OCHIN members only; information about the CUES tools is available here.**

Learn more: A Practical Guide on Intimate Partner Violence, Human Trafficking, and Exploitation and Technology Tools

Community Partners & Resources

HCs and domestic/sexual violence (DSV) programs are natural partners given their shared mission to improve the health, wellness, and safety of their clients and to prevent violence before it begins. Including each other as part of multidisciplinary care teams is a crucial step to support both staff as well as survivors in your community and helps promote bi-directional referrals. DSV advocates work with survivors and their families to promote safety and heal from violence in many ways, including:

- **Safety planning** (led by DSV advocates to improve safety: when abuse is present, when preparing to leave, or after a relationship or abuse has ended)
- **Housing** (emergency and transitional)
- **Legal advocacy, restraining orders and court accompaniment**
- **Support groups/counseling**

To identify a DSV program in your area, contact your state, or Tribal coalition, or contact the National Domestic Violence Hotline: 800-799-SAFE (7233). In addition, you can reach the StrongHearts Native Helpline at 844-7NATIVE (762-8483).

Call to Action

HCs can create supportive environments where older adults receive information about healthy relationships and feel safe to disclose abuse, while building organizational capacity to respond effectively. Success requires leadership commitment, comprehensive staff training, clear policies, and strong community partnerships. Implementing these evidence-based strategies enables HCs to better address positive health and safety outcomes for older patients while respecting their autonomy and dignity.

Additional Resources

- Futures Without Violence and Health Partners on IPV + Exploitation
- National Center for Equitable Care for Elders
- National Adult Protective Services Association
- National Center on Law and Elder Rights
- National Clearinghouse on Abuse in Later Life
- National Coalition Against Domestic Violence

References

1. Todahl, J., Nekkanti, A., & Schnabler, S. (2020). Universal Screening and Education: A client-centered protocol for normalizing intimate partner violence conversation in clinical practice. *Journal of Couple & Relationship Therapy*, *19*(4), 322–346. doi.org/10.1080/15332691.2020.1835595
2. U.S. Department of Justice. (2024, December 9). *About elder abuse*. Elder Justice Initiative (EJI), United States Department of Justice. justice.gov/elderjustice/about-elder-abuse
3. NCOA. (2024, July 8). *Get the facts on elder abuse*. ncoa.org/article/get-the-facts-on-elder-abuse
4. World Health Organization. (2024, June 15). *Abuse of older people*. who.int/news-room/fact-sheets/detail/abuse-of-older-people
5. USC Center for Elder Justice. (n.d.). *What is elder abuse?* elderjustice.usc.edu/what-is-elder-abuse
6. U.S. Preventive Services Task Force. (2025). Screening for intimate partner violence and caregiver abuse of older or vulnerable adults. *JAMA*, *334*(4), 329. doi.org/10.1001/jama.2025.9009
7. Schulman, E. A., & Hohler, A. D. (2012). The American Academy of Neurology Position Statement on Abuse and Violence. *Neurology*, *78*(6), 433–435. doi.org/10.1212/wnl.0b013e318245d21c
8. American Medical Association . (2019). *Violence and Abuse Family and Intimate Partner Violence H-515.965*. AMA Policy Finder. policysearch.ama-assn.org/policyfinder/detail/ipv?uri=%2FAMADoc%2FHOD.xml-0-4664.xml
9. American College of Obstetricians and Gynecologists. (2021). Elder abuse and women's health. *Obstetrics & Gynecology*, *137*(3). doi.org/10.1097/aog.0000000000004298
10. Beach, S. R., Carpenter, C. R., Rosen, T., Sharps, P., & Gelles, R. (2016). Screening and detection of elder abuse: Research opportunities and lessons learned from emergency geriatric care, intimate partner violence, and child abuse. *Journal of Elder Abuse & Neglect*, *28*(4–5), 185–216. doi.org/10.1080/08946566.2016.1229241
11. Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women's Health*, *24*(1), 92–99. doi.org/10.1089/jwh.2014.4870
12. Wang, X. M., Brisbin, S., Loo, T., & Straus, S. (2015). Elder abuse: An approach to identification, assessment and intervention. *Canadian Medical Association Journal*, *187*(8), 575–581. doi.org/10.1503/cmaj.141329
13. Moore, C., & Browne, C. (2016). Emerging innovations, best practices, and evidence-based practices in elder abuse and neglect: A review of recent developments in the field. *Journal of Family Violence*, *32*(4), 383–397. doi.org/10.1007/s10896-016-9812-4
14. Gassoumis, Z. D., Martinez, J. M., Yonashiro-Cho, J., Mosqueda, L., Hou, A., Han, S. D., Olsen, B., Louis, A., Connolly, M., Meyer, K., Marnfeldt, K., Salinas Navarro, S. A., Yan, M., & Wilber, K. H. (2023). Comprehensive Older Adult and Caregiver Help (COACH): A person-centered caregiver intervention prevents elder mistreatment. *Journal of the American Geriatrics Society*, *72*(1), 246–257. doi.org/10.1111/jgs.18597
15. Burnes, D., Connolly, M.-T., Salvo, E., Kimball, P. F., Rogers, G., & Lewis, S. (2022). Rise: A conceptual model of integrated and restorative elder abuse intervention. The Gerontologist, 63(6), 966–973. doi.org/10.1093/geront/gnac083
16. Lewis, S., Connolly, M., Salvo, E., Kimball, P. F., Rogers, G., MacNeil, A., & Burnes, D. (2023). Effect of an elder abuse and self-neglect intervention on repeat investigations by adult protective services: RISE project. Journal of the American Geriatrics Society, 71(11), 3403–3412. doi.org/10.1111/jgs.18506

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