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RESEARCH ARTICLE

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Use of clinical vignettes to assess health care professionals' identification and response to elder abuse in dementia care: a cross-sectional study

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ABSTRACT

Elder abuse affects nearly 15% of older Australians, with those living with dementia at increased risk. This study explored how Australian health care providers identify and respond to different types of elder abuse using six hypothetical vignettes. An online cross-sectional survey (N = 130) evaluated identification and response to instances of elder abuse among geriatricians, general practitioners, and nurse practitioners. Rates of accurate identification were highest for physical (94.3%) and psychological abuse (91.5%), followed by sexual abuse (76.1%), neglect (72.3%), and financial abuse (72%). While most participants provided an appropriate response to psychological abuse, neglect, and financial abuse (100%, 100%, 97.8%), fewer reported an appropriate response to physical (37%) and sexual (67%) abuse. Older age was associated with lower identification accuracy for psychological and physical abuse. General practitioners were more likely to correctly identify neglect. Findings highlight important knowledge and response gaps, underscoring the need for targeted education and training.

KEYWORDS

Abuse identification; community dementia care; dementia; elder abuse

Introduction

Elder abuse is defined as "*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*" (World Health Organization. Elder Abuse Fact Sheet, 2022). Elder abuse encompasses psychological, financial, physical, and sexual abuse, as well as neglect. Elder abuse has significant

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impacts, greatly increasing the likelihood of placement in a nursing home and of hospitalization (Dong & Simon, 2013). Elder abuse is associated with premature mortality (Yunus et al., 2017) health care use (Yunus et al., 2017) and increased rates of depression, anxiety, and other negative psychological outcomes (Dong et al., 2013; Mouton et al., 2010).

A recent national study exploring the prevalence of elder abuse in Australia found that 14.8% of community dwelling people aged 65 years and older reported experiencing elder abuse in the past 12 months (Qu et al., 2021) with psychological abuse being the most prevalent followed by neglect. Women were slightly more likely than men to report an experience of elder abuse (15.9% cf. 13.6%) (Qu et al., 2021). However, it is important to note that this study excluded individuals with cognitive impairment or those unable to participate due to frailty or other health limitations. As a result, the reported prevalence likely underestimates the true scope of elder abuse, particularly among more vulnerable groups such as people living with dementia or those residing in institutional care settings. However, Australian prevalence rates are consistent with international studies. A meta-analysis of 52 prevalence studies across 28 countries finding an overall elder abuse prevalence rate of 15.7%, with psychological abuse the most common, followed by financial abuse, neglect, physical abuse, and sexual abuse (Yon et al., 2017). With the global population of adults aged 60 years and older set to more than double to about two billion by 2050 and with expected increases in life expectancy (World Health Organization. Elder Abuse Fact Sheet, 2022), the number of people affected by elder abuse is expected to increase dramatically to 320 million victims by 2050 (World Health Organization, 2017). The United Nations Decade of Healthy Ageing (2021–2030) identifies elder abuse as a critical global issue (World Health Organization, 2022).

Older people with cognitive impairments such as dementia are particularly vulnerable to elder abuse (Dyer et al., 2000; Kaspiew et al., 2015). Having poor health, a disability, or a long-term medical condition has independently been shown to double the risk of experiencing elder abuse (Qu et al., 2021) and individuals with dementia generally have a high level of dependence on informal supports, and a reduced ability to monitor and report their own circumstances which further increases their vulnerability. The prevalence of elder abuse reported in studies of people with a diagnosis of dementia varies widely (Dong et al., 2014; McCausland et al., 2016; Wiglesworth et al., 2010). A 2016 review of 49 international studies found rates vary from 0.3% to 78.4% in the community and 8.3%–78.3% in institutional settings (Fang & Yan, 2018). A 2025 systematic review and meta-analysis of 30 studies found that the pooled rate of overall abuse among older adults with dementia was 42.6%, with psychological abuse the most prevalent, followed by financial abuse, neglect, and physical abuse (Shen et al., 2025). In Australia, data collected from calls to the Elder Abuse Prevention Unit Helpline in Queensland during

the 2022–23 financial year found that the victim of abuse was cognitively impaired in 17.7% of the cases, and dementia was the most frequently reported cognitive impairment (Gillbard & Leggatt-Cook, 2023). Severity of cognitive impairment and behavioral disorders, a greater number of caregiving hours, a worse relationship with caregiver, and perceived caregiver burden have been found to be associated with increased occurrence of abuse among people with dementia (Serra et al., 2018).

Health care professionals can play a critical role in detecting and responding to elder abuse. As front-line care providers for older people in Australia, general practitioners, geriatricians, and nurse practitioners are in a unique position to observe changes in a patient's circumstances over time and identify potential threats to their safety (Ries & M, 2018). They often observe their patients with dementia over a long period of time, visit them in their home environment, and meet caregivers and other family members. Clinical and professional guidelines empahsize the critical role of health care providers in detecting and responding to elder abuse, including the importance of understanding and recognizing indicators of abuse, understanding reporting requirements, and offering appropriate support and referrals (Royal Australian College of General Practitioners, 2025a, 2025b). However, research suggests that health care providers often fail to detect and respond to elder abuse. For example, a US study of primary care physicians found most did not routinely screen for abuse, and a quarter of respondents could not identify a factor that might alert them to potential abuse (Taylor et al., 2006). A UK study of general practitioners found that less than 50% had any training about elder abuse and the majority had not identified a case in the previous 12 months (McCreadie et al., 2000). In Sweden, a similar survey found that while 77% could identify a patient at risk and 25% were aware of someone suspected of abuse, they were rarely making reports (Saveman & Sandvide, 2001). In an Australian study of health care professionals including doctors, nurses, and allied health staff, between one-quarter and two-fifths of health professionals did not identify abusive strategies using the Caregiving Scenario Questionnaire (Hempton et al., 2011).

Barriers to detecting and responding to elder abuse among health care professionals are multifaceted and complex. These include a lack of consensus on definitions of elder abuse (Yon et al., 2017) limited knowledge about the signs and symptoms of elder abuse, uncertainty regarding the role of health care providers in reporting elder abuse (O'Brien, 2010; O'Brien et al., 2014; Ross, 2023), a lack of knowledge about reporting requirements which can delay early detection (Ross, 2023), a lack of confidence in the systems responsible for following up reports of elder abuse (McCreadie et al., 2000; Ries & M, 2020), and concerns about their ability to improve the victims' situation (Harrell et al., 2002). These barriers align with applied ecological models that emphasize that elder

abuse emerges from interactions between individual vulnerabilities, relationship dynamics, and broader organizational or societal factors (Schiamberg & Gans, 2000). When patients have dementia, additional barriers include communication challenges which may make it difficult for the patient to disclose instances of abuse, cognitive decline which may hinder a person's ability to recognize and report abuse or impair recall of past incidents, and misinterpretation of symptoms such as behavioral disturbances and mood changes which may be mistakenly attributed to the progression of the disease rather than underlying abuse (Hansberry et al., 2005). Compounding these challenges is the increasing fragmentation of health and support services, along with the dismantling of multidisciplinary teams that traditionally played a key role in identifying and responding to elder abuse.

While existing research highlights the prevalence and complexity of abuse among older individuals with dementia, there are limited data on how well-equipped health care professionals are to identify and respond to such cases. Understanding this is crucial to early intervention and the development of clear reporting and response pathways, which is a key focus of governmental initiatives including Australia's *National Plan to End the Abuse and Mistreatment of Older People 2024–2034, 2025*. This study therefore aimed to describe among general practitioners, geriatricians, and nurse practitioners in Australia the:

(1) Proportions who accurately identify and appropriately respond to different types of elder abuse in community dementia care using hypothetical clinical vignettes; and
(2) Sociodemographic and practice characteristics associated with accurate identification of elder abuse.

Methods

Study design

An online cross-sectional survey of general practitioners, geriatricians, and nurse practitioners was conducted.

Participant eligibility

Individuals were eligible to participate if they were a general practitioner, nurse practitioner, or geriatrician; had a caseload that included people aged 65 years and older; and were currently practicing or had been practicing in Australia within the last 12 months.

Recruitment

A multicomponent recruitment process was used to identify, contact, and invite eligible individuals to participate in the survey. Advertisements containing brief information about the study were circulated by professional organizations (e.g., Australian and New Zealand Society for Geriatric Medicine), Primary Healthcare Networks, and the Australasian Medical Publishing Company database. The Australasian Medical Publishing Company database is a comprehensive contact database of registered medical practitioners in Australia, maintained by the Australian Medical Association. It includes up-to-date information on General practitioners, Specialists, and other health care professionals including nurses and nurse practitioners. The advertisements explicitly stated that the study examined health care professionals' experiences and perspectives related to elder abuse in older adults, including identification, management, and reporting. Participants used a link embedded in the advertisement to obtain a copy of the detailed participant information statement and commence the electronic survey. Completion of the survey was taken as participants' informed consent for participation. Participants received an AUD$100 gift voucher as reimbursement for their time and were provided with a certificate of research participation to recognize their contribution to the research.

Data collection

Data were collected via an online questionnaire using the QuestionPro platform between November 2022 and April 2023. The questionnaire included 53 items and took approximately 12 minutes to complete. The questionnaire included items to capture the sociodemographic and practice characteristics of participants and six clinical vignettes to examine practitioners' ability to identify and respond to hypothetical elder abuse scenarios.

Measures

Practitioner identification and action on elder abuse. Participant identification and action on elder abuse was measured using six study-specific vignettes (see Table 1). Vignettes can be used in health and social research to examine clinical decision-making in a controlled and standardized manner, allowing researchers to assess practitioner responses to sensitive, complex, or ethically challenging scenarios that are difficult to observe directly in practice (Sheringham et al., 2021). A study-specific measure was developed to reflect Australian clinical and legal contexts, which are not fully captured by existing standardized instruments. This approach allowed for the inclusion of specific response options relevant to Australian guidelines and practice, enhancing the

Table 1. Description of vignettes used in the study.

Vignette	Description
Vignette 1. Neglect	Your patient, Mabel, is 89. She lives alone and has moderate dementia. You are aware that her only child, Liz, lives 3 hour's drive away. During a consultation you recommend an Aged Care Assessment to organize services and care options for Mabel. Liz and Mabel agree to this. After some weeks you receive correspondence from a care provider notifying you services have been put in place with Liz as the contact person. Six months later, the coordinator of the care service calls you to report Mabel's increasing needs. They mention there are concerns about Mabel's weight loss and personal hygiene. The coordinator also tells you they had contacted Liz, but she disagreed there was a need to discuss increasing Mabel's services.
Vignette 2. Financial abuse	Your patient, David is 72. He has a diagnosis of dementia. While he had capacity to do so, he made legal documents to appoint his eldest son Michael his substitute (i.e., enduring) decision-maker for financial and health care decisions. After David couldn't live alone any longer, he moved into Michael's home. Michael sold David's home and used the funds to renovate his own property including adding a room and bathroom for David. Within 12 months, David's condition worsened, and Michael brought David in to talk to you about arranging residential aged care. Michael mentions that his sister wants David to go to a "high end" aged care facility as David's house proceeds should cover this. However, Michael tells you there isn't any money left to pay for this.
Vignette 3. No Abuse	Your patient Sally is 88. Recently, her husband Brian passed away suddenly. She and Brian have a son living overseas who phones regularly. Sally is fairly independent, although she has mild dementia. Sally is finding it difficult to manage tasks like paying bills as Brian always looked after these. During a consultation, she mentions that bills go "from the letterbox to the bin" as she can't face them or thoughts they raise of her loss of Brian. You also find out she is walking to the corner shop for groceries but buys mainly tinned and dry packaged items. She is losing weight and giving less attention to her personal hygiene and grooming.
Vignette 4. Physical abuse	Your patient Jan is 75. She lives with her partner Tim. Jan has advanced dementia and her speech is limited to a small number of phrases, which she repeats often. Tim brings Jan in for a routine review. Previously when seeing you Jan has used the phrase "cranky old man" with a laugh in Tim's direction. Tim also laughed at this "joke" as it is one of her repetitive phrases. Today while examining Jan, you notice some bruises on Jan's neck. When you try to talk to Jan about them, she is quite teary but cannot say what has happened. You noticed that Tim hurried Jan out the door, expressing impatience with her slowness.
Vignette 5. Psychological abuse	Your patient Max is 68. He lives with his wife Anna who is his carer due to his moderate dementia. They have two children and three grandchildren who live close by. During a routine appointment, Anna tells you that she is struggling to cope with the increasing demands as Max's caregiver. When discussing support options, Anna says she usually gets Max to cooperate with her requests by telling him that his grandchildren will not be allowed to visit if he doesn't do what she asks. Max mentions that Anna gets "cross" at him a lot and will no longer allow him to go to lawn bowls with his friends, an activity he has always enjoyed, because she finds it too time-consuming. He also mentions that Anna tells him she will "put him into a nursing home" if he refuses to go to respite care. You know that Max has always dreaded this idea and note that he seems withdrawn.
Vignette 6. Sexual abuse	Your patient, Alice, is 92. She has advanced dementia with limited communication abilities. Alice lives with her daughter who has brought her to see you for a suspected urinary tract infection, her third in the past four months. While examining Alice, you notice bruising on her chest and upper arms, and scratches on her thighs, the cause of which cannot be explained by Alice or her daughter. During the consultation, Alice mentions that her male neighbor often pops in to keep her company while her family are at work. Alice's daughter seems surprised by this, because Alice seems fearful of their neighbor and always avoids him if they see him in the street.

measure's relevance to the target population. Five vignettes described situations consistent with elder abuse, and one described a situation that did not meet criteria for abuse. The vignettes covered the five sub-types of elder abuse as defined by the World Health Organization and recognized in Australian

contexts (The Australian Law Reform Commission, 2017; World Health Organization. Elder Abuse Fact Sheet, 2022). Vignettes were developed with clinician and legal input in line with Royal Australian College of General Practitioner (RACGP) guidelines (Royal Australian College of General Practitioners. White Book, 2022) and National Elder Abuse Help Resources (Elder Abuse Action Australia, n.d.) to reflect current understandings of the signs and symptoms of elder abuse. All vignettes were specific to community-dwelling patients living with dementia. Following the presentation of each vignette, two items assessed knowledge to correctly identify the type of abuse described and knowledge of the appropriate action to take in response to the suspected elder abuse. The two items (verbatim) were:

(i) "Do you suspect elder abuse is occurring?" Participants were asked to respond by selecting one option only from: "yes, financial; yes physical; yes psychological; yes, neglect; yes, sexual; don't know; no."
(ii) "What is the most appropriate response?" Participants who answered "yes" to the question "Do you suspect elder abuse is occurring" and identified the correct type of abuse were then asked the appropriate action to take by selecting: "Nothing; Monitor, ensuring the patient is physically safe; Seek advice from an elder abuse helpline/service; Refer to the aged care assessment team; Report to the police or refer to Public Guardian/Advocate; Don't know." Participants could select multiple actions.

Sociodemographic and practice characteristics. Participants were asked to self-report their gender, age, country of birth, year of medical/nursing graduation, highest medical/nursing qualification, whether they were actively practising within the last 12 months, if they had any special interest related to elder abuse, and whether they had completed any continuing professional development (CPD) relating to elder abuse. To capture practice characteristics, participants were asked to self-report their main practice setting, postal code of main practice, whether they offered home visiting services to their patients. Participants were also asked to estimate the proportion of their caseloads that were aged 65 years and older, and the proportion of their caseload aged 65 years and older who had a diagnosis of dementia.

Statistical analysis

Practice postcode was categorized as "major city," "regional," or "remote" according to the Accessibility and Remoteness Index of Australia (ARIA+) (Hugo Centre for Migration and Population Research. Accessibility and Remoteness Index of Australia (ARIA+) [ARIA], 2018). Descriptive statistics were used to summarize the demographic and practice characteristics of the

sample and correct/incorrect and appropriate/inappropriate responses to the vignette scenarios. Categorical variables were presented as counts and frequencies. 95% confidence intervals for proportions were calculated using the Clopper–Pearson method.

Standards for coding responses were determined *a priori*. Detection of abuse was coded as "correct" where the participant selected the correct sub-type of abuse intentionally presented in the vignette, and "incorrect" where the participant selected the incorrect sub-type of abuse presented or selected "Don't know." Participant actions in response to correctly identified abuse were classified as either *appropriate* or *inappropriate*, informed by relevant guidelines. Across all vignettes, a response was coded as *inappropriate* if the participant selected only "Do Nothing." For vignettes involving financial abuse, psychological abuse, and neglect, an *appropriate* response was defined as selecting any action other than "Do Nothing" or "Don't Know." For vignettes involving physical or sexual abuse, an *appropriate* response required selecting "Report to Police" as one of the actions given RACGP guidelines state that: "*If the patient is assessed as at immediate risk: . . . where the patient has been assaulted or sexually abused, the police will need to be notified*" (Royal Australian College of General Practitioners. White Book, 2022). For all vignettes, responses that included "Don't Know" were still considered *appropriate* if at least one appropriate action was also selected.

To examine the sociodemographic and practice characteristics associated with accurate detection of elder abuse, logistic regression analyses were used. The dependent variables were the accurate detection of each specific subtype of abuse: financial abuse, psychological abuse, neglect, physical abuse, and sexual abuse, and the independent variables were clinician-related factors gender, age, practitioner type, practice setting, remoteness of practice, and provision of home visits. We ran five regression models, one for each subtype of abuse. Issues of over-fitting were identified in the psychological abuse and physical abuse models. To address this and enhance model reliability, variables contributing to over-fitting were removed. This meant the practitioner type was removed from the models for psychological abuse and physical abuse. Additionally, practice type, practice setting, and provision of home visits were removed from the physical abuse model. Therefore, for psychological abuse, the predictors retained were gender, age, practice setting, remoteness of practice, and provision of home visits. For physical abuse, the predictors retained were gender, age, and remoteness of practice.

Ethics approval

This research was approved by the University of Newcastle College Human Ethics Advisory Panel (H-2022–0300). The research was conducted in accordance with the principles stated in the Declaration of Helsinki.

Results

Participant characteristics

The sociodemographic and practice characteristics of the sample are provided in Table 2. The sample included 130 health practitioners, including 55 general practitioners, 33 Geriatricians, and 42 Nurse practitioners. Most participants were female (60.8%), 50% were born in Australia, 70% worked in a community-based setting, and 67.7% practiced in a major city. Most of the sample (69.2%) reported a special interest in aged care and 33.1% had completed elder abuse continuing professional development in the past 2 years.

Practitioner detection and response to clinical vignettes describing elder abuse

Table 3 provides data about the proportion of practitioners who accurately detected each type of elder abuse. The highest proportion of participants correctly identified abuse in the vignettes describing physical abuse (94.3%) and psychological abuse (91.5%). Fewer participants correctly identified abuse in the vignettes describing sexual abuse (76.1%), neglect (72.3%), and financial abuse (72%). For the vignette describing no abuse, 67.7% correctly identified that abuse was not present. The highest proportion of incorrect responses were given for the scenarios depicting no abuse (22.6%) and sexual abuse (21.4%), while the highest proportion of "Don't know" responses were given for the scenarios depicting financial abuse (14.4%) and neglect (13.1%). Table 4 provides data about the action practitioners would take following the identification of abuse. An appropriate response was provided for the clinical vignettes describing psychological abuse, neglect, and financial abuse by most participants (100%, 100%, 97.8% respectively). However, only 67% of participants provided an appropriate response to the vignette describing sexual abuse, and 31% of participants provided an appropriate response to the vignette describing physical abuse.

Factors associated with correct identification of abuse

Table 5 provides the findings of the logistic regression examining the factors associated with practitioners' accurate detection of elder abuse. Practitioner age was significantly negatively associated with correct identification of abuse in both the psychological abuse and physical abuse vignettes. Each additional year of age was associated with a 12% decrease in the odds of correct identification of psychological abuse (OR = 0.88, 95% CI [0.80, 0.95], $p = .004$) and an 8.5% decrease in the odds of correct identification of physical abuse (OR = 0.915, 95% CI [0.84, 0.99], $p = .025$).

Table 2. Sociodemographic and practice characteristics of the sample (N = 130).

Category	Characteristic	GP n (%)	Geriatrician n (%)	Nurse Practitioner n (%)	Total n (%)
Number		55 (42.3%)	33 (25.4%)	42 (32.3%)	130 (100%)
Gender	Male	32 (58.2%)	10 (30.3%)	8 (19.0%)	50 (38.5%)
	Female	23 (41.8%)	22 (66.7%)	34 (81.0%)	79 (60.8%)
	Not specified	0 (0%)	1 (3.0%)	0 (0%)	1 (0.8%)
Age #	<45 years	24 (43.6%)	19 (57.6%)	3 (7.5%)	46 (35.9%)
	45–54 years	11 (20.0%)	7 (21.2%)	18 (45.0%)	36 (28.1%)
	55+ years	20 (36.4%)	7 (21.2%)	19 (47.5%)	46 (35.9%)
Country of birth	Australia	24 (43.6%)	10 (30.3%)	31 (73.8%)	65 (50.0%)
	United Kingdom	7 (12.7%)	6 (18.2%)	9 (21.4%)	22 (16.9%)
	India	3 (5.5%)	1 (3.0%)	0 (0%)	4 (3.1%)
	Malaysia	3 (5.5%)	4 (12.1%)	1 (2.4%)	8 (6.2%)
	China	3 (5.5%)	0 (0%)	0 (0%)	3 (2.3%)
	New Zealand	1 (1.8%)	0 (0%)	0 (0%)	1 (0.8%)
	Other	14 (25.5%)	12 (36.4%)	1 (2.4%)	27 (20.8%)
Years of practice	<1 year	0 (0%)	2 (6.1%)	5 (11.9%)	7 (5.4%)
	1–5 years	2 (3.6%)	5 (15.2%)	10 (23.8%)	17 (13.1%)
	6–10 years	17 (30.9%)	7 (21.2%)	10 (23.8%)	34 (26.2%)
	11–15 years	8 (14.5%)	5 (15.2%)	7 (16.7%)	20 (15.4%)
	16–20 years	3 (5.5%)	6 (18.2%)	1 (2.4%)	10 (7.7%)
	20+ years	25 (45.5%)	8 (24.2%)	9 (21.4%)	42 (32.3%)
Main practice setting	Community based service	54 (98.2%)	9 (27.3%)	29 (69.0%)	92 (70.8%)
	Non-community-based service	1 (1.8%)	24 (72.7%)	13 (31.0%)	38 (29.2%)
Special interests*	Abuse and violence- yes	9 (16.4%)	3 (9.1%)	10 (23.8%)	22 (16.9%)
	Aged care- yes	29 (52.7%)	29 (87.9%)	32 (76.2%)	90 (69.2%)
	Dementia and related disorders- yes	20 (36.4%)	32 (97.0%)	22 (52.4%)	74 (56.9%)
	Elder abuse- yes	8 (14.5%)	12 (36.4%)	12 (28.6%)	32 (24.6%)
Completed elder abuse CPD in past 2 years	Yes	10 (18.2%)	11 (33.3%)	22 (52.4%)	43 (33.1%)
	No	45 (81.8%)	22 (66.7%)	20 (47.6%)	87 (66.9%)
Remoteness of main practice	Major city	37 (67.3%)	29 (87.9%)	22 (52.4%)	88 (67.7%)
	Inner/outer regional	17 (30.9%)	4 (12.1%)	16 (38.1%)	37 (28.5%)
	Remote/very remote	1 (1.8%)	0 (0%)	4 (9.5%)	5 (3.8%)
Visit patients at home	Yes	32 (58.2%)	15 (45.5%)	14 (33.3%)	61 (46.9%)
	No	23 (41.8%)	18 (54.5%)	28 (66.7%)	69 (53.1%)

(*Continued*)

Table 2. (Continued).

Category	Characteristic	GP n (%)	Geriatrician n (%)	Nurse Practitioner n (%)	Total n (%)
Provides care in residential aged care facility	Yes	28 (50.9%)	22 (66.7%)	24 (57.1%)	74 (56.9%)
	No	27 (49.1%)	11 (33.3%)	18 (42.9%)	56 (43.1%)
Estimated proportion of caseload aged 65+	<25%	13 (23.6%)	0 (0%)	6 (14.3%)	19 (14.6%)
	25–50%	21 (38.2%)	0 (0%)	13 (31.0%)	34 (26.2%)
	51–75%	18 (32.7%)	2 (6.1%)	5 (11.9%)	25 (19.2%)
	>75%	3 (5.5%)	31 (93.9%)	18 (42.9%)	52 (40.0%)
Estimated proportion of caseload aged 65+ with dementia	<25%	52 (94.5%)	6 (18.2%)	19 (45.2%)	77 (59.2%)
	25–50%	1 (1.8%)	14 (42.4%)	9 (21.4%)	24 (18.5%)
	51–75%	2 (3.6%)	5 (15.2%)	6 (14.3%)	13 (10.0%)
	>75%	0 (0%)	8 (24.2%)	8 (19.0%)	16 (12.3%)

*Multiple responses possible – totals will be greater than 100%. # n= 2 missing responses for this variable.

Table 3. Proportion of practitioners who accurately detected each type of elder abuse (N = 130).

	Financial n (%[95%CI])	Psychological n (%[95%CI])	Neglect n (%[95%CI])	Physical n (%[95%CI])	Sexual n (%[95%CI])	Not Abuse n (%[95%CI])
Detection						
Correct	90 (72 [63.3%-79.7%])	108 (91.5 [85.0%-95.9%])	94 (72.3 [63.8%-79.8%])	115 (94.3 [88.5%-97.7%])	89 (76.1 [67.3%-83.5%])	84 (67.7 [58.8%-75.9%])
Incorrect	17 (13.6 [8.1%- 20.9%])	7 (5.9 [2.4%-11.8%])	19 (14.6 [9.0%-21.9%])	5 (4.1 [1.3%-9.3%])	25 (21.4 [14.3%-29.9%])	28 (22.6 [15.6%-31.0%])
Don't know	18 (14.4 [8.8%-21.8%])	3 (2.5 [0.5%-7.3%])	17 (13.1 [7.8%-20.1%])	2 (1.6 [0.2%-5.8%])	3 (2.6 [0.5%-7.3%])	12 (9.7 [5.1%-16.3%])
Missing	5	12	0	8	13	6

Table 4. Proportion of practitioners who accurately responded to each type of elder abuse.

	Financial N = 90 n (% [95%CI])	Psychological N = 108 n (% [95%CI])	Neglect N = 94[a] n (% [95%CI])	Physical N = 115[b] n (% [95%CI])	Sexual N = 89 n (% [95%CI])
Response adequacy					
Appropriate	88 (97.8 [92.2%-99.7%])	108 (100 [96.6%-100.0%]	93 (100 [96.1%-100.0%])	35 (31.0 [22.6%-40.4%])	60 (67.4 [56.7%-77.0%])
Inappropriate	2 (2.2 [0.3%-7.8%])	0 (0.0 [0.0%-3.4%])	0 (0.0 [0.0%-3.9%])	78 (69.0 [59.6%-77.4%])	29 (32.6 [23.0%-43.3%])
Do nothing[#]	1 (1. [0.0%-6.0%])	0 (0.0 [0.0%-3.4%])	0 (0.0 [0.0%-3.9%])	0 (0.0 [0.0%-3.2%])	0 (0.0 [0.0%-4.1%])
Speak to patient alone	43 (47.8 [37.1%-58.6%])	81 (75.0 [65.7%-82.8%])	73 (78.5 [68.8%-86.3%])	67 (59.3 [49.6%-68.4%])	38 (42.7 [32.3%-53.6%])
Speak to patient's family/carer	54 (60.0 [49.1%-70.2%])	86 (79.6 [70.8%-86.8%])	72 (77.4 [67.6%-85.4%])	60 (53.1 [43.5%-62.5%])	65 (73.0 [62.6%-81.9%])
Monitor and document	61 (67. [57.1%-77.2%])	92 (85.2 [77.1%-91.3%])	69 (74.2 [64.1%-82.7%])	84 (74.3 [65.3%-82.1%])	59 (66.3 [55.5%-76.0])
Seek advice	59 (65.6 [54.8%-75.3%])	74 (68.5 [58.9%-77.1%])	39 (41.9 [31.8%-52.6%])	89 (78.8 [70.1%-85.9%])	54 (60.7 [49.7%-70.9%])
Refer to ACAT	27 (30.0 [20.8%-40.6%])	43 (39.8 [30.5%-49.7%])	45 (48.4 [37.9%-59.0%])	24 (21.2 [14.1%-29.9%])	6 (6.7 [2.5%-14.1%])
Report to police*	1 (1.1 [0.0%-6.0%])	0 (0.0 [0.0%-3.4%])	1 (1.1 [0.0%-5.8%])	35 (31.0 [22.6%-40.4%])	60 (67.4 [56.7%-77.0%])
Refer to public guardian/advocate	27 (30.0 [20.8%-40.6%])	9 (8.3 [3.9%-15.2%])	4 (4.3 [1.2%-10.6%])	12 (10.6 [5.6%-17.8%])	5 (5.6 [1.8%-12.6%])
Don't Know	2 (2.2 [0.3%-7.8%])	1 (0.9 [0.0%-5.1%])	0 (0.0 [0.0%-3.9%])	0 (0.0 [0.0%-3.2%])	1 (1. [0.0%-6.1%])

[#]The only inappropriate response for the financial abuse scenario, psychological abuse scenario, and neglect scenario.

* The only appropriate response for physical and sexual abuse scenarios.

a. *N*= 1 missing response. b. *n*=2 missing responses.

Table 5. Factors associated with practitioners' accurate detection of elder abuse among community-dwelling people with dementia.

		Financial		Psychological		Neglect		Physical		Sexual	
		Adjusted OR (95% CI)	P	Adjusted OR (95% CI)	P	Adjusted OR (95% CI)	P	Adjusted OR (95% CI)	P	Adjusted OR (95% CI)	P
Sociodemographic characteristics											
Gender	Male	Ref	0.27	Ref	0.30	Ref	0.06	Ref	0.34	Ref	0.57
	Female	1.699 (0.66–4.44)		2.364 (0.47–13.6)		2.769 (0.98–8.64)		2.534 (0.36–21.3)		1.331 (0.49–3.62)	
Age	–	1.007 (0.97–1.05)	0.74	0.880 (0.80–0.95)	**0.004**	0.970 (0.93–1.01)	0.16	0.915 (0.84–0.99)	**0.03**	0.979 (0.94–1.02)	0.32
Practitioner type	General Practitioner	2.050 (0.50–8.38)	0.31	N/A	–	9.129 (2.56–38.3)	**0.001**	N/A	–	2.165 (0.46–10.3)	0.33
	Geriatrician	Ref	–	N/A		1.426 (0.39–5.37)	0.59	N/A	–	Ref	–
	Nurse Practitioner	1.969 (0.56–7.08)	0.29	N/A		Ref		N/A	–	1.807 (0.42–8.14)	0.43
Practice characteristics											
Remoteness of main practice	Major City	1.816 (0.71–4.73)	0.22	0.383 (0.04–2.26)	0.32	1.507 (0.56–4.01)	0.41	0.378 (0.02–2.87)	0.40	1.263 (0.45–3.45)	0.65
	Inner/outer regional/ Remote/ Very remote	Ref		Ref		Ref		Ref		Ref	
Main practice setting	Community	Ref	0.28	Ref	0.17	Ref	0.24	N/A	–	Ref	0.41
	Non-community	0.521 (0.16–1.68)		0.252 (0.03–1.76)		2.109 (0.62–7.70)		N/A	–	1.789 (0.46–7.56)	
Visit patients at home	Yes	0.839 (0.34–2.04)	0.70	0.125 (0.01–0.82)	0.05	0.404 (0.15–1.06)	0.07	N/A	–	0.812 (0.31–2.11)	0.67
	No	Ref		Ref		Ref		N/A	–	Ref	

Practitioner type was the only significant factor associated with the correct identification of neglect, with general practitioners significantly more likely to accurately identify neglect compared to nurse practitioners (OR = 9.129, 95% CI [2.56, 38.3], $p = .003$). No predictors were statistically significant in adjusted models for the vignettes describing sexual abuse or financial abuse.

Discussion

The ability of health care professionals to accurately identify and appropriately respond to instances of elder abuse is critical to the health and wellbeing of older adults, particularly in the context of the care of people with dementia given their increased vulnerability. This study used hypothetical vignettes to assess how well general practitioners, geriatricians, and nurse practitioners in Australia could identify and appropriately respond to various forms of elder abuse, providing important insights into current levels of awareness and decision-making. This information is crucial for informing future educational interventions and policy development aimed at improving elder abuse detection and management in clinical practice.

Studies have consistently found low levels of knowledge and significant uncertainty in identifying elder abuse among health care providers (Ahmed Mph et al., 2016; Erlingsson et al., 2006; Johansson et al., 2024). In this study, over 90% of practitioners correctly identified psychological and physical abuse. Psychological abuse is consistently identified as the most prevalent type of elder abuse among both among the general population of older adults and people with dementia (Shen et al., 2025) suggesting it may be readily recognized in clinical scenarios due to more overt or familiar clinical presentation. However, rates of correct identification were notably lower for sexual abuse (76.1%), neglect (72.3%), and financial abuse (72%). These difficulties may be even more pronounced when assessing people with dementia, where fluctuating cognition, dependency on caregivers, and atypical presentations can obscure warning signs or complicate interpretation of risk. Lower rates of recognition may stem from more subtle or ambiguous clinical signs, limited clinical exposure, or uncertainty around what constitutes these types of abuse (Pelotti et al., 2013). Organizational and contextual factors, such as high workload, limited access to specialist resources, and variable support from colleagues or multidisciplinary teams, may also impact health care providers' ability to identify elder abuse. Of note is that participants demonstrated the lowest accuracy in identifying that no abuse occurred in the vignette designed to depict a non-abusive situation. This finding may reflect a heightened sensitivity to abuse indicators and concern for community dwelling older adults demonstrating behavioral changes without sufficient confidence or clarity in distinguishing between acceptable practices and mistreatment or neglect.

Increasing age was significantly associated with reduced odds of accurately identifying psychological and physical abuse, which is consistent with previous research. For example, a cross-sectional study of health care workers in Japan that found older age was associated with lower knowledge of elder abuse (Yi & Hohashi, 2018). These findings may reflect generational differences in training and knowledge of elder abuse, particularly given greater emphasis on elder abuse in health care provider training and the availability of continuing professional development courses which may mean that younger professionals have more exposure to contemporary definitions and guidelines for recognizing elder abuse. It may also reflect evolving definitions of abuse. Definitions of what constitutes abuse have changed over time, influenced by growing awareness of power dynamics, consent, and protection of vulnerable people (Teaster et al., 2020). Older health care professionals whose foundational training may not have addressed issues of elder abuse within current frameworks might be less likely to identify certain behaviors as abusive. These generational gaps highlight the importance of ongoing education and the need for updated training materials that reflect current best practices in elder abuse recognition and response.

Practitioner type was also significantly associated with identification of abuse, with general practitioners significantly more likely to correctly identify neglect compared to nurse practitioners. Previous studies examining differences in the detection of elder abuse among health care providers have shown mixed findings. A cross-sectional study of doctors and nurses in Malaysia found that doctors were more knowledgeable about elder abuse than nurses (Ahmed Mph et al., 2016). In contrast, a study conducted with health care workers in Japan found that public health nurses and social workers were more knowledgeable than doctors and that medical doctors had the lowest level of knowledge of elder abuse (Yi & Hohashi, 2018). These findings may reflect variations in clinical training, clinical experience, or differing contexts in which health care professionals typically engage with older adults in community care. However, in our study, differences in detection by provider type were only significant for one subtype of abuse, suggesting that while professional roles may influence recognition of elder abuse, the relationship is likely more nuanced and may also depend on the visibility of specific abuse indicators. Future research should explore these contextual factors in more detail to inform targeted strategies for improving abuse recognition across health care providers. Understanding the nuances of how different professionals encounter and perceive elder abuse may aid in tailoring interventions that address the specific educational needs and clinical roles of the diverse health care providers who care for older adults. Given the heightened susceptibility of people with dementia to elder abuse and the diagnostic complexities involved, developing dementia-specific guidance and training may be particularly important to improve detection accuracy.

This study highlights potential gaps in health care professionals' knowledge of and response to elder abuse using hypothetical vignettes, even in a sample where most participants reported an interest in aged care and a third had completed elder abuse-related continuing professional development. Findings underscore the need to strengthen training, especially in recognizing and responding to less visible neglect, financial abuse and sexual abuse. Targeted training is essential to build confidence in detecting and responding to elder abuse across the full spectrum of abuse presentations.

Limitations

This study used vignettes to explore practitioners, likely identification and response, which may not reflect the reality of identifying and responding to elder abuse in real-world clinical practice. In particular, there may be a disparity between the action a practitioner believes they would take in a given situation and their actual behavior (Erfanian et al., 2020) which may be subject to self-reporting bias and social desirability effects. In addition, participants were explicitly prompted to consider whether elder abuse was present and, if so, to identify the type of abuse from predefined categories. While this structured approach enhanced consistency across responses, it may have primed participants toward recognizing abuse and facilitated classification, potentially leading to an overestimation of practitioners' knowledge. However, the study vignettes were developed by clinicians to ensure consistency between the information presented in vignettes and real-world clinical situations thereby enhancing relevance and realism. While not a substitute for real-world observations, the use of vignettes allowed for controlled examination of practitioner decision-making in a standardized context and is consistent with approaches used to examine elder abuse, including the widely used Caregiving Scenarios Questionnaire (Selwood et al., 2007). Future research could complement these findings with observational or longitudinal studies to better understand actual behaviors and contextual influences in clinical settings. As recruitment was conducted via online advertisement, the sample may be biased toward individuals who are more digitally active or who had a particular interest in elder abuse, which could limit the representativeness of the sample. As the response rate and any potential bias in the sociodemographic characteristics of those who responded is unknown, this limits our ability to comment on the generalizability of findings.

Conclusion

There are notable gaps in identification and response to abuse types, particularly physical and sexual abuse, among Australian general practitioners,

geriatricians, and nurse practitioners. This data highlights gaps in the current clinical practice that may leave vulnerable older adults, especially those living with dementia, at continued risk of harm. There is a clear need for targeted training and support to equip health care professionals with the necessary skills, knowledge, and confidence to effectively recognize and manage all forms of elder abuse.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author, JB. The data are not publicly available due to containing information that could compromise the privacy of research participants.

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