A Review of Elder Abuse Screening Tools for Use in the Irish Context

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This review presents a discussion of a selection of tools designed to highlight the potential for elder abuse and it examines them for possible use within the Irish context. These tools while referred to as screening tools, in general, highlight suspicion of elder abuse rather than giving rise to a definitive diagnosis of abuse. The Irish policy document (DOHC 2002), recommended that the basic reporting assessment of elder abuse should involve the detection of elder abuse. Elder abuse screening tools have been suggested as a method of assisting practitioners to detect the risk of elder abuse (Fulmer et al. 2005) and these screening tools may offer the capacity to highlight potential abuse which can lead to further investigation. The capacity of screening tools to detect potential abuse is particularly important as many professionals struggle to recognise elder abuse (Heath et al. 2005; Kennedy 2005; Newton 2005; Cooper et al. 2008a,b; Perel-Levin 2008; Killick and Taylor 2009). The paper presents the aims, the background rational and the approach adopted for the review. This is followed by a brief introduction to the context of elder abuse within the Irish population, risk factors for elder abuse, challenges in screening for potential elder abuse, discussion of a number of elder abuse screening tools and recommendations.

The aims of this review are:

1. To examine elder abuse screening tools internationally and identify a tool(s) of particular merit for potential use in the Irish context
2. To identify issues related to the use of elder abuse screening tools internationally
3. To make recommendations regarding the use of elder abuse screening tools in the Irish context.

1.1 Rationale for this review
Various Irish reports have identified the need to facilitate mechanisms which will assist in the early identification of elder abuse (DOHC 2002; National Council on Ageing and Older People 2009). Consequently, screening tools may offer a method of identifying older people who may be at risk of abuse or have a greater probability of being subjected to abuse. This is particularly relevant in an ageing Irish population (Layte 2009; Layte et al. 2009) in terms of negative experiences and outcomes for older people who are subjected to abuse (Lachs et al. 1998; Lachs et al. 2002; Dong et al. 2009; WHO 2011). This review examines elder abuse screening tools and sets out to identify tools which have the potential to transfer for use in the Irish setting. If available, the use of a standardised, reliable and valid screening tool(s) will facilitate more generic understanding and inter-rater reliability giving rise to more clarity in recognising potential elder abuse. However, prior to using any tool adequate training and education must be provided for healthcare professionals who may use the tool in practice.

1.2 Method
A literature search was undertaken in CINAHL and PUBMED using the terms ‘elder abuse and screening tools’ and ‘elder abuse detection’ for the years 1980-2010. Grey literature was searched through a review of internet websites using the same search terms. In addition, consultation took place with experts who had published work in relation to screening tools which have demonstrated merit in terms of reliability and validity.
The world’s population is ageing. In Ireland, demographics indicate that approximately 11.5 percent of the population is aged 65 years or older (CSO 2006). However, due to advances in areas such as healthcare, pharmaceuticals, welfare protection and changes in infertility rates, the volume of older people will increase. The Economic and Social Research Institute (Morgenroth 2009) estimate that older people in Ireland will rise from 11.5 percent in 2006 to 15.1 percent in 2021. Furthermore, the number of old persons (65 years and over) is projected to almost double in every geographical region in Ireland between 2011-2020 (CSO 2008). Within the context of a rising older person population, it is anticipated that most older people will reside in the community (Duggan and Murphy 2009).

2.1 The extent of elder abuse

Elder abuse is a significant issue in societies globally (Fulmer and O’Malley 1987; Mellor and Brownell 2006; Brandl et al. 2007; Phelan 2010). From its formal recognition (Baker 1975), there have been particular challenges in defining precisely what constitutes elder abuse (Johnson 1986; Bennett et al. 1997) due to its complex, multi-factorial contexts (Lachs and Pillmer 2004; Bomba 2006) and varying cultural interpretations.

Elder abuse prevalence studies indicate that between two to five percent of community dwelling older people experience some form of abuse. A recent study in Ireland (Naughton et al. 2010) indicated a prevalence of 2.2 percent in community dwelling older people, and this rose to 2.9 percent when the definition included abuse by neighbours or acquaintances (Naughton et al. 2010). This broadly concurs with other international studies on elder abuse prevalence (Wetzel 1996; Pillmer and Finkelhor 1998; Comijs 1998a, 1998b; O’Keefe et al. 2007), however, some prevalence studies have identified a much higher rate, for example in Israel (18.4% excluding neglect) (Eisikovits et al. 2005; Lowenstein et al. 2009) and the United States (11.4%) (Acierno et al. 2010). While prevalence studies seek to enumerate the extent of elder abuse in society, many of these studies represent ‘impressionistic estimates’ (Bonnie and Wallace 2003:21).

It has been observed that elder abuse prevalence statistics are likely to be underestimates of true figures, a phenomenon which has been referred to as the ‘iceberg theory’ (Tatara et al. 1998; Rhodes 2005). The National Elder Abuse Incidence Study (NEAIS) (Tatara et al. 1998) estimated that for every one reported case of elder abuse, up to 5.3 cases are not reported. Fulmer (2003) argues that it is more likely that at least one in ten cases do not come to the attention of official bodies and that the lack of professional reporting is due to the absence of appropriate screening instruments.

The detection of elder abuse in Ireland is highlighted as being particularly important when Irish prevalence figures (Naughton et al. 2010) are compared to referrals of elder abuse to the HSE elder abuse service (HSE 2011). Despite efforts to formally address the issue of elder abuse in Ireland through dedicated services and staff training, referrals remain low compared to prevalence statistics. In this context, the availability and use of screening tools may offer a greater pathway to detection of potential abuse and consequently, the further development of responses to elder abuse. Effective service provision is dependent on efficient assessment techniques (Imbody and Vandsburger 2011).

2.2 Risk factors for elder abuse

Screening tools are generally based on a review of risk factors associated with a higher probability of a disease/disorder. Particular elder abuse risk factors have been suggested but additional research is required due to conflicting findings. However, some risk factors have gained moderate support and have been showed to predict abuse (Cohen et al. 2007) as well as facilitating the detection of abuse (Nagpaul 2001). For example, studies indicate that living with another person increases risk (Lachs et al. 1997; Hansberry et al. 2005; Naughton et al. 2010). Cognitive impairment of the older person (Compton et al. 1997; Naik et al. 2010) or the caregiver (Miller et al. 2006) also increases risk as does alcohol dependence (Campbell Reay and Browne 2001; WHO 2006). Past childhood abuse (Campbell Reay and Browne 2001), cognitive and functional impairment (Lachs et al. 1997; Shugarman et al. 2003; Laumann et al. 2008), caregiver stress (Wang et al. 2009), and mental health problems health problems (Kingston and Penhale 1995) are also identified as risk factors.

In addition, intergenerational violence (Pillmer 1986; Erlingsson et al. 2005), dependency (Kruger and Moon 1999; Erlingsson et al. 2005; Buri et al. 2006) gender, being in the older old group (Buri et al. 2006; Naughton et al. 2010), social isolation (Carp 2000; Buri et al. 2006), poor social support (Shugarman et al. 2003) and a history of volatile intrapersonal relationships (Acierno 2003; Erlingsson et al. 2005) suggest susceptibility to abuse. Some risk factors have been proposed as theoretical frameworks to explain elder abuse, however, no theory has adequately explained, with empirical evidence, the complexity of elder abuse.
The concept of screening or case finding comes from epidemiology. Its purpose is the early identification of risk of a disease or disorder so that early treatment may be initiated resulting in a decrease in the disease related mortality and morbidity rates (United States Preventative Services Task Force 1996; Petersen 1997). As such, screening represents a major instrument in public health and is an important element in current Irish health policies (DOHC 2001a; 2001b). While screening tools are not diagnostic, they do highlight cases which have a higher statistical probability of a disease or disorder (Stampfer et al. 2004; Kettles et al. 2004). In relation to elder abuse Yaffe notes that screening tools can draw attention to cases which warrant further investigation by a practitioner (Yaffe et al. 2011).

The concept of screening may appear simple but is influenced by the presence of classic screening criteria (Wilson and Junger 1968). Screening may be universal, such as the newborn metabolic screening testing or selective, in populations deemed at risk, for example, screening for cognitive impairment in older people. However, as noted by Wilson and Junger (1968:7), ‘in theory, screening is an admirable method of combating disease...In practice there are snags’. In the case of screening for elder abuse, its complexity has been noted by Lachs (2004) who points out that the traditional paradigm of screening programmes is unrealistic for elder abuse if a traditional disease–model analysis is applied. In particular, issues such as abuser involvement in care, active efforts to hide the abuse and possible limited access to the older person may preclude screening (Lachs and Pillemer 2004).

3.1 Screening in family violence

The spectrum of family violence may be divided into intimate partner violence, child protection and elder abuse. The issue of screening for family violence has been subject to debate and while generic screening tools do hold some merit, variations in the three domains necessitate specific screening foci. For example, trauma in older people differs from other generations (Brown et al. 2004). One of the most common tools to identify family violence is the Conflict Tactics Scales (CTS) (Straus 1979) and this has shown some utility in elder abuse assessment with cognitively intact older people (Beech et al. 2005; Cooper et al. 2008a; 2009). Although elder abuse screening tools have potential to trigger professional intervention in both preventing elder abuse and identifying elder abuse, the United States Preventative Service Task Force on Family Violence (1996; 2004) stated that there was insufficient empirical evidence to recommend for or against screening tools in the domain of family violence (which includes elder abuse). For example, concerns focus on whether screening tools equate to improved outcomes (Waalen et al. 2000) and there is limited empirical data regarding the potential ill-effects of screening (Rabin et al. 2009).

The foregoing concern concurs with conclusions from a recent systematic review which examined screening tools for intimate partner violence (Rabin et al. 2009). Findings revealed a lack of consensus in appropriate comparison measures for testing sensitivity and specificity, a wide variance of sensitivities and specificities and the need for additional reliability and validity testing (Rabin et al. 2009). Despite varied perspectives, many medical organisations advocate screening (American Medical Association (AMA) 1992, Programme of Action for Children 2004) as a standard in routine care as awaiting evidence of improved screening outcomes could result in risk exposure for an abused person (Halpern et al. 2005).

Furthermore, although the impact of inter-personal violence is significant in terms of mortality and morbidity, detection rates by healthcare professionals remain relatively low (Feldhaus et al. 1997). While some work has been undertaken in the assessment of interpersonal violence and recommendations for routine screening (Ramsey et al. 2002), the World Health Organisation (2008) has noted that, compared to other age cohorts, assessing abuse in older people is not as advanced. The benefits of screening transcend the individual older person as screening can lead to rationalisation of resource allocation, improved education and improved responses; although case investigation should not take weaken a focus on protection (Bonnie and Wallace 2003).

Consideration needs to be given to the minimisation of bias when screening for abuse. In using a screening tool, caution has been urged to ensure that respondents are not primed towards particular answers through the discussion on the purpose of the screening tool or the discursive orientation of the questions (Bonnie and Wallace 2003). The importance of the orientation of questions was noted by Acerino et al. (2010) where culturally neutral open ended questions were considered to maximise disclosure of elder abuse. Thus, it is
suggested that screening questions in abuse are contextualised within social behaviours and non-threatening language (Laumann et al. 2008). However, it is suggested that following general questions which contextualise the older person's reality, direct queries are essential to establish the precise nature of the abuse (Lachs and Pillemer 2004; Oswald et al. 2004). Another important issue is the development of rapport between interviewer and interviewee which can allow open and honest disclosure (Phelan 2010). This is pertinent for engagement with both the older person and the alleged perpetrator as a non-judgemental, empathetic attitude is fundamental to facilitating difficult discussions.

Concerns have been articulated regarding gender and screening for elder abuse. Some authors have argued that a particular focus should be afforded to gender based screening (Reeves et al. 2007; Yaffe et al. 2007; Paranjape et al. 2009) as older men's experiences may be marginalised (Reeves et al. 2007; Yaffe et al. 2007). Equally, it has been noted that gender issues which transcend the interpersonal violence domain have been neglected (Paranjape et al. 2009).

The method of screening has also been subject to debate as self-completed questionnaires have been shown to be preferable in intimate partner violence (MacMillan et al. 2006), whilst telephone interviews have shown comparable results to face-to-face interviews (Acierno et al. 2003). However, screening methods that are not face-to-face prohibit direct observation for non-verbal cues in the participant's responses, such as eliciting understanding of the question or facial reactions. For self-completed questionnaires, there is an inherent assumption of literacy and comprehension skills which may be problematic for older people (Daly and Jogerst 2005; Lalor et al. 2009). However, Yaffe et al. 2011 have used a self-complete elder abuse screening tool which has demonstrated some success. Nevertheless, it has been argued that face-to-face interviewing can be the most effective method of screening (Chuang and Liebschutz 2002). It can increase the degree of empathy afforded the person being screened for abuse (Acierno et al. 2003) and improve the validity of the screening (WHO 2008). What is essential is that privacy is afforded to the older person to disclose abuse in a safe environment. Thus, care should be taken to interview the older person alone. In relation to confidentiality, it has been suggested that when privacy to complete is facilitated, self-completed questionnaires (Hawkins et al. 2009), and telephone screening using a yes/no response format may heighten confidentiality (Acierno et al. 2003).

3.2 Using technology to screen

Some efforts have been made in the use of computerised interpersonal violence screening (McNutt et al. 2005; Hawkins et al. 2009). McNutt et al. (2005) examined the use of computers to self-screen for interpersonal violence immediately prior to a scheduled physician visit. Results of the screen then accompanied the patient into the face-to-face visit. In contrast, Hawkins et al. (2009) created specific software. (Point of Information Systems (PCIS), for use by health care professionals with their personal digital assistant (PDA). Both methods of screening demonstrated some promising results, such as speeding up the process for referrals and the elimination of duplicate documentation. However, there are some issues which relate to using these on older adults, such as competency with computers and the administration of generic screening tools rather than those specific to elder abuse.

3.3 Screening for elder abuse

In reviewing approaches to screening tools, a variety of terms are used to convey the purpose of the instrument. These terms range from indexes of abuse, instruments to identify risk of abuse, elder abuse questionnaires, elder abuse screening tools, elder abuse screening test, algorithms, protocols and elder abuse assessment. The fundamental function of any assessment instrument is to guide practitioners through a standardised screening process and to ensure that signs of abuse are not missed (Anetzberger 2001; Peral-Levin 2008). For the purposes of this discussion, the term screening tool is used to describe instruments developed to ‘screen’ for potential abuse, while the terms guidelines and protocols are used to describe any other approaches to reviewing an older person for potential elder abuse.

An important part of the management of elder abuse is its early identification, and screening for elder abuse has been advocated as fundamental to the routine assessment of older people (Aravanis et al. 1993; American Medical Association 1992; Lachs and Pillemer 2004) particularly due to its prevalence (O’ Brien 1996). However, as early as 1988, Kosberg identified a failure of
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professionals to detect abuse or to be aware of its occurrence. Many professionals struggle to recognise elder abuse (Heath et al. 2005; Kennedy 2005; Newton 2005; Mandiracioglu et al. 2005; Cooper et al. 2008b; Killick and Taylor 2009; Caciula et al. 2010; Hempton et al. 2010), which makes screening tools attractive in their potential ability to detect the risk of elder abuse in diverse settings. Identification of elder abuse may be hindered by issues such as ageism (Gutman and Spencer 2010; Phelan 2011), a lack of direct observation of abuse (Bonnie and Wallace 2003), family privacy (Kosberg 1988; Phelan 2010), complacency (WHO 2002), complexity (Antzeberger 2001), sensitivity of the assessor (Shefet et al. 2007), service setting (O Brien 1996), time constraints (Jones et al. 1997), a lack of knowledge or education and training in elder abuse (WHO 2002; Fulmer et al. 2004).

A number of other factors in professionals’ failure to identify elder abuse include confusion as to whether presenting symptoms are associated with age related changes or abuse (Kimball 1995; Bonnie and Wallace 2003; Lachs and Pillemer 2004), and the subtlety of presenting symptoms (Fulmer et al. 1984; Ailbheai et al. 2005). Apathy towards positive intervention pathways (Anetzerber 2001; Selwood et al. 2007), a lack of time and unstable definitions of abuse (Jones et al. 1997), ethical dilemmas (Bergeron and Gray 2003; Donovan and Regehr 2010) and the invisibility of elder abuse (Reis and Nahmiash 1998) are also suggested as reasons why many professionals struggle to recognise elder abuse. Moreover, Anetzberger (2001) argues that elder abuse is not equal in terms of categorical assessment as its various forms may have different standards of recognisability. acknowledging these difficulties, Bomba (2006:111) argues that elder abuse should be constructed as a geriatric syndrome as this approach ‘provides a conceptual starting point from which the physician and health care professional can begin to address mistreatment from screening to management’ stages. However, employing the term ‘syndrome’ may have the effect of medicalising a problem which is essentially an issue immersed in complex intrapersonal, interpersonal and societal dynamics.

The WHO (2008) points out that older people do not generally wish to disclose abuse and as many as 80 percent of cases may not be diagnosed. Older people themselves may not disclose due to cognitive impairment (Nelson et al. 2004; Laumann et al. 2008), embarrassment (Bergeron 2006), the perpetrator being a family member with negative unsupportive attitudes (Zink et al. 2004), the taboo nature of elder abuse (Krueger and Patterson 1997; Kosberg 1998; Twomey et al. 2005), abuse being normalised (Quinn and Tomita 1997) or fear of repercussions and further abuse (Mowlam et al. 2007). In addition, if the older person is in some way dependent on the abuser, the removal of the abuser may, in reality or in the older person’s perception, mean changes in their living arrangements or being placed in long-term care. Consequently, elder abuse is generally identified by a third party (Fulmer et al. 2004; Phelan 2009). This may be difficult as it is suggested that perpetrators are careful to cover up abuse and to provide plausible explanations for any presenting problems and often isolate the older person (Carp 2000). Furthermore, older people have reduced social interaction mandates and contact with health care professionals can provide a valuable opportunity to identify potential elder abuse (Cohen et al. 2006).

If elder abuse is not identified early, intervention is delayed or prevented. The Diagnostic and Treatment Guidelines on Elder Abuse and Neglect (American Medical Association 1992) recommend that screening for elder abuse be a fundamental part of all clinical settings where older people interface with healthcare professionals. Thus, elder abuse case identification is central to the care of older people. Identification has an impact on issues such as the rationale for specific funding for care of older people, the development of responsive services and also highlights the need for both professional and public awareness and education (Bonnie and Wallace 2003). In tandem with the need to improve methods of detection, it is the necessity to have sufficient training and support for professionals to address suspected cases of elder abuse (WHO 2008). Despite this, research in elder abuse screening tools has progressed slowly (Fulmer et al. 2004) and substantial research is required to support the development of universal screening for elder abuse (Bonnie and Wallace 2003; United States Task Force on Preventative Violence 2004). Fulmer (2008) indicates that issues of culture, cognitive impairment, physician fear of false positives, intentional versus unintentional abuse and exploitation can present challenges to screening the older person for abuse. Moreover, concerns persist regarding the effectiveness of interventions for elder abuse which could worsen the abuse situation (Lachs and Pillemer 2004). Despite this, the identification of elder
abuse is greater when using a specific screening tool than is reported in prevalence studies (Cohen et al. 2006, Yaffe et al. 2008).

Bonnie and Wallace (2003) explored a framework for elder mistreatment screening and case identification which encompassed four levels. It proposes firstly that, appropriate settings within which to screen the older person are identified, such as accident and emergency departments or the person’s home. Secondly, a pre-screening process is proposed which would identify and target particularly vulnerable older people who demonstrate an increased risk to abuse. Thirdly, it proposes the initiation of the screening process and, if the screening test is positive, the fourth level encompasses a recommendation for case identification investigation.

Screening tools can also be related to the context of their utilisation. For example, brief screening tools are more appropriate for busy, high turnover areas, such as accident and emergency units, whilst, longer, more comprehensive screening tools are more suitable for areas such as in-patient units and community contexts (Fulmer et al. 2004). Some assessment tools advocate the inclusion of a medical examination (American Medical Association 1992; Lachs and Pillemer 2004), while others involve verbal assessment only (Fulmer et al. 1984; Sengstock and Hwalek 1987; Wang et al. 2007; Yaffe et al. 2008). However, the World Health Organisation (2008) suggests that screening tools for the primary health care setting are critical as they have the ability to raise awareness of the issue of elder abuse and can assist in developing competencies in the management of elder abuse. Consequently, the choice for an appropriate screening tool must take into account the balance between brevity and comprehensiveness (Rabin et al. 2009) while also demonstrating accuracy and ease of use (Bonnie and Wallace 2003). In addition, professional perspectives may result in subtle differences and it has been suggested that elder abuse education includes a sensitisation of interdisciplinary predispositions so that holistic approaches to elder abuse may be improved (Yaffe et al. 2009). As discussed previously, another important factor in screening for elder abuse is that, as far as possible, it should be undertaken in private with the older person to allow a candid discussion. Most importantly, skilled communication strategies are necessary to facilitate the disclosure of sensitive information in the screening encounter and are essential when communicating results both to the older person and their family (Fulmer 2008; WHO 2008).

Elder abuse screening tools for long term care facilities are lacking. Institutional abuse differs from abuse in the community due to issues of an expectation of formal caregivers. Abuse in long term care may be constituted by abusive behaviour, abusive attitudes and abuse practices (Gilleard 1994). Abusive behaviour may also be related to nursing staff burn-out and shortages (Saveman et al. 1999; Goergen 2001; Shinnat-altman and Cohen 2009; Post et al. 2010), the physical conditions of the nursing home (Millard and Roberts 1991), and intrinsic managerial failings (Bennett et al. 1997). Other challenges include a general low reporting rate of elder abuse. For example, in one study incident rates of reporting abuse to nursing home staff were as low as 20.7 per 1,000 residents, while formal reports to adult protective services constituted 18.4 per 1,000 residents (Jogerst et al. 2006). Studies vary from 11 percent to 91 percent of staff observing abuse, while 2 percent to 87 percent disclosed their perpetration of abuse (Pillemer and Moore 1989, Goergan 2001, Malmedal et al. 2009). Larger institutions with larger volume of older people may increase risk (Jogerst et al. 2006).

The potential for an older person with impaired mental capacity to experience abuse is noted (Compton et al. 1997; Choi and Mayer 2000; Cooney et al. 2006; Naik et al. 2010). Older people with dementia are particularly prone to abuse (Cooper et al. 2008a, Wiglesworth et al. 2010, Yan and Kwok 2011) which may be due to higher care requirements and behavioural challenges (Cooper et al. 2008a). In a study of caring for a relative with dementia (CARD) over half reported physical or psychological abuse and one third met the criteria of significant abuse (Cooper et al. 2009b). However, screening for elder abuse when an older person is cognitively impaired is problematic as self-reporting may be unreliable or the older person may not be able to report abuse (Cooney et al. 2006; Selwood et al. 2007). Laumann et al. (2008:2) argue that ‘screening for impairment is key to modelling and understanding elder mistreatment’. This is significant as dementia can be unrecognised, particularly in nursing homes (MacDonald and Carpenter 2003; Cahill et al. 2010) where behavioural disturbances of the older person can lead to abusive contexts (Brehthauer et al. 2005). Despite concerns relating to elder abuse in older people with dementia,
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there is a paucity of information on validated screening tools related to older people with dementia (Yan and Kwok 2011). Yet, the use of generic elder abuse screening tools can pose particular challenges for the health care professional as capacity cannot be ascertained during ordinary conversation (Naik et al. 2007; Naik et al. 2008). Thus, any elder abuse screening method for older people who have capacity challenges must be sensitive and specific enough to discriminate abuse while concurrently taking the potential presence of dementia into account.

Although there are a number of screening tools available, there is scant knowledge or widespread use of these tools (Bonnie and Wallace 2003). Many tools have been used for research purposes only where issues of sensitivity and specificity are not addressed and have low efficiency in clinical settings. Other concerns centre on the vocabulary used in the tools as well as the time necessary to complete (WHO 2008). Screening tools may be completed on the basis of direct questioning of the older person or caregiver. They may also be completed as self-reports by the older person or caregiver (Cohen et al. 2007). For screening tools that require responses from the older person, challenges arise in the context of their ability to respond competently as there may be concerns regarding mental incapacity, frailty, high anxiety, fear or other factors. Screening tools which require the caregiver to respond may be complicated by inaccurate answers (Bonnie and Wallace 2003). In addition, some commentators have highlighted that elder abuse screening tools need to be flexible enough to take cultural issues into account (Wang et al. 2006; Wang et al. 2007; WHO 2008; Yan and Kwok 2011).

3.3.1 Screening tools and validation

Screening tools for elder abuse should meet the epidemiological criteria which support the use of a validated instrument used for screening purposes (Wilson and Junger 1968). What is important is that a screening tool has the ability to demonstrate psychometric properties in the context of reliability and validity. This translates to the ability of an indicator or item on a scale to represent a theoretical concept. A screening test must also demonstrate a high sensitivity to and specificity in testing for elder abuse. Thus, a screening tool for elder abuse must be ‘practical, be easy to administer, have appropriate and clear wording suitable for different contexts, and show a high sensitivity rate’ (WHO 2008: 6). Given the foregoing considerations, the elder abuse screening tools in the discussion which follows represent those which have been subject to psychometric testing, specifically used for elder abuse, and have been reported in peer reviewed publications. Bearing in mind that screening tools for elder abuse do not provide definitive identification of abuse but rather highlight the risk of or potential for abuse and must be used with this in mind, the following screening tools are discussed:

- The Hwalek-Sengstock Elder Abuse Screening Test
- Vulnerability Abuse Screening Scale
- The Elder Assessment Instrument
- The Indicators of Abuse Screen
- The Brief Abuse Screen for the Elderly
- The Caregiver Abuse Screen
- The Elder Abuse Suspicion Index
- Elder Psychological Abuse Scale
- Caregivers Psychological Elder Abuse Behaviour Scale
- Older Adult Psychological Abuse Measure
- The Older Adult Financial Exploitation Measure

**The Hwalek-Sengstock Elder Abuse Screening Test**

Recognising the lack of uniformity and comprehensive approach in how professionals identified elder abuse, Sengstock and Hwalek (1987) developed the Hwalek-Senstock Elder Abuse Screening Test (H-S EAST) to identify an older person at risk of abuse. Preliminary reviews of both published and unpublished literature on elder abuse and child abuse identified seven indexes which were analysed for inclusion and exclusion criteria in relation to types of abuse. Six categories resulted which included the capacity to screen for physical abuse, psychological neglect, material abuse, and violation of personal rights. Sengstock and Hwalek (1987) also included a category of risk indicators, which could contribute to the potential for elder abuse to occur. The H-S EAST (Sengstock and Hwalek 1987) was developed from a larger study that involved pooling and rating 1,000 items by an expert, five person panel who were members
of the Institute of Gerontology at Wayne State University. This resulted in a 15 item instrument which screens for three factors: violation of personal rights, contextual factors contributing to the older person’s vulnerability and potential abusive circumstances (Neale et al. 1991). Construct validity was demonstrated as a score of three or more reflected a risk of abuse, exploitation or neglect (Neale et al. 1991). Further discriminate analysis demonstrated that six of the fifteen items were predictive of the potential presence of elder abuse. As such, the (H-S EAST) is a brief screening tool which is suitable for use in multiple environments.

Psychometric support for this tool was also demonstrated in two further studies (Neale et al. 1991; Moody et al. 2000). Neale et al. (1991) used three groups of older people to test the H-S EAST and findings supported the construct validity of the instrument. Moody et al. (2000) also used the H-S EAST in a study of 100 African American, Hispanic, and white older people living in public housing in the US. Study results demonstrated that principal components factor analysis supported the H-S EAST tool structure for a total of 10 items (factor loadings = 0.4 or >), explaining 38 percent of the variance. A discriminant function analysis showed that 6 items were as effective as the 9-item model in classifying cases (71.4%) as abuse. Despite the H-S EAST demonstrating some value in screening for elder abuse in this study, other studies have raised questions regarding the tool’s discriminatory abuse, particularly in relation to cognitive impairment (Buri et al. 2009). Furthermore, Fulmer et al. (2004) suggest that the H-S EAST requires additional refinement to discriminate abuse from other types of elder mistreatment. Further testing to refine the psychometric properties is also needed (Anthony et al. 2009).

In summary, the H-S EAST tool (Sengstock and Hwalek 1987) is a brief instrument which has demonstrated some promising results in screening for elder abuse. However, there have been some concerns regarding its ability to discriminate between abuse and non–abuse, the types of abuse manifestation and the need for further refinement of the psychometric properties of the tool has been noted.

The Vulnerability Abuse Screening Scale

The Vulnerability to Abuse Screening Scale (VASS) was developed in the context of an Australian Longitudinal Study on Women’s Health (Women’s Health Study (WHS)) (Schofield et al. 2002), which examined the health and well-being of three age cohorts of women; 18-23 years, 45-50, and 70-75 years over a 20 year period. The VASS represents an adaptation of the H-S EAST (Sengstock and Hwalek 1987) as further questions were added. The two additional questions demonstrated high face validity with one based on the Conflict Tactics Scale (CTS) (Strauss 1979) and the second based on a screening tool developed for the assessment of abuse during pregnancy (McFarlane et al. 1992). The third question, ‘Have you ever been in a violent relationship with a spouse/partner?’ was added by the study researchers (Schofield et al. 2002). In an effort to establish construct validity, factor analysis and correlation with a wide range of other variables were used. Two other measurement scales were used in the study: the Medical Outcomes Study Health Survey Short Form (SF-36) (Ware, Kosinski and Keller 1994) and the Duke Social Support Index (Koenig et al. 1993). In addition, participants were also questioned about the amount of chronic, acute health problems, visits to the family doctors, alternative medicine practitioners, hospital admissions or awaiting hospital admissions, medications and other health traits. Social supports, assistance with activities of daily living and life satisfaction were also elicited. Acknowledging the lack of a gold standard to test sensitivity and specificity of the H-S EAST, findings from this study of 12,340 older women aged 70-75 years did not support the inclusion of dimensions of violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations. The researchers concluded that a screening tool which focuses on vulnerability and coercion could provide a simple and more refined system to elicit the potential for elder abuse (Schofield et al. 2002).

Following the initial study (Schofield et al. 2002), the revised tool, the VASS, consisted of four factors: vulnerability, dependence, dejection and coercion (Schofield and Mishra 2003). Each of the factors contained three sub-items. The tool was tested over a subsequent three year follow-up period within the Australian Longitudinal Study on Women’s Health (WHS). The sample for the VASS study comprised 10,421 older people aged between 73-78 years. Concurrent measurements were also used to assess stress, life events (modified from Norbeck 1984), social support (Koenig et al. 1993), dependence (Domino and Affonso 1990, Pollack and Duffy 1990, Scheier et al. 1994), health (Ware
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et al. 1994), acute and chronic illnesses, use of health services, medication use, body mass index and demographic details. Cronbach’s alpha for the four factors were: Dependence (.74), Dejection (.44), Vulnerability (.45) and Coercion (.31). Consequently, the VASS demonstrated moderate to good internal consistency as a brief screening tool. In terms of the four factors, construct validity considered the relationship between the four factors and the psychosocial variables hypothesised as associated with abuse.

Vulnerability was closely related to stress, particularly within close relationships, while negatively associated with social support (Schofield and Mishra 2003). A negative association was found in the relationship of coercion and the ability to depend on others as well as the belief that conflict could be resolved by discussion. Dejection was associated with low social support, unstable dependence on others, less control of health, stress regarding living relationships and interpersonal conflict with children. Dependence was correlated with areas such as better physical health, lower stress, and lower health service use.

Schofield and Mishra (2003) suggest that dependence may provide a protective element against poorer health as dependent older people are generally in receipt of care. Some additional support of the VASS factors was recently demonstrated in a Chinese study (Dong et al. 2011) where 411 older people over 60 years were assessed using the VASS, a modified Geriatric Depression Scale (Yesavage et al. 1983) and the Social Support Index (Berkman et al. 1992). Depression was associated with increased risk of reporting elder abuse, although social supports are proposed as having a modifiable effect on the abusive environment.

While the VASS has shown some promising psychometric results, the authors (Schofield and Mischa 2003) acknowledge that issues remain in relation to the reliability and internal consistency of the coercion factor. A particular concern was the difficulty in establishing predictive validity of the test and additional qualitative research is recommended to generate knowledge on abusive experiences of older people. When Buri et al. (2009) used the VASS as one of the elder abuse screening tools in Iowa in the United States, findings from their telephone study of 44 older people who were referred to a social service agency indicated that the discriminatory ability of the VASS could be influenced by issues such as mental capacity status and refusal to complete the screen. Thus, although the VASS has expanded the H-S EAST and it has been used with a large sample, it remains relatively untested and additional work needs to be undertaken in determining predictive value (Schofield and Mishra 2003).

The Elder Assessment Instrument

The Elder Assessment Instrument (EAI) was first introduced in 1984 (Fulmer et al. 1984) and has been adapted to different clinical areas (Fulmer 2008). It is completed by a healthcare professional who undertakes a one-to-one interview and physical assessment of the older person to determine if abuse may have occurred. The test takes between 12-15 minutes to complete and encompasses both subjective and objective assessment. The constituents of the screening tool are derived from the literature which proposes causative factors in elder abuse but also accommodates indicators from other domains in the family violence spectrum. The tool is composed of 41 non-scoring items which are sub-divided into seven sections: general assessment, possible abuse indicators, possible neglect indicators, possible exploitation indicators, possible abandonment indicators, and a summary section. Each item is completed based on a five point scale ranging from ‘no evidence’ to ‘definite evidence’ (1-4) and the fifth point allows for a ‘inability to assess’. Neglect is also reviewed under the section ‘general assessment’ (Cohen 2011). The 41 items are graded according to a likert-type scale and the final summary section attempts to identify evidence of elder abuse. The tool contains a final commentary section which allows the assessor to ‘explain why she or he is interpreting a clinical sign or symptom in a particular way’ (Fulmer 2008: 54).

The EAI functions to provide a risk indicator for abuse and can underpin the need for further review and referral of the older person. Referral is warranted if there are positive indicators of abuse without sufficient clinical explanation, if the older person discloses abuse or if there is high risk of probable abuse, neglect, exploitation or abandonment (Fulmer 2003). In terms of validity and reliability, a study of 501 older people in an emergency department showed an internal consistency reliability (Cronbach’s alpha) of 0.84 and a test/retest reliability of 0.83 (P<.0001) (Fulmer and Wettle 1986). The EAI was
also shown to have a sensitivity of 71 percent, a specificity of 93 percent and a content validity index of 0.83 (Fulmer et al. 2004). The EAI does have some merit in testing for elder abuse but does not give a score on probability of abuse (Cohen 2011). The tool has demonstrated some promising results in identifying elder abuse, but is victim focused and does not capture an assessment of the caregiver or perpetrator (Imbody and Vandsburger 2011) and although the EAI has demonstrated some success further empirical testing is required.

The Indicators of Abuse Screening Tool

The Indicators of Abuse (IOA) screen (Reis and Nahmiash 1998) is administered by a trained professional to discriminate potential abusive and non-abusive situations. The test takes approximately two to three hours to complete and is focused on the home environment. The IOA was developed from the compilation of a 60-itemed preliminary checklist, with 48 items drawn from possible indicators and 12 focussing on background and demographic details (Reis 2000). The sixty items were tested within a larger study (PROJECT CARE) (Reis and Nahmiash 1995a,b,c) within a residential area of a North American city using 341 participants. The study used participants from the age of 55 years, who had unpaid caregivers. From this study 29 items were isolated which could predict whether abuse was potentially occurring. The items focus on mental and psychosocial features in the caregiver characteristics, the care-receiver characteristics and the interpersonal care receiver-caregiver context. Measurements on the IOA scale range from an evaluation of the item’s ‘non-existence’ to ‘yes/severe’ with coding accommodated for items which were not applicable or were not determinable during the screening test. True positives for abuse were identified in 78 to 84.4 percent of screened older people while non-abuse cases were identified in 99.2 percent of those screened (Reis and Nahmiash 1998). Reliability was determined by the IOA’s high internal consistency (Cronbach alpha coefficient .91-.92). However, although the IOA has the capability to identify risk of abuse, its content is based on indicators and interviewers’ skills may impact on the use of the tool (Cohen et al. 2006). In 2006, Cohen and colleagues expanded the IOA scale (E-IOA) by introducing a series of sub-indicators (Cohen et al. 2006). These were based on high risk and were drawn from literature on psychiatric disorders (American Psychiatric Association’s 1994, Goldman 1994) and a model of bio-psychosocial assessment social work relating to older people (Greene 2000). Four indicators were removed from the original IOL. These indicators related to past poor relationships as this was correlated to poor current relationships; the existence of falls was considered a possible sign of abuse rather than a high risk indicator; ‘no permanent doctor’ was considered not applicable to the Israeli context and ‘suffered abuse in the past’ was removed as this was seen as demonstrating a high certainty of abuse in the present. Further assessment included a determination based on evident signs and symptoms of abuse which were elicited from the physical, mental, sexual, and the economic signs of abuse and neglect developed by Mount Sinai Hospital (Ansen and Breckman 1988). Evaluation of the list of signs of abuse ranged from 1 = ‘to a great extent’ to 5 = ‘not at all’ or ‘not possible to receive information’. In a pre-test sample, Cronbach alpha for the E-IOA was .78 to .91. In a sample of 108 (Cohen et al. 2006) and a further sample of 730 older people from the age of 65 years (Cohen et al. 2007), the tool discerned 92.9 percent of older people as being at risk of abuse and 97.9 percent of older people who were probably not abused. Further testing of 1,317 older people over 70 years of age also demonstrated good validity and reliability (Cohen et al. 2010).

In summary, the IOA does show some strength in terms of validity and reliability and is easy to score (Meeks-Sjostrom 2004) however; the tool requires completion by a trained professional and is based on the professional’s subjective score in relation to each item (Imbody and Vandsburger 2011, Cohen 2011). Furthermore, the time to complete the screen may prohibit its use in clinical practice (Fulmer et al. 2004). Although, the IOA has been tested by Reis and Nahmiash (1998) in the home environment and the E-IOA by Cohen et al. (2006) in the acute hospital environment, neither have been used in long term care facilities for older people. Furthermore, E-IOA tools are weak in identifying areas of financial abuse (Cohen et al. 2006).

Brief Abuse Screen for the Elderly

Reis and Nahmiash (1995c) developed the Brief Abuse Screen for the Elderly (BASE) as part of PROJECT CARE.

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This tool contains five questions to sensitise those who use the tool to the possibility of elder abuse. It has the advantage of taking approximately one minute to complete by a trained professional. Questions focus on the suspicion level, the abuse type and the immediacy of response, however, it does not assess for specific risk factors or signs of abuse or neglect (Imbody and Vandsburger 2011). Psychometric testing (n=492) demonstrated predictive validity which ranged from 89-91 percent (Reis and Nahmiash 1995c). While the BASE has some merit as a screening instrument, its use is limited as it should be administered in conjunction with the IOA tool (Reis and Nahmiash 1998) rather than as a stand-alone assessment. This complicates the screening process and can elongate assessment.

**The Caregiver Abuse Screen**

Developed in the context of a large scale elder abuse and intervention research project (PROJECT CARE) (Reis and Nahmiash 1995a, b, c), the CAS focuses on current physical, psychological, or financial abuse as well as neglect. It encompasses eight questions which screen the caregiver of the older person giving the option of a ‘yes’ or ‘no’ answer. Questions are orientated towards eliciting a suspicion of one of the abuse types without specific reference to particular abuse behaviours. The screen takes between one to two minutes to complete. Theoretical links are made by the authors in relation to an external locus of control and the neutralisation theory, which explains abuse as involving particular rationalisations of the caregiver’s behaviour. Such rationalisations are not challenged within the context of the screening tool (Reis and Nahmiash 1995a). Psychometric testing of the instrument was undertaken with 44 abusive caregivers receiving the PROJECT CARE abuse intervention model. Two contrast groups were also recruited. The first contained a sample of 45 non-abusive caregivers receiving assistance from the health and social care services. The second group consisted of 50 non-abusive caregivers recruited from the same or similar geographical area who were not in receipt or any external health or social care assistance.

Three abuse/aggression scales were used to examine convergent validity: the IOA (Reis and Nahmiash 1998), two Ryden Agression Subscales (Ryden 1988a, b) and the H-S EAST (Neale et al. 1991). In addition, personality traits were measured using a number of scales or sub-scales which were administered in the context of the interview. Concurrent validity was supported by the fact that ‘known’ abusers scored much higher that the two non-abusing groups, thus indicating the tool’s ability to distinguish between abusive and non-abusive caregivers. There were no differences between the two non-abusing groups. Internal consistency of the tool measured at Cronbach’s alpha 0.71. Statistical correlations were also found using the three abuse/aggression scales with a cut off significance of p<0.05. In the assessment of construct validity, the exploratory factor analysis focused on the tool’s ability to identify a possibility of physical, psychological or financial abuse and the tool’s ability to discriminate for neglect.

Reis and Nahmiash (1995a) suggest that the CAS has particular merit in initial screening for potential elder abuse by using it in combination with the IOA screening tools to provide a ‘first alert’ (Reis and Nahmiash 1995a: 57). A Brazilian study (Reichenheim et al. 2009) indicated some concerns in relation to the dimensionality of the tool however, it is suggested that with some improvements and refinements to the CAS it may ‘show stronger correlations with external variables and thus raise further support for its measurement validity and by extension, measurement equivalence’ (Reichenheim et al. 2009:882). Thus, in terms of its psychometric properties, the CAS requires further refinement and, as with the BASE, can be complicated by a requirement to concurrently complete the IOA.

**The Elder Abuse Suspicion Index**

The Elder Abuse Suspicion Index (EASI) was developed by Yaffe et al. (2008) following a review of the literature on elder abuse, a consideration of obstacles to recognising elder abuse, an examination of existing screening tools and the characteristics of screening in use by physicians. The tool was designed for physicians with the aim that it would contribute towards a decision to refer the older person for further investigation if elder abuse was suspected (WHO 2008). This resulted in nine potential questions regarding screening for elder abuse. Focus groups consisting of 31 doctors, nurses and social workers who reviewed potential elder abuse detection questions. Despite the three professional groups having differing conceptual approaches (Yaffe et al. 2009), five final questions were identified as fundamental to screening for elder abuse. Following piloting of these five
questions with three older people, an additional sub-question was added to elicit the frequency of the abuse type. The study (Yaffe et al. 2008) suggested eliminating the question on frequency as it did not impact on the sensitivity of the tool nor was frequency considered essential by the World Health Organisation (2008) review. Finally, a sixth question was added to articulate the need to include physician observation of the older person. The final items on the tool focused on closed, behaviourally specific questions, preface statements which were contextually orientated and the assessment of active abuse by people with whom the older person has contact with (WHO 2008).

A sample of 953 cognitively intact older people was screened with the EASI and three weeks later the Social Worker Evaluation (SWE) was completed on the same population. The SWE is a standardised assessment which allows in-depth evaluation of older people at risk of being abused and takes an average of 66 minutes to complete (WHO 2008). Social workers who undertook the SWE were blinded to the result of the EASI. The EASI was identified as having a relatively high specificity and sensitivity. The sensitivity of each of the six questions ranged from 0.03-0.23, whilst the specificity ranged from 0.72-0.99. However, it was noted that when the first question, which addressed risk, was removed the sensitivity reduced from 0.47 to 0.32. The authors (Yaffe et al. 2008) suggest that the first question is important as a primer for other EASI responses and such questions may be necessary to encourage full disclosure (Acierno et al. 2003). Overall the correlation of the EASI and the SWE indicated a sensitivity rate of 0.44 and a specificity rate of 0.77 (Yaffe et al. 2008).

The EASI does have potential for use in the practice setting in terms of brevity with 69.2 percent of physicians who completed the post-study survey indicating that the EASI took two minutes or less to complete (Yaffe et al. 2008). In addition, 95.8 percent of physicians indicated that the questions were ‘very easy’ or ‘somewhat easy’ (Yaffe et al. 2008). However, it is noted that older people who have been subject to repeated abuse may require a more in-depth screen to identify abuse.

In 2008, the WHO used the EASI as a basis for developing an elder abuse screening tool that would be culturally and geographically acceptable in areas outside of Canada. Focus groups from eight participating countries (Australia, Brazil, Chile, Costa Rica, Kenya, Singapore, Spain and Switzerland) were used. Each participating country convened three focus groups comprised of older people and four focus groups comprised of primary health care professionals. Further workshops considered the concept of the SWE, local understandings and interventions related to elder abuse and the efficacy of the Pan American Health Organisation (2002) guidelines on elder abuse and neglect. Findings from this study indicate that the EASI tool was simple to complete, covered the important categories of elder abuse and although there were minor issues in relation to local cultural interpretations, the tool was culturally transferable. Comments also indicated that neglect was not addressed sufficiently. The WHO (2008) suggested some alterations to the six questions within the EASI screening tool, but, to date, the revised tool has not been piloted in clinical practice. Although the EASI tool was developed for physician use, the WHO (2008) suggests as an alternative nurses could administer the tool.

Currently, the EASI has been translated into Spanish, French, Japanese, German, Hebrew and Arabic (Yaffe M. Personal communication 5/12/10). Recently, the EASI has been adapted for self-completion by older people (Yaffe et al. 2011). The first five questions were retained but the sixth question, which was originally focused on physician observation, was eliminated. This decision was considered supported by psychometric evaluation as when the sixth question was eliminated, sensitivity decreased by 0.01, while specificity increased by a similar quantity (Yaffe et al. 2008). The response options were reduced to ‘yes’ or ‘no’ as ‘did not answer’ was removed. The revised EASI, referred to as EASI-sa, was completed by 210 cognitively intact older people who were stratified into eight groups to evaluate the screening tool (Yaffe et al. 2011). Readability and acceptability of the tool was positively evaluated and the refusal rate to complete was low. Completion time ranged from two to five minutes with the tool acting as an elder abuse awareness training method for the older people in 27.2 percent of cases as well as increasing understanding of the manifestations of elder abuse. Yaffe and colleagues (2011) indicate that further validation studies will focus on comparing outcomes from the EASI and the EASI-sa.

Although the EASI does not assess the caregiver, it has particular merit in being a rapid assessment which assesses for potential abuse and allows practitioners to
incorporate their subjective assessment. As a tool, it provides for the identification of older people at potential risk of elder abuse and highlights individuals whose case may require further probing and, if deemed necessary, referral to elder abuse services. The tool appears to be culturally transferable, suitable for use in multiple settings, to have the potential to be used by professions other than physicians (WHO 2008) and has demonstrated acceptability and value in the context of self-completion by the older person.

**Caregivers Psychological Elder Abuse Behaviour Scale**

In Taiwan, Wang et al. (2006) developed two elder abuse screening tools which focused on identifying the potential for psychological abuse. Wang et al. (2005; 2006) noted that although psychological abuse is the most common form of abuse, it is generally underestimated due to a lack of evidence or a minimisation of the significance of elder abuse. The Caregivers Psychological Elder Abuse Behaviour Scale (CPEABS) takes ten minutes to complete and focuses on eliciting information from the caregiver. The CPEABS consists of 20 items which are rated on a one to four likert scale, ranging from “1 = never behave this way”, to “4 = often behave this way”.

The CPEABS has been tested in both long term care (Wang 2005) and in the home environment (Wang et al. 2006). Caregivers in long term care environment completed the scale which was used in conjunction with the Caregiver’s Burden Scale (CBS) (adapted from Wu 1995). Results indicated that caregivers with higher levels of education, higher work burdens and those who lacked specialist geriatric training were more prone to potentially abuse. Psychological abuse was also more associated with younger caregivers rather than their older counterparts. In testing the CPEABS in the home environment, Wang et al. (2006) also used the CBS. Scores were added and could range between 20-80, with a higher score demonstrating a higher possibility to abuse. Reported psychometric results indicate a content validity of .95 and a Cronbach’s alpha of .85. The test-retest reliability was established .64, (p< .001) over a two week period (Wang et al. 2006).

While the CPEABS (Wang et al. 2006) has the ability to probe into psychological abuse and has been tested in both community and long term settings, it is specific to one typology. Although psychological abuse is a prevalent type of elder abuse, it often co-exists with other typologies, and using this tool alone would not illuminate such co-morbidity. A generic screening tool for all typologies should be used as the front-line assessment while the CPEABS (Wang et al. 2006) could facilitate further investigation of psychological abuse within a specialised referral service. Furthermore, additional empirical testing and a review of cultural transferability are required.

**Elder Psychological Abuse Scale**

The Elder Psychological Abuse Scale (EPAS) was developed by Wang et al. (2007) in Taiwan. Following a review of the literature and in-depth focus group interviews which discussed the concept of psychological abuse of older people, the items were reviewed by experts in the area of gerontology (academic and clinical). This resulted in a 32 item scale which focuses on discussion with the older person (Q 1-7), active observation (Q8-13) and an interview with the caregiver (Q14-32). Concurrent validity was tested using the Barthel Index (BI) for activities of daily living and the Short Portable Mental State Questionnaire (SPMSQ) (Pfeiffer 1975).

The EPAS was tested on 195 older people over 60 years of age who were resident in institutional care settings and Wang et al. (2007) report an average of 5-10 minutes for completion. Reliability was established in a K-R20 co-efficient of 0.82 for internal consistency. Concurrent validity was obtained by evaluating the relationship with the BI and SPMSQ with an overall correlation of -0.32 (p<.001). This demonstrated that older people with cognitive impairment or with functional dependency were at a higher risk of psychological abuse. Psychometric testing does indicate that the EPAS is a stable tool for screening for psychological elder abuse. It may also be used as a more refined screening tool in order to quantify and identify psychological abuse although it’s yes/no format has limited ability to further explore the depth of the psychological abuse experience. As with the CPEABS (Wang et al. 2006), screening is limited to psychological abuse and the tool would benefit from additional empirical testing and a review of cultural transferability.
The Older Adult Psychological Abuse Measure

As part of a study to develop scales for a comprehensive Older Adult Mistreatment Assessment (OAMA), Conrad and colleagues (2010a) developed the Older Adult Psychological Abuse Measure (OAPAM) and the Older Adult Financial Exploitation Measure (described below). Trochim’s (1989) three dimensional concept mapping approach was used to conceptualise psychological abuse of older people (Conrad et al. 2010a). Statements from the literature on the topic of psychological abuse and those developed by a national panel of 16 experts in this area were rated using a severity score from 1-5 and then clustered using Concept Systems software. Results comprised a hierarchy of severity 1) isolation, 2) insensitivity and disrespect 3) shaming and blaming 4) threats and intimidation and 5) trusted other risk factors. Statements were then generated for questionnaires and developed for both third party review and self-report (Conrad et al. 2010a). The questionnaires were then reviewed by nine focus groups comprised of both staff members from adult protective services and older people. A further four cognitive interviews were conducted with four older people with substantiated elder abuse. This resulted in a 31 item client-self report measure, the OAPAM. Using 22 staff in Adult Protective Services in the Chicago area, 226 older people, who were substantiated for at least one abuse type, were recruited to participate in the study, all of whom consented to the study and demonstrated a Mini-Mental State Examination (MMSE) score of at least 17. Statistical analysis was conducted using the Rasch measurement module (Rasch 1960), which has the ability to test use an item hierarchy and contributes to theory building and test construct validity. The test construct dimensionality raw variance was 43.1 percent which supported the unidimensionality of the tool. The Rasch person reliability was .86, which is equivalent to a Cronbach’s Alpha of .92, and item reliability was demonstrated as high at .97. A shorter from of the OAPAM using 18 items was also developed and met stringent Rasch analysis (Rasch person reliability .78 corresponding to a Cronbach’s alpha of .87, item reliability was .96).

The OAPAM (Conrad et al. 2010a) has been demonstrated as a useful tool in screening for potential psychological abuse of older people and has also identified relevant graduations of severity of psychological abuse. Further validity testing in other populations would contribute to the ability of the OAPAM to elicit suspicion of psychological abuse and to potentialise the effectiveness of service response in prevention and amelioration.

The Older Adult Financial Exploitation Measure

The only validated financial abuse screening tool reported in the literature is the Older Adult Financial Exploitation Measure (OAFEM) (Conrad et al. 2010b), which represents part of the developmental work by Conrad and colleagues within the Older Adult Mistreatment Assessment (OAMA) research. The OAFEM identifies individual components of financial abuse and a related severity hierarchy. Using statements on financial abuse from the literature and brainstorming with expert panels, a list was produced which reflected aspects of financial abuse. The list was then arranged into a conceptual framework using Trochim’s (1989) concept mapping and components rated for severity by the expert panel.

The concept mapping and expert review work resulted in six clusters and gave rise to an 82 item scale, which was further reduced to 79 items. The clusters focused on: theft and scams, financial victimisation, financial entitlement, coercion, signs of possible financial exploitation and money management. Possible responses to the questions on the OAFEM include a positive, negative, suspected or not-applicable response for the specific forms of financial abuse listed. Initial psychometric testing by 22 trained staff on 227 older people who had substantiated abuse demonstrated enhanced professional decision making in suspected cases of financial abuse. Adequate cognitive capacity is required to complete the OAFEM. Consequently, completion requires a Mini-Mental Status Exam score of 17 or above or competent investigator judgment (Conrad et al. 2009). Further psychometric testing refined the tool to a 30 item scale which has demonstrated validity. Within the sample, 173 people endorsed one or more items on the 30 item scale which uses different cut-off points, but it has the potential to indicate more serious financial abuse (Conrad et al. 2010b). The latest version of the OAFEM has been reduced to a 25 item tool (personal communication with Conrad 2011), which addresses the issue of a lengthy completion time compared to the 79 item tool.
The OAFEM (Conrad et al. 2010b) has demonstrated specific merit in identifying potential financial abuse of older people; in addition the reduction of items on the tool has decreased the time required for completion. The OAFEM screens specifically for financial abuse and may have particular value in the context of screening if a practitioner's suspicion of financial abuse is aroused and may also be useful when other abuse types have been identified. Identification of potential financial abuse is particularly relevant in the context of recent studies which have identified financial abuse as the most common form of elder abuse (Naughton et al. 2010, Acieno et al. 2010, Lifespan of Greater Rochester Inc. et al. 2011).

3.4 Assessment guidelines

In addition to screening tools, a number of assessment protocols and guidelines have been developed to assist assessment of elder abuse. While screening tools generally have a specific closed response to particular focussed questions, assessment protocols and guidelines are generally comprised of open-ended questions (Anthony et al. 2009). Such guidelines include the American Medical Association's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect (1992) which recommends that assessment for elder abuse is incorporated into a routine geriatric practice. Thus, it can be a lengthy process but is underpinned by the practical support of a flow chart (Fulmer et al. 2004). The use of flow charts or algorithms has been considered a priority for elder abuse detection and management (Kreuger et al. 1997) and they allow a simple and clear pathway for decision making. Other guidelines use a broad qualitative approach (Johnson 1981; Rathbone- McCuan 1980; Tomita 1982) while Bomba (2006) has developed a single page assessment and management tool for elder abuse incorporating assessment (adapted from Lachs 1998), best practice guidelines (adapted from the National Association of Adult Protective Services Administrators consensus statement), screening (adapted from a modified H-S EAST (Scholfield 1999), suspicion of abuse (Modified Ohio Elder Abuse and DVLL Screening tool (Ejaz 2001) and abuse management and monitoring (modified AMA 1992). Although these assessment protocols and guidelines do raise practitioners' sensitivity to elder abuse, the majority have not been validated. Two screening protocols were identified as being commonly cited in the literature and are reviewed below.

The American Medical Association Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

Although the United States Task Force on Preventative Violence (2004) did not support the routine use of screening tools for elder abuse, the AMA (American Medical Association 1992) recommends that nine questions related to elder abuse are interwoven into assessment of the older person. Questions focus on establishing the safety of the older person, functional and cognitive assessment, general health, social connections, finance, psychological status and, if identified, a description of the abuse. The guidelines include a flowchart which identifies care pathways and referral resources. Although, the guidelines do provide some guidance, assessment is lengthy, neglect is not considered and the discrimination between disease and maltreatment is not differentiated (Fulmer et al. 2004). Consequently, Fulmer et al. (2004) report that they are not well utilised by practicing clinicians. In 2009, Buri et al. tested the sensitivity and specificity of the AMA guidelines in comparison with elder abuse screening tools. Results indicate that the AMA had a test-retest reliability of 0.825 (p<0.001) and a Cronbach's alpha of 0.734. In a review of the receiver-operator characteristic curve, the AMA guidelines were not effective in discriminating abuse from non-abuse.

Although the American Medical Association (1992) assessment of guidelines direct attention to the assessment of elder abuse, they are focused on a medical review by a physician. The guidelines suggest a full medical assessment, which is a lengthy process and not suitable for multiple settings. Moreover, the discriminatory ability of using the guidelines is poor when compared to specific elder abuse screening tools, which reduces its value as a formidable tool to trigger elder abuse suspicion.

Screening Tools and Referral Protocol

Following gaps in existing protocols for screening for elder abuse, the Benjamin Rose Institute, a non-profit, non-sectarian organisation in Cleveland, Ohio developed Screening Tools and a Referral Protocol (Bass et al. 2001). The Screening Tools and a Referral Protocol (STRP) were developed to improve identification and referral for older people in Ohio who may be subjected to elder abuse. The STRP is comprised of five sections: Introduction, Referral Protocol, Actual Abuse Screen, Suspected Abuse
Screening Tool and Risk of Abuse Screening Tool (Bass et al. 2001). The introduction centres on providing the practitioner with a preamble to the topic of elder abuse and focuses on raising awareness regarding the topic, through information and case examples. As legal reporting is mandated in the United States, the introduction also gives a description of the pertinent state laws. The referral protocol contains a one page decision making flow chart for identifying, reporting and referral of the problem. Decision making and subsequent actions are assisted through use of the screening tools which accompany the STRP. The protocol is divided into pathways for risk of abuse or actual/suspected abuse situations.

The Actual Abuse Tool (AAT) asks if there has been a reliable report of abuse and provides a list (non-exhaustive) of the prominent types of abuse and neglect and their behavioural manifestations. The AAT also contains a decision/action sheet which supports decision making in the case. The Suspected Abuse Tool (SAT) is used when actual abuse is not reliably reported. Common signs and symptoms of abuse are considered in a check-list format. Positive responses indicate that the case requires follow-up. This part of the STRP also contains a decision making section to indicate how particular conclusions were justified. When there is an absence of actual abuse and the practitioner cannot identify related signs of abuse when there is suspicion of abuse, the Risk of Abuse Tool (RAT) is completed. This tool evaluates the presence of risk factors that are commonly associated with abuse. Thus, the RAT assesses the heightened risk of abuse rather than its presence or possible presence. It has sections which focus on both the older person and the person who may be susceptible to abusing. Five risk factors are accorded particular importance: alcohol use, activities of daily living dependencies, instrumental activities of daily dependencies, cognitive impairment and depression and are supported by further guidance in what the authors entitle ‘extended tools’ (Bass et al. 2001). Psychometric testing has not been recorded.

The STRP (Bass et al. 2001) provides a template for screening for abuse, particularly alerting the practitioner to information on elder abuse and guidance on procedural pathways and assessment in the context of actual, suspected and risk of elder abuse. However, its lack of empirical testing is a major limitation and further work is required to demonstrate its psychometric properties and value in being a valid and reliable tool in screening for elder abuse.
4. Discussion

The debate of whether screening tools are a valid and reliable method of assessing potential elder abuse continues. This is a particular issue in both the medical and legal domains as reasonable certainty of the occurrence of elder abuse remains elusive in some cases (McNamee and Murphy 2006, Imbody and Vandsburger 2011). A major complicating factor in the development of screening methods is the diverse interpretations of elder abuse. In addition, as Lachs (2004) notes, traditional disease orientated approaches to screening do not readily apply to elder abuse. Screening tools can raise practitioner awareness to the possibility of elder abuse and may raise the index of suspicion, particularly in cases where the signs of maltreatment are observable (Bomba 2006). However, the items within some screening tools are often based on overt signs of abuse which makes the recognition of subtle abuse challenging (Anthony et al. 2009). Moreover, although screening tools do require cultural sensitivity, cultural norms are not an excuse to ignore abuse (WHO 2008).

While progress has been made in screening older people for potential elder abuse, the validated tools examined in this discussion require further refinement. For instance, Antzberger (2001) indicated that existing tools do not adequately discriminate between actual abuse, signs of suspected abuse and risk indicators of abuse. Furthermore, some tools have only been tested on relatively small sample sizes, which limit their generalisability. Other concerns focus on an examination of domestic violence in older people as an element of elder abuse as well as clear delineations of legal and clinical parameters. Taking into account the complexity of elder abuse, it may be argued that raising practitioner awareness through education may override a reliance on screening tools (Lachs and Pillemer 2004). From an ethical point of view, any system of increasing practitioner awareness or systematic screening of elder abuse demands appropriate and flexible intervention pathways. Moreover, screening tools need to be ‘fit for purpose’ for the environment in which they are utilised (Bomba 2006). This is a particular issue when screening older people who have mental capacity challenges as no screening tool has indicated validity or reliability in detecting potential elder abuse with this group.

The target setting for completing a screening tool is also an issue. Busy areas demand a brief tool, while other domains may have the capacity to engage in a lengthier screening assessment. Therefore, it is unlikely that any one elder abuse screening tool will meet all the requirements for universal setting (Anthony et al. 2009). A notable absence of screening tools is in the domain of residential care as most screening tools focus on the dyadic relationship of abuse within the home environment. Although the EAI (Fulmer 1984) has been identified as useful for assessment of abuse in residential care (Meeks-Sjostrom 2004), any screening tool which focuses on residential abuse would need to consider the contextual differences relating to elder abuse, such as systems of care challenges. Some tentative efforts have been made (Cohen et al. 2010), but further development and refinement is required. In particular, a screening tool for elder abuse in residential care would need to address context issues inherent in the systems of care as well as interpersonal dynamics. Overall, what must be borne in mind is that the focus of screening tools in elder abuse has been to raise practitioners’ suspicion of abuse and to help them identify potential abuse with a view to further investigation and referral.
5. Conclusion and Recommendations

Conclusion

In conclusion, screening tools for elder abuse may have the ability to provide a systematic, standardised, multi-disciplinary objective assessment to detect potential elder abuse. However, further testing of screening instruments is fundamental to refining the validity and reliability of such tools. Although some screening tools have shown some promise, particular categories of abuse may have been omitted, particularly the area of sexual abuse. Within the context of the screening tools reviewed in this discussion, it is proposed that two tools demonstrate particular merit for possible use in the Irish context namely, the EASI and the OAFEM. The EASI has the ability to screen for all abuse manifestations. The EASI has and continues to be used in differing cultures and has been subject to WHO (2008) review and support. It is a relatively rapid screening instrument, is easily completed and has the capacity to be practitioner administered and, more recently, self-administered. Most importantly, it addresses all categories of elder abuse and measures potential abuse within the preceding twelve month period.

Recommendations

In relation to the OAFEM, financial abuse is a particular concern within the Irish context and the OAFEM appears to have potential in terms of targeting identification of the possible presence of financial abuse. As financial abuse is the most common form abuse in Ireland (Naughton et al. 2010) and the second most common abuse among HSE referrals for the elder abuse service (HSE 2011), the use of a specific tool to detect financial abuse is likely to be important. Although, this tool has only been tested in a limited way with older people, psychometric results to date demonstrate positive results in terms of validity and reliability, therefore OAFEM as a tool to lead to the detection of financial abuse warrants further examination.

The following recommendations are offered bearing in mind that no definitive screening tool for the detection of elder abuse exists, and that screening tools for elder abuse are not diagnostic but rather can identify the potential presence of abuse and highlight cases which may warrant further investigation and referral.

- That consideration be given to piloting the Elder Abuse Suspicion Index (EASI) in the Irish context and that it be subjected to further psychometric testing. It is recommended that piloting should encompass a multi-disciplinary and multi-setting approach and that participants in the pilot study should receive training on the issue of elder abuse and the use of the EASI.

- That the OAFEM be the subject of further study for potential validation.


References


References


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References


