The Elder Abuse Suspicion Index:
A Pilot Study to Test its Reliability in an Irish Context

Amanda Phelan, Gerard Fealy, Carmel Downes, and Nora Donnelly
NCPOP Board of Programme Directors

Professor Gerard Fealy, Dr. Amanda Phelan, Professor Denis Cusack, Professor Cecily Kelleher, Dr. Martin McNamara,
Dr. Anne O’ Loughlin, Professor Suzanne Quin, Professor Tony Fahey.

This study was funded by the Health Service Executive (HSE) as part of the work of the National Centre for the
Protection of Older People (NCPOP) at University College Dublin.

This report should be cited as:

Reliability in an Irish Context.

National Centre for the Protection of Older People (NCPOP)
UCD School of Nursing, Midwifery and Health Systems

Health Sciences Centre
University College Dublin
Belfield, Dublin 4, Ireland

Tel: +353 (0)1 716 6467 Fax: +353 (0)1 716 6498
Email: ncpop@ucd.ie Web: www.ncpop.ie

© UCD and HSE, 2014
The authors are grateful to the participating healthcare professionals who conducted assessments using the Elder Abuse Suspicion Index (EASI) instrument and all the staff in the participating general practice settings, hospitals, hospice, local health settings, health centres and day centres.

The authors also gratefully acknowledge the following:

- The Health Service Executive (HSE) which funds the National Centre for the Protection of Older People (NCPOP) and the programme of research of which this study is a part.
- The HSE management and steering committees and the NCPOP user group for their guidance and advice throughout the study.
- Professor Mark Yaffe for providing guidance on the conduct of the study.
- Dr Gillian Paul for her support during the study planning process.
- Ricardo Segurado, Tim Grant and Bahman Honari, CSTAR, for advice on statistical design and analysis.
- Ms. Gay Grant RGN for assistance with data collection.
- Ms Sandra McCarthy for her assistance with editing the report.
- The NCPOP International Advisory Committee, comprising Professor Simon Biggs, University of Melbourne, Australia and Professor Karl Pillemer, Cornell Institute for Translational Research on Aging, Cornell University.
# Contents

Acknowledgements ........................................................................................................................................... i  
Executive Summary........................................................................................................................................... v  

Chapter 1: Introduction ................................................................................................................................. 1  
  1.1 Background ........................................................................................................................................... 1  
  1.2 Report structure .................................................................................................................................... 1  

Chapter 2: Review of the Literature .............................................................................................................. 2  
  2.1 Introduction .......................................................................................................................................... 2  
  2.2 Risk factors in elder abuse ..................................................................................................................... 2  
  2.3 Screening ............................................................................................................................................. 2  
  2.4 Screening tools in elder abuse .............................................................................................................. 2  
  2.5 Issues related to elder abuse screening tools ....................................................................................... 4  
  2.6 Identifying screening tool for use in this study .................................................................................... 5  
  2.7 The Elder Abuse Suspicion Index ....................................................................................................... 6  
  2.8 Conclusion .......................................................................................................................................... 7  

Chapter 3: Study Design .................................................................................................................................. 8  
  3.1 Introduction .......................................................................................................................................... 8  
  3.2 Developing the EASI tool ..................................................................................................................... 8  
    3.2.1 Assessment of face validity .............................................................................................................. 8  
    3.2.2 Survey with healthcare professionals ............................................................................................. 8  
    3.2.3 Cognitive interviews with older people .......................................................................................... 9  
    3.2.4 Adjustment of the tool .................................................................................................................. 10  
  3.3 Development of protocols and training ............................................................................................... 10  
  3.4 Piloting the EASI tool ........................................................................................................................... 10  
    3.4.1 Recruitment of study sites and healthcare professionals ............................................................... 10  
    3.4.2 Recruitment of older people .......................................................................................................... 11  
    3.4.3 Instruments .................................................................................................................................... 12  
    3.4.4 Data collection .............................................................................................................................. 13  
    3.4.5 Referral process ............................................................................................................................ 13  
    3.4.6 Case verification ........................................................................................................................... 13  
    3.4.7 Data analysis ............................................................................................................................... 14  
  3.5 Ethical considerations and data collection procedures ........................................................................ 14
### Chapter 4: Results

- 4.1 Introduction
- 4.2 Sample of older people
- 4.3 Administration of the EASI
- 4.4 Suspicion of abuse
- 4.5 EASI items
  - 4.5.1 Questions 1-6
  - 4.5.2 Impact of a Yes/No response to Question 1 on subsequent EASI Questions
- 4.6 Onward referral
- 4.7 Tracking and Substantiation of Abuse

### Chapter 5: Discussion and Conclusions

- 5.1 Discussion
- 5.2 Limitations
- 5.3 Conclusions and recommendations

### References

### Appendices

- Appendix 1
- Appendix 2
- Appendix 3
List of Tables

Table 3.1  Pre pilot survey with healthcare professionals to establish the face validity of the EASI ........9
Table 3.2  Study site and data collector by region ................................................................................9
Table 4.1  Sample characteristics ........................................................................................................16
Table 4.2  Number of pre-EASI screenings conducted by Occupation of Professional ........................17
Table 4.3  Characteristics of those who had a positive score on the EASI tool (n=79) .........................17
Table 4.4  Association between respondent characteristics and EASI screening outcome .................17
Table 4.5  Suspicion of abuse identified by perpetrator and numbers ..................................................18
Table 4.6  Results of the EASI assessments ...........................................................................................18
Table 4.7  Subsequent positive responses to EASI for older people who scored ‘yes’ to question one ....19
Table 4.8  Subsequent positive responses to EASI for older people who scored ‘no’ to question one ....19
Table 4.9  Results of EASI by respondents’ dependency ......................................................................19
Table 4.10  Association between dependency on others and raising a suspicion of abuse on the EASI ...20
Table 4.11  Positive Predictive Value of EASI Screening Tool ............................................................21

List of Figures

Figure 4.1  Recruitment pathway ........................................................................................................16
Figure 4.2  EASI results by dependency (Q1).....................................................................................19
Introduction

Elder abuse is a challenge in global societies (Phelan 2013). Prevalence studies have demonstrated that between 2 and 20 per cent of community-dwelling older people may experience some form of abuse (O’Keefe et al. 2007; Naughton et al. 2010; Lowenstein et al. 2009; Acerino et al. 2009; Lifespan of Greater Rochester, Inc. et al. 2011). However, it is recognised that this only represents a proportion of true figures as, in reality, the prevalence of abuse may be much higher (Rhodes 2005; Lifespan of Greater Rochester, Inc. et al. 2011). Therefore, it is important to study methods which increase the likelihood of discovering abuse. One such method is screening older people for elder abuse.

The concept of screening is based on the early identification of the 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, 2004; Petersen 1997). Although the application of traditional screening principles to elder abuse has been questioned due to the non-traditional epidemiological characteristics and complexity of abuse (Lachs & Pillemer 2004), screening tools and standardised elder abuse assessments have the potential to increase awareness and understanding of abuse among both practitioners and older people themselves. This is particularly important as many professionals struggle to recognise abuse (Heath et al. 2005; Kennedy 2005; Newton 2005; Mandiracioglu et al. 2005; Cooper et al. 2008; Killick & Taylor 2009; Caciula et al. 2010; Hempton et al. 2010).

Screening tools for elder abuse are only suitable for older people without cognitive impairment, although prevalence studies indicate that elder abuse is higher in older people with conditions such as dementia (Yan & Kwok 2010). Acknowledging this and following on from a comprehensive literature review on screening tools undertaken by the National Centre for the Protection of Older People (NCPOP) (Phelan & Treacy 2011), the Elder Abuse Suspicion Index (EASI) (Yaffe et al. 2008) was identified as having the potential to assist healthcare practitioners in identifying a suspicion of elder abuse and prompting referrals to the appropriate intervention services.

Study aims and objectives

The aim of this study was to test the reliability of the Elder Abuse Suspicion Index (EASI) in the Irish context. The objectives of the study were to:

1. Refine the EASI tool for use in the Irish context
2. Develop Irish protocols and related documents for use of the screening tool
3. Provide training for selected healthcare professionals using the EASI tool in this study
4. Pilot the EASI tool with selected healthcare professionals
5. Correlate EASI results with confirmed cases of elder abuse by senior case workers (SCW) or social workers (SW)
6. Make amendments to EASI protocols as required.

Study design

The study set out to examine the reliability of the Elder Abuse Suspicion Index (EASI) in the Irish context and was conducted in two stages. In order to ascertain the suitability of the EASI in Ireland, the first stage involved establishing the face validity of the tool. This involved a survey among 18 healthcare professionals to review the linguistic and content properties of the tool. In addition, cognitive interviewing was undertaken with six older people. Following this process, minor adjustments were made to the EASI tool. In stage two a data collection instrument was developed for those administering the tool in order to capture information on older people’s consent, cognitive assessment, EASI completion, commentaries on individual cases, referral information and demographic characteristics like age, gender and so forth. The research team also developed a bespoke training and support programme for participating healthcare staff. In stage two, sites were recruited to participate in data collection. Older people were eligible to be included in the study if they were over 65 years of age, could converse in English fluently, were not in acute distress, were not a nursing home resident and had the required cognitive ability as determined by the Mini Mental Score Examination (MMSE) (Folstein et al. 1975 or the 6-CIT (Brooke & Bullock 1999).
Study results

A total of 44 sites were recruited and a total of 800 older people were approached to participate in the study. Nine older people declined to participate and a further 75 were excluded as they did not meet the criterion for cognitive capacity or did not complete the cognitive assessment. The final sample for analysis was 716.

The sample comprised 473 (67%) women and 233 men (33%). Fifty five per cent (n=388) of the sample was aged 80 years or older while the remaining 45% (n=321) were 65-79 years of age. For the six questions on the EASI tool, 79 older people provided responses which generated a suspicion of elder abuse.

Of the 79 older people whose EASI responses indicated a suspicion of abuse, just 19 agreed to undergo onward referral to elder abuse response services. In following up the 19 referred cases, six of the cases were lost to the study due to a number of possible reasons, including subsequent withdrawal of consent for onward referral, resolution of the case prior to onward referral or the case being subsequently categorised as unsuitable for referral. Thirteen cases were reviewed by a senior case worker (SCW) or a social worker (SW). Analysis of these referred cases showed that 10 out of the 13 cases were substantiated cases of elder abuse and that the types of abuse identified correlated with the typologies identified in the assessment using the EASI tool. In the remaining three cases, two were retained on the SCW or SW caseload, as they were complex cases involving vulnerability, while the third case was closed due to a refusal by the older person to have the suspicion of abuse assessed further.

Statistical analysis of the cases was undertaken and this did not provide any evidence indicating a precision rate lower than 70% at 5% significance level. Thus, there was no evidence to indicate that the EASI does not demonstrate adequate positive predictive value to support its implementation in the Irish setting.

The EASI contained a commentary section and, although this was not a required element in the data collection process, 64 of the 79 completed EASI screening assessments contained commentaries that offered insights into the possible abusive situation, helped to explain why some older people declined onward referral, and also identified older people who continued to live in potentially abusive situations. A review of these comments provided further insight into the EASI screening process and supported the decision by the healthcare worker to recommend referral of the case to a SCW or SW. The evidence from assessors’ comments also suggests that there were barriers that prevented older people from consenting to onward referral. These barriers included reluctance on the part of the older person to take up the offer of referral where a partner or close family member was involved, fear of reprisal from the abuser or fear of financial hardship.

Conclusion

This study aimed to establish the reliability of the EASI screening tool in the Irish context. As there was no evidence to indicate that the EASI does not demonstrate adequate positive predictive value to support its implementation in the Irish setting, it may be concluded that the EASI tool has utility in the Irish context. While 10 out of 13 cases initially identified in an EASI screening assessment were subsequently substantiated after onward referral to the dedicated elder abuse service, a larger number of cases is required to achieve adequate evidence, at 5% significance level, that the EASI demonstrates at least 70% positive predictive value.

One of the limitations of the study was the fact that the EASI tool was only suitable for administering to older people with cognitive capacity. This meant that potentially at-risk older people, i.e. older people with cognitive impairment, were not screened. In some of the cases, it was not possible to blind the SCW or SW to the fact that the EASI was the trigger of suspicion that led to the referral of the older person to their service. Additionally, the study did not examine the acceptability of the EASI tool to service providers or to older people.
Executive Summary

Recommendations

In addressing the issues emerging in this pilot study, several recommendations are offered. The primary recommendation relates to the EASI itself, while other recommendations are presented as a consequence of other data analysis in the study.

• When conducting health and/or social assessments of older people, front-line practitioners should consider using the EASI tool. Where possible this could be integrated into the suite of assessments contained in the ©InterRAI assessment for older people currently being implemented in Ireland. Assessment using the EASI is recommended on an annual basis for all eligible older people.

Commentaries provided by assessors when conducting the EASI screening of older people provided some insights into the possible reasons why older people declined onward referral to elder abuse services.

These provide for additional recommendations, as follows:

• Older people availing of services across a range of sectors have particular needs. These warrant further investigation with regard to future sector development to ensure service provision is equitable and socially inclusive.

• Further research is required into the barriers that prevent older people from accepting onward referral and support from formal services.

• The apparent tolerance and normalisation of abusive behaviour on the part of older people themselves requires further investigation.

• The findings of this study, with reference to personal security in relation to financial abuse and intimidation, point to the need to further develop empowerment programmes and interventions for older people.
1.1 Background

Elder abuse is a challenge in global societies (Phelan 2013). Prevalence studies have demonstrated that between 2 to 20 per cent of community-dwelling older people may experience some form of abuse (O’Keefe et al. 2007; Naughton et al. 2010; Lowenstein et al. 2009; Acerino et al. 2009; Lifespan of Greater Rochester, Inc. et al. 2011). However, it is recognised that this only represents a proportion of true figures as, in reality, the incidence of abuse may be much higher (Rhodes 2005; Lifespan of Greater Rochester, Inc. et al. 2011). This phenomenon is described as the ‘iceberg theory’ (Department of Health and Human Services 1998), since formal services are only aware of some cases of abuse, while many remain hidden.

Because of the taboo nature of abuse and the fact that it is most prominent within families, its visibility may be obscured by issues such as family loyalty, fear of repercussions, as well as a failure on the part of the victim, the perpetrator, other family member or health professionals to see behaviours as abusive (Phelan 2013). For this reason it is important that systems can be implemented to both provide a targeted discussion point on the topic of abuse and a review of the possibility of abusive activities being experienced by the older person. Within a determined focus on improving response systems to elder abuse and based on the findings of a literature review on screening tools undertaken by the National Centre for the Protection of Older People (NCPOP) (Phelan & Treacy 2011), two screening measures were identified as having particular merit in the Irish context. As financial abuse is the most prevalent type of abuse identified in a recent Irish prevalence study on elder abuse (Naughton et al. 2010), the Older Adult Financial Exploitation Measure (OAFEM) (Conrad et al. 2010) was piloted with senior case workers for the protection of older people and social workers and the findings of the study are described in a separate report (Phelan et al. 2014). This report presents the findings of a study to test the reliability of the six-item Elder Abuse Suspicion Index (EASI) screening tool (Yaffe et al. 2008) in the Irish context.

The objectives of the study were to:

1. Refine the EASI tool for use in the Irish context
2. Develop Irish protocols and related documents for use of the screening tool
3. Provide training for selected healthcare professionals using the EASI tool in this study
4. Pilot the EASI tool with selected healthcare professionals
5. Correlate EASI results with confirmed cases of elder abuse by senior case workers (SCW) or social workers (SW)
6. Make amendments to EASI protocols as required.

1.2 Report structure

This report is presented in five chapters. Chapter 1 describes the background to the study and the study aims and objectives. Chapter 2 presents an overview of the literature pertaining to screening for elder abuse, risk factors in elder abuse and the identification of the EASI as the tool for use in this study. Chapter 3 describes the research design for the study and presents the methodological pathway and methods used in the research process. Chapter 4 presents the findings of the study. Chapter 5 discusses the implications of the study findings, with reference to the international literature and also presents recommendations and limitations arising from the study.
2.1 Introduction

The world’s population is ageing. In Ireland, population demographics indicate that approximately 11.7 per cent of the population is aged 65 years or older (CSO 2012). A rising older person population increases the potential numbers of older people at risk of abuse. As elder abuse is difficult to discover and its prevalence is underestimated (DHSS 1998; Rhodes 2005), elder abuse screening tools are essential in raising the need for further investigation if risk factors are identified (Fulmer 2001). Irish prevalence figures for elder abuse point to a rate of 2.2–5.5 per cent¹, which equates to 10,201–25,735 community-dwelling older people being abused in some way in the Irish community (Naughton et al. 2010). In 2013 the elder abuse service recorded 2,437 cases of elder abuse, suggesting that many cases remain hidden to formal responses (HSE 2014). In terms of type of abuse perpetrated, psychological abuse was the most common reason for referral, with financial abuse being the second most common form of abuse (HSE 2014). In contrast, the national prevalence study identified financial abuse as the most common form of abuse with psychological abuse constituting the second most frequent form of abuse experienced by older people (Naughton et al. 2010).

2.2 Risk factors in elder abuse

Screening tools are generally based on a review of risk factors associated with a higher probability of a somatic disease, such as cancer. 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 shown to have a predictive value in elder abuse (Cohen et al. 2006) as well 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; Cohen 2008; Naughton et al. 2010). Cognitive impairment in the older person (Compton et al. 1997; Naik et al. 2006) or in the caregiver (Miller et al. 2006) also increases risk, as does alcohol dependence (Campbell-Reay & Browne 2001; WHO 2006), past childhood abuse (Campbell-Reay & Browne 2001), cognitive and functional impairment (Lachs et al. 1997; Shugarman et al. 2003; Laumann et al. 2008), caregiver stress (Wang et al. 2009), mental health problems (Kingston & Penhale 1995), intergenerational violence (Pillemer 1986; Erlingsson et al. 2005), dependency on caregiving (Kruger & Moon 1999; Erlingsson et al. 2005; Buri et al. 2006), gender, (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 (Acerino 2003; Erlingsson et al. 2005). Some risk factors have been proposed as theoretical frameworks to explain elder abuse; however, no theory has adequately explained, with supporting empirical evidence, the complexity of elder abuse.

2.3 Screening

The concept of screening comes from the field of epidemiology (Bonita et al. 2006). Its purpose is the early identification of the 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, 2004; Petersen 1997). As such, screening represents a major instrument in public health and is an important element in Irish health policies (DOHC 2001a; 2001b). Screening tools are not diagnostic, but do highlight cases which have a higher statistical probability of a disease or disorder (Stampfer et al. 2004; Kettles et al. 2004) and therefore warrant further investigation by a practitioner (Yaffe et al. 2012). While the concept of screening may appear simple, it is influenced by the presence of classic screening criteria (Wilson & Junger 1968). In particular, issues such as involvement in care, active efforts to hide the abuse and possible limited access to the older person may preclude screening (Lachs & Pillemer 2004).

2.4 Screening tools in elder abuse

The literature on elder abuse screening tools indicates a variety of terms used to convey the purpose of a screening tool. These terms range from indexes of abuse, an instrument to identify risk of abuse, elder abuse questionnaires, elder abuse screening tools, elder abuse screening test, algorithms, protocols and elder abuse assessment. However, the fundamental function of any assessment instrument is to guide practitioners through a standardised screen to ensure that the signs of abuse are not missed (Anetzberger 2001).
An important part of the management of elder abuse is early identification, and hence 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 & Pillemer 2004, Pisani & Walsh 2012) particularly due to its prevalence in society (Phelan 2013). However, as early as 1988, Kosberg identified a failure by professionals to detect abuse or 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. 2008; Killick & Taylor 2009; Caciu la et al. 2010; Hempton et al. 2010), which makes screening tools attractive in their potential to detect the risk of elder abuse in diverse settings.

Identification of elder abuse may be hindered by issues such as ageism (Gutman & Spencer 2010; Phelan 2010), a lack of direct observation of abuse (Bonnie & Wallace 2003), family privacy (Kosberg 1988; Phelan 2010), complacency (WHO 2008), complexity (Antzeberger 2001), sensitivity of the assessor (Shefet et al. 2007), service setting (O ’Brien 1996), a lack of knowledge, education and training in elder abuse (WHO & INPEA 2002; Fulmer et al. 2004), confusing presenting symptoms with age-related changes rather than abuse (Kimball 1995; Bonnie & Wallace 2003; Lachs & Pillemer 2004), subtlety of presenting symptoms (Fulmer et al. 2004), apathy towards positive intervention pathways (Antezberger 2001; Selwood et al. 2007), a lack of time and unstable definitions (Jones et al. 1997), ethical dilemmas (Bergeron & Gray 2003; Donovan & Regehr 2010), and the invisibility of elder abuse (Reis & Nahmiash 1998). Aneztberger (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 healthcare professional can begin to address mistreatment from screening to management'. However, employing the term ’syndrome’ may have the effect of medicalising a problem that is, in essence, an issue immersed in complex intrapersonal, interpersonal and societal dynamics.

The WHO (2008) points out that older people do not generally wish to disclose their experience of abuse and as many as 80 per cent of cases may not be formally identified. Older people may not disclose abuse due to cognitive impairment (Nelson et al. 2004; Laumann et al. 2008), embarrassment (Bergeron 2006), the perpetrator being a family member and the older person experiencing negative unsupportive attitudes (Zink et al. 2005), the taboo nature of elder abuse (Krueger & Patterson 1997; Kosberg 1998; Twomey et al. 2005), abuse being normalised (Quinn & Tomita 1997) or fear of repercussions like 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, translate to being placed in residential care. Consequently, elder abuse is generally identified by a third party (Fulmer et al. 2004; Phelan 2009), although this may be difficult as perpetrators are careful to cover up abuse and provide plausible explanations for any presenting problems and often isolate the older person (Carp 2000).

If elder abuse is not identified early, intervention is delayed or prevented. In its Diagnostic and Treatment Guidelines on Elder Abuse and Neglect the American Medical Association (1992) recommended that screening for elder abuse should be a fundamental part of all clinical settings where older people interface with healthcare professionals. Thus, elder abuse case finding is central to the care of older people and has an impact on issues such as the rationale for specific funding, the development of responsive services and highlights the need for both professional and public awareness and education (Bonnie & Wallace 2003). In tandem with the need to improve methods of detection, it is necessary to have sufficient training and support for professionals to address suspected cases of elder abuse (WHO 2008). However, research into elder abuse screening tools has progressed slowly (Fulmer et al. 2004) and substantial research is required to support universal screening for elder abuse (Bonnie & Wallace 2003; United States Preventative Services Task Force 2004). Fulmer (2008) writes that issues of culture, cognitive impairment, clinician 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 may even worsen the abuse situation (Lachs & Pillemer 2004).
Bonnie and Wallace (2003) explored a framework for elder mistreatment screening and case identification, which encompassed four levels. Firstly, appropriate settings are identified to screen the older person, such as the accident and emergency department or the home. Secondly, a pre-screening process identifies and targets particularly vulnerable older people who demonstrate an increased risk to abuse. Thirdly, the screening process itself is initiated and, fourthly, if the screening test is positive, a case identification investigation is commenced. While such principles are useful, elder abuse is linked to vulnerability, which may not be reflective of all older people’s contexts in abuse cases.

2.5 Issues related to elder abuse screening tools

Although elder abuse screening tools have the 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. 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). Despite varied perspectives, many medical organisations advocate screening for abuse (American Medical Association (AMA) 1992, (Kellogg 2005)) as a standard in routine care as awaiting evidence of improved outcomes could risk negative outcomes for an abused child or adult (Halpern et al. 2005).

Furthermore, although there are significant impacts of inter-personal violence, 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 when compared to other age cohorts, assessing abuse in older people is not as advanced.

Another consideration focuses on minimising bias when screening for abuse. In using a screening tool, caution has been urged so that respondents are not primed towards giving particular answers through very in-depth discussion on the purpose of the screening tool or the discursive orientation of the questions (Bonnie & Wallace 2003). It is also suggested that screening questions in abuse are contextualised within social behaviours and non-threatening language (Laumann et al. 2008). In addition, the extrapolation of screening tools to different countries, cultures and ethnic groups requires careful consideration so that the language is comprehended by both the surveyor and the respondent (Drennan 2003). Another important issue is the development of rapport with the older person by the professional, which can allow open and honest disclosure in a safe environment (Phelan 2010).

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), while telephone interviews have shown comparable results to in-person interviews (Acierno et al. 2003). However, both methods of non-face-to-face screening 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 some older people (Daly & Jogerst 2005; Lalor et al. 2009). Consequently, it has been argued that face-to-face interviewing can be the most effective method of screening (Chuang & Liebschutz 2002) and increase the degree of empathy afforded to the person being screened for abuse (Acierno et al. 2003) as well as the validity of the screening (WHO 2008).

Screening tools are also influenced by the context of their utilisation. For example, brief screening tools are more appropriate for busy, high turnover areas, such as accident and emergency units, while 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 include a comprehensive medical examination (American Medical Association 1992; Lachs & Pillemer 2004), while others involve verbal assessment combined with observation (Fulmer et al. 1984; Sengstock & Hwalek 1987; Wang et al. 2007; Yaffe et al. 2008).
The WHO (2008) suggests that screening tools for the primary healthcare setting are critical as they have the ability to raise awareness of the issue of elder abuse and 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 & Wallace 2003). Professional perspectives may result in subtle differences and it has been suggested that elder abuse education should include sensitisation of interdisciplin ary predispositions so that holistic approaches to elder abuse may be improved (Yaffe et al. 2009). 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 for a candid discussion. Most importantly, skilled communication strategies allow sensitive details to emerge in the context of screening and are essential in communicating positive results both to the older person and the family (Fulmer 2008; WHO 2008).

The potential for an older person with mental capacity challenges to experience abuse is significant (Compton et al. 1997; Choi & Mayer 2000; Cooney et al. 2006; Naik et al. 2006; Downes et al. 2013). However, screening for elder abuse when the older person is cognitively impaired is problematic since self-reporting may be unreliable (Cooney et al. 2006; Selwood et al. 2007, Downes et al. 2013). Laumann et al. (2008:2) argue that 'screening for impairment is [the] key to modelling and understanding elder mistreatment'. This is significant as dementia can be unrecognised, particularly in residential care homes (McDonald et al. 2003; Cahill et al. 2009) where behavioural disturbances of the older person can lead to abuse through overzealous professional responses (Bredthauer et al. 2005). Despite concerns relating to elder abuse in older people with dementia, there is a paucity of information on validated screening tools for this population (Yan & Kwok 2010). Yet, the use of generic elder abuse screening tools can pose particular challenges for the healthcare professional as cognitive capacity cannot be ascertained during ordinary conversation (Naik et al. 2006). Thus, any elder abuse screening method for older people who have cognitive capacity challenges must be sensitive and specific enough to distinguish abuse from other causes, based on available data, while concurrently taking the context of dementia into account. In this regard, Pisani and Walsh (2012) suggest that comprehensive observation for signs of abuse by a multi-disciplinary team is preferential to direct questioning of older people with cognitive challenges.

Although there are a number of screening tools available, there is scant knowledge on their widespread use (Bonnie & Wallace 2003). In addition, some commentators have highlighted that elder abuse screening tools need to be flexible enough to take cultural factors into account (Wang et al. 2006; Wang et al. 2007; WHO 2008; Yan & Kwok 2010). Many tools have been used for research purposes only and have low efficacy in clinical settings, where issues of sensitivity and specificity are not addressed. Other concerns may centre on the vocabulary used in the tools as well as their completion time (WHO 2008). For screening tools that require responses from the older person, challenges arise in the context of the ability to respond competently as there may be concerns regarding mental incapacity, frailty, high anxiety, fear or other factors. In addition, screening tools that require the caregiver to respond may be complicated by untruthful answers (Bonnie & Wallace 2003).

2.6 Identifying screening tool for use in this study

Screening tools for elder abuse may have the ability to provide a systematic, standardised, multi-disciplinary objective assessment for potential elder abuse. However, further testing of screening tools 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 in the area of sexual abuse. Following a comprehensive review of literature on screening tools by the National Centre for the Protection of Older People (Phelan & Treacy 2011), two screening tools were identified as having particular merit in the Irish context, the EASI tool (Yaffe et al. 2008) and the OAFEM tool (Conrad et al. 2010). The results of a pilot of the OAFEM tool are presented in a separate report (Phelan et al. 2014). The EASI is a brief screening tool and has been implemented in many countries as well as being subject to WHO (2008) review and support. It is relatively easy to administer, easily completed and has the capacity to be practitioner-administered or self-administered (Yaffe et al. 2012).
2.7 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 screeners used by physicians. The tool was originally designed for physicians who would use findings to support a decision to refer the older person for further investigation if elder abuse was suspected (WHO 2008). Initial work on the EASI items resulted in nine potential questions regarding screening for elder abuse. Following this, focus groups consisting of 31 doctors, nurses and social workers reviewed potential elder abuse detection questions. Despite differing conceptual approaches amongst the three professional groups (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; however, this was subsequently eliminated from the final EASI as it did not impact on the sensitivity of the tool (Yaffe et al. 2008; WHO 2008). A sixth question was also added to articulate the need to include the healthcare professional’s observation for possible presenting signs of abuse (Appendix 1). Following the EASI developmental process, the final items focused on closed, behaviourally-specific questions and preface statements, which were contextually orientated and assessed active abuse by people with whom the older person had contact in the previous twelve months (WHO 2008). Using a period of the previous twelve months reflects common approaches used in prevalence studies (O’Keefe et al. 2008, Naughton et al. 2010) using the Conflict Tactics Scales (Straus 1979).

Following the developmental process, a sample of 953 cognitively intact older people were screened with the EASI and three weeks later a Social Worker Evaluation (SWE) was completed. The SWE is a standardised assessment that allows in-depth evaluation of older people who are identified as 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, while the specificity ranged from 0.72–0.99 (Yaffe et al. 2008). However, it was noted that when the first question, which addressed risk, was removed the tool 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 has potential in terms of brevity, with 69.2 per cent 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 per cent of physicians indicated that the questions were ‘very easy’ or ‘somewhat easy’ (Yaffe et al. 2008). However, older people who have been subjected to repeated abuse may require a more in-depth screen to identify abuse.

In 2008, the WHO used the EASI tool as a basis for developing an elder abuse screening tool that would be culturally and geographically acceptable in areas outside of Canada. Eight countries participated (Australia, Brazil, Chile, Costa Rica, Kenya, Singapore, Spain and Switzerland), with each participating country convening three focus groups comprising older people and four focus groups comprising primary healthcare professionals. Further workshops considered the concepts inherent in 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 indicated that the EASI tool was simple to complete and addressed the important categories of elder abuse and, although there were minor issues in relation to local cultural interpretations, the tool was culturally transferable. However, 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) suggested that nurses could also administer the tool.
The EASI has been translated into Spanish, French, Japanese, German, Hebrew and Arabic (Yaffe, personal communication 5/12/10). Recently, the EASI has been adapted for self-completion by older people and tested in a feasibility study (Yaffe et al. 2012). The first five questions were retained, but the sixth question, which was originally focused on physician observation, was eliminated. This decision was supported by previous 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, 2012). The response options were reduced to ‘yes’ or ‘no’ as the option for ‘did not answer’ was removed. The revised EASI-self-administered (EASI-sa) tool was completed by 210 cognitively intact older people who were substratified into eight groups to evaluate the screening tool. 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 per cent of cases as well as demonstrating increased understanding of the manifestations of elder abuse (Yaffe et al. 2012). Yaffe and colleagues indicated that further validation studies would focus on comparing outcomes from the EASI and the EASI-sa (Yaffe et al. 2012).

2.8 Conclusion

Screening for elder abuse has been subject to some debate, yet studies acknowledge that prevalence rates of elder abuse are underestimates of the true picture. Thus, there is a need to develop systems to prevent elder abuse and to identify its perpetration as early as possible. However, the efficacy of self-reported screening tools is low in older people with cognitive challenges; thus screening tools are not appropriate for this group, although they are at a higher risk of abuse (Yan & Kwok 2010). Acknowledging this limitation to screening older people for abuse, in a review of screening tools (Phelan & Treacy 2011), the EASI was identified as being of potential use in assessment of older people with no cognitive impairment in Ireland and may contribute to raising both professionals’ and older people’s awareness of potential abuse situations and appropriate onward referrals.
3.1 Introduction

This chapter describes the research strategy and pathway, recruitment and sampling, data collection methods and data analysis, and ethical considerations. A mixed methods design was adopted for this study, as the approach is of considerable value in the investigation of complex or sensitive issues in healthcare in that it facilitates the emergence of rich and nuanced data (Bowling, 2009). The mixed methods approach consisted of two phases. Phase 1 involved the assessment of the face validity of the EASI tool. This involved surveying healthcare professionals and cognitive interviewing of older people. Phase 2 involved the pilot of the EASI tool among healthcare practitioners.

3.2 Developing the EASI tool

3.2.1 Assessment of face validity

Although validation of the EASI tool has been undertaken in Canada (Yaffe et al. 2008), it was necessary to review the linguistic properties of each of the six items to ensure appropriateness and understandings in the Irish context and to address any potential cultural issues that might exist in respect of its administration in an Irish population. Therefore, the first stage of the study focused on ensuring the suitability of the EASI tool within an Irish population by assessing the face validity of the tool. Face validity indicates that the instrument is appropriate in terms of purpose and content (Parsian & Dunning 2009). It involves an evaluation of the readability, style, feasibility and clarity of the language used (DeVon et al. 2007). Two methods were used to assess the face validity of the EASI. These were a survey with healthcare professionals and cognitive interviewing with older people.

3.2.2 Survey with healthcare professionals

A self-administered postal questionnaire was distributed to healthcare professionals from a range of disciplines involved in the routine assessment of older people (Appendix 2). In total 18 healthcare professionals participated in the survey. These included five general practitioners, one consultant geriatrician, seven public health nurses, one emergency department nurse and four social workers.

The survey focused on the linguistic properties of each of the EASI questions, in terms of comprehensiveness and clarity and allowed for both qualitative commentary and quantitative responses. In order to ensure a good response rate, the steps recommended by Dillman (1983) were followed. These included designing the questionnaire to be as succinct and concise as possible with clear instructions to guide completion, including a stamped-addressed envelope with the postal survey, and following up with reminders for individuals who did not reply.

In responding to the survey, all 18 respondents made some comments in relation to the wording, structure and appropriateness of each of the questions in the EASI tool. A summary is provided here. Some respondents considered the word ‘banking’ in Question 1 to be too narrow as it excluded other financial activities, such as collecting pensions and paying bills. Some respondents suggested that the phrase ‘relied on’ be substituted for ‘support’, ‘help’ or ‘assistance’. One of the respondents commented that each of the items listed in Question 2 could be asked separately and another suggested that Question 2 be rephrased as ‘has anyone you lived with or know prevented you from getting food’. Another suggested that the phrase ‘prevented you … from being with people you wanted to be with’ should be changed to ‘visiting’ or ‘seeing’ or ‘contacting’.

With regard to Question 3, one respondent suggested alternative wording to replace ‘shamed’, including ‘put you down’ or ‘made you feel bad about yourself’. One respondent felt that the use of the word ‘force’ in Question 4 might be too strongly worded to capture more subtle forms of undue influence. Another participant commented that Question 4 could be asked differently, such as: ‘has anyone ‘taken advantage of you?’ ‘asked for money?’ or ‘put you under pressure to?’.

With regard to Question 5, which addressed physical and sexual abuse, two respondents commented that the question was too complicated. It was felt that the first part of the question ‘has anyone made you feel afraid’ might be overshadowed by the introduction of subsequent parts of the question, thereby preventing subtle forms of abuse from being detected. One respondent suggested that Question 5 was too sensitive to address during a short consultation and that the language was inappropriate for use with competent older adults. In relation to Question 6, which determines if the suspicion of abuse is based on the healthcare professional’s observations of the person during the consultation, one respondent commented that it was better to assess a person’s eye contact and to assess if they appeared withdrawn in the presence of a suspected abuser.
Chapter 3: Study Design

Overall the tool elicited positive comments from respondents. Most respondents believed that the tool was user friendly and easy to administer, clear and easy to understand and covered all types of abuse. Some respondents commented that some questions contained too many items and needed to be broken down. One respondent commented that older people with mild cognitive impairment would benefit from elder abuse screening and questioned whether the EASI tool could be used with this cohort. A summary of the responses in relation to the survey is presented in Table 3.1. These indicate a predominant satisfaction with the EASI tool in relation to the clarity of language and clarity of meaning of each item.

### 3.2.3 Cognitive interviews with older people

The second phase of establishing the face validity of the EASI tool involved cognitive interviewing of older persons. Cognitive interviewing is a method used to elicit a respondent’s reception and interpretation of questions and the extent to which the questions were answered in the anticipated way. Cognitive interviewing focuses on the identification of response error (Anderson et al. 2010; Drennan, 2003) and consists of a number of domains, including comprehension of the question, retrieval from memory of relevant information, decision processes and response processes (Tourangeau, 1984; Willis, 1999). Bias may be identified in each of these areas thus limiting the ability of the instrument being tested to elicit the intended information.

A self-selecting sample of older people was recruited through an active retirement group. Prior to recruitment, prospective participants received information about the study and were advised to contact the research team for further information. The cognitive interviews were conducted a minimum of two weeks after recruitment in order to give the participants time to seek further clarity regarding participation and to review their decision. The study sample consisted of six community-dwelling older people with cognitive capacity.

During each cognitive interview, the researchers noted items that the participant found difficult to answer, caused hesitation or needed to be explained. This could indicate a lack of clarity in the participant’s receptive understanding of the item’s content. Following the interview the participants were invited to identify questions which they found difficult to comprehend or complete and the researchers raised any issues noted during the process.

In general, all the participants found each of the six items clear and easy to understand. However, some issues were identified. One participant commented that he/she felt that some of the questions could be embarrassing for older people and that it would be advisable for the healthcare professional administering the questionnaire to preface the questions with an introduction flagging that the questions may be sensitive or difficult to answer. One participant suggested that the phrase ‘relied on’ be substituted for ‘assisted’. Another participant suggested that in many relationships there was a tacit division of

<table>
<thead>
<tr>
<th>Question</th>
<th>Language clear</th>
<th>Meaning Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.1. Have you relied on people for any of the following: Bathing, dressing, shopping, banking, or meals?</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Q.2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Q.3 Have you been upset because someone talked to you in a way that made you feel shamed or threatened?</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Q.4. Has anyone tried to force you to sign papers or to use your money against your will?</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Q.5 Has anyone made you feel afraid, touched you in ways that you did not want, or hurt you physically?</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Q.6 Health professional: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?</td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>
labour, wherein one person might assume responsibility to do tasks such as shopping or banking and this did not mean the older person was unable to undertake this in terms of ‘relying’ on that person, but it merely reflected the partnership arrangements. Another participant commented that Question 4 could include a reference to telephone scams as it was felt that it was an area in which older people are very susceptible to abuse.

3.2.4 Adjustment of the tool

Following a review of both the pre-pilot survey with healthcare professionals and the cognitive interviewing with older people, the research team met to discuss the findings. The comments and observations were discussed in depth and it was agreed that staff training should assist practitioners to clarify elements of the questions. The research team was mindful of the imperative to not change the inherent psychometric properties of the EASI, and only minor adjustments were made to the EASI tool to increase clarity. Footnotes were added at the end of the six items to provide an explanation of ‘banking’ and to expand this to include post office and credit union accounts. It was also agreed that the phrase ‘relied on’ would be further qualified as meaning ‘unable to do independently’. Thus, the EASI was used largely in its original format in order to retain its psychometric properties for testing its reliability in an Irish context. The revised EASI tool used in the pilot study is included in Appendix 3.

3.3 Development of protocols and training

Following the assessment of face validity of the EASI, the research team developed study protocols for healthcare professionals to follow, which provided a step-by-step guide in how to administer the EASI tool to older people. The study protocols included information and guidelines about participant eligibility criteria, the recruitment and consent process, conducting the cognitive assessment test, administering the EASI tool, the referral process and follow-up procedures for suspected cases of elder abuse. Protocols were developed for each of the study sites (n=44) to allow for the study to be implemented in compliance with local policies and procedures. Separate protocols were prepared for general practices, public health nurses and community registered general nurses in local health offices, hospital sites, the hospice site and Health Service Executive (HSE) day centres. These protocols were sent to relevant members of staff in each study site for review and feedback.

Training for participating health professionals was facilitated by the development of training material, comprising a PowerPoint presentation and a DVD. The PowerPoint presentation consisted of background information on elder abuse in Ireland and explained the steps involved in conducting the EASI screening assessment. The online training DVD replicated the content of the PowerPoint material with audio recording provided by a member of the research team. The DVD was available in hard copy and also from the National Centre for the Protection of Older People (NCPOP) website, providing an accessible alternative to face-to-face training. However, the majority of training was provided directly to trainees. DVD training with follow-up telephone support was provided for a small number of healthcare professionals involved in the study.

3.4 Piloting the EASI tool

3.4.1 Recruitment of study sites and healthcare professionals

The study aimed to recruit a sample of healthcare professionals working in a variety of health care settings, who would, in turn, recruit older people to the study. Healthcare professionals involved in assessing older people as a routine part of their professional work were asked to use the EASI screening tool on a pilot basis. The healthcare professionals included consultant geriatricians, emergency department nurses, social workers, occupational therapists, clinical nurse specialists in gerontology, general practitioners, general practice nurses, public health nurses and community registered general nurses.

A number of sites in which the EASI could be piloted by health professionals were identified and sites were recruited through a combination of purposive sampling and self-selection. The aim was to recruit two general hospitals, two local health offices and an unspecified number of general practices. Key sampling criteria included access to community-dwelling older people and geographical coverage, in order to ensure that the tool was piloted on a national basis and achieved both urban and rural coverage.

Initial contact and invitation to participate was made to the clinical directors of the suitable hospitals and their discipline heads. Two hospital sites which satisfied the sampling criteria were recruited to the study. Training of healthcare professionals took place prior to the study commencing, while two further information sessions were conducted by the research team during piloting of
the tool in order to support healthcare professionals’ participation in the study. Hospital site 2 withdrew from the study a few months after data collection commenced due to the fact that the key liaison person at the hospital left to take up a position elsewhere. Community registered general nurses (CRGNS) and public health nurses (PHNS) were invited to participate through local health offices. A total of twelve local health offices expressed an interest in participating in the study and from this two were selected. Thirty-five general practices were contacted and invited to participate. Those who expressed an interest in the study were then sent further information. In the event, five general practices agreed to participate in the study.

As the study progressed, it became evident that participating sites were not recruiting older people at the anticipated rate and that additional study sites would need to be recruited in order to increase the number of older people being screened with the EASI. The strategy to enhance the recruitment of older people involved two members of the research team, who were trained healthcare professionals, conducting EASI assessments in Health Service Executive (HSE) day centres. Day centres in the catchment area of the two local health area offices participating in the study and day centres in the Dublin region were invited to participate in the study. In total, 30 day centres agreed to participate in the study.

Recognising the challenges for staff in administering the EASI in the hospital site (H1), a member of the research team, who is a registered nurse, administered the EASI tool at that site.

As part of the ongoing recruitment of staff to administer the EASI tool, an invitation to participate was also issued to CRGNS/PHNs through the Institute of Community Health Nursing (ICHN). Two individuals (CN1 & CN2) and one community rehabilitation team comprising four PHNs at CN3 grade were recruited via this method. A number of individuals who learned about the study at the World Elder Abuse Awareness Day (WEAAD) event hosted by the NCPOP in June 2013 expressed an interest in becoming data collectors and were facilitated in doing so. These included two clinical nurse specialists based in a hospice (HP1) and a social worker based in a hospital (H3). All participating healthcare professionals were provided with an information sheet outlining the healthcare professional’s role in the study.

Table 3.2 below lists each study site and its corresponding location by region.

<table>
<thead>
<tr>
<th>Study site/data collector</th>
<th>Site identifier</th>
<th>HSE Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Sites</td>
<td>H1</td>
<td>East</td>
</tr>
<tr>
<td></td>
<td>H2 (withdrew)</td>
<td>Midlands</td>
</tr>
<tr>
<td></td>
<td>H3</td>
<td>East</td>
</tr>
<tr>
<td>Hospice Site</td>
<td>HP1</td>
<td>East</td>
</tr>
<tr>
<td>Local Heath Office Sites</td>
<td>LHO 1</td>
<td>South</td>
</tr>
<tr>
<td></td>
<td>LHO 2</td>
<td>South East</td>
</tr>
<tr>
<td>General Practice Sites</td>
<td>GP1</td>
<td>Midlands</td>
</tr>
<tr>
<td></td>
<td>GP2</td>
<td>South West</td>
</tr>
<tr>
<td></td>
<td>GP3</td>
<td>North West</td>
</tr>
<tr>
<td></td>
<td>GP4</td>
<td>East</td>
</tr>
<tr>
<td></td>
<td>GP5</td>
<td>East</td>
</tr>
<tr>
<td>CRGNS &amp; PHNs</td>
<td>CN1</td>
<td>North West</td>
</tr>
<tr>
<td></td>
<td>CN2</td>
<td>East</td>
</tr>
<tr>
<td></td>
<td>CN3</td>
<td>East</td>
</tr>
<tr>
<td>Day Centres</td>
<td>DCW1</td>
<td>South East</td>
</tr>
<tr>
<td></td>
<td>DCC1</td>
<td>South</td>
</tr>
<tr>
<td></td>
<td>DCD (1-28)</td>
<td>East</td>
</tr>
</tbody>
</table>

3.4.2 Recruitment of older people

Inclusion and exclusion Criteria

The EASI tool could be offered to all older people who came in contact with healthcare professionals involved in the pilot provided they met the eligibility criteria for participation. The inclusion criteria were as follows: being aged 65 years or older, having English as a first language or being able to otherwise converse in English, having no evidence of distressing health symptoms and demonstrating cognitive capacity, as verified by a cognitive assessment test administered by the healthcare professional. The exclusion criteria were: being resident in a residential care facility, having a known diagnosis of cognitive impairment, having an acute psychiatric episode or an acute emergency episode.
Chapter 3: Study Design

Procedures
The research team developed a number of study materials to facilitate the recruitment of older people. These included a study poster, an information leaflet and an information sheet. The poster was available for display in the various study sites in order to promote awareness of the study. The participant information leaflet and information sheet provided information about the aims of the study, what was required of participants, the benefits and risks of participation, how confidentiality and privacy would be maintained and the right to withdraw from the study at any stage.

Participating healthcare professionals were instructed to provide potential participants with an information leaflet and to allow them sufficient time to consider the information before being asked to participate in the study. Following this step, healthcare professionals were instructed to check whether persons met the inclusion criteria and were willing to participate in the study during the healthcare consultation. For those who expressed an interest in participation, healthcare professionals were instructed to review the Participant Information Sheet with the person to ensure their understanding, address any questions that the person might have and to proceed to obtaining written consent from the person.

At the point of recruitment, the consent sheet was separated from the data collection tool and stored separately. Each data collection instrument was coded for setting and participant. Older people were advised that their consent sheet would only be retrieved by an NCPOP researcher if a response triggered a referral to a SCW or SW. This recoupling of the data collection tool and the consent form enabled the research team to track the referral to elicit the reliability of the EASI tool in screening for elder abuse.

3.4.3 Instruments
Assessment of cognitive capacity
The EASI has been validated with cognitively intact older populations; therefore it was necessary to screen older participants for cognitive impairment (Yaffe et al. 2008). No cognitive assessment screening tools have the ability to comprehensively assess all cognitive domains and choice is dependent on purpose, individual presentation and setting (Cullen et al. 2007).

Several widely-used cognitive assessment screening tools were identified and reviewed in order to identify the most appropriate cognitive assessment test for use in the study. The Mini-Mental State Examination (MMSE) (Folstein et al. 1975) and the 6-item Cognitive Impairment Test (CIT) (Brooke & Bullock 1999) were chosen to assess participant’s cognitive status. Both tests are supported as suitable for cognitive assessment by the National Institute for Clinical Excellence (NICE 2006). The 6-Item CIT was selected as the screening tool of choice and a valid alternative to the MMSE, primarily due to its brevity and ease of administration. It consists of 6 items, which take 3 to 4 minutes to administer, as compared to the MMSE, which contains 30 items and takes 5 to 10 minutes to complete (Sheehan 2012). The 6-item CIT has been used in research with older people (Etgen et al. 2010). It has also been used by various healthcare professionals, including nurses and physicians (Brooke & Bullock 1999; Queally et al. 2010) and has been recommended for use in various settings, including primary care and specialist settings (Mitchell & Srinivasa 2010; Tuijl et al. 2011). In comparison to the MMSE, the 6-CIT has demonstrated greater sensitivity in detecting mild dementia (Brooke & Bullock 1999) and has not been found to be sensitive to educational level and dexterity issues (Tuijl et al. 2011), thus making it a suitable screening instrument for testing cognitive impairment in older persons. Where a score of 0–7 is obtained on the 6-Item CIT, the older person was eligible to participate in the study (Appendix 3).

The MMSE is a validated screening tool, which is frequently used both in practice and research, and has also been used previously in the validation of the EASI (Yaffe et al. 2008). In Ireland, the MMSE is familiar to and utilised widely by many healthcare professionals; therefore an option of recording the MMSE score as an alternative to the 6-CIT score was facilitated. Where a score of ≥ 24 was obtained on the MMSE Test, the older person was deemed eligible to participate in the study.

EASI
The EASI tool has been extensively described in Chapter 1 and is included in Appendix 1. The revised EASI tool used in this study is presented in Appendix 3.
3.4.4 Data collection
The study involved healthcare professionals based in 44 study sites administering the EASI tool to older people with whom they came into contact and who met the inclusion criteria, consented to participate and demonstrated sufficient cognitive capacity to participate. Initially the data collection period was scheduled to run for five months (1st November until 30th April 2013). This period was later extended in order to increase the number of older people screened with the EASI. The extended data collection period facilitated the recruitment of additional participants from new study sites and provided existing study sites with additional time to administer more assessments. Data were collected over a period of 10 months in total.

To ensure minimal disruption to services during the piloting of the tool, healthcare professionals were instructed to administer the EASI tool during routine consultations and assessments of older people. The EASI was administered to participants in a private area or room. The data collection process involved participating healthcare professionals administering a cognitive assessment test to each older person who consented to participate in the study. A person was deemed eligible to participate in the study if he/she scored 0–7 on the 6-item CIT or \( \geq 24 \) on the MMSE. The study protocol required that healthcare professionals take the usual course of action when suspecting cognitive impairment, for example, by referring the person to elder abuse services for further investigation. Participants who demonstrated no evidence of cognitive impairment were assessed with the EASI tool. Data collectors advised each older person with whom the EASI screening was conducted that information on resources and services for older people were included in the Participant Information Sheet.

3.4.5 Referral process
Where the outcome of the EASI assessment indicated a suspicion of elder abuse, the data collector was requested to discuss the outcome with the older person and to advise the older person of services he/she might avail of. With the older person’s consent, a request for referral was communicated through the appropriate channels and according to local standard procedures. The referral made no reference to either the study process or the EASI. The data collector recorded the name of the person to whom the referral was sent, either a SCW or a SW, to enable tracking of the referral by the research team at a later date.

The referral protocol varied from the standard study referral protocol in some study sites in order to ensure compliance with local elder abuse policy. Where a member of the NCPOP was the data collector, the referral protocol was similar to the study’s standard referral protocol and differed only in that the request for referral was communicated to a member of staff who was then responsible for conducting the referral as per the local standard.

Blinding of the results of the EASI assessments to all case investigators for suspicions of elder abuse was desirable in order to eliminate any potential biases. In order for the SCWs to remain blinded to the EASI study, members of the research team could not make the referral to the SCW or SW and instead the referral was made by the person in charge of the study site. This procedure involved obtaining the older person’s consent for the research team member to discuss the outcome of the EASI assessment with appropriate personnel.

Within the study, it was not possible for the EASI to be blinded to all elder abuse case investigators. While the SCW is a dedicated officer for elder abuse case investigations, in several study sites, the initial case investigator for a suspicion of elder abuse was the on-site social worker who was aware that the EASI tool was being piloted at the site. In one study site, the person who was collecting data for the study was also the initial case investigator for a suspicion of elder abuse.

3.4.6 Case verification
All study participants (i.e. older people and data collectors) were made aware at the outset that the research team would track referrals in order to determine the case outcome of the investigation conducted by the SCW or SW. To ensure anonymity of confidential data in the tracking process, as far as possible, a research team member recoupled the consent form and data collection tool and identified the relevant SCW or SW to whom the referral was forwarded. This was to facilitate the identification of the referred older person by the investigating SCW or SW. The information regarding the case assessment was requested via an EASI tracker form, which used the older person’s code identifier and not name. The EASI tracker form was accompanied by a separate form, which identified the code with the corresponding older person’s name. Both were placed in a sealed envelope.
A second member of the research team, who was blinded to the recoupling of the data forms, visited the investigating SCW or SW in person to facilitate completion and return of the EASI tracker form. This ensured a secure medium of recoupling and communicating information back to the research team. The case outcome options which the case investigator was required to report were as follows: a) no record of referral; b) substantiated case; c) unsubstantiated case; d) continuing case; e) case closed. The case investigator was also asked to indicate on the tracking form the type(s) of abuse being investigated and which type(s) of abuse were substantiated. The investigating SCW or SW was also requested to complete the EASI tracker form and place it in a sealed envelope, which was subsequently returned to the research team, and to dispose of the second identifier form.

3.4.7 Data analysis

In consultation with CSTAR, the national statistical advice service, it was determined that the most appropriate statistical analysis to establish the reliability of the EASI was to determine its positive predictive value. The predictive value of a screening test is a measure of the probability that people with a positive screening test truly have the condition or disease for which the screening test was designed. Data obtained in the course of the study were managed and analysed using the Statistical Package for the Social Sciences (SPSS version 20.0) (SPSS Inc. Chicago IL). Frequencies were calculated for: the number of people who were eligible to participate in the study; the number of positive EASI screens; the numbers of referrals to a SCW or SW; and the number of people who scored positive on the EASI, but declined onward referral.

Narrative data obtained from open-ended questions generated through the data collector’s notes and comments were analysed in respect of identifiable person(s) against whom the suspicion of abuse was raised and also reasons provided by participants who screened positive for a suspicion of abuse for not wishing to be referred.

3.5 Ethical considerations and data collection procedures

Ethical approval for the study was sought from the Human Sciences Research Ethics Committee, University College Dublin (UCD). The survey of healthcare professionals to establish the face validity of the EASI was granted exemption from full ethical review, in keeping with standard practice in research among health professionals. Full ethical approval was obtained for the phases of the study involving cognitive interviewing with older people and the piloting of the EASI tool among healthcare professionals. The Assistant National Director for Older Person Services in the Health Service Executive agreed to support the study and granted permission to the research team to conduct the study with CRGNs and PHNs in local health offices and within HSE day centres. As independent practitioners, general practitioners individually consented to participate in the study. For the remaining study sites, full ethical approval was granted by local research ethics committees.

As part of the process of ensuring that the study was conducted ethically and sensitively, a number of issues were considered, including informed consent, confidentiality and anonymity, participant distress and safety, and follow-up support in the event of disclosures. The disclosure protocol, previously used by the research team (Naughton et al. 2010) was followed. Participants were informed on the information sheet and by the researcher before the interview commenced that if, in the course of the screening, they should disclose information indicating that they themselves or another person was in a situation of extreme or immediate (e.g. life-threatening) harm, then the researcher had an obligation to report this to services for the protection of older people. At the end of a screening interview, or where an interview was terminated prematurely, the participant was given an information sheet outlining sources of help in the event of them having experienced abuse.

Prospective participants were given an information leaflet which outlined information about the study, including the right to privacy, confidentiality, anonymity, and to withdraw from the study at any time. An invitation to participate in the study was extended only after the person had sufficient time to consider this information. Healthcare professionals were instructed to review the information sheet with those who expressed an interest in the study in order to ensure their full understanding and to give prospective participants the opportunity to
have their questions answered before signing the consent form. The information sheet outlined instructions on how to withdraw from the study if the participant so wished.

Each EASI screening tool completed by the health professional was assigned an identifier code. The signed consent form was separated from the completed EASI tool and each was stored separately in locked boxes in order to decouple identifying information. In the event of a triggering of a suspicion, the consent form and the data collection form was temporarily recoupled to enable the research team to track the referred person’s case outcome from the investigating SCW or SW using the referred person’s name; however returned information identified the person’s case only by his/her identifier code, with the person’s name removed. In this way, identifying personal information was rendered anonymous. Data containing identifiable information was stored securely on password protected computers and in a locked filing cabinet and only accessible to the research team.

Safety protocols were developed in order to minimise the risk of distress to participants. After the EASI screening was completed or where the EASI screening was terminated prematurely, each participant was directed to the information sheet containing sources of help in the event that a person had experienced mistreatment. Where the tool identified suspected cases of elder abuse, the healthcare professional was instructed, subject to the participant’s consent, to make a referral to an investigating SCW or SW for further investigation, except where local protocol obliged staff to report suspicions of abuse, irrespective of whether or not the person gave consent. If a participant disclosed information that indicated they were in a situation of extreme and immediate harm, data collectors were obliged to follow their local disclosure protocol. In the event, this latter scenario did not arise in the process of data collection.
4.1 Introduction

This chapter presents the results of the pilot of the EASI tool conducted by healthcare professionals between November 2012 and April 2014.

4.2 Sample of older people

In total, 800 older people were approached to participate in the pilot study. Of the 800 people recorded as being approached, 791 agreed to participate and provided written consent, resulting in a response rate for consent of 98.75 per cent. A cognitive capacity test was then administered to determine eligibility to complete the EASI screen. The vast majority of older people underwent a cognitive examination test with the 6-CIT (98.6%) with a small proportion of data collectors using the MMSE (1.1%), while two older people did not complete a cognitive test (0.3%) and were therefore excluded from the study. Following cognitive capacity assessment, just under one tenth (9.3%, n=73) of interested participants were deemed to lack cognitive capacity and were excluded from the study. Thus, following attrition of those who declined to participate in the study and those who were deemed ineligible to participate, a total of 716 EASI screening assessments were conducted and included in the final sample. The recruitment process is represented in Figure 4.1 below.

Table 4.1 summarises the profile of participants by age and gender. Data is also provided in relation to whether the older person was accompanied. The majority of respondents were women (67%, n=473), while men comprised 33% of the sample (n=233). More than half of participants were aged 80 or older (55%, n=388) with the remaining 45% (n=321) aged between 65 and 79 years. The vast majority of older people who were approached to participate in the study were unaccompanied (96.2%, n=677); however a small number of older people were recorded as being accompanied at the screening (3.8%, n=27).

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>33% (n=233)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>67% (n=473)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-79</td>
<td>45% (n=321)</td>
<td></td>
</tr>
<tr>
<td>≥80</td>
<td>55% (n=388)</td>
<td></td>
</tr>
<tr>
<td>Accompanied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3.8% (n=27)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>96.2% (n=677)</td>
<td></td>
</tr>
</tbody>
</table>

4.3 Administration of the EASI

The EASI tool was piloted at 44 sites. These were grouped into five main sites of recruitment, as follows: day centres; general practices; local health offices; hospice and hospital sites.

All those who administered the EASI tool to older people were trained healthcare professionals. The vast majority of EASI screenings were administered by two members of the research team, both of whom were nurses. As Table 4.2 illustrates the majority of EASI screenings were conducted by nurses (57%, n=412) followed by general practitioners (17%, n=120).
Chapter 4: Results

Table 4.2: Number of pre-EASI screenings conducted by Occupation of Professional

<table>
<thead>
<tr>
<th>Health care professional</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCPOP (x2 Nurses)</td>
<td>412</td>
<td>57</td>
</tr>
<tr>
<td>General practitioner</td>
<td>120</td>
<td>17</td>
</tr>
<tr>
<td>Specialist nurse in gerontology</td>
<td>76</td>
<td>11</td>
</tr>
<tr>
<td>PHN/Community RGN</td>
<td>52</td>
<td>7</td>
</tr>
<tr>
<td>Day centre nurse co-ordinator</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td>Social worker</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Other*</td>
<td>6</td>
<td>.8</td>
</tr>
<tr>
<td>Total</td>
<td>716</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Includes Practice Nurse; non-consultant hospital doctor; consultant; N = 716

4.4 Suspicion of abuse

A suspicion of elder abuse was indicated for just over one tenth of the sample (11%, n=79). Table 4.3 illustrates the characteristics of those who had a positive score on the EASI screen. Over half were aged between 65 and 79 (52.6%, n=41) with the remainder aged 80 and over (47.4%, n=37). More than half of those for whom a suspicion was raised were female (59%, n=46) as compared to approximately two fifths who were male (41%, n=32). A small number of those for whom a suspicion of abuse was raised were accompanied during the screening compared to those who were not at 2.6% (n=2) and 97.4% (n=76) respectively.

The association between respondent characteristics and scores on the EASI screening tool is summarised in Table 4.4. Statistical analysis revealed that neither age nor gender was associated with the outcome of the EASI assessment. The association between being accompanied and how the older person scored on the EASI tool was also explored but the sample of respondents that were accompanied was too small (n=2) for a test of significance to be conducted.

Table 4.3 Characteristics of those who had a positive score on the EASI tool (n=79)

<table>
<thead>
<tr>
<th>Positive EASI Score</th>
<th>Age</th>
<th>Gender</th>
<th>Accompanied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65-79</td>
<td>≥ 80</td>
<td>Male</td>
</tr>
<tr>
<td>52.6% (n=41)</td>
<td>47.4% (n=37)</td>
<td>41% (n=32)</td>
<td>59% (n=46)</td>
</tr>
</tbody>
</table>

Table 4.4 Association between respondent characteristics and EASI screening outcome

<table>
<thead>
<tr>
<th></th>
<th>Suspicion of Abuse</th>
<th>No Suspicion of Abuse</th>
<th>χ²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>1.879</td>
<td>.170</td>
</tr>
<tr>
<td>64-79</td>
<td>12.8% (n=41)</td>
<td>87.2% (n=280)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 80</td>
<td>9.5% (n=37)</td>
<td>90.5% (n=351)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>2.553</td>
<td>.110</td>
</tr>
<tr>
<td>Female</td>
<td>9.7% (n=46)</td>
<td>90.3% (n=427)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13.7% (n=32)</td>
<td>86.3% (n=201)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Person Accompanied</td>
<td></td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Accompanied</td>
<td>7.4% (n=2)</td>
<td>92.6% (n=25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Accompanied</td>
<td>11.2% (n=76)</td>
<td>88.8% (n=601)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* not significant † Due to the small number of accompanied participants, significance testing was not possible.

Healthcare professionals were given space to write notes and make comments on the EASI form in respect of each participant. Although they were not requested to note any particular details, the majority (81%, n=64) elaborated on the older person’s ‘yes’ response(s) on the EASI. The content of the notes and comments were analysed to identify the person or persons about whom any positive answers in the EASI related to and contributed to an understanding of the case context. Of the 79 people for whom a suspicion of elder abuse was raised using the EASI tool, 52 of the completed EASI assessments contained written comments which identified a perpetrator(s). For reporting purposes, the comments were grouped into categories and are presented in Table 4.5.
Chapter 4: Results

Table 4.5: Suspicion of abuse identified by perpetrator and numbers

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family (son)</td>
<td>10</td>
</tr>
<tr>
<td>Family (spouse)</td>
<td>10</td>
</tr>
<tr>
<td>Family (daughter)</td>
<td>6</td>
</tr>
<tr>
<td>Family (other)</td>
<td>6</td>
</tr>
<tr>
<td>Healthcare professional/worker</td>
<td>10</td>
</tr>
<tr>
<td>Friend/neighbour/acquaintance/social group</td>
<td>6</td>
</tr>
<tr>
<td>Service professional/worker</td>
<td>6</td>
</tr>
<tr>
<td>Fellow patient/resident</td>
<td>2</td>
</tr>
<tr>
<td>Salesperson/door caller</td>
<td>2</td>
</tr>
<tr>
<td>Not clear/no perpetrator indicated</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>*80</td>
</tr>
</tbody>
</table>

*One older person identified two perpetrator sources

As detailed in Table 4.5, most suspicions of abuse were raised in respect of family members. Among these, a son (n=10) and spouse/ex-spouse (n=10) featured most often as the perpetrator of the abuse, as indicated by the older people who screened positive. The next most-frequently reported perpetrators were as follows: daughter (n=6); grandson (n=1); daughter-in-law (n=1). Three of the completed EASI assessment comments referred to children/family members but were not more specific.

Table 4.6: Results of the EASI assessments*

<table>
<thead>
<tr>
<th>Within the last 12 months…</th>
<th>Yes</th>
<th>No</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Have you relied on people for any of the following: bathing, dressing, shopping,</td>
<td>393</td>
<td>322</td>
<td></td>
</tr>
<tr>
<td>banking or meals?</td>
<td>55</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Q2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing</td>
<td>8</td>
<td>704</td>
<td></td>
</tr>
<tr>
<td>aides or medical care, or from being with people you wanted to be with?</td>
<td>1.1</td>
<td>98.7</td>
<td>1 0.1</td>
</tr>
<tr>
<td>Q3. Have you been upset because someone talked to you in a way that made you feel</td>
<td>68</td>
<td>647</td>
<td></td>
</tr>
<tr>
<td>shamed or threatened?</td>
<td>9.5</td>
<td>90.5</td>
<td></td>
</tr>
<tr>
<td>Q4. Has anyone tried to force you to sign papers or to use your money against your</td>
<td>12</td>
<td>702</td>
<td></td>
</tr>
<tr>
<td>will?</td>
<td>1.7</td>
<td>98.3</td>
<td></td>
</tr>
<tr>
<td>Q5. Has anyone made you afraid, touched you in ways that you did not want or hurt you</td>
<td>8</td>
<td>704</td>
<td></td>
</tr>
<tr>
<td>physically?</td>
<td>1.1</td>
<td>98.9</td>
<td></td>
</tr>
<tr>
<td>Q6. Healthcare Professional: Elder abuse may be associated with findings such as:</td>
<td>8</td>
<td>692</td>
<td></td>
</tr>
<tr>
<td>poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruiseses,</td>
<td>1.1</td>
<td>98.6</td>
<td>2 0.3</td>
</tr>
<tr>
<td>inappropriate clothing, or medication compliance issues. Did you notice any of these</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>today or in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Responses in Table 4.6 represent where questions were completed in the EASI. All questions demonstrated a small number of incompletions by the data collector ranging from 1-14. Thus, responses do not total 716 for any of the six questions and percentages are based on the total percentage of completed responses from each individual question.

N=716

4.5 EASI items

This section describes the proportion of positive responses to each of the items in the EASI.

4.5.1 Questions 1-6

As demonstrated in Table 4.6, in relation to Question 1, the primer question, over half of the sample (55%, n=393) was reliant on other people for personal care and other tasks. The second highest positive response in the sample was yielded for Question 3, indicating some form of psychological abuse. Just under one tenth of the sample (9.5%, n=68) experienced shame and feeling threatened as a result of how someone talked to them. Accordingly, most of the suspicions of abuse indicated by the EASI tool were related to psychological abuse. Relatively small proportions of the sample responded positively to items 2, 4 and 5. In respect of financial abuse just under two per cent of the sample (1.7%, n=12) reported that someone had pressured them to sign papers or with regard to spending their money. Approximately one per cent of the sample (1.1%, n=8) reported being prevented by another person from doing certain things while the same proportion (1.1%, n=8) responded positively to Question 5, which concerned physical or sexual abuse. Based on the healthcare professionals’ observations of the older person during consultations and/or in the previous twelve months, just one per cent of professionals (1.1%, n=8) observed signs that gave rise to concern that abuse might be occurring.
4.5.2 Impact of a Yes/No response to Question 1 on subsequent EASI Questions

Table 4.7 summarises the number of positive responses to the trigger question (Question 1) \((n=393)\) and the subsequent positive responses to Questions 2 to 6, inclusive.

Table 4.7: Subsequent positive responses to EASI for older people who scored ‘yes’ to question one

<table>
<thead>
<tr>
<th>Questions 2-6</th>
<th>No. of positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 2</td>
<td>7</td>
</tr>
<tr>
<td>Q 3</td>
<td>43</td>
</tr>
<tr>
<td>Q 4</td>
<td>9</td>
</tr>
<tr>
<td>Q 5</td>
<td>4</td>
</tr>
<tr>
<td>Q 6</td>
<td>4</td>
</tr>
</tbody>
</table>

Responses which elicited a negative to Question 1 \((n=321)\) but a positive to any other questions are outlined in Table 4.8.

Table 4.8: Subsequent positive responses to EASI for older people who scored ‘no’ to question one

<table>
<thead>
<tr>
<th>Questions 2-6</th>
<th>No. of positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 2</td>
<td>4</td>
</tr>
<tr>
<td>Q 3</td>
<td>27</td>
</tr>
<tr>
<td>Q 4</td>
<td>5</td>
</tr>
<tr>
<td>Q 5</td>
<td>6</td>
</tr>
<tr>
<td>Q 6</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 4.9 demonstrates that of the older people that responded ‘yes’ to Question 1, 10.2 per cent \((n=40)\) responded ‘yes’ to a second question on the EASI, which was predominantly related to a suspicion of psychological abuse. This compares to 6.2 per cent \((n=20)\) of older people who indicated that they were not reliant on another person as identified in Question 1. Figures are also included for additional positive responses to two or more items.

Table 4.9 Results of EASI by respondents’ dependency

<table>
<thead>
<tr>
<th>‘Yes’ on Q1</th>
<th>‘No’ on Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>No on all other items</td>
<td>342</td>
</tr>
<tr>
<td>Yes to 1 other item</td>
<td>40</td>
</tr>
<tr>
<td>Yes to 2 other items</td>
<td>8</td>
</tr>
<tr>
<td>Yes to 3 other items</td>
<td>2</td>
</tr>
<tr>
<td>Yes to 4 other items</td>
<td>1</td>
</tr>
<tr>
<td>Yes to 5 other items</td>
<td>0</td>
</tr>
</tbody>
</table>

Comparisons between the responses related to a ‘yes’ or ‘no’ answers to Question 1 are demonstrated in Figure 4.2.

Figure 4.2 EASI results by dependency (Q1)
The association between participant’s responses to Question 1 and whether or not a suspicion of abuse was indicated by the EASI was explored and the results are illustrated in Table 4.10. In total, 79 suspicions of abuse were raised by the EASI screening. The analysis indicated that older people who were reliant on people for daily activities were more likely to raise a suspicion of abuse on the EASI than those who were not reliant at 13% (n=51) and 9% (n=28) respectively. However, this relationship was not statistically significant.

Table 4.10 Association between dependency on others and raising a suspicion of abuse on the EASI

<table>
<thead>
<tr>
<th>Dependency</th>
<th>Suspicion of Abuse</th>
<th>No Suspicion of Abuse</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependant</td>
<td>13% (n=51)</td>
<td>87% (n=342)</td>
<td>3.301</td>
<td>.069</td>
</tr>
<tr>
<td>Not dependent</td>
<td>9% (n=28)</td>
<td>91% (n=294)</td>
<td></td>
<td>ns</td>
</tr>
</tbody>
</table>

*ns not significant

4.6 Onward referral

Of those who screened positive for a suspicion of elder abuse (11%, n=79), just under a quarter (24.1%, n=19) were recorded as being referred on to a SCW or SW, meaning that over three quarters (75.9%, n=60) were not referred.

Healthcare professionals were provided with the facility to record notes and make comments on the EASI form in respect of each participant and could elaborate on the reported positive responses for each abuse type. Sixty-four responses which generated a ‘yes’ response to one or more of the EASI questions focusing on a suspicion of abuse (Questions 2–6) included written descriptions or comments. Most of these descriptions referred to incidents of abusive behaviours perpetrated by family, neighbours or friends and included being spoken to in a threatening, belittling or aggressive way, being threatened with a nursing home admission, to incidents of financial abuse, physical abuse and imposed social isolation. The majority of these behaviours were described as ongoing in the older person’s life and led to them living in fear and experiencing anxiety.

Some descriptions in the assessors’ notes pertained to older people receiving poor treatment from health, local authority and transport services. These included not being facilitated to access a bus on several occasions when limited mobility was present leading to the older person being distressed and frustrated, being involved in a drunken brawl, feeling afraid after being asked to be ‘extra nice’ by a male worker, not being treated respectfully by medical staff and experiencing belittling customer service. There was also a description of one older person being robbed and intimidated by strangers in his/her own home. Other comments recorded by the assessors suggested that potentially abusive behaviours did not fall within the definition of abuse; these included older people’s self-reported accounts of experiences which they found upsetting, such as being placed in a care facility which they interpreted as unsuitable, misinterpreting communication as verbal abuse due to poor hearing, and receiving a utility bill which has already been paid.

Assessors’ comments also highlighted possible barriers to onward referral. As stated above, of the 79 positive screens for a suspicion of elder abuse, sixty older people declined onward referral. Although assessors were not requested to note any particular details, some elaborated on the reasons for non-referral. In most cases, no reason was stated for a person not consenting to a referral. In six recorded cases, some form of intervention had already taken place. In other words, a SCW or SW, the Gardaí, a public health nurse or a solicitor had already been involved. In the case of four individuals, the problem had been resolved and they did not believe a referral was warranted. One person reported feeling afraid that they would get their child into trouble if they were referred to the special elder abuse service. Another reported wanting to deal with the issue themselves rather than accept a referral. One person reported feeling afraid that a referral would make the situation worse, while another indicated that previous interaction with a social worker made the situation worse. One participant reported that the incident in question was a once-off while another reported that the incident in question was a misunderstanding that had since been resolved, thereby making a referral unnecessary. In one account, the older person stated that his wife was afraid that their care assistant would be withdrawn. A small number of participants (n=3) were recorded as stating that they did not want a referral at present, but would consider it in the future. Two older people expressed the view that
they could only see the SCW or SW in the day care centre due to the abuser being present at home, while another stated that she would be unable to access the service as her husband also went to the day centre with her.

4.7 Tracking and Substantiation of Abuse

Referrals to the SCW or SW service were tracked in order to ascertain the case outcome of the investigation. Nineteen older people agreed to be referred to the SCW or SW. In following up the 19 referred cases, six of the cases were lost to the study due to a number of possible reasons, including subsequent withdrawal of consent for onward referral, resolution of the case prior to onward referral or the case subsequently categorised as unsuitable for referral.

Thirteen cases were reviewed by the senior case workers for the protection of older people (SCW) or the social worker (SW). These 13 cases were tracked to determine their outcome and 10 cases were found to have been substantiated for abuse. In 9 of these 10 cases, one form of abuse was substantiated and in one case, two forms of abuse were substantiated. Typologies identified in the EASİ correlated to the SCW or SW substantiation of abuse typology. Seven of these cases were substantiated for verbal/emotional/psychological abuse. One case was substantiated for neglect abuse while three cases of financial abuse were substantiated.

The primary statistical analysis was a test of proportion based on the positive predictive value of the EASİ instrument; this involved a measure of the proportion of the sample that screened positive for suspicion of elder abuse. A suspicion of elder abuse was indicated for just over one tenth of the sample (11%, n=79). However, only 13 of those cases were reviewed by a SCW or SW. Ten cases out of 13 (76.9%) were substantiated for abuse and chi square test of proportion was used to establish the positive predictive value of the EASİ instrument. The test result did not provide any evidence indicating a positive predictive value lower than 70% as illustrated in Table 4.11. Thus, there is no evidence indicating that the EASİ does not demonstrate adequate positive predictive value to support its implementation in the Irish setting. However, a larger number of cases is required to achieve adequate evidence, at 5% significance level, that the EASİ tool demonstrates at least 70% positive predictive value.

Table 4.11 Positive Predictive Value of EASİ Screening Tool

<table>
<thead>
<tr>
<th>Tool</th>
<th>Value</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearsons Chi Square</td>
<td>0.34</td>
<td>1</td>
<td>.069 *</td>
</tr>
</tbody>
</table>

*not significant

The three remaining cases that were not substantiated included two that were continuing cases on the SCW or SW caseload, i.e. not substantiated or unsubstantiated. These were described as complex cases. One involved co-dependency of two vulnerable older people, the second involved unresolved financial abuse and the third involved a refusal to agree to onward referral, despite a positive suspicion of abuse.

---

2 As 66 cases were unavailable for statistical analysis, the positive predictive value was calculated based on an estimated value of 13 cases identified by the EASİ tool and a real value of 10 that were substantiated for abuse by a SCW or SW.
5.1 Discussion

Elder abuse is a significant societal challenge. Its identification is hampered by many issues, including ageism, a lack of recognition of acts being abusive, family taboo and family expectations. Elder abuse can occur in all environments, but as most older people live at home, most perpetrations of elder abuse are in the home environment. In addition, the predominant perpetrator of abuse in the home is a family member (Phelan 2013). Prevalence studies indicate that between 2 and 20 per cent of older people living in the community may experience some form of elder abuse (O’Keefe et al. 2007; Naughton et al. 2010; Lowenstein et al. 2009; Acerino et al. 2009; Lifespan of Greater Rochester, Inc. et al. 2011). The Irish prevalence study conducted in 2010 (Naughton et al. 2010) demonstrated a much higher experience of elder abuse than cases formally referred to the HSE (HSE 2014). However, these figures relate only to people with mental capacity. Research indicates that figures are far higher in older people with capacity challenges (Yan & Kwok 2010) and elder abuse prevalence rates are recognised as underestimations (DHSS 1998; Lifespan of Greater Rochester, Inc. et al. 2011). The imperative of integrating methods of self-, perpetrator- and third-party identification of elder abuse is demonstrated by comparing the Irish prevalence study figures with the actual number of referrals to the HSE elder abuse service; the overall national prevalence at 2.2 per cent was equivalent to 10,201 older people (Naughton et al. 2010), whereas the recorded number of referrals in 2013 was 2,437 (HSE 2014). This suggests that there is a substantial deficit in the formal identification and reporting of cases.

One approach to the identification of elder abuse is the use of standardised screening tools. Although an epidemiological approach involving screening tools has engendered some debate (Waalen et al. 2000, Lachs & Pillemer 2004), several tools have emerged which have been empirically tested. In a review of published elder abuse screening tools (Phelan & Treacy 2011), two were identified as appropriate for the Irish setting: the EASI and the OAFEM. This study aimed to examine the reliability of the EASI in the Irish context. Its focus was on elucidating the reliability of the EASI in the Irish context by determining the positive predictive value of the tool. Prior to the piloting of the tool, a survey was undertaken with inter-disciplinary healthcare professionals and cognitive interviewing with older people. This process was useful in clarifying minor issues in the tool’s application to the Irish setting, in terms of semantically contextualising the EASI items.

Although the study initially recruited sufficient and diverse study sites, data collection was a significant challenge. Data collection was hampered by the slow recruitment of older people by healthcare professionals in some study sites and the withdrawal of one hospital site after the data collection process commenced. Anecdotally, barriers to recruitment included staff shortages and work pressures resulting in a lack of time to participate in the study. The total number of older people who were not approached by healthcare professionals is unknown due to time constraints of data collectors and other barriers. In the original study conducted by Yaffe et al. (2008) the recruitment and cognitive testing of older people was conducted by research assistants specifically employed in the study, whereas in the present study, healthcare professionals were responsible for all aspects of data collection, which may have made their participation somewhat burdensome. The slow recruitment impacted the study in three main ways. Firstly, the time required for data collection had to be substantially extended to generate a greater and sufficient sample size. Secondly, sometime into the data collection, two members of the research team who were health professionals engaged in data collection. This involved extending data collection sites to day care centres and this intervention resulted in a total of 60.3 per cent of the final sample size. Thirdly, in a parallel effort to recruit additional older participants, additional healthcare sites were recruited, based on individual health professionals expressing an interest in participation in the study. In the event a total of 44 individual sites participated in the study.

A total of 800 older people were recorded as being invited to participate in the study. A high number of older people consented to participation, with only 9 individuals declining participation. Following cognitive testing, the final sample of eligible participants was 716. The sample was over represented by females (67%), which is unreflective of the proportionate older person gender difference in the general Irish population (CSO 2012). There were also slightly more participants in the over 80 age group (55%, n=388) as opposed to the 65-79 age groups (45%, n=321), which supports the findings of the TILDA study (McNamara et al. 2013), which showed that the characteristics with which age are correlated (i.e. poor self-rated health, activities of daily living impairments) increase health service utilisation.
As 800 older people were approached to participate in the study a striking finding is that 73 older people, representing 9.3 per cent of the total consenting sample, did not pass the cognitive test. This finding supports Cahill et al.’s (2009) findings that cognitive impairment is under-detected in older people. Moreover, although many studies state the MMSE (Folstein et al. 1975) is the most widely used cognitive assessment tool (Pedrero-Chamizo et al. 2013), in this study the 6-CIT (Brooke & Bullock 1999) was used in 98.6 per cent of the consenting older people (n=791). This may be due to the shorter timeframe in administering the 6-CIT (Sheehan 2012) and also the fact that the 6-CIT assessment tool was printed in the data collection literature (Appendix 3) with an option of alternatively only recording an MMSE score if the latter tool was more familiar to the data collector.

The screening tool generated a suspicion of abuse in 79 older people. In Question 1, the trigger question, 393 older people (55%) reported that they relied on other people for bathing, dressing, shopping, banking or meals. This high response is unsurprising in the context that the vast majority of older people were attending day care centres, which provide care for older people with self-care deficits or are socially isolated (Haslett 2003). Consequently, older people attending day care centres live in the community and are very often reliant on others in the community setting. However, although dependency has been shown to be a risk factor for elder abuse (Kreuger & Moon 1999; Erlingsson et al. 2005; Buri et al. 2006), it is not, in itself, indicative of abuse. Thus, a positive response is not directly correlated to abuse. Yet when Yaffe et al. (2008) removed this question, the sensitivity of the EASI tool was reduced. Question 1 was therefore considered a primer question (Yaffe et al. 2008).

In this study, of those who scored yes to Question 1, 13 per cent (n=51) individuals were subsequently identified as having a suspicion of abuse in questions 2-6. This compares to a total of 9 per cent (n=28) of older people who were not reliant on anyone, but for whom a suspicion of abuse was indicated. While those in this study for whom a suspicion of abuse was raised were more likely to be dependent on someone for their daily needs this association was not found to be statistically significant.

From the 79 older people who triggered a suspicion of abuse, only 19 agreed to onward referral. The advantage of this study was the high number of assessors’ clarification comments related to the suspicion of abuse, which provided further insight into the referral process. The review of these comments, which numbered 64 in total, demonstrated support for valid referral and subsequent intervention by a SCW or SW. Excluding those cases where the assessors’ written comments indicated resolution or non-abuse, a substantial number of recorded descriptions demonstrated older people’s experiences, which were of potential concern. However, considering the proportionately small number of onward referrals consented to by older people, it may be important to focus on possible barriers to giving consent in the screening process. The evidence from assessors’ descriptions indicates that such barriers included reluctance on the part of the older person to take up the offer of referral where a partner or close family member was involved, fear of reprisal from the abuser or fear of financial hardship.

While the EASI tool highlighted a range of potentially abusive situations, two issues emerged relating to the use of the tool. In some cases it was apparent that the situation was resolved and in some cases the older person had previously interacted with the elder abuse services. In these circumstances, an onward referral would be inappropriate. In other cases, additional information was needed to clarify the circumstances of the issue being reported by the older person, such as the report of a ‘drunken brawl’. Nevertheless, there still remained a substantial number of older people who declined onward referral, which supports the proposition that many cases do not receive the attention of formal services (Lifespan of Greater Rochester, Inc. et al. 2011). In two cases, older people expressed fear of the perpetrator becoming aware of the intervention. Other older people refused onward referral services because they did not wish to get their family member(s) in trouble; one feared making the situation worse and others feared withdrawal of services. Others did not give any explanations.

In tracking the 19 cases, six were lost to the study. In following up on these six cases, every effort was made to identify the case referrals with the SCWs or SWs, but it was not possible to establish the precise reasons for their not reaching the case investigator. Possible reasons may include subsequent resolution or subsequent withdrawal of consent prior to onward referral. However, the overall number of older people who consented to onward referral was low. As already observed, this may be attributed to fear of engaging with formal services, kinship loyalty to the perpetrator, fear of further aggravating the situation, a perception that the abuse was a once off or had been resolved or a refusal of service intervention.
Following the piloting process among the 44 study sites just 13 case referrals were available for analysis to establish the positive predictive value of the EASI. In 10 of the cases, the EASI demonstrated its utility in reliably identifying a suspicion of elder abuse. In the other three cases, there were significant issues related to abuse. In one case, the older person withdrew from services, while the suspicion of abuse was acknowledged. The remaining two cases were complex, demonstrating elements of potential abuse, and therefore remained on the SCW or SW’s caseload as ‘continuing cases’. In total, abuse was substantiated in 10 of the 13 cases reviewed by SCW or SW. Statistical analysis suggested that the EASI screening tool may have a positive predictive value in an Irish context.

5.2 Limitations

There were a number of limitations in this study. One of the limitations was the fact that the EASI tool was only suitable for administration to older people with cognitive capacity. This meant that potentially at-risk older people were not screened. In some of the cases, it was not possible to blind the SCW or SW to the fact the EASI was the trigger of suspicion that led to the abuse referral.

There were limitations in terms of sample size and, in particular, the total number of onward referrals that were reviewed for the purpose of establishing the positive predictive value of the EASI tool. This limitation was the result of the challenges in recruiting older people to the study and the relatively high number who declined onward referral where a positive screen was identified by the EASI.

The perspectives of the healthcare professionals who conducted the EASI assessments were not elicited as part of the study design. This meant that the experiences of practitioners in administering the tool were not systematically assessed. Such information would be valuable in understanding how practitioners experience broaching the sensitive issue of elder abuse with older people. Additionally, the study did not examine the acceptability of the EASI tool to service providers or to the older people who took part in the study.

The administrative difficulties encountered during the study suggest that there may be practical barriers and feasibility issues that may affect implementation fidelity of the instrument in the Irish setting. These issues include the time required and impact on clinic processes.

However, the time to complete the EASI would be reduced considerably where the process of obtaining consent and formal cognitive assessment was not part of the EASI administration process.

In Yaffe’s et al. (2008) pilot study, the recruitment and cognitive testing of older people was conducted by research assistants employed to the study. In this pilot study healthcare professionals were responsible for these tasks, possibly making their participation in the study more burdensome.

It was not possible to implement a blanket blinding of the tool to all case investigators of referrals for suspicion of abuse. In one case, the investigating individual was a staff member at the study site and was therefore aware that the study was taking place and in another case the data collector was also the initial case investigator for suspicions of elder abuse.

5.3 Conclusions and recommendations

Prevention and timely intervention are critical aspects of addressing elder abuse. Fundamental to this is the ability to case find older people who may be potentially or actually abused and initiate appropriate referral and investigation. The use of screening tools assists healthcare practitioners to focus on risk areas and trigger areas of possible concern.

The EASI tool was chosen for piloting in Ireland following a review of suitable elder abuse screening tools (Phelan & Treacy 2011). Following systematic steps to pilot its use in Ireland, suspicions of abuse were indicated in 79 older people and, although the number of positive screens represented 11 per cent of the total sample screened, just 2.6 per cent of onward referrals were made. The reasons for older people refusing onward referral following a positive screen warrant further investigation. While 10 out of 13 cases initially identified in an EASI screening assessment were subsequently substantiated after onward referral to the dedicated elder abuse service, a larger number of cases is required to achieve adequate evidence, at 5% significance level, that the EASI demonstrates at least 70% positive predictive value.
Chapter 5: Discussion and Conclusions

Recommendations

In addressing the issues emerging in this pilot study, several recommendations are offered. The primary recommendation relates to the EASI itself, while other recommendations are presented as a consequence of other data analysis in the study.

- When conducting health and/or social assessments of older people, front-line practitioners should be considered using the EASI tool. Where possible this could be integrated into the suite of assessments contained in the ©InterRAI assessment for older people currently being implemented in Ireland. Assessment using the EASI is recommended on an annual basis for all eligible older people.

Commentaries provided by assessors when conducting the EASI screening of older people provided some insights into the possible reasons why older people declined onward referral to elder abuse services. These provide for additional recommendations, as follows:

- Older people availing of services across a range of sectors have particular needs. These warrant further investigation with regard to future sector development to ensure service provision is equitable and socially inclusive.

- Further research is required into the barriers that prevent older people from accepting onward referral and support from formal services.

- The apparent tolerance and normalisation of abusive behaviour on the part of older people themselves requires further investigation.

- The findings of this study with reference to personal security in relation to financial abuse and intimidation point to the need to further develop empowerment programmes and interventions for older people.


References


Appendix 1: The Elder Abuse Suspicion Index (EASI)

**EASI QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone prevented you for getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been upset because someone talked to you in a way that made you feel shamed or threatened?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone tried to force you to sign papers or to use your money against your will?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Q. 1-5 asked of the patient; Q. 6 answered by the doctor within the last 12 months:

The EASI was developed by Yaffe et al. (2008) to raise a healthcare professional’s suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of “yes” on one or more of questions 2-6 may establish concern.


© The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459).
Appendix 2: Survey of Healthcare Professionals

Pilot Study of the
Elder Abuse Suspicion Index (EASI)

The Elder Abuse Suspicion Index (EASI) is a screening tool developed by Yaffe et al. (2008). The tool can be used by healthcare professionals to screen for elder abuse. The National Centre for the Protection of Older People (NCPOP) at UCD is conducting a study to establish the reliability of the EASI tool for use in an Irish context.

As a health professional whose work routinely involves the assessment of older people, I invite you to contribute to this study.

- This will simply involve you examining the six-item EASI tool and completing the enclosed short questionnaire, which seeks your views on aspects of the content and presentation of the tool.
- We are looking for your professional opinion of each question in the EASI tool.
- We are surveying older people separately to gain their views on the questionnaire.
- The tool is for use with a general population of older people with full cognitive capacity.
- This questionnaire should take no more than 5 minutes to complete.
- Please return the completed questionnaire via the stamped-addressed envelope which is provided.

Thank you for agreeing to complete this questionnaire.
### EASI Tool Question 1. Have you relied on people for any of the following: Bathing, dressing, shopping, banking, or meals?

1. Is the language used in Question 1 clear to you?  
   - Yes  
   - No

   If ‘No’, please indicate which words or phrases are unclear:

   If appropriate, please suggest alternative words or phrases:

2. Is the meaning of Question 1 clear to you?  
   - Yes  
   - No

   If ‘No’, please comment:

### EASI Tool Question 2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?

3. Is the language used in Question 2 clear to you?  
   - Yes  
   - No

   If ‘No’, please indicate which words or phrases are unclear:

   If appropriate, please suggest alternative words or phrases:

4. Is the meaning of Question 2 clear to you?  
   - Yes  
   - No

   If ‘No’, please comment:

### EASI Tool Question 3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

5. Is the language used in Question 3 clear to you?  
   - Yes  
   - No
If ‘No’, please indicate which words or phrases are unclear:

If appropriate, please suggest alternative words or phrases:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Is the meaning of Question 3 clear to you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If ‘No’, please comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EASI Tool Question 4. Has anyone tried to force you to sign papers or to use your money against your will?**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Is the <em>language</em> used in Question 4 clear to you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If ‘No’, please indicate which words or phrases are unclear:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If appropriate, please suggest alternative words or phrases:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Is the meaning of Question 4 clear to you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If ‘No’, please comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EASI Tool Question 5. Has anyone made you feel afraid, touched you in ways that you did not want, or hurt you physically?**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Is the <em>language</em> used in Question 5 clear to you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If ‘No’, please indicate which words or phrases are unclear:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Is the meaning of Question 5 clear to you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>If ‘No’, please comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EASI Tool Question 6.** Health professional: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

<table>
<thead>
<tr>
<th>11.</th>
<th>Is the language used in Question 6 clear to you?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If ‘No’, please indicate which words or phrases are unclear:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If appropriate, please suggest alternative words or phrases:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12.</th>
<th>Is the meaning of Question 6 clear to you?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If ‘No’, please comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please provide any overall comments on the EASI tool:**

Thank you for taking the time to complete this questionnaire.
### Appendix 3 Data Collection Tool

**Assessing the risk of elder mistreatment**

**Assessment Tool**

<table>
<thead>
<tr>
<th>Official use only</th>
<th>Centre</th>
<th>Study ID</th>
</tr>
</thead>
</table>

**Section 1: Background Information**

*Please complete for those who do **and** do not express an interest in participating.*

This tool should be administered to an older person that meets the following criteria:

- Is aged 65 years and over.
- Has English as their first language or can otherwise converse in and understand English.
- Has no evidence of distressing health symptoms.
- Does not have a known diagnosis of cognitive impairment.

*Please note, this assessment tool should not be administered in a residential care setting.*

**Please complete in respect of the patient (please tick ✓)**

<table>
<thead>
<tr>
<th>Age group</th>
<th>65–74</th>
<th>≥ 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Older person accompanied?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Occupation of professional administering the tool (please tick one box only ✓)**

<table>
<thead>
<tr>
<th>Consultant Geriatrician</th>
<th>NCHD</th>
<th>Public Health Service Nurse</th>
<th>Emergency Dept RN</th>
<th>Specialist Nurse in Gerontology</th>
<th>Social Worker</th>
<th>General Practitioner</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

Please record in the person’s medical or nursing notes that the older person has been asked to participate.
## Assessing the risk of elder mistreatment

### PARTICIPANT CONSENT FORM

*Please tick the response box as appropriate for each statement below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have read and understood the Participant Information Sheet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have had the opportunity to ask questions and discuss the study.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have received satisfactory answers to all my questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have received enough information about the study and I understand what the study involves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that I am free to withdraw from the study at any time without giving a reason and without this affecting my future medical care.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>I consent to participate in this study.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participant’s name (in print): ______________________________

Participant’s signature: ______________________________

Healthcare professional’s name (in print): ______________________________

Healthcare professional’s signature: ______________________________

Date: ______________________________
### Section 3: Cognitive Impairment Assessment

Please conduct EITHER the 6-Item Cognitive Impairment Test OR the MMSE. Please ensure the older person is alone and that there is no visible clock in the room.

#### 6-ITEM COGNITIVE IMPAIRMENT TEST

*Please circle the appropriate score as per response*

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. What year is it?</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Incorrect</td>
<td>4</td>
</tr>
<tr>
<td>Q2. What month is it?</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Incorrect</td>
<td>3</td>
</tr>
<tr>
<td><strong>Give the person an address phrase to remember with 5 components:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack Murphy, 45 Main Street, Cork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3. About what time is it (within an hour)?</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Incorrect</td>
<td>3</td>
</tr>
<tr>
<td>Q4. Count backwards from 20 to 1</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1 Error</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>More than 1 error</td>
<td>4</td>
</tr>
<tr>
<td>Q5. Say the months of the year in reverse</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1 Error</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>More than 1 error</td>
<td>4</td>
</tr>
<tr>
<td>Q6. Repeat the address phrase</td>
<td>Correct</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1 Error</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2 Errors</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3 Errors</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>4 Errors</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>All wrong</td>
<td>10</td>
</tr>
</tbody>
</table>

**Total Score:**

#### Interpreting the 6-Item Cognitive Impairment Test results

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>The older person is eligible for the study.</td>
<td></td>
</tr>
<tr>
<td>8 or more</td>
<td>The study is not suitable for the older person and the healthcare professional should take the normal course of action when suspecting cognitive impairment (e.g., referral to a medical practitioner for further investigation).</td>
<td>EXIT POINT If the study is not suitable for the older person, please place this tool in the dedicated NCPOPIP box and thank the older person for their interest in the study.</td>
</tr>
</tbody>
</table>
Section 3: Cognitive Assessment Test (Continued)

The MMSE

- If a MMSE has been conducted in the last 5 days and you are satisfied that the older person remains cognitively intact then there is no need to conduct a second MMSE, please record the score and date of the most recent MMSE below.

- Otherwise please conduct an MMSE and record the score along with the date below.

Interpreting the MMSE results

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 or more</td>
<td>The older person is eligible for the study.</td>
</tr>
<tr>
<td>Less than 24</td>
<td>The study is not suitable for the older person and the healthcare professional should take the normal course of action when suspecting cognitive impairment (e.g. referral to a medical practitioner for further investigation).</td>
</tr>
</tbody>
</table>

Please provide a record of the cognitive assessment

- 6-Item CIT administered (please tick) [ ] OR MMSE administered (please tick) [ ]
- Date of assessment __________________________
- Score obtained: __________________________
- Date of assessment __________________________
- Score obtained: __________________________

EXIT POINT

- Where the older person does not meet the 6-Item CIT or the MMSE cut off score they are withdrawn from the study.
- Please place the assessment tool (with Sections 1-3 completed) in the dedicated NCPOP box and thank the older person for their interest in the study.

Where the older person meets the 6-Item CIT or MMSE cut off score and has given consent please proceed to Section 4: Administration of the EASI.
**Section 4: Administration of the EASI**

*Please record the response to each question by placing a tick as appropriate.*

<table>
<thead>
<tr>
<th>EASI Questions</th>
<th>Yes</th>
<th>No</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you relied on* people for any of the following: bathing, dressing, shopping, banking**, or meals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Has anyone tried to force you to sign papers or to use your money against your will?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Healthcare Professional: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Relied on means unable to do independently.
**Banking includes post office and credit union accounts and so forth.
© The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1038459).

**Interpreting the EASI results**

- A 'YES' response to one or more of questions 2 to 6 on the EASI indicates a suspicion of abuse.

**Please record the outcome of the EASI (please tick as appropriate)**

<table>
<thead>
<tr>
<th>Suspicion raised</th>
<th>No suspicion raised</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Please record the outcome of the assessment above and in the person’s medical or nursing notes.
- Please make the participant aware that the Participant Information Sheet provides details of support services.
- Where the EASI indicates suspicion of elder mistreatment proceed to Section 5: Referral.
- Where the EASI does not indicate a suspicion of elder mistreatment please thank the older person for their interest in the study and place the assessment tool in the NCPOP Box.
Section 5: Referral

Where the EASI indicates suspicion of elder abuse discuss the outcome with the individual. Please advise the individual that you wish to make a referral to a senior case worker for the protection of older people/social worker.

It is important that the following points are followed:

- The participant must agree to any such referral.
- The healthcare professional conducts the referral as per their local standard procedures.
- A list of senior case workers for the protection of older people is provided in this booklet.
- The referral should not include information on the EASI.

Please record whether a referral was agreed to or declined (please tick ✓)

<table>
<thead>
<tr>
<th>Referral agreed to</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If a referral is made please indicate the name and address of the social worker / senior case worker the case has been referred to:

The data collection tool is now complete.

- Please place the tool and the consent form in their respective dedicated NCPOP boxes.
- Please note that the tool and the consent form are stored in separate NCPOP boxes.
- Please thank the older person for their interest in the study.
- Please advise the older person that should they have any queries or wish to withdraw from the study please contact Research Administrator, at the National Centre for the Protection of Older People at UCD (contact details are provided below and on the Participant Information Sheet). Withdrawal can take place for up to 8 weeks after the date of assessment.

Notes or Comments by Healthcare Professional:

Thank you for completing this assessment tool. Should you have any queries please contact:

Research Administrator,
National Centre for the Protection of Older People,
UCD School of Nursing, Midwifery and Health Systems,
Health Sciences Centre,
Belfield,
Dublin 4

Tel: (01) 716 8487
Email: ncpop@ucd.ie
www.ncpop.ie