SCREENING FOR ELDER ABUSE

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1. INTRODUCTION

Elder Abuse is defined by the, World Health Organization as «a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person»[1].

This definition considers multiple forms of abuse: physical, psychological, sexual, financial, and neglect. These, and other typologies as self-neglect, give the impression that the forms of abuse are independent. However, research shows that older adults who experience abuse often experience more than one form.

The prevalence of elder abuse is very difficult to estimate. There are several factors to consider, especially if we wish to compare prevalence rates, because different methodologies often result in contrasting numbers. A systematic review conducted by Yon and colaborators, of prevalence studies in community settings that included studies from 28 countries allowed a more accurate idea of the global prevalence of elder abuse. Their findings indicate a prevalence of overall abuse of 15.7%. As for the prevalence of specific types of abuse, there is an es-

[1] Who (2002) p. 3.

timation of 2.6% for physical abuse, 0.9% for sexual abuse, 11.6% for psychological abuse, 6.8% for financial abuse, and 4.2% for neglect[2].

There are several theories used to explain elder abuse. The Caregiver Stress Theory is probably the more frequently mentioned theoretical framework used to explain elder abuse[3], as it is one of the most criticized. According to this theory, elder abuse is a situational phenomenon that occurs when a caregiver faces challenges greater than his/her resources or ability to cope. The result is an increase in stress levels and a feeling of burden. An overburdened caregiver is likely to make poor decisions, not providing the best care possible[4].

The Social Learning Theory developed by Albert Bandura to explain the acquisition of new behaviours have also been applied to the learning of aggressive behaviours[5]. Social learning proposes that violent behaviour is learned through observation and modelled into our behavioural repertoire. Therefore, someone exposed to violence would have violent behaviour incorporated as a valid relational strategy. Violence is then conceptualized as cyclic, first learned, then taught, which is why this approach is also known as the cycle of violence theory.

The Social Exchange Theory is not precisely a theory but rather a family of theories derived from various fields, such as sociology, psychology, and economics. According to the premises of social exchange, every social interaction is an exchange. For each interaction, the involved persons will try to maximize rewards at the minimum cost possible. If both persons involved in an exchange perceive it as rewarding and with a fair distribution of costs and rewards, the interaction is mutually satisfying and balanced[6].If an exchange is perceived as unfair, balance is broken, and the person who perceives unfairness can resort to abusive behaviours to seek compensation. Some authors have proposed that older adults participate in exchanges at a disadvantage when compared to other adults. This is mainly caused by their diminished social status and an age-related decay in personal resources[7].

These theories and others mentioned in the literature are not mutually exclusive, sometimes reflecting only part of the explanation.

Evidence shows that abuse in later life is linked to adverse health impacts, such as: higher risk of mortality, hospitalization, experience disability, and nursing home placement; suicidal thoughts and attempts; chronic pain; lung, bone ore joint problems; metabolic syndrome; gas-

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[2] Yongjie Yon *et al.* (2017).
[3] Kathleen Wilber, y Dennis Mcneilly (2001).
[4] Amala Mathew y Sobha Nair (2017).
[5] Albert Bandura (1978).
[6] George Casper Homans (1961); Peter Blau (1964).
[7] J. J. Dowd (1975).

trointestinal symptoms; stress, depression or anxiety; and traumatic injuries. If detected early enough, elder abuse victims can have the opportunity of an intervention to reduce risks. This can prevent serious harm from occurring or even save lives. Incidents that may appear relatively minor can have a debilitating and long-lasting effect on older people.

Older persons are a large group of users of health care services, which is why the role of health and social care professionals in identifying elder abuse is the key. However, identification can be a complex and lengthy process that requires multi-professional collaboration.

There are several methods and processes to detect abuse. Fundinho and Ferreira-Alves mention three methods that are at the starting point of any process to detect abuse: i) Self-revelation: when an older adult reveals that he or she has been a target of abusive behaviours. That revelation can be made to a healthcare professional, to a social worker, a judicial entity, a law enforcement agency, to his or her social network as a friend or a family member, or anyone; ii) Complaint to an authority: when there is a complaint to any form of legal representation be it anonymous or not, based on evidence or suspicion; iii) Using screening procedures: when a screening procedure tests positive. The screening procedure may be employed based on suspicion or routine by any professional with skills to do so, in any context where screening is possible[8].

Screening procedures for elder abuse have been proposed for some time and are particularly relevant within the conceptualization of elder abuse as a public health issue.

Screening procedures for elder abuse have been tried out in several contexts, but there is a special emphasis on the healthcare and social contexts. The importance of the healthcare system, in particular, is reinforced in Caldwell, Gilden and Muelle's definition of abuse screening as the «assessment of current harm or risk for harm from family and intimate partner violence in asymptomatic persons in a healthcare setting»[9].

The objective of screening for elder abuse is the early detection of cases that will be forwarded to detailed assessment. Having different screening forms helps professionals properly decide which circumstances warrant follow-up[10]. There are several forms of screening for elder abuse. Cohen has proposed a typology of screening tools where instruments are classified into three categories: direct questioning tools, signs of abuse, and indicators of risk for abuse[11].

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[8] João Fundinho e José Ferreira-Alves (2019).
[9] Hollie Caldwell, Gail Gilden y Martina Muelle (2013), p.20.
[10] Farida Ejaz (2001).
[11] Miri Cohen (2011).

The use of screening procedures was the focus of the SAVE —Screening for Abuse Victims among Elderly— Project. This project involving six european partners aimed to improve the adoption of screening programs for elder abuse in health and social care settings, by providing training and support to professionals on how to use and implement them effectively.

2. METHODOLOGY

2.1. Literature Review

SAVE is an European project funded under the Erasmus+ programme, with the specific objectives: i) increase knowledge of screening tools and their suitability in the identification of violence against older persons in social and health care services; ii) improve the capacity of social and health care professionals to identify and intervene and support and refer the cases of violence against older persons to relevant services; iii) develop educators' competencies to teach professionals how to deal with violence against older persons and to support and mentor them; iv) produce an interactive training program for improving active and innovative learning of social and health care teachers, trainers and professionals in identification and intervention in case of violence against older persons.

Alined with this objectives, the SAVE project aimed to produce four intelectual outpus, availables in the project website: i) A literature review about the number and quality of screening instruments for older adult's mistreatment; ii) A training curriculum and material on identification and intervention on violence against older persons to be implemented face-to-face; iii) Country specific recommendations for the use of screening instruments; iv) An online course to mainstream project results to a wider audience.

The literature review aimed to i) List arguments in favour and against screening for elder abuse; ii) Find what professionals conduct screening and in what contexts;iii) Discover how professionals and older adults perceive screening; iv) Enumerate the existing screening instruments, their characteristics and effectivness.

To accomplish this objectives, we formulated three questions to guide our choice of methodology and search:

1. What arguments can be used in favour or against the screening process?

2. What professionals conduct screening, in what contexts and how is screening perceived by professionals and older adults?

3. What screening instruments are used, in what countries, and what are their psychometric characteristics?

Eight databases: Web of Science, Scopus, Science-Direct, Pubmed, SAGE, EBSCO, Scielo and Ageinfo were searched for articles published in scientific papers or made available by relevant organisations in the elder abuse field from 1975 to February 2021. We used all possible combinations of the following keywords: «elder abuse»; «mistreatment»; «older adults violence»; «screening»; «assessment», and; «measurement».

The application of the search strategy resulted in a reference database gathered and managed using Mendeley. Article selection was conducted by three researchers, experts in the field of elder abuse. The three researchers conducted article selection independently, in a three-step procedure, by analyzing titles and abstracts in the first two steps and the full-text in the third step.

A total of 7386 titles were identified, which dropped to 4354 titles after removing duplicates. The first step of article selection was applying general selection criteria that consisted of removing all articles that did not approach the subject of elder abuse. The application of this step resulted in 847 titles that would be scanned for relevant information regarding our three questions. The second step was the analysis of the relevance of the article for each of the specific questions. In this step, the researchers analysed the 847 titles for relevant information for answering each of the three questions. It was considered that one article could have relevant information for more than one question. The third step was the application of specific criteria. The characteristics of articles that would be relevant for the objectives of each question were summarised and applied by full-text analysis to the articles that resulted from the previous step. The application of the specific criteria resulted in 19 articles used for data extraction regarding question one, 25 articles regarding question two, and 87 articles regarding question three.

2.2. Save Screening Pilot

After completing the training, some health and social service professionals carried out a screening pilot between may and july of 2022 at their workplaces.

The criteria for belonging to the target group of the SAVE project screening pilot were: at least sixty five years of age, be cognitively competent and capable of consciously deciding based on the information received about their participation in the survey.

The health and social care professionals assessed the person competence based on their observations or knowledge of the elderly person.

The interviewees and the older people who voluntarily participated in the survey received oral and written information about the project and the purpose of the interview.

Before piloting the screening tool, each country drew up practical guidelines, considering the practices and legislation of its own country.

The screening tools used were the Elder Abuse Suspicion Index (EASI)[12]and the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)[13].

3. RESULTS

3.1. Literature review

Based on our findings, the most relevant advantage of screening older adults for abuse is that there can be no intervention on abuse without its identification. Screening procedures offer a research-informed methodology to identify elder abuse and also help with a systematic way to document cases. The propagation of these procedures also helps raise awareness of social and healthcare professionals about elder abuse[14]. Some points discourage the use of screening, mainly arising from knowledge gaps about the process Screening's possible negative effects have been identified, but their frequency is unknown[15]. The cost-effectiveness of screening programs is unknown. Limitations on the effectiveness and applicability of specific screening instruments also pose obstacles to the elaboration of screening programmes.

As for the perceptions about screening, in general, professionals find screening a useful tool, but it competes with the many other demands of their work, and they report difficulties mainly related to lack of time, knowledge and training on the subject[16].

The older person´s opinion about screening is not often considered, and more extensive research is necessary to fill this gap.

Regarding the tools, we found tuenty nine instruments available for use in the practice setting. Few instruments meet the general rules of effectiveness, and the more effective instruments are also time-consuming and require extensive training. These findings help us identify two major challenges for screening: 1) the development and test of effective instruments of fast application and 2) the training of

[12] Mark Yaffe *et al.* (2008).
[13] Anne Victoria Neale, Melanie Hwalek, Richard Scott y Carolyn Stahl (1991).
[14] Georgia Anetzberger (2008).
[15] XinQi Dong (2015).
[16] Chiara Gallione (2017).

professionals to administer and interpret such tools and verify that all the next procedures are guaranteed.

Making the balance of potential risks, benefits and instrument limitations, it is probable that selective screening of risk groups, another modality of screening[17], could be more beneficial, but even for that, we have no conclusive evidence[18].

It is important to notice that the screening process is not diagnostic and will require additional assessment before conclusions are drawn.

The screening tools are particularly valuable for training professionals in internalising organised forms of inquiry. However, more important than the tools is developing the competencies that underlie the screening process, namely listening skills and problem-solving and promoting a broader view of the circumstances and factors around and within the older adult that can determine elder abuse.

3.2. Training curriculum

The training curriculum was organized in four modules of three hours each:

— Module one - Introduction to elder abuse prevalence, signs and symptoms.
— Module two - Screening of elder abuse.
— Module three - How to screen: Ethics and privacy.
— Module four - Challenges of working with elder victims of violence.

At the end of the training, that adopted a combination of theoretical / input sessions and practical exercises / active learning activities to engage professionals to practically apply the theory they have learnt, participants should know: i)What is elder abuse; ii) How to recognize elder abuse applying screening methods and tools; iii) How to intervene in case abuse is detected.

In Portugal the training curriculum target 34 social and health care professionals working in home care, residential care facilities, health centres and hospitals.

A training results assessment form was used to assess the competence acquired by the participants at the end of the training programme.

[17] Mark Speechley, *et al.* (2017).
[18] X. N. Wang, *et al.* (2015).

3.3. Guidelines for screening

The guidelines for screening were developed and adapted to each country in accordance with specific legislation and standards, and covered topics as: Why mistreatment or violence against elderly people is a health problem; Obstacles experienced by older people in reporting their experiences of violence; Obstacles identified by professionals to question about mistreatment; Violence against elderly people as a violation of their human and civil rights; The impact of the COVID-19 pandemic on the mistreatment of older people; Professional ethics and violence against elderly people; Carrying out abuse screening; Guidelines for screening interviews; Framework for the EASI and H-S/EAST; Responses that raise concern/ suspicion; Action protocol; Professional Secrecy and mandatory reporting; What to do when you suspect that the person does not have the capacity to make decisions; and the procedures for the SAVE screening pilot.

3.4. Screening pilot

Using screening instruments for identification of elder abuse is still rare in European countries. Therefore, the countries participating in the SAVE project wanted to apply screening/systematic questioning in different settings to gain experience in the use of screening tools and their usefulness in various services for the elderly.

In preparation to the application, the partnership conducted a survey involving 86 professionals working in the elderly care. Results showed that 44 for 100 had never received training on elder abuse and 38 for 100 only sometimes, showing that there is lack of trained professionals in the field although 87 for 100 think it is important or very important to know how to screen for elder abuse. 94 for 100 believe there is room to improve their work-based practices in relation to recognition of elder abuse and the area where they think there is more need to strengthen their skills is in fact training on elder abuse and accessing to practical tools for recognition.

In the survey conducted in Portugal, a total of 70 elderly people without cognitive impairment were interviewed. Nurses of primary health care and long-term care facilities and a Psychologist and a Social Educator in day care facilities, applied the tools. EASI tool was applied in the context of primary health care and HS-EAST in long-term care, day care facilities and nursing homes. Six older persons refused to answer questions.

The EASI tool, was used for fifty four participants. Thrity (55,6 for 100) belonged to the age group of sixty five to seventy four years

old, tuenty two to the age group of seventy five to eihgty four years old (40,7 for 100) and two respondents (3,7 for 100) were eighty five years old or over. Of them, Thirty one (57,4 for 100) were women and tuenty three (42,6 for 100) males. Half of the respondents were interviewed in the presence of a relative or a carer and the other half alone in a private room. Regarding cohabitation, 11,1 for 100 (n=six) lives alone; 66,7 for 100 (n=thirty six) lives with a spouse and 24,1 for 100 (n=thirteen) lives with someone else. None of the elderly showed signs of abuse and it was not necessary to proceed with any follow-up after the screening.

The HS-EAST tool was used for the interviews of sixteen older persons in the context of long-term care, day care facilities and nursing homes. Eleven of them were women and five were men. Eight of them belonged to the age group of sixty five to seventy four years old, six to the age group of seventy five to eighty four years old and two were eighty five years old or over. Of them seven lived alone, six lived with a spouse and three with someone else. All respondents were interviewed alone, in a private room. None of the older persons showed signs of abuse and it was not necessary to proceed with any follow-up after the screening.

Regarding the older persons' experiences of being asked about abuse, only one elderly person mentioned that the topic —elder abuse— was uncomfortable. All the others mentioned that the questions did not cause any discomfort, that it is important to talk about the topic and were pleasantly surprised that health professionals were concerned about their well-being and were attentive to these issues. All participants said that we should ask these questions to all the elderly.

About the professional's experiences of using screening tools, in general it was a positive and rewarding experience.

The questions they considered the most difficult were related to the intimacy of personal and family relationships and when the professional had no previous relationship with the older person. The professionals experienced that questioning is easier and more natural when there is already a relationship of trust with the older person. The time was a problem in some cases, because of the lack of professionals. Time of using EASI was between five and twenty minutes and HS-EAST questions took between ten and sixty minutes. The application of the screening instrument was easier in the primary health care; the respondents were more committed to the questioning than older persons in day centres and nursing homes.

Some professionals considered that the training for the implementing of the instruments should be longer.

4. DISCUSSION

Despite the many obstacles to the identification of older adults suffering abuse, its covert nature, the fact that most victims go unidentified, and the prevalence of the problem as well the potentially severe or lethal consequences for the victims has resulted in vigorous advocacy of screening for abuse[19].

Elder abuse can only be addressed if detected. Interventions by authorities mandated under public policies to prevent or treat the problem cannot occur without an appropriate referral. Screening is used to promote the safety and well-being of older people and, in most cases, to fulfil legally mandated reporting responsibilities. Screening tools help improve the professional awareness of the problem and guide users through a systematic process of observation and documentation to ensure that manifestations of elder abuse will not be missed[20].

There are arguments against the screening process itself, and some associated with difficulties in using some screening instruments. Doing generalized screenings for abuse without known effective remedies and resources or without having a specialized team for follow-up assessment is highly questionable.

False-positive results could cause psychological distress to older adults and families and jeopardize the physician-patient relationship[21].

False-negative results may negate the abusive situations and provide false assurance, further increasing older adults' risk for adverse outcomes, discouraging clinicians from seeking further history, and preventing recognizing those who are genuinely at risk[22].

Some progress has been made in screening older people for abuse; areas for future research are still open, as no studies investigated the possible adverse effects of patient or caregiver testing and their impact on clinical processes, costs, time requirement, or impact on self-report.

To disclose and give details about abusive situations, the victims should feel that the practitioner is trustworthy, empathetic, sensitive to their difficulties, and not judgmental. Unfortunately, often it takes time and effort to achieve this favourable atmosphere, which is also limited by time constraints.

In the saving screening pilot, older people were generally very positive about being asked about elder abuse and considered it important.

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[19] Georgia Anetzberger (2001); Muhammad Akbar Baig, et al. (2015).
[20] Georgia Anetzberger (2008).
[21] XinQi Dong (2015).
[22] Chiara Gallione (2017).

This result is in line with a survey conducted in Canada by Mark Yaffe and colaborators in 2012[23].

5. CONCLUSIONS

Elder abuse is a widespread phenomenon worldwide. Its exact prevalence is very difficult to estimate, and its identification is a complex topic requiring a multidisciplinary approach.

The training curriculum and the screening guidelines, based on an extensive literature review, as well as the experience and lessons learned during the screening pilot, are a very important contribution to identifying and intervening in mistreatment of elderly people. The online course allowed us to reach a wider audience of health and social service professionals, as well as other professionals who work with older people, students and the general population, increasing awareness and knowledge about Elder Abuse.

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