SAVE
SCREENING FOR ABUSE VICTIMS AMONG ELDERLY

WHAT WE KNOW ABOUT SCREENING OLDER ADULTS FOR MISTREATMENT:
RESULTS FROM THE SAVE PROJECT LITERATURE REVIEW

WWW.PROJECTSAVE.EU

Authors:

Fundinho, J. F., School of Psychology (Epsi), University of Minho, Portugal

Machado, M. M., School of Nursing (ESE), University of Minho, Portugal

Petronilho, F. A., School of Nursing (ESE), University of Minho, Portugal

Ferreira-Alves, J., School of Psychology (Epsi), University of Minho, Portugal

Contributions from the SAVE partnership:

Boccaletti L. , Milianta S., ANS soc. coop. soc. , Italy

Melon M.C., Grassi S., Patuzzo M., CADIAI soc. coop. soc., Italy

Papastavrou E., Cyprus University of Technology | Nikolaidou E., Charitou P., Cyprus State Health Services Organisation, Community Nursing, Cyprus

Perttu S., Empowering Old Age Coop - Osk VoiVa, Finland

Kacprzykowska A., Rogalska E., Daab M., PCG Polska, Poland

Disclaimer:

Suggested citation:

Fundinho, F., Machado, M., Petronilho, F. and Ferreira-Alves, J. (2021) What we know about screening older adults for mistreatment: results from the SAVE Project literature review. Available at: https://www.projectsave.eu/

Acknowledgements:

Table of Contents

Abstract

Background

Elder abuse is a widespread phenomenon worldwide. Using screening tools to identify suspected cases of abuse could be a helpful strategy to support professionals in recognising the signals and indicators of mistreatment and base the decision to request more comprehensive assessments. This literature review aims to answer three questions: 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? and; 3) what screening instruments are used, in what countries, and what are their psychometric characteristics?

Method

A systematic review of the literature was conducted. Eight databases were searched, using multiple combinations of the keywords "elder abuse", "mistreatment", "older adults", "violence", "screening", "assessment", and "measurement".

Results

We found 7386 references, then analysed according to pre-established criteria resulting in 19 papers with relevant information for question 1, 25 for question 2 and 87 for question 3.

As arguments in favour of screening, results indicate that identification of cases is key for intervention. Screening promotes the safety and well-being of older people and, when applicable, helps with legal reporting responsibilities. It also provides a base for assessment, heightens the professional awareness of the problem, and guides users through a systematic process of observation and documentation to ensure that manifestations of elder mistreatment will not be

overlooked. As arguments against screening, the resulting point to the time-consuming application process, the false negative/positive results, and its potential consequences for the older persons, their families, and professionals. The absence of knowledge about the frequency of adverse effects of elder abuse screening and their impact on clinical processes, costs and time requirements are also indicated as points against screening.

Screening is mainly conducted by healthcare and social professionals. Nurses, physicians, and social workers were frequently reported as the primary professionals who screen for mistreatment. Very little information was found regarding the opinion of older adults about the screening process.

Regarding screening tools, thirty-seven instruments were cited in the literature. Of these, eight tools were only used in research and are not yet field-tested. The twenty-nine remaining tools can be organized into four categories: 1) screening tools based on direct questioning that are short and versatile yes/no questionnaires used in multiple contexts by different professionals; 2) screening procedures based on observation or in-depth assessment, which are time-consuming and require extensive training and professional skills, but are also more accurate; 3) screening tools that specify the abuser, focusing on specific relationships and often require the evaluation of the alleged abuser; and 4) Screening tools for assessing a single form of abuse. Of these four categories, direct questioning tools are more flexible, adaptable, and easier to use but are also less reliable.

Conclusion

The literature on elder abuse screening points to several compelling arguments both in favour and against screening. Though it is understood that screening is an important tool to raise suspicion on elder abuse, the lack of effective and practical tools and the unknown extent of potential negative consequences of screening are important factors to consider when thinking about the implementation of screening programmes. More research is necessary to fill these gaps and help professionals to make informed decisions. The use of screening tools beyond their distal possible positive effects on older adults is particularly

useful to train social and healthcare professionals who deal with older adults more frequently. As such, training these professionals in good screening practices is essential to make screening feasible, raise awareness about elder abuse, and promote a broader view of the circumstances and factors around and within the older adult that can determine elder abuse.

1. Background

Violence against older adults has been a growing concern in modern society. The Screening for Abuse Victims among Elderly (SAVE) project is a strategic partnership and collaboration platform formed between teams from five countries (Poland, Finland, Italy, Portugal, and Cyprus) to improve the identification and intervention on abuse by social and healthcare professionals and to train them in the use of screening procedures.

This document represents one of the outcomes of project SAVE. This document aims to present in a systematic way what information is known about screening older adults for mistreatment. This information was collected by conducting a systematic review of the literature. We will adopt the following structure in this document: first, we will present a summary of the basic concepts related to elder abuse as a phenomenon and the objectives of this literature review; second, we will present the methodology adopted to conduct this review; third, we will present our findings and; fourth, we will discuss our results and what they tell us about screening older adults for mistreatment.

Elder abuse as a phenomena

Basic phenomenological knowledge of elder abuse implies answering four questions:

1. What is elder abuse? (or how it is defined);
2. How many people experience elder abuse? (or what is its prevalence);
3. Why does it happen? (or what theories are there to explain it?), and;
4. How is elder abuse detected?

In the following sections, we will briefly approach the basic concepts that underlie questions one, two, and three and give particular relevance to question four about the detection of abuse, the question at the heart of project SAVE.

Defining elder abuse

Many attempts have been made to define mistreatment against older people. The name of the concept has changed over time, showing a natural evolution of knowledge in this area. In the scientific literature, we can first track this concept

to a letter exchange between physicians in a medical journal who realized that some of their older female patients showed signs of physical violence, primarily due to improper care (Baker, 1975; Burston, 1975). As a result of this discussion, the term "granny battering" was coined, mainly to describe physical violence directed at older women receiving care from their adult children. The literature on child abuse largely influenced this first conception of violence against older people. The term "granny battering" was adopted for being parallel to "baby battering", the term used at that time to designate child abuse.

The conceptualization of violence against older adults evolved over the next twenty-seven years. Multiple aspects were added to the concept that turned it into a more inclusive picture. This conceptual expansion includes the widening of possible victims, potential perpetrators, and contexts where abuse happens. These changes were proposed over time (check Mysyuk, Westendorp and Lindenberg, 2013; for a description of the evolution of the concept of elder abuse) and culminated in the Toronto Declaration by the World Health Organization. In this document, the WHO (World Health Organization, 2002, p. 3) defined elder abuse as:

"Elder Abuse is 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."

Though the Action on Elder Abuse group first proposed this definition (Action on Elder Abuse, 1995), the Toronto Declaration can be considered a landmark on the meaning of abuse since it brought the issue into a public health perspective, mainly influencing the awareness about elder abuse. Since this document, no significant changes have been introduced in the conceptualization of abuse, making the WHO definition the more widespread definition of elder abuse, adopted by several other international groups such as the International Network for the Prevention of Elder Abuse (INPEA).

The definition of elder abuse proposed by the WHO can be considered a general definition of abuse. This definition considers multiple forms of abuse: physical,

psychological, sexual, financial, and neglect (World Health Organization, 2002). This suggests that specific definitions of abuse can be formulated, one for each form. Though there is no universally accepted typology of abuse and terminology varies a little, there are five forms of abuse where there is a more substantial agreement (Action on Elder Abuse, 1995; World Health Organization and International Network for the Prevention of Elder Abuse, 2002; American Psychological Association, 2012):

- Physical abuse: inflicting pain or injury, physical coercion, physical or chemical restrainment;
- Psychological/emotional abuse: inflicting emotional or mental anguish;
- Sexual abuse: non-consensual contact of any kind
- Financial exploitation: illegal, improper, or unauthorized use of the older adults funds or resources;
- Neglect (and abandonment): intentional or unintentional failure or refusal to fulfil care-taking obligations.

Besides these five forms of abuse, others are often considered by researchers and policy-makers. The more frequent example is self-neglect. Self-neglect can be defined as an involuntary behaviour of the older adult that threatens his/her own health or safety (NCEA, no date). As the perpetrator of self-neglect is also the victim, this form of abuse is often excluded from typologies of abuse. Other forms of abuse might include denial of rights (De Donder *et al.*, 2011) or spiritual abuse (Department of Justice Canada, 2009).

The use of these typologies is often counter-productive. They 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 of abuse. A good and well-known example is psychological abuse that is frequently present alongside other forms of abuse (Anetzberger, 1998). In fact, by definition, any other form of abuse can also be considered psychological abuse (physical violence can also be considered a form of humiliation and, therefore, be a form of psychological abuse).

Prevalence of elder abuse

The prevalence of elder abuse is very difficult to estimate. There are several factors to consider, especially if we wish to compare prevalence rates. Different methodologies (e.g., face-to-face interviews, telephone interviews, judicial database analysis, screening tools) often result in contrasting numbers. Therefore the accuracy of prevalence rates must be treated with some caution. What is beyond doubt is that abuse exists.

A systematic review conducted by Yon *et al.* (2017) 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 estimation 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.

In the partner countries of project SAVE, there are various prevalence rates of elder abuse. Table 1 presents the prevalence rate of elder abuse in the partner countries of the SAVE project. As it can be seen, the issue of elder abuse is widespread in Europe. The values presented are merely informative, and comparison between countries is discouraged as the prevalence rates were estimated by different studies using different methods and sample sizes. We found no studies reporting the prevalence of elder abuse in Cyprus.

Table 1 - Prevalence of elder abuse in the partner countries of project SAVE

	Poland (Filipska *et al.*, 2019)	Finland (de Donder *et al.*, 2011)	Italy (Badenes-Ribera, Fabris and Longobardi, 2021)	Portugal (Gil *et al.*, 2014)	Cyprus
Prevalence rate of elder abuse	38.5%	25.1%	20.1%	12.3%	-

Theories to explain elder abuse

Explaining why abuse happens and what processes underlie abusive relationships is fundamental to understanding abuse. Without ideas or explanations for why abuse happens, assessing abuse becomes a limited skill. Although the causes of abuse are yet unknown, there are several theoretical explanations for why abuse happens. Though theories need to be tested, they offer a backbone to the conceptualization of abuse and a base for adopting preventive strategies.

There are several theories used to explain elder abuse. In a recent systematic review about theories of abuse, there were identified thirteen theories and models used in this field (Fundinho, Pereira and Ferreira-Alves, 2021), though there may be more. This document does not aim to elaborate on the theoretical explanations of elder abuse, so we will just briefly describe the main idea behind the three more frequently used theories.

The Caregiver Stress Theory is probably the more frequently mentioned theoretical framework used to explain elder abuse (Wilber and McNeilly, 2001), as it is one of the most criticized (Brandl and Raymond, 2012). According to this theoretical hypothesis, 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 and unleashing his/her frustrations on the care recipient (Mathew and Nair, 2017). This theory has been criticized on several points, but mainly for being used as a strategy to blame the victim and reduce the perpetrator's accountability (Brandl and Raymond, 2012).

Social Learning Theory is a theory developed by Albert Bandura (1978) to explain the acquisition of new behaviours that have also been applied to the learning of aggressive behaviours. Social learning proposes that violent behaviour is learned through observation and modelled into our behavioural repertoire. Therefore, someone exposed to violence would have someone with 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.

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 of material (e.g., money) or non-material goods (e.g., social approval). 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 (Homans, 1961; Blau, 1964). 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 (Dowd, 1975).

These theories and others mentioned in the literature are not mutually exclusive, sometimes reflecting only part of the explanation. Plus, not all theories are supported by research to the same degree (for a systematic review summarizing evidence in favour or against multiple theories, check Fundinho, Pereira and Ferreira-Alves, 2021).

Detecting elder abuse

The identification of elder abuse is a very complex topic that often requires a multidisciplinary approach. The identification of abuse is challenging for various reasons. The multiple ways abuse manifests itself is one of them (Lachs and Pillemer, 2004; Cohen, 2011). Healthcare professionals have been identified as ideal for detecting abuse (Lachs and Pillemer, 2004), but there is no exclusivity in that position. Workers from the social sector and law enforcement are also in a privileged position to detect abuse.

There are several methods and processes to detect abuse. Fundinho and Ferreira-Alves (2019) mention three methods that are at the starting point of any process to detect abuse:

- *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 (a nurse or physician), to a social worker, a judicial entity, a law enforcement agency, to his or her social network (a friend or a family member), or anyone.

- ▪ *Complaint to an authority*: when there is a complaint to any form of legal representation (law enforcement, courts), be it anonymous or not, based on evidence or suspicion.
- ▪ *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.

The use of screening procedures is the focus of the SAVE project, and that is the detection method that we will focus on for the remainder of this document.

The screening process: what we know and what we need to know

The concept of screening has its origins in the field of epidemiology and is currently at the heart of the public health systems (Lachs and Pillemer, 2004). 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 (2013) 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." (p. 20). However, other contexts are equally important, but a list of professionals and contexts where screening is conducted has never been compiled systematically, and, as a result, the extent of the application of screening procedures is not known.

The function of screening for elder abuse is no different from screening for a disease. The objective 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 (Ejaz *et al.*, 2001). There

are several forms of screening for elder abuse. Cohen (2011) 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.

- Direct questioning tools: consist of sets of questions either asked directly by professionals or self-administered aimed at eliciting disclosure of abusive situations;

- Signs of abuse: consists of lists of signs of different types of abuse (e.g., bruises), often constructed based on professional experience;

- Indicators of risk: consists of looking for factors associated with abuse (risk factors), even in the absence of signs of abuse or disclosure. The presence of risk indicators is by no means equivalent to the identification of abuse, and risk assessment often leads to further assessment.

These three categories of screening tools do not differ only on methodology and content; they also differ in their ability to detect abuse correctly. In a study by Cohen et al. (2007), three screening tools were applied, one of each type. The results showed a disparity in the rates of identification of abuse between the tools. In the direct questioning tool, 5.9% of older adults disclosed abuse, but a professional assessment found signs of abuse in 21.4%, and 32.6% were at high risk of abuse. However, it is not unusual for a screening tool to have more than one of these types. Consider, for example, item 2 of HS/EAST that asks, "Are you helping to support someone?". The item is applied with a direct questioning method, but the content refers to a risk factor of abuse. Examples like these can be found in other screening tools, meaning that the distinction between types is not strictly linear. Nevertheless, this typology of screening tools is helpful because signs of abuse and risk factors provide different degrees of evidence that should be considered (Anetzberger, 2001).

There are several questions about screening that remain unanswered. Although there are several literature reviews about screening tools (e.g., Gallione *et al.*, 2017; McCarthy, Campbell, and Penhale, 2017), new information is continuously being published, and we need to be updated about how many screening tools there are and how good are they in detecting abuse. Also, it has been proposed that screening tools might behave differently in multicultural groups (Cohen,

2011), so it is essential to check how a screening tool behaves across various validations. Besides the characteristics and performance of the screening tools, there is information about the screening process that remains underreported. Though there is a general idea that screening is conducted by healthcare and social care professionals, it is not known what the professionals' perceptions about screening are. Do professionals feel that screening is helpful? Do they feel prepared to apply screening procedures? Little information is available about these critical issues. Equally important is the perception of older adults about screening. The opinion of older adults regarding screening remains mostly unheard, and there is no synthesis of information about the potential consequences of screening.

Objectives of the literature review

The current literature review is a product of Project SAVE. As such, it aims at summarising knowledge about the process of screening older adults for mistreatment. In alignment with project SAVE, we can sum up the aims of this literature review as:

   I. To List arguments in favour and against screening for elder abuse;
  II. To find what professionals conduct screening and in what contexts;
 III. To discover how professionals and older adults perceive screening;
  IV. To enumerate the existing screening instruments and the countries where they are used;
   V. To summarise the characteristics of the screening tools and their effectiveness.

To accomplish these objectives, we can formulate three questions to guide our choice of methodology and search. This literature review will search for answers for the following three questions:

   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?

We believe that these questions sum up the state-of-the-art about screening older adults for abuse. The findings in the result section will be organized according to these questions.

2. Methodology

A systematic review of the literature was conducted to answer our questions. This methodology was adopted because it allows us to search, assess and integrate all relevant evidence of our topic of interest with a structured procedure. A structured and extensive procedure in a literature review allows for bias-reduced conclusions.

Search strategy

Eight databases (Web of Science, Scopus, Science-Direct (Elsevier), Pubmed (Medline), 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".

Article selection criteria

The application of the search strategy described in the previous section resulted in a reference database gathered and managed using Mendeley, a reference management software. 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.

The process of identification of eligible studies is illustrated in Figure 1. A total of 7386 titles were identified, which dropped to 4354 titles after removing duplicates from the database. 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 from the database. 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.

Figure 1 – Article selection procedure flowchart.
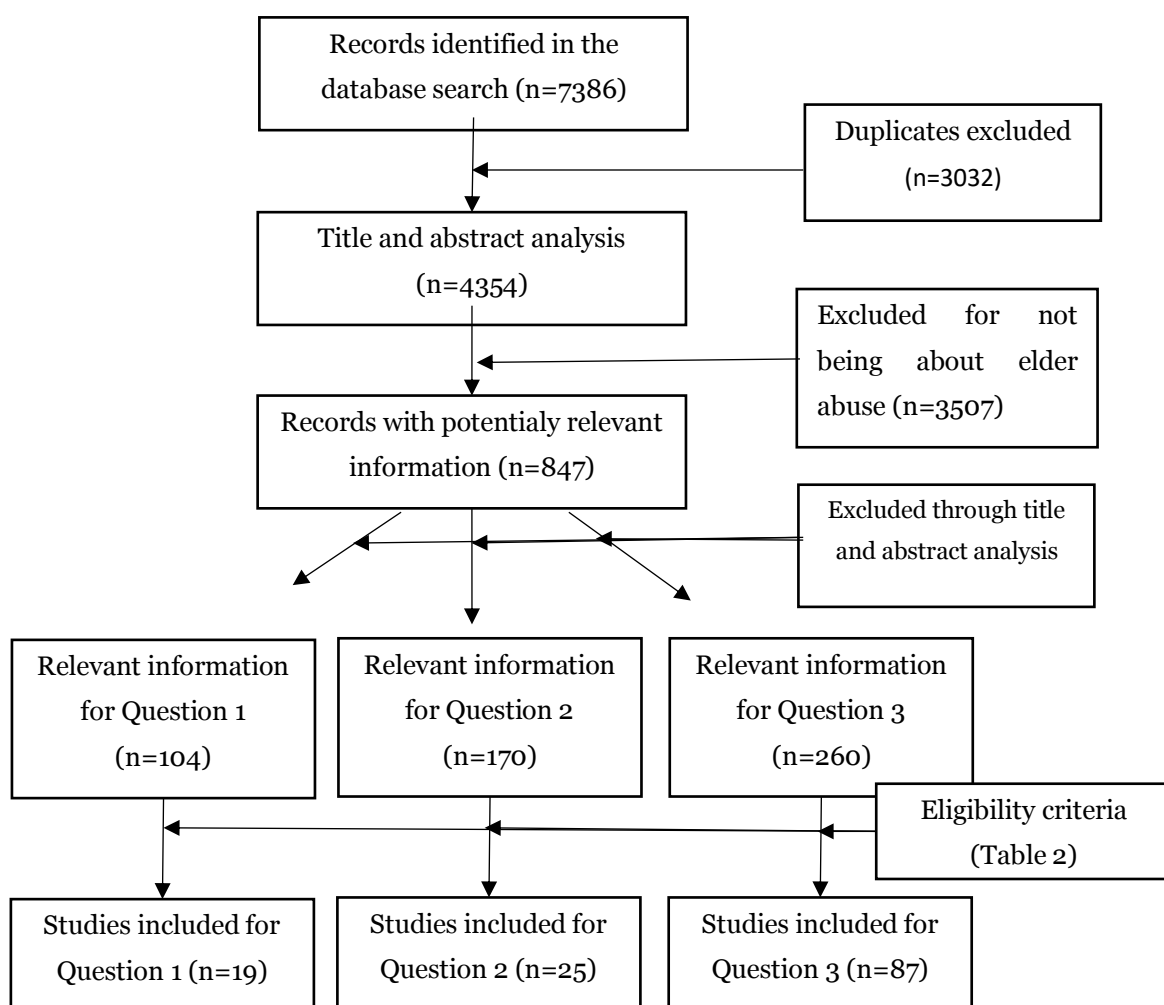
In the case of question 3, only empirical studies describing the screening tools' psychometric characteristics are useful; thus, literature reviews were not included. The reference lists of the literature reviews related to question 3 were reviewed to include additional articles that were not already found in the

database. This step resulted in 104 articles relevant to question 1, 170 articles relevant to question 2, and 260 articles relevant to question 3.

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. To be selected for data extraction, the articles would have to fulfil at least one of the criteria presented in Table 2.

Table 2 - List of specific criteria used for article selection in step 3.

Question	Specific Criteria
Question 1: What arguments can be used in favour or against the screening process?	Present guidelines about the screening process
	Conceptual paper about screening
	Discussions or reviews that describe points in favour or against screening
Question 2: What professionals conduct screening, in what contexts, and how is screening perceived by professionals and older adults?	Present data about professionals who apply screening instruments
	Opinion papers or discussions about the practice of screening
	Papers about the consequences of screening
	Papers about professionals' perceptions/experiences about screening
	Papers about older adults' perceptions/experiences about screening
	Clinical cases where screening was involved
Question 3: What screening instruments are	Validation or adaptation of screening measures
	Research that used screening tools

used, in what countries, and what are their psychometric characteristics?	Psychometric data of screening tools

The application of the specific criteria resulted in 19 articles used for data extraction regarding question 1, 25 articles regarding question 2, and 87 articles regarding question 3.

Data extraction

For each question, the selected articles were independently analyzed by three researchers. First, the researchers collected the more relevant details for each question from a full-text analysis and summarised them in three summary tables. Then, the decision of what details were relevant was conducted by mutual agreement. Finally, the information summarised was used to draw the findings presented in the next section.

3. Findings

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

From the analysis of 19 articles, we cannot definitively decide in favour or against screening older adults for mistreatment. None of the studies we reviewed provided evidence that screening for elder abuse reduces the harm or risk of older adults' premature death, disability, or suffering or addressed possible adverse effects of the screening process. The current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults (Curry *et al.*, 2018).

There are, however, some arguments in favour and against screening, mainly when using specific screening tools.

Arguments in favour

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 (Anetzberger, 2001; Anthony *et al.*, 2009; Cohen, 2011; Baig *et al.*, 2015).

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 (Antezberger, 2008).

Routine and systematic use of tools to screen for abuse has a valuable part in the clinical setting. It provides the framework for at least a primary evaluation of risk in older adults in their encounters with physicians, nurses, social workers, and other health care practitioners (Anthony *et al.*, 2009). Also, direct questioning tools can be administered in less than five minutes, appealing to clinicians working in fast-paced clinical settings (Cohen, 2011; Hoover and Polson, 2014). Studies show that professionals' identification using structured tools elicited abuse rates higher than those found in other prevalence studies (Cohen, 2011).

Risk assessment results can be used to determine the need for more comprehensive assessments, thereby supporting a prudent allocation of resources. Screening and assessment instruments can guide investigations, facilitate case plan development, and inform intervention while supporting resource allocation and education and training needs (Anthony *et al.*, 2009; Baig *et al.*, 2015).

Arguments against

We found arguments against the screening process itself, in general, and some ideas associated with difficulties in using some screening instruments. The available views are the following:

Doing generalized screenings for abuse without known effective remedies and resources or without having a specialized team for follow-up assessment is highly questionable. Physicians, nurses, and other healthcare providers should be educated regarding elder abuse and neglect, specifically regarding individuals at risk, state reporting requirements, and initial response strategies, and this should be coupled with public education. Still, we are not at the point to encourage, let alone mandate, active screening. False-positive results could cause psychological distress to older adults and families and jeopardize the physician-patient relationship (Dong, 2015).

False-negative results may negate the abusive situations and provide false assurance, further increasing older adults' risk for adverse outcomes (Dong, 2015), discouraging clinicians from seeking further history, and preventing recognizing those who are genuinely at risk (Gallione *et al.*, 2017).

False positives can lead to labelling and punitive attitudes, causing psychological distress, and might lead to family tension, loss of personal residence, or financial resources that lead to loss of autonomy for the victim. The debate of whether screening tools are a valid and reliable method of assessing potential elder abuse continues. 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 (Gallione *et al.*, 2017). There is also concern that screening might put older adults at greater risk and more harm toward older adults (Dong, 2015).

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 (Cohen, 2011).

Screening can increase referrals and the workload of social welfare or adult protective services and discomfort and stress for the older person and his family (Cohen, 2011).

Dong (2005) presented the Wilson-Jungner Criteria for Appraising the Validity of a Screening Program and their application to the screening for elder abuse:

1. The condition being screened for should be an important health problem. Given its prevalence, morbidity, increased mortality, and negative effect on the quality of life, elder abuse meets the threshold. (PASS)

2. The natural history of the condition should be well understood. The complexity and multiplicity of variables, including the victim, perpetrator(s), environment, and cultural factors, result in a poorly understood problem. (FAIL)

3. There should be a detectable early stage. Abuse may occur without warning. Early risk factors may not progress to abuse. The time frame for progression from risk factors to abuse is unknown. (FAIL)

4. Treatment at an early stage should be of more benefit than at a later stage. Knowledge of interventions effective at an early stage is not well established and frequently lacking in many communities. (FAIL)

5. A suitable test should be devised for the early stage. Most available screening tests detect established abuse. Tests that identify risk factors lack the ability to predict future abuse and may well result in increased false positives and negatives. (FAIL)

6. The test should be acceptable. Given the multiplicity of sites for screening (e.g., clinics, hospitals), many may feel screening is outside their purview. The brevity of a typical encounter reduces the opportunity for screening questions. (FAIL)

7. Intervals for repeating the test should be determined. Intervals for screening are not well established. Repeated questions may alienate patients or caregivers. (FAIL)

8. Adequate health service provision should be made for the extra clinical workload resulting from screening. There is no financial compensation for the extra time to screen in medical settings and address a positive test's consequences. Most healthcare centres are volume-driven. (FAIL)

9. The physical and psychological risks should be less than the benefits. Physical and psychological risks should be minimal but could disrupt a functioning relationship. (PASS)

10. The costs should be balanced against the benefits. The price of screening should include economic, social, mental, and societal costs. A positive screen may result in an inadequate intervention, allowing the problem to escalate. (FAIL) (Dong, 2015).

Arguments related to the use of screening tools

Given that elder abuse is an issue of great complexity, with multiple representations, and that does not follow a traditional disease trajectory typical of epidemiology, some authors recommend against the use of a specific, single screening tool (Baig *et al.*, 2015).

Some tools require specialized training to be applied appropriately, and there are no clear guidelines as to the nature of that training (Santos and King, 2010; Cohen, 2011).

When we use direct questioning tools, if the MMSE is positive, further assessment should clarify cognitive impairment before screening for abuse. Cognitive deficits may be limited to specific domains, and a patient may retain memory and capacity in others.

The tools can be classified according to the 3-dimensional model of screening for abuse proposed by Cohen (2011): (1) direct questioning for abuse or inviting the older adult to fill a self-report tool for abuse, (2) inspecting for signs of abuse, and (3) evaluating the risk of abuse. A single tool may fall into more than one category. The direct questioning tools are an essential element in screening; although most older persons suffering abuse will not initiate telling someone about their problem, some will admit to being abused when asked directly by a trusted professional. Yet others may continue denying being abused. Another limitation of direct questioning is that it can be applied only with mentally intact individuals. Finally, caution is also needed as false-positive results may be obtained due to family conflicts, feelings of anger and hostility toward family members, and dissatisfaction with familial relationships.

Identification of signs of abuse requires skills in non-threatening and non-judgmental interviewing. Assessment of signs of abuse is often bound up with uncertainty and ambiguity for the practitioner, as signs of abuse in later life are frequently difficult to distinguish from symptoms of illness. Even more

problematic is identifying psychological abuse, which usually shows in psychological outcomes such as apathy, depression, and fearfulness, congruent with the reactions of older people to loss, illness, or cognitive deterioration. In addition, screening for signs of neglect does not allow differentiation between neglect and self-neglect, even though both these types of neglect need immediate intervention. Tools for identifying signs of abuse are also of value in increasing practitioners' awareness and alertness to the various possible signs of abuse.

Risk of Abuse Indicators tools focuses on screening for risk of abuse indicators, even in the absence of evident signs of abuse or when the older person does not report it.

Ideally, the three previous screening modes are needed to optimize the identification of cases of abuse.

The different modes of screening may overlap considerably in their abuse identification, but it has been shown that each method identifies cases not identified by the other two. So the more modes of screening that can be applied, the less ambiguous the choice will be. However, it is recognized that practitioners generally do not have the time, conditions, or skills to perform 3-level screening (Cohen, 2011).

Existing screening and assessment instruments tend to focus on indicators of physical abuse and exploitation that are readily observable and typically rely on the knowledge and judgment of the assessing professional (Anthony *et al.*, 2009). The existing tools and protocols described neither the content of required training nor how agencies assure that training is received (Anthony *et al.*, 2009). None of the screening tools has the qualities that are the key to effective identification and referral of elder abuse:

- A clear distinction between examples of actual abuse, signs of suspected abuse, and factors related to being at risk of elder abuse;
- Specific consideration of domestic violence, in late life, as a component of elder abuse;
- Delineation of appropriate laws and agencies for addressing elder abuse by state and community (Anetzberger, 2001).

No research has probed the sensitivity of screening tools to cultural differences. Therefore, another question that should be raised is the applicability of the screening tools for multicultural groups of older adults (Cohen, 2011).

Screening procedures, uses and limitations

There are, described in the literature, several screening procedures that include screening instruments, mostly used for research purposes and to help and guide the professionals who deal with the problem of elder abuse.

According to Baig and collaborators (2015), the screening protocol must have four components:

1. Decision points;
2. Action steps;
3. Footnotes;
4. Screening tools.

There are some general orientations for procedures or protocols to be effective:

- The screening tools should remain broad and be developed and tested on their ability to detect multiple types of elder mistreatment. The challenge may be to train multidisciplinary professionals to administer and interpret such tools (Gallione et al., 2017).
- Training programs should be provided to convey the professional's knowledge and establish a sense of competence in handling cases of identified or suspected abuse or risk of abuse (Cohen, 2011).
- The basic attitude of practitioners when dealing with older adults and their families should not be one of blame and criticism but of problem-solving and devising the most appropriate solution (Cohen, 2011).
- The professionals should consider how the interview can be conducted to afford the maximum privacy and how it can be structured so that the patient and family members are interviewed separately. The interview and examination of an elderly patient should always be conducted first, away from the caregiver or suspected abuser. The protocol should include basic demographic questions that enable the professional to determine the patient's family composition and socioeconomic status. It should proceed to general questions that give him a sense of the overall well-being of the

older person and then screen for the various types of abuse or neglect (physical, psychological, and financial). The protocol should target common indicators for each type of mistreatment and include specific questions for the patient. Screening and assessment for elder mistreatment should follow a typical pattern (Aravanis *et al.*, 1993).

- Elder abuse protocols should include definitions of elder abuse, family violence, self-determination, risk factors, screening tools, working with diverse groups, and local referral agencies. In addition, they should be embedded in elder abuse training to facilitate awareness and proactive responses to elder abuse (Blundell, Warren and Moir, 2020).

- Elder abuse protocols must be localized to maintain relevance to different areas, including rural and remote communities (Blundell, Warren and Moir, 2020).

- Monitoring and evaluation of elder abuse protocols are needed to understand their efficacy and any issues related to content and use, which is critical if protocols are to remain current and relevant (Blundell, Warren and Moir, 2020).

- Give service providers a referral protocol for using the tools and identify potential sources of help when elder abuse and domestic violence in late life are detected. Formal training related to the tools and protocol (Antezberger, 2008).

There are also some recommendations regarding referral procedures. If there is suspected or confirmed elder abuse, standard referral procedures to appropriate services are critical, and reporting elder abuse in some countries is mandatory (Baig *et al.*, 2015). The referral protocol should be a one-page flow chart that provides an overall framework for problem identification and reporting. It incorporates only the key, basic elements for determining whether a client may be a victim of elder abuse and where clients should be referred for a more in-depth assessment. The protocol begins with the client's input through an initial visit, phone call, in-person contact, or in the context of providing other types of services, such as during emergency room visits or family counselling sessions.

It should be understood that, as with all disease screening tests, the screening process results in the label of "positive" or "negative", but it is not diagnostic and warrants additional testing and assessment before conclusions are drawn (Caldwell, Gilden and Muelle, 2013).

Question 2. What professionals conduct screening, in what contexts, and how do professionals and older adults perceive screening?

Professionals and contexts involved in screening

From the analysis of 25 articles, several professionals were involved in screening processes as first responders, nurses, doctors, dentists, social workers, psychologists, occupational therapists, hospital staff in general, counsellors, law professionals, police, organizations' administrators, ethics experts, nursing homes staff and home care professionals. The contexts were diverse as primary healthcare, emergency settings, general and geriatric hospitals, nursing homes, long-term care, community settings, dental clinics and home care.

How do professionals perceive screening

In the studies that include the professionals' perspectives, they are asked about the advantages and difficulties of the screening process or the use of some specific screening tools. In general, professionals perceive screening as helpful in identifying elder abuse. Still, there are several difficulties presented by different professional groups, most of them related to lack of time to do all they need and lack of knowledge and training on the subject.

The study of Schmeidel *et al.* (2012) interviewed nurses, physicians, and social workers to explore healthcare professionals' perspectives on elder abuse to better understand the problems of reporting and generate ideas for improving the detection and reporting process. Nurses, physicians, and social workers approach elder abuse with different values that they have developed over their years of practice. Physicians were more focused on known diseases or physical conditions that they could treat and with which they were familiar. Both nurses and physicians cited that they had to prioritize what could best fit into the limited time

they had, and most often, elder abuse did not fall at the top of that priority list. In addition, physicians noted that elder abuse is not a problem that can be quickly or cleanly ameliorated. Assessment for elder abuse was a significant practical barrier that many found difficult to overcome with their resources. A lack of time was one of the most commonly mentioned problems; both nurses and physicians felt they had so many other tasks to deal with that there was not enough time to address elder abuse. While the laws surrounding elder abuse try to clarify what constitutes elder abuse and whom the law protects, interpreting and implementing the law in clinical practice proved to be more difficult for most nurses, physicians, and social workers. Another barrier is the internal system of responsibility within a clinic or hospital and the external reporting system to the Department of Human Services. Overall, social workers were the most informed about the detection and reporting of elder abuse, likely because they had all undergone the process of trying to report cases. A few thought that education and awareness of elder abuse could be improved for clinicians. Nurses and physicians were not nearly as comfortable with their knowledge of abuse as social workers (Schmeidel *et al.*, 2012).

According to the study of Swagerty (2003), elder abuse may be missed or not reported, by physicians, because of:

1. Ignorance on the subject (they have little or no specific training in recognizing mistreatment);
2. Ageism or an unfavourable attitude toward older adults;
3. Lack of awareness, as there is little information in the medical literature about the subject;
4. Reluctance to attribute signs of mistreatment;
5. Isolation of the victims or patients not seen often by physicians or health care providers;
6. Subtle, nonspecific presentation, such as poor hygiene or dehydration;
7. Desire to avoid getting involved;
8. Fear of or wish to avoid confrontation
9. Reluctance to report mistreatment that is only suspected;

10. Mistreated person requests that abuse not be reported (patient/physician privilege);
11. Lack of knowledge about proper reporting;
12. Fear of jeopardizing the relationship with the hospital or nursing facility.

The older adults' voice in the screening process

Only one study included the older adults' perspective. It was about how they felt by answering the questions of a screening instrument. The experience of answering REAGERA-S was reported as "mostly positive" by 20% (n = 12) and "neither positive nor negative" by 78% (n = 46). Participating in the interview was reported as "mostly positive" by 39% (n = 23) and "neither positive nor negative" by 58% (n = 34). Older adults reporting abuse were more likely to experience the interview as "mostly positive" than patients classified as not experiencing abuse (Simmons *et al.*, 2020a).

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

From the analysis of 87 articles, we found data and descriptions about 37 screening tools. Of these 37 screening tools, eight tools presented in eight articles were early research versions of screening tools for elder abuse. These tools were unnamed, and the articles presented only early psychometric results. No follow-up studies with these tools were found at the date of the reference collection. Consequently, we considered these eight tools to be only of interest for research. The remaining 29 screening tools (see Annexe I) presented various similarities among them. We classified these tools into four categories according to these similarities. The first category included instruments designed for a quick application, dichotomous answering systems (Yes/No), and used in multiple contexts and by different professionals. We named this category screening tools based on direct questioning. The instruments in the second category require a longer period of time to apply, and rely on observational and professional skills. We named this category screening procedures based on observation or in-depth

assessment. In the third category were included instruments that focus on mistreatment committed by a specific person. These instruments focus on specific relationships and frequently include the evaluation of the alleged abuse. We named this category screening tools that specify the abuser. The fourth category of screening tools consists of tools designed to assess one specific type of abuse. We called this category screening tools for assessing a single form of abuse.

In the following sections, we will describe each of these categories in more detail and the screening tools that fit into them.

a) Screening tools based on direct questioning

In this category, we found eight screening tools, included and tested in 35 articles. Table 3 summarises the main characteristics of these screening tools. As previously mentioned, all of these tools have a yes/no answering system and were designed aiming for a fast application. In addition, these instruments were designed to be applicable in various contexts or were intended for a specific context and later validated to others. Self-answerable versions of these instruments are also common. In terms of length, the shortest tools have six items (EASI and ED Senior AID), and the longest has 22 items (GMS), although the number of items is not a full-proof indicator of application easiness as the complexity of the items vary from screening tool to screening tool.

Table 3 – Characteristics of the screening tools based on direct questioning

Screening Tool	Number of items	Cutoff-point	Relevant psychometric information	Sensitivity/ specificity
Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)	15	4 or more "Yes"	Internal Consistency: Cronbach's Alpha ranged from .29 to .745; Internal structure: three theoretical factors not supported by factor analysis; Score associated with lower quality of life, depression. Positively associated with VASS	Sensitivity and specificity: worst result: 0.643 and 0.907; best result: 0.974 and 0.784. AUC from ROC analysis: 0.884 and 0.938
Elder Abuse Suspicion Index (EASI)	5+1	1 "Yes"	Dependence on ADL, family conflict, depression, anxiety, neurocognitive disorders and malnutrition associated with abuse score.	Sensitivity: 0.47 and specificity 0.75
Vulnerability to Abuse Screening Scale (VASS)	12	1 "Yes"	Internal Consistency: Cronbach's Alpha ranged between .819 and .83; Internal structure: Four factors – dependence, dejection, vulnerability and coercion – found by EFA in 2 studies; Score associated with depression.	Sensitivity of 0.909 and specificity of 0.497

Emergency Department Senior Abuse Identification (ED Senior AID)	6	1 "Yes"	Good inter-rater reliability	Sensitivity: 0.94 and specificity 0.90
Responding to Elder Abuse in GERiAtric care- Self-administered (REAGERA-S)	10	1 "Yes" on questio ns 1 to 9	-	Sensitivity: 0.875 and specificity 0.923
Geriatric Mistreatment Scale (GMS)	22	1 "Yes"	Internal Consistency: Cronbach's Alpha = .83; Associated with depression, low social support, functionality, low socioeconomic status and food insecurity.	-
Korean Elder Abuse Scale	20	-	Internal Consistency: Cronbach's Alpha = .89; Association between score and PTSD	-
Weinberg Center Risk and Abuse Prevention Screen (WC-RAPS)	11	-	Internal structure: two factors – abuse and risk – with adequate fit found by CFA; Internal Consistency: Cronbach's Alpha for the factors was .90 and .82;	-

Of the screening tools found, Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) was the more frequently used, being applied in 17 studies across eight countries (United States of America, Singapore, Brazil, Iran, Bosnia and Herzegovina, India, Turkey, and Australia). The original tool was developed in the USA by Hwalek and Sengstock (1986). The subsequent studies provide validation studies for different populations, translations for other languages, and

additional information regarding the tool's psychometric characteristics. The Vulnerability to Abuse Screening Scale (VASS; Schofield and Mishra, 2003) was the second more frequently cited screening tool, referred to in 6 studies. This instrument was initially designed in Australia in a longitudinal study with women and was based on H-S/EAST. In subsequent studies, it was adapted to be also used with older men and in various contexts. Besides Australia, we found indications of the instrument being used in seven other countries: the USA, Singapore, Turkey, Brazil, Poland, India, and France. The Geriatric Mistreatment Scale (GMS), originally from Mexico (Giraldo-Rodríguez and Rosas-Carrasco, 2013), was cited in 4 studies and has also been used in a study in the USA. The Elder Abuse Suspicion Index (EASI) was developed to be used by medical staff in Canada (Yaffe *et al.*, 2008). Besides the original study, we found two more studies using this measure, one in Portugal and one in Romania, where the measure was applied in other contexts. Though this article was excluded from the systematic review for not presenting psychometric data, there is also a self-administered version of EASI (Yaffe, Weiss and Lithwick, 2012). Then we found the Emergency Department Senior Abuse Identification (ED Senior AID; Platts-Mills *et al.*, 2018), used in two studies in the USA, the Responding to Elder Abuse in GERiAtric care-Self-administered (REAGERA-S; Simmons *et al.*, 2020), used in one study in Sweeden, the Korean Elder Abuse Scale (Choi *et al.*, 2018), used in one study in South Korea and, finally, the Weinberg Center Risk and Abuse Prevention Screen (WC-RAPS; Teresi *et al.*, 2019), used in one study in the USA. Regarding the effectiveness of the tools, we can consider several indicators. Perhaps the most important is the sensitivity and specificity of the measure. Sensitivity, also known as the true positive rate, refers to the percentage of people who screen positive for elder abuse and are actually experiencing abuse. Specificity, or true negative rate, refers to the percentage of people who screen negative for abuse and are not experiencing abuse. The higher these values are, the better the instrument is at correctly identifying abuse. As a general rule of thumb, a screening instrument is considered useful if the sum of sensitivity and specificity is higher than 1.5 (Power, Fell and Wright, 2013); a lower score is

considered to have too many misses, and a score of 2 would mean that the test is perfect and the result is always correct.

Five of the eight screening tools based on direct questioning have presented data about sensitivity and specificity analysis. We found no sensitivity and specificity results for the GMS, the Korean Elder Abuse Scale and the WC-RAPS. Though their psychometric characteristics are promising, it is impossible to fully assess their efficacy without sensitivity and specificity data.

ED Senior AID and REAGERA-S present very high values, indicating a high efficiency in identifying correctly elder abuse. However, few studies are using these instruments, and, therefore, we had access to few psychometric indicators of these instruments. Though these instruments are very promising, more studies are required to understand their effectiveness fully.

Three of the eight instruments presented more extensive psychometric data and sensitivity and specificity analysis. These are H-S/EAST, EASI and VASS. EASI showed in the original study sensitivity and specificity of 0.47 and 0.75 (Yaffe *et al.*, 2008), respectively, that when added equal to 1.22, below the value of the rule of thumb. VASS presented a sensitivity of 0.909 and specificity of 0.497 calculated only for the French version (Grenier *et al.*, 2016). These indicators added equal 1.406, just below the threshold. Finally, H-S/EAST had more than one study regarding sensitivity and specificity. The best results were obtained in the Turkish validation, which presented a sensitivity of 0.974 and a specificity of 0.784 (Özçakar *et al.*, 2017), and the worst result was from a study conducted in the USA (Neale *et al.*, 1991) with a sensitivity of .643 and a specificity of .907. Both the worst and best sensitivity and specificity results are above the 1.5 threshold of adequacy. As such, if we had to rank these three instruments in order of efficacy in detecting elder abuse, the order would be H-S/EAST, VASS, and EASI, keeping in mind that both VASS and EASI are below the adequacy threshold for a screening tool efficiency.

Screening tools based on direct questioning also have some limitations. These instruments rely on the report of older adults, meaning that cognitive deficits make their results unreliable. For their use to be appropriate, it is also necessary to screen for cognitive impairment. Plus, relying on the disclosure of abuse can

decrease the rate of true positives since it is well known that people that experience mistreatment tend to be unwilling to disclose information that might lead to its detection. Another limitation is that these instruments tend to be brief, and not asking about the more frequent details that help identify abuse may leave many cases undetected. Perhaps these two are the reasons why it is challenging to find screening tools based on direct questioning with good sensitivity and specificity. Finally, as previously discussed, this type of instrument tends to be unreliable.

Based on their characteristics, construction, and effectiveness in detecting elder abuse, we can say that these tools are handy when it is only possible to conduct quick evaluations. This type of instrument can be used as the first line of inquiry in a screening process. These instruments are handy from a pedagogical perspective for training professionals to consider screening elder abuse as a systematic and organized task. Training is required to use them correctly, but mainly on general skills (building rapport, listening and communication skills, and so forth), and no profession-specific skills are required. The similarity between instruments means that the skills necessary to use one tool based on direct questioning apply to the use of the others. However, considering that this type of instrument is not very reliable, both positive and negative scores must be interpreted with caution.

b) Screening procedures based on observation or in-depth assessment

Regarding this category, we found nine instruments with information displayed in 18 studies. Table 4 summarises the main characteristics of these instruments. These tools are lengthy and time-consuming and require professional expertise and assessments. Three of these tools could also have been included in the following category (screening tools that specify the abuser) because they also require assessing the alleged abuser. They were, however, included in this category because of the level of expertise and detail necessary for that assessment.

Table 4 – Characteristics of the tools based on observation or in-depth assessment

Screening tool	Number of items	Relevant psychometric information	Sensitivity/ specificity
Client Assessment and Risk Evaluation (CARE)	43	Internal structure: CFA revealed a 5-factor structure – Living conditions; Financial status; Physical and medical status; Mental status; Social interaction/support/ isolation/connectedness; with good fit; Internal Consistency: Construct Reliability of the subscales ranges from .78 to .93	-
Detection Scales for the Risk of Domestic Abuse and Self-Negligent Behavior in Elderly Persons (EDMA)	Older adult scale 33; Alleged abuser 21	Internal Consistency: Cronbach's Alpha of both scales = .93; Internal structure: EFA revealed a three-factor structure in both scales; Older adult scale's dimensions – "abandonment, neglect, and self-neglect", "domestic abuse without self-neglect", "specifically self-neglect".; Alleged abuser scale's dimensions - "inflicted inappropriate treatment or abuse", "restrictive behaviors", "inability to offer proper treatment".;	Sensitivity and specificity: 93.2% and 88%
Elder Assessment Instrument - Reviewed (EAI - R)	51	Associated with HS-EAST score.	-
Elder Assessment Instrument (EAI)	44	88.9% of agreement between two judges	Sensitivity and

			specificity: .71 and .93
Expanded Indicators of Abuse (E-IOA)	45+39	Internal consistency: Cronbach's Alpha ranged from .78 to .96; Internal structure: three-factor structure for the caregiver indicators and four-factor for the older adults's indicators; Associated with a measure of disclosure of abuse and a measure of signs of abuse.	From ROC Analysis: ≥2.7 Sensitivity = 0.929, Specificity = 0.979; AUC from ROC analysis: 0.92;
Indicators of Abuse (IOA)	27	Internal consistency: Cronbach's Alpha = .94; Internal structure: one study finds this screening tool to be unifactorial, but other finds a two-factor solution (risk indicators of the caregiver and risk indicators of the older adult)	≥16 Sensitivity = 0.94, Specificity = 0.85
QUALCARE	56	Interrater reliability: 65% in pilot test; Internal Consistency: Cronbach's Alpha = .97; Internal structure: EFA and CFA showed a 3 factor structure: Environmental subscale; physical subscale and Psychological subscale; Associated with mental status, ADL, burden and stressful life events.	clinically significant EA/N at mean subscale scores ≥ 3.5 Calculated for each subscale: high sensitivity (0.811 to 0.977) but a wide range for specificity (0.167–1.000)

Risk on Elder Abuse and Mistreatment Instrument (REAMI) 22	three factors: risk factors of the older person, risk factors of the environment/ possible perpetrator and signals of elder abuse, with good fit and internal consistency	-
Signs of abuse inventory 34	Internal Consistency: Cronbach's Alpha from subscales ranged from .67 to .91; Associated with the presence of indicators of abuse (risk measure).	-

The tool based on observation or in-depth assessment more frequently referred to in the analysed papers was the Expanded Indicators of Abuse (E-IOA; Cohen *et al.*, 2006), mentioned in four studies conducted in Israel. The E-IOA is a larger version of the Indicators of Abuse (IOA), developed in Canada by Reis and Nahmiash (1998) and also part of our list, alongside its Spanish version (Touza, Martínez-Arias and Prado, 2018). The IOA and E-IOA are instruments based on detecting risk factors for elder abuse and assessing both risk factors of the caregiver and older adult. These instruments were designed to be applied by social services and healthcare professionals while performing a psychosocial assessment. The E-IOA differs from IOA for being adapted to a semi-structured interview style. Additionally, some items were excluded due to cultural differences, and others were expanded to include sub-indicators of abuse.

Then we have QUALCARE (Linda R. Phillips, Morrison and Chae, 1990), a tool based on the detection of risk factors for elder abuse, mentioned in three studies conducted in the USA, where the instrument was developed. QUALCARE was designed to assess the quality of care provided by caregivers, approaching abuse as closely associated with low-quality care (Pickering *et al.*, 2017). This instrument relies on observation and physical examinations, incorporated in the daily practice of trained professional nurses.

The Signs of Abuse Inventory is mentioned in three studies conducted in Israel, where the tool was developed based on previous instruments (Cohen *et al.*, 2006). As the name indicates, this tool focuses on detecting signs of abuse, explicitly employing an interview and physical evaluation conducted by trained social workers and nurses. Then we have the Elder Abuse Instrument (EAI; Fulmer *et al.*, 2000), mentioned in two studies, and the revised version of EAI noted in one study (Fulmer *et al.*, 2012). The studies involving these instruments were conducted in the USA. Both tools rely upon detecting signs of abuse based on observation by trained professionals, specifically primary care providers, emergency department nurses, and adult protective services investigators. The difference between EAI and the revised version is the inclusion of extra items.

The Client Assessment and Risk Evaluation (CARE) instrument is mentioned in one study conducted in the USA (Burnett *et al.*, 2014). It is a risk assessment instrument designed for professionals working in adult protection services and relies both on observation and a professional assessment.

The Detection Scales for the Risk of Domestic Abuse and Self-Negligent Behavior in Elderly Persons (EDMA) was developed in Spain by Touza, Prado and Segura (2012). This instrument bases its assessment process on questions of disclosure of abuse, risk factors and signs of abuse. The application of this instrument implies the assessment of the older adult and the alleged abuser. Assessment is conducted by direct questioning and observation by social services professionals. The last tool we found was the Risk on Elder Abuse and Mistreatment Instrument (REAMI), mentioned in one study. This tool was developed in Belgium (De Donder *et al.*, 2018) and it was designed to be applied by healthcare and social workers based on the professional assessment made of their knowledge of the cases they follow. The instrument items are mostly based on the assessment of risk factors but also consider some signs of abuse.

Regarding the effectiveness of these instruments in detecting elder abuse, we have to consider not only sensitivity and specificity but, since these tools rely on observational and professional skills, also the agreement between observers. Unfortunately, we found no results regarding observer agreement or sensitivity/specificity regarding CARE, EAI-R, REAMI, and the Signs of Abuse

Inventory. Thus, though the general psychometric characteristics of these instruments look adequate, more information is necessary to consider their efficacy in detecting elder abuse.

The QUALCARE tool presented a full scale interrater reliability of 0.65, below the point of 0.70, the value the authors considered a good criterion (Linda R Phillips, Morrison and Chae, 1990). The available sensitivity and specificity results were not calculated for the full scale but for each subscale (Pickering *et al.*, 2017). While the subscales sensitivity ranged between high values (0.811 to 0.977), there was too much variation in specificity (0.167–1.000) to really understand the efficacy of this tool.

Four other tools presented sensitivity and specificity results for the total scale. All were above the rule-of-thumb for screening tools' usefulness (Power, Fell and Wright, 2013). The best result was found for E-IOA, using a cutoff point of 2.7 indicators, presenting a sensitivity of 0.929 and a specificity of 0.979 (Cohen *et al.*, 2006). These results are better than those found using the IOA, which presented a sensitivity of 0.94 and a specificity of 0.85 but used a more significant cutoff point of 16 (Touza, Martínez-Arias and Prado, 2018). The different results between these similar instruments might be due to cultural differences since the IOA data was collected in Spain while the E-IOA data was collected in Israel. The EDMA tool, also developed in Spain (Touza, Prado and Segura, 2012), presented excellent sensitivity and specificity values (0.932 and 0.88), but as these values were reported in only one study, it would be helpful to determine the accuracy of these results.

Lastly, sensitivity and specificity values of EAI (0.71 and 0.93) were not as good as the other instruments but presented high interrater agreement (88.9%), which is a good indicator for a tool based on observation (Fulmer *et al.*, 2000). In summary, instruments based on observation or in-depth assessment seem to be very accurate in detecting elder abuse. However, they seem to be particularly influenced by different cultural contexts. Also, not enough information about the interrater agreement is available, an indicator that is crucial to assess instruments based on observation or professional judgements.

Although instruments based on observation or in-depth assessment seem to be remarkably accurate, they have some limitations. One of the main downsides of using these procedures is that they require a considerable amount of time to be adequately applied. Some of them are recommended to be applied in more than one session due to their length (e.g. QUALCARE). Moreover, this form of procedure requires much more extensive training than any other form. Some of the necessary skills to use these procedures are frequently profession-specific. For example, some instruments might need a physical examination and not all professional classes that apply screening are prepared to do that kind of examination. Plus, these assessment forms require profound case knowledge and are not compatible with many settings where contact between the professional and the older adult is limited. It should also be considered that these detailed assessments are more permeable to cultural influences, as we noted in some of the results. That means that all of these procedures must be adequately adapted and tested before using any specific population.

There are also some positive aspects in the use of screening procedures based on observation or in-depth assessment. The efficacy of these instruments in detecting elder abuse is higher than any other type of instrument. That means that screening with this type of instrument allows for a better allocation of resources in the post-screening period. Also, as they rely primarily on professional observations and judgments, some of the few tools can be used with older adults with cognitive impairment. Before deciding to use this type of instrument, it is necessary to carefully weigh the cost-benefits of using this accurate yet time-consuming procedure, based on the resources available.

c) Screening tools that specify the abuser

We found six instruments that could be classified as tools that specify the abuser. However, four of these demand observation or detailed professional assessments and fit better for the previous category. They were the IOA, the E-IOA, QUALCARE, and EDMA. As a result, in this category, we will only include the remaining two instruments whose primary focus was on abuse in specific relationships, namely caregivers and family members of older adults. These two

instruments were mentioned in seven different studies. In Table 5, we have summarised the main characteristics of these instruments

Table 5 – Characteristics of screening tools that specify the abuser

Screening tool	Number of items	Relevant psychometric information	Sensitivity/ specificity
Caregiver Abuse Screen (CASE)	8	Internal Consistency: Cronbach's Alpha ranges from .68 to .86; Internal structure: 1 study showed adequate fit for a unidimensional solution, while others supported a two-factor solution; Associated with IOA, HS-EAST, CTS, caregiver burden, depression, coping, low social support and Alzheimer's disease-related behavioural disturbances.	-
Family Members Mistreatment of Older Adults Screening Questionnaire (FAMOASQ)	15	Internal Consistency: Cronbach's Alpha = .89; Internal structure: Results from EFA load all 15 items in 1 factor, but 8 factors are presented.	Sensitivity of 86% and specificity of 90%; AUC 0.93

Of these two screening tools, CASE was mentioned in six studies and FAMOASQ in one.

CASE was developed in Canada (Reis and Nahmiash, 1995), and it has been used in China, Italy, Brazil, and Iran. CASE is composed of 8 yes/no direct questions to a caregiver aiming to disclose abusive situations. It has been tested with both professional and non-professional caregivers. As the questions are asked to one caregiver, it can only assess the abuse perpetrated by that person.

FAMOASQ was developed in Mexico (Ruelas-González *et al.*, 2018) to be used in primary care settings to interview and assess abuse perpetrated by older adult family members. The questions are directed at the older adult and not the family members. This instrument focuses on the assessment of risk factors with 15 yes or no questions.

Regarding the effectiveness of these measures in detecting elder abuse, CASE has no studies with sensitivity and specificity analysis. However, the available psychometric information is promising, showing associations with several other instruments to assess elder abuse. FAMOASQ shows good sensitivity and specificity, but there is not enough information about its psychometric characteristics

This type of instrument has several limitations. First, it has a considerably narrow scope, only assessing abuse from a restricted number of perpetrators. Second, and specifically with the instrument CASE, the method of inquiry is based on the disclosure of abuse by the person who commits it. It stands to reason that many persons will deliberately hide information and provide false answers in this situation unless their responses are collected within a caring and empathic relationship.

Nevertheless, these instruments might be helpful under certain conditions, for instance, when there is a clear suspicion of the perpetrator of abuse. Also, these instruments may be beneficial if used together with other forms of inquiry, allowing the collection of information from multiple sources.

d) Screening tools for assessing a single form of abuse

In this review, we found ten instruments that assess only one form of abuse. Of these, four assessed psychological/emotional abuse, one assessed neglect, two assessed self-neglect, one assessed both neglect and self-neglect, and two assessed financial exploitation. No instruments were found for the assessment of physical or sexual abuse. These instruments varied considerably in length, method of inquiry, and need for professional evaluation, but their common feature is focusing on particular forms of abuse. In Table 6, we summarize the main characteristics of these tools.

Table 6 – Characteristics of screening tools for assessing a single form of abuse

Screening tool	Number of items	Relevant psychometric information	Sensitivity/ specificity
Psychological/Emotional Abuse			
Caregiver Psychological Elder Abuse Behavior Scale (CPEAB)	20	Internal consistency: Cronbach's alpha =.85; Positively associated with burden	-
Elders' Psychological Abuse Scale (EPAS)	32	Internal Consistency: K-R20 =.82; Test-retest agreement ranged from 79% to 100%; Psychological abuse was associated with cognitive impairment and physical impairment.	-
Older Adult Psychological Abuse Measure (OAPAM)	31	Internal Consistency: Cronbach's alpha =.87;	-
Perceived Emotional Abuse Scale for Adults (PEASA)	61	Internal Consistency: Cronbach's alpha =.95;	-
Financial Exploitation			
Financial Exploitation Vulnerability Scale (FEVS)	9	Internal Consistency: Cronbach's alpha =.85; Internal structure: EFA+CFA indicated a unifactorial structure, but with low model fit; score related with poor performance in executive function, reading difficulties and lower education.	Sensitivity = 0.75, Specificity = 0.70; AUC from ROC analysis: 0.82
Older Adult Financial Exploitation Measure (OAFEM)	3 versions: 79 items; 54 items	Internal consistency: Rasch person reliability = .92; Internal structure: Unidimensional;	-

	and items	30	Score associated with low numeracy	
Neglect and Self-neglect			
Signs of neglect inventory	12	Internal consistency: Cronbach's alpha for the factors = .82; Associated with caregiver burden, lower educational level, lower socioeconomic status, incontinence and higher frailty.	
Self-Reported Neglect Scale (SRNS)	12	Internal structure: EFA and CFA indicates a two-factor structure (basic needs and Psychological needs) with good fit; Internal consistency: Cronbach's alpha for the factors = .81 and .91; Positively correlated with VASS, GMS (neglect), and depression	-
Self-Neglect Severity Scale (SSS)	37	High interrater reliability	0.86 and 0.53
Vulnerability Risk Index of Self-Neglect	18	-	AUC from ROC analysis: 0.76

Four instruments were found to assess psychological and emotional abuse. Each tool was mentioned in one study. CPEAB (Wang, Lin and Lee, 2006) and EPAS (Wang, Tseng and Chen, 2007) were both developed in Taiwan, focusing on psychological abuse committed by caregivers. CPEAB is a self-report measure based on the disclosure of abuse, but EPAS is more extensive, requires observation for signs of abuse, and inquiring both older adults and caregivers for disclosure of abuse. OAPAM was developed in the USA (Conrad *et al.*, 2011) to be used as a support tool for adult protective services who based their questioning on looking for disclosure of abuse and signs of psychological abuse. PEASA was developed in Turkey (Aslan and Erci, 2020) and is a direct questioning-based tool. None of these instruments presented sensitivity/specificity analysis, and all

of them showed limited psychometric information. These instruments were used in a few studies, so there is not enough information about their effectiveness in detecting psychological abuse.

Two instruments regarding the assessment of financial exploitations were found. FEVS is a short-form risk assessment tool developed in the USA (Campbell and Lichtenberg, 2020). OAFEM was mentioned in three studies, two conducted in the USA and one in Ireland. This instrument has three forms of varying length and aims to disclose abuse and assess risk and signs of abuse. This instrument was constructed to support adult protective services (Conrad *et al.*, 2010). Regarding efficacy in detecting financial exploitation, only FEVS reports sensitivity and specificity analysis, and the values are below the rules-of-thumb for adequacy. OAFEM reports a variety of psychometric indicators, but there is no information regarding the measure's ability to detect financial exploitation.

We found four instruments regarding neglect and self-neglect, each mentioned in one study. The Signs of Neglect Inventory (Cohen, 2008) was developed in Israel and focused exclusively on neglect. This tool was set to be managed by nurses and social workers to look for signs of neglect via direct questioning and a physical examination.

The SRNS is a self-report instrument designed in Poland that inquires older adults, aiming to disclose both neglect and self-neglect (Zawisza *et al.*, 2020). The SSS (Kelly *et al.*, 2008) and the Vulnerability Risk Index of Self-Neglect (Wang *et al.*, 2020) were developed in the USA, and both assess exclusively self-neglect. Both instruments rely on observation, but the SSS is used by adult protective services to determine the risk of self-neglect, and the Vulnerability Risk Index of Self-Neglect is used by healthcare workers to identify signs of self-neglect. Regarding the effectiveness of these instruments, only SSS and the Vulnerability Risk Index of Self-Neglect conducted sensitivity/specificity analysis. However, for SSS, the values are low, and for the Vulnerability Risk Index of Self-Neglect, the values are not presented. Although the other instruments present promising psychometric characteristics, more studies are necessary to determine if these instruments are efficacious in detecting neglect and self-neglect.

Screening tools that assess only one form of abuse have several limitations. First, and more prominent, their assessment of elder abuse is limited to a single representation of abuse. Second, there are no instruments to assess physical and sexual abuse. This means that if an assessment by type were intended, there would not be instruments to determine two types of abuse. Third, of the analysed instruments, none seems to be exceptionally reliable. And fourth, the instruments vary significantly in the assessment method and extension; as such, using more than one would pose considerable organizational problems.

Despite these limitations, there might be situations where these instruments can be helpful. In cases where it is known that the older adult experiences one specific form of abuse, one of these instruments can be used to assess the case routinely and track changes. The instruments regarding financial exploitation can be beneficial since this form of abuse is sometimes difficult to detect, particularly in healthcare settings. All things considered, screening tools that assess a single form of abuse can have their uses but have limited usefulness for screening purposes.

Characterising the use of screening tools and procedures in the partner countries

To understand how screening and screening tools are used in the partner countries of project SAVE, the representatives of each country answered a set of questions regarding their national situation concerning screening processes, the use of screening tools, and the intervenients in the screening procedure. Information was gathered based on reviewing published scientific papers, consulting official national documentation/procedures, consulting documentation/guiding principles from professional associations, consulting professionals in the field and their professional knowledge.

Screening process:

Are there screening procedures currently in use?

As far as we were able to determine, there are no screening procedures currently in use in Italy, Cyprus, and Portugal. In Portugal, there are some research

initiatives and some previous initiatives related to the SAFE Project. APAV, the leading governmental organization for victim protection, does risk assessment for various age groups, including older adults. But there is no information about what measures are used.

In Poland, some cities have their one screening procedures using tools as the Geriatric Mistreatment Scale (GMS), The Self-Reported Neglect Scale (SRNS), and Vulnerability to Abuse Screening Scale (VASS), and they have the *Blue Card procedure* for general violence. In Finland, the screening instruments are not specialized for elder abuse, but there is a domestic violence inquiry and assessment form that includes the following routine questions:

Have you ever experienced physical, psychological, or sexual violence or abuse in any of your intimate relationships?

Does the violence you experienced still affect your health, well-being, or life management?

Is there any physical, psychological or sexual violence or abuse in your current intimate relationships?

If the client/patient answers "yes" to Questions 2 and 3, the interview continues with detailed assessment questions. The Domestic violence inquiry and assessment form also includes the client's own assessment of how much she/he thinks violence affects her/his current health, well-being, and safety. Finally, the professional makes her/his own assessment of the situation and where the client/patient should be referred to.

Are there any standard criteria recommended to trigger the screening process? Or is every older adult screened?

There are no recommended standard criteria triggering the screening process in Portugal, Italy, Cyprus, Finland, and Poland. In Finland, the National Institute for Health and Welfare recommends the systematic use of the Domestic violence inquiry and assessment form in social and health care services, including elderly care.

In what health/social contexts are these procedures applied?

None of the partner countries does systematic screening for elder abuse. In Poland, the Blue Card procedure is initiated when a professional, during his/her

duties, has suspicions of violence against a person due to a report made by a family member or by a witness/subject of abuse.

In Cyprus, assessment after complaint or report is conducted in clinical settings, homes, daycare settings, and emergency departments.

In Finland, the domestic violence inquiry and assessment form (THL) is applied nationally in maternity and child health clinics that are part of the public health centres.

What type of professionals conduct screening?

In all countries, health and social professionals may conduct screening.

Do they have any specific training on the screening process for abuse of older adults?

There is no specific and systematic training on the screening process for abuse of older adults in any country.

Do they use standardized instruments (screening tools)?

In Poland, in the Blue Card procedure, the instruments are defined in the Regulation of the Council of Ministers of 13 September 2011 on the "Blue Card" procedure and "Blue Card" forms. The standardized tools used are the GMS and VASS. No other country uses, officially, standardized instruments.

Are they validated for the country?

In Poland, VASS is validated for the country. In Portugal, QEEA (Questions to elicit elder abuse), EASI, VASS, and HS-EAST have indicators of validity.

Screening recommendations:

Are there any thoughts or ideas advanced by health or social services about screening for abuse in older persons?

In general, the health and social services recommendations are for suspected cases, not for mass screening, but there are some initiatives:

In Poland, in the case of the Blue Card procedure, the recommendations are for the systematic collection of data, involvement of services and activities, educational activities aimed at society, a more individualized approach to matters, and informing victims of violence about the Blue Card procedure.

In Finland, the EASI screening tool (Yaffe *et al.,* 2008) was translated into Finnish by the specialized medical team of Malmi hospital in December 2017

according to the protocol given by the instrument's author. This instrument was piloted in the Malmi hospital emergency department on 15-21 January 2018 and 4-17 June 2018. Before piloting, the medical expert team did a one-month follow-up of the Medical Examination Protocol of Battered Patient (PAKE) in the emergency unit to see how often the PAKE protocol was used with older patients. The result was that only one 61-year-old patient came to the emergency room for being assaulted by his grandson. The team concluded that older persons who are victims of domestic violence are rarely recognized in emergency rooms. Therefore it was decided to use EASI for screening purposes. It was agreed that EASI would be used to ask persons of 75 or older, who seemed competent, and who came to the emergency unit. Emergency and short-term units staff were trained for the first pilot (15-21 January 2018). For the second pilot (4-17 June 2018), the staff was trained by an expert on intimate partner violence (Sirkka Perttu). In total, 39 professionals were trained to use EASI. Twenty-six EASI forms were completed in the two pilots. Five patients reported suffering from at least one of the forms of violence mentioned on the instrument, namely, threats and physical and sexual violence. Two patients (older women) refused to answer the questions; one of them was escorted by her adult son, and the other admitted to being a victim but refused to talk about violence and did not want any help either. A total of ten professionals from emergency services completed feedback questionnaires. They reported that violence is a sensitive issue for the patients; many of them refused to answer. The experiences of professionals varied: "it took a surprisingly long time to use the form", "very delicate issue for the patients", "very much needed to ask", "patients did not want to answer".

Who decides if screening will take place? Are there guidelines?

In Poland, the Blue Card procedure may be initiated by representatives of social services, police, education, health care units, or members of the alcohol problem-solving commission. Suspicion of violence in the family is sufficient to initiate the procedure. In the case of systemic screening, the decision lies in the hands of healthcare entities' and social care institutions' management. If they represent the public sector, a local government's board or a regional welfare policy centre's approval may be sought.

In Cyprus, there are no guidelines on screening, but they are subjected to the regulations of each service or setting whether assessment for abuse should be done.

In Finland, the decision can be made by local/regional medical and nursing directors of hospitals or health centres in public and private services. Social and health care can also decide to screen (as implemented in 2004, when the ministry decided to use screening instruments in maternity and child health clinics). There are official screening instructions for the screening tool currently in use.

In Italy, there are no guidelines, but there is a recommendation for risk triage (which includes elder abuse) to all older adults over 75 years that are admitted into the emergency services (Mussi, Pinelli and Annoni, 2008).

In Portugal, there are no guidelines, but the decision can be made by local/regional institutions' clinical councils.

What results or consequences are attributed to the screening process?

From the EASI piloting in Malmi hospital in Finland, it was learnt that:

there has to be practical information on screening: how will it be done, who will use the screening questionnaire (all staff or only some part of the staff, e.g. registered nurses or practical nurses, doctors)

where the information will be spread – in the meetings, training, some other way in each unit, there should be a responsible person who takes care of the practical issues for implementation: regularly reminds about screening, collects completed questionnaires, etc.

the training for the use of screening instruments has to be as practical as possible: role-playing, how to ask and discuss with the patient/client etc.

Screening and professional obligations:

Is there any professional training in your country that states that screening for abuse should be done to all older adults?

No, there is not.

Is there any professional training in your country that identifies criteria/signs/symptoms that make the screening for abuse advisable?

In Poland, the services involved in the Blue Card procedure have training about the procedure, but the training is general, about the abuse, not about elder abuse,

which makes a big difference. The Team of the Association for Counteracting Domestic Violence "Blue Line" also provides training. The training concerns organization of activities and work of an interdisciplinary team, starting work in interdisciplinary teams based on the Blue Cards procedure, working with people who experience violence, working with people using violence (intervention and help), sexual violence against adults. The complete training offer is on the website http://www.niebieskalinia.org/oferta-szkolen-na-zamowienie

In Cyprus, sessions presented occasionally in conferences about elder abuse are only for attendees and not for all staff employees. In the context of continuing nursing education, some seminars are organized on domestic violence in general and on the abuse of the elderly in particular. The Community Nursing Committee of the Cyprus Nurses and Midwifery Association has organized seminars and workshops for Domestic Violence and Elder Abuse. These educational events aimed to raise awareness of health care professionals, mainly nurses, midwives, and health visitors, about elder abuse, early identification and intervention.

There is no specific screening training in Finland, but social and healthcare professionals in Helsinki receive training (not systematic) on how to identify abuse and how to follow-up cases. Also, professionals in Eastern Finland receive training (not systematic) on how to identify abuse.

In Portugal, primary healthcare elder protection committees have training in elder abuse that they should disseminate to their teams, and The Victim Support Association (APAV) also provides training to raise awareness about elder abuse in society.

Are any professionals obligated to screen?

In Poland, Portugal, Cyprus and Italy, there is no obligation to screen.

In Finland, only public health nurses in maternity and child health clinics are obligated to screen.

When screened positive, is there any legal obligation to report?

In Italy, a legal obligation to report exists for healthcare professionals and civil servants anytime they become aware of a crime that can be prosecuted *ex officio*.

In Poland, filling in the Blue Card is not equal to submitting a notification of a crime. It does not constitute grounds for initiating criminal proceedings. If the

notification is submitted and proceedings are initiated, it may be used as evidence. The "Blue Cards" documentation informs the police that there is violence in a given family. The district officer is obliged to contact the family in question no later than within seven days. The district officer has to recognise the situation and monitor it systematically and provide assistance during monthly visits. In the case of public institutions (e.g. schools, offices), we are dealing with an absolute obligation to notify about the commission of a crime. The notification of a violent crime is required by Art. 12 sec. 1 and 2 of the Act of July 29, 2005, on Counteracting Domestic Violence: "Persons who, in connection with the performance of their official or professional duties, suspect that an ex officio crime involving domestic violence has been committed, shall immediately notify the Police or the prosecutor of this fact.". The obligation to report crimes prosecuted ex officio is mentioned in Art. 304 § 2 of the Code of Criminal Procedure: *"state and local government institutions which have a reasonable suspicion of committing an offense prosecuted ex officio, in a situation posing a direct threat to human health and life, are obliged to immediately notify the prosecutor or the Police about it, and take the necessary steps until the arrival an authority established to prosecute crimes or until the authority issues an appropriate order to prevent the obliteration of traces and evidence of an offense."*

In Cyprus, no screening is conducted but, the Attorney General's Office is particularly sensitive to the handling of domestic violence cases. By official letter of the Attorney General, file no. 50 (C) /1992/N.42 and date: 11.6.1998 to all state officials and employees: "every state official/employee, such as Welfare Officer, Police Officer, Doctor, Psychiatrist, Psychologist, Professor, Teacher, Health Visitor when it comes to his perception a case of violence or possible domestic violence is obliged to report to the General Office within 7 days."

In Finland, it is compulsory to report to the social care authorities.

In Portugal, report suspicion is not equal to submitting a notification of a crime. Therefore, it does not constitute grounds for initiating criminal proceedings. However, if the information is presented, after a more detailed evaluation, criminal proceedings may start, and be used as evidence for law enforcement.

What are the links or relationships between the informed technical decision to screen for abuse and the legal system in your country?

Except for mandatory reporting covered in the previous topic, there seems to be no connection between screening and the legal system.

When screened positive, is there any follow-up?

In Poland, the interdisciplinary team (Blue Card Procedure) monitors the situation per the support action plan agreed with the victim.

In Finland, follow-up is compulsory for social workers.

In Portugal, the primary healthcare elder protection committees and APAV follow-up on the reported cases.

What kind of follow-up?

In Poland, for organizational units of social assistance, the follow-up activities include:

Social work, including regular visits to the community, informing about the conditions of using cash benefits from social service, an indication of the possibility of using psychological, legal and counselling assistance - medical, professional and family, referring a person suspected of being affected by domestic violence to a facility for victims of domestic violence, in particular to a specialized victim support centre domestic violence, referring children to care and educational day support facility (e.g. after-school club educational focus), notification of the family and guardianship court about the situation of children.

For the Municipal Committee for Resolving Alcohol Problems: referral to participate in support groups for co-addicts, informing about legal possibilities regarding the obligation to surrender the person to whom there is a suspicion that he is using domestic violence to undergo drug addiction treatment, referral to participate in a therapeutic group, referral to participate in a self-help group.

For the Police: systematic visits to check the safety of a person suspected of being affected by domestic violence, inform the person alleged to be affected by domestic violence that physical and psychological abuse is a crime and outline aspects of criminal liability, informing about the possibility of conducting a medical examination, initiation of preparatory proceedings, requesting the prosecutor to apply appropriate preventive measures.

For Education: providing a child/children from a family with cases of abuse with psychological and pedagogical help in a kindergarten, school, or other institution, respectively in the form of therapeutic class, aptitude-building activities, didactic and compensatory classes, specialist classes: corrective and compensatory, speech therapy, socio-therapeutic and other therapeutic activities, classes related to the choice of education and profession, as well as education and career planning vocational - in the case of middle school and high school students, advice and consultation, providing parents/guardians with psychological and pedagogical assistance in the form of advice, talks, workshops or training, material assistance and its type: vacation, food, school scholarship, school allowance, speak at a psychological and pedagogical clinic, including a specialist clinic, referral to therapeutic help, notification of the family and guardianship court about the child's situation, informing the parent/guardian about the possibility of obtaining assistance offered by care and educational institutions of day support.

For the healthcare services: referring a person suspected of being affected by domestic violence to a doctor with an indication of further possible medical consultations, guiding a person suspected of being affected by domestic violence for psychiatric consultations, referring a person suspected of being affected by domestic violence to a doctor to obtain a medical certificate stating if the causes and type of bodily injuries are related to domestic violence.

In Finland, by home visits or social/health care appointments. Also, documentation is compulsory.

In Portugal, by home visits or social care appointments.

4. 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. In this systematic review, we aimed to 1) understand the pros and cons of screening procedures, 2) understand the perception professionals and older adults have about screening, and 3) systemize the existing screening tools.

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 (Antezberger, 2008). Some points discourage the use of screening, mainly arising from knowledge gaps about the process. Screening's possible negative effects have been identified (Cohen, 2011; Dong, 2015; Gallione *et al.*, 2017), but their frequency is unknown. 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 (Gallione *et al.*, 2017). 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 a considerable variability of instruments available for use in the practice setting (see Annexe I). As exposed in the findings section, 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) to train professionals of multiple fields to administer and interpret such tools and verify that all the next procedures are guaranteed.

The SAVE project aims to develop a training curriculum about elder abuse screening, directed to social and healthcare professionals, thus helping with the second challenge.

There is also an urgent need for more research to know the consequences and even possible dangers that screening can uncover. Such information is essential to develop guidelines about screening, which is also an objective of the current project.

Although the possible negative effects of screening have not been sufficiently studied, the characteristics of the instruments alone, particularly their low effectiveness in detecting abuse and their application time, suggest that the decision to screen must be carefully pondered. Based on the lack of knowledge about potential adverse effects of screening and the characteristics of the tools currently available, the mass application of a specific screening tool cannot be recommended, a conclusion that has been reached before (Wang *et al.*, 2015). Making the balance of potential risks, benefits and instrument limitations, it is probable that selective screening of risk groups, another modality of screening (Speechley *et al.*, 2017), could be more beneficial, but even for that, we have no conclusive evidence (Wang *et al.*, 2015). In health care settings, screening should, perhaps, be targeted to those at higher risk of suffering from mistreatment. There is enough research informing about what groups are at higher risk. Even the adoption of selective screening is not without its challenges. Criteria for inclusion must be scientifically-informed and precise in order to avoid stigmatizing specific groups or placing them at a higher risk than before. Criteria can also be broad or narrow, depending on the availability of resources (e.g., trained professionals, time). It is, nevertheless, important to remember that the screening process is not diagnostic and will require additional assessment before conclusions are drawn. Lastly, it is important to note that 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.

References

Action on Elder Abuse (1995) "New definition of abuse." London: Action on Elder Abuse Bulletin.

American Psychological Association (2012) "Elder Abuse and Neglect: In Search of Solutions." Washington D.C.: APA.

Anetzberger, G. J. (1998) "Psychological abuse and neglect: A cross-cultural concern to older Americans," in Prevratil, J. F. and Tatara, T. (eds.) *Understanding and Combating Elder Abuse in Minority Communities*. Long Beach, CA: Archstone Foundation, pp. 141–151.

Anetzberger, G. J. G. J. (2001) "Elder abuse identification and referral: The importance of screening tools and referral protocols," *Journal of Elder Abuse and Neglect*, 13(2), pp. 3–22. doi: 10.1300/J084v13n02_02.

Anthony, E. K. E. K. *et al.* (2009) "Assessing elder mistreatment: Instrument development and implications for adult protective services," *Journal of Gerontological Social Work*, 52(8), pp. 815–836. doi: 10.1080/01634370902918597.

Aravanis, S. C. *et al.* (1993) "Diagnostic and Treatment Guidelines on Elder Abuse and Neglect," *Archives of Family Medicine*, 2(4), pp. 371–388. doi: 10.1001/archfami.2.4.371.

Aslan, H. and Erci, B. (2020) "The incidence and influencing factors of elder abuse and neglect," *Journal of Public Health (Germany)*, 28(5), pp. 525–533. doi: 10.1007/s10389-019-01071-7.

Badenes-Ribera, L., Fabris, M. A. and Longobardi, C. (2021) "Elder Mistreatment in an Italian Population: Prevalence and Correlates," *The International Journal of Aging and Human Development*, 92(1), pp. 83–99. doi: 10.1177/0091415019875454.

Baig, M. A. *et al.* (2015) "Community emergency medicine: Benefits and challenges of screening for elder abuse in the emergency department of a developing country.," *World Journal of Emergency Medicine*, 6(4), pp. 261–264.

Baker, A. (1975) "Granny-battered," *Modern Geriatrics*, 5, p. 2024.

Bandura, A. (1978) "Social Learning Theory of Aggression," *Journal of Communication*, 28(3), pp. 12–29. doi: 10.1111/j.1460-2466.1978.tb01621.x.

Blau, P. M. (1964) *Exchange and Power in Social Life*. New York: John Wiley & Sons.

Blundell, B., Warren, A. and Moir, E. (2020) "Elder abuse protocols: identifying key features and establishing evidence for their use and effectiveness," *Journal of Elder Abuse and Neglect*, 32(2), pp. 134–151. doi: 10.1080/08946566.2020.1736225.

Brandl, B. and Raymond, J. (2012) "Policy implications of recognizing that caregiver stress is not the primary cause of elder abuse," *Generations*, 36(3), pp. 32–39.

Burnett, J. *et al.* (2014) "Four Subtypes of Self-Neglect in Older Adults: Results of a Latent Class Analysis.," *J Am Geriatr Soc*, 62(6), pp. 1127–1132. doi: 10.1111/jgs.12832.

Burston, G. R. (1975) "Letter: Granny-battering.," *British medical journal*, 3(5983), p. 592. doi: 10.1136/bmj.3.5983.592-a.

Caldwell, H. K., Gilden, G. and Muelle, M. (2013) "Elder abuse screening instruments in primary care: An integrative review, 2004 to 2011," *Clinical Geriatrics*, 21(1), pp. 20–25.

Campbell, R. J. and Lichtenberg, P. A. (2020) "A Short Form of the Financial Exploitation Vulnerability Scale," *Clinical Gerontologist*. doi: 10.1080/07317115.2020.1836108.

Choi, Y. J. *et al.* (2018) "Associations among elder abuse, depression and PTSD in South Korean older adults," *International Journal of Environmental Research and Public Health*, 15(9). doi: 10.3390/ijerph15091948.

Cohen, M. *et al.* (2006) "Development of a screening tool for identifying elderly people at risk of abuse by their caregivers," *Journal of Aging and Health*, 18(5), pp. 660–685. doi: 10.1177/0898264306293257.

Cohen, M. *et al.* (2007) "Elder abuse: Disparities between older people's disclosure of abuse, evident signs of abuse, and high risk of abuse," *Journal of the American Geriatrics Society*, 55(8), pp. 1224–1230. doi: 10.1111/j.1532-5415.2007.01269.x.

Cohen, M. (2008) "Research assessment of elder neglect and its risk factors in a hospital setting," *Internal Medicine Journal*, 38(9), pp. 704–707. doi: 10.1111/j.1445-5994.2008.01630.x.

Cohen, M. (2011) "Screening tools for the identification of elder abuse," *Journal of Clinical Outcomes Management*, 18(6), pp. 261–270.

Conrad, K. J. *et al.* (2010) "Self-report measure of financial exploitation of older adults," *Gerontologist*, 50(6), pp. 758–773. doi: 10.1093/geront/gnq054.

Conrad, K. J. *et al.* (2011) "Self-report measure of psychological abuse of older adults," *Gerontologist*, 51(3), pp. 354–366. doi: 10.1093/geront/gnq103.

Curry, S. J. S. J. *et al.* (2018) "Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement," *JAMA - Journal of the American Medical Association*, 320(16), pp. 1678–1687. doi: 10.1001/jama.2018.14741.

Department of Justice Canada (2009) *Abuse of Older Adults: Department of Justice Canada Overview Paper*. Ottawa.

de Donder, L. *et al.* (2011) "European map of prevalence rates of elder abuse and its impact for future research," *European Journal of Ageing*, 8(2), pp. 129–143. doi: 10.1007/s10433-011-0187-3.

De Donder, L. *et al.* (2011) "Perpetrators of abuse against older women: A multi-national study in Europe," *Journal of Adult Protection*, 13(6), pp. 302–314. doi: 10.1108/14668201111194212.

De Donder, L. *et al.* (2018) "Risk on Elder Abuse and Mistreatment - Instrument: Development, psychometric properties and qualitative user-evaluation," *Educational Gerontology*, 44(2–3), pp. 108–118. doi: 10.1080/03601277.2017.1417810.

Dong, X. (2005) "Medical implications of elder abuse and neglect," *Clinics in Geriatric Medicine*, 21(2), pp. 293–313. doi: 10.1016/j.cger.2004.10.006.

Dong, X. (2015) "Screening for Elder Abuse in Healthcare Settings: Why Should We Care, and Is It a Missed Quality Indicator?," *Journal of the American Geriatrics Society*, 63(8), pp. 1686–1688. doi: 10.1111/jgs.13538.

Dowd, J. J. (1975) "Aging as exchange: a preface to theory," *Journals of Gerontology*, 30(5), pp. 584–594. doi: 10.1093/geronj/30.5.584.

Ejaz, F. K. *et al.* (2001) "Evaluating the Ohio elder abuse and domestic violence in late life screening tools and referral protocol," *Journal of Elder Abuse and Neglect*, 13(2), pp. 39–57. doi: 10.1300/J084v13n02_04.

Filipska, K. *et al.* (2019) "Prevalence of elder abuse and neglect: screening in Poland families," *European Geriatric Medicine*, 10(5), pp. 817–825. doi: 10.1007/s41999-019-00224-x.

Fulmer, T. *et al.* (2000) "Elder neglect assessment in the emergency department," *Journal of Emergency Nursing*, 26(5), pp. 436–443. doi: https://doi.org/10.1067/men.2000.110621.

Fulmer, T. *et al.* (2012) "Screening for elder mistreatment in dental and medical clinics," *Gerodontology*, 29(2), pp. 96–105. doi: 10.1111/j.1741-2358.2010.00405.x.

Fundinho, J. F. and Ferreira-Alves, J. (2019) "Conhecer o fenómeno: Tópicos para a formação básica de profissionais," in Paulino, M. and Costa, D. (eds.) *Maus tratos a pessoas idosas*. 1st ed. Lisboa: PACTOR, pp. 191–209.

Fundinho, J. F., Pereira, D. C. and Ferreira-Alves, J. (2021) "Theoretical approaches to elder abuse: a systematic review of the empirical evidence," *The Journal of Adult Protection*, ahead-of-p(ahead-of-print). doi: 10.1108/JAP-04-2021-0014.

Gallione, C. *et al.* (2017) "Screening tools for identification of elder abuse: a systematic review," *Journal of Clinical Nursing*, 26(15–16), pp. 2154–2176. doi: 10.1111/jocn.13721.

Gil, A. P. M. *et al.* (2014) "Elder Abuse in Portugal: Findings From the First National Prevalence Study," *Journal of Elder Abuse & Neglect*, 6566(August), pp. 1–22. doi: 10.1080/08946566.2014.953659.

Giraldo-Rodríguez, L. and Rosas-Carrasco, O. (2013) "Development and psychometric properties of the Geriatric Mistreatment Scale," *Geriatrics and Gerontology International*, 13(2), pp. 466–474. doi: 10.1111/j.1447-0594.2012.00894.x.

Grenier, F. *et al.* (2016) "Evaluation of French version of the Vulnerability to abuse screen scale (VASS), a elder abuse screening tool | Évaluation du Vulnerability to abuse screen scale (VASS), version française d'un test de

dépistage de la maltraitance du sujet âgé," *Geriatrie et Psychologie Neuropsychiatrie du Vieillissement*, 14(2), pp. 142–150. doi: 10.1684/pnv.2016.0595.

Homans, G. C. (1961) *Social Behaviour: Its Elementary Forms.* New York: Harcourt, Brace & World, Inc.

Hoover, R. M. and Polson, M. (2014) "Detecting Elder Abuse and Neglect: Assessment and intervention," *American Family Physician*, 89(6), pp. 453–460.

Hwalek, M. A. and Sengstock, M. C. (1986) "Assessing the Probability of Abuse of the Elderly: Toward Development of a Clinical Screening Instrument," *Journal of Applied Gerontology*, 5(2), pp. 153–173. doi: 10.1177/073346488600500205.

Kelly, P. A. *et al.* (2008) "Exploring self-neglect in older adults: Preliminary findings of the self-neglect severity scale and next steps," *Journal of the American Geriatrics Society*, 56(SUPPL. 2), pp. S253–S260. doi: 10.1111/j.1532-5415.2008.01977.x.

Lachs, M. S. and Pillemer, K. (2004) "Elder abuse," *The Lancet*, 364(9441), pp. 1263–1272. doi: https://doi.org/10.1016/S0140-6736(04)17144-4.

Mathew, A. and Nair, S. B. (2017) "Theoretical Perspectives on Elder Abuse : A Framework Analysis for Abused Elderly in Kerala," *IOSR Journal of Humanities and Social Science*, 22(9), pp. 29–33. doi: 10.9790/0837-2209042933.

McCarthy, L., Campbell, S. and Penhale, B. (2017) "Elder abuse screening tools: A systematic review," *Journal of Adult Protection*, 19(6), pp. 368–379. doi: 10.1108/JAP-10-2016-0026.

Mussi, C., Pinelli, G., & Annoni, G. (2008). L'anziano e il Pronto Soccorso: il Triage. *G Gerontol*, *56*, 109-17.

Mysyuk, Y., Westendorp, R. G. J. and Lindenberg, J. (2013) "Added value of elder abuse definitions: A review," *Ageing Research Reviews*, 12(1), pp. 50–57. doi: 10.1016/j.arr.2012.04.001.

NCEA (no date) *Types of Abuse.* Available at: http://www.ncea.aoa.gov/FAQ/Type_Abuse/index.aspx (Accessed: June 15, 2016).

Neale, A. V *et al.* (1991) "Validation of the Hwalek-Sengstock Elder Abuse Screening Test," *The Journal of Applied Gerontology*, 10(4), pp. 406–418. doi: 10.1177/073346489101000403.

Özçakar, N. *et al.* (2017) "Adaptation, reliability, and validity study of the hwalek–sengstock elder abuse screening test (H-S/EAST): A Turkish version," *Turkish Journal of Medical Sciences*, 47(6), pp. 1894–1902. doi: 10.3906/sag-1606-166.

Phillips, Linda R., Morrison, E. F. and Chae, Y. M. (1990) "The QUALCARE Scale: developing an instrument to measure quality of home care," *International Journal of Nursing Studies*, 27(1), pp. 61–75. doi: https://doi.org/10.1016/0020-7489(90)90024-D.

Phillips, Linda R, Morrison, E. F. and Chae, Y. M. (1990) "The QUALCARE Scale: testing of a measurement instrument for clinical practice," *International Journal of Nursing Studies*, 27(1), pp. 77–91. doi: https://doi.org/10.1016/0020-7489(90)90025-E.

Pickering, C. E. Z. *et al.* (2017) "Identifying elder abuse & neglect among family caregiving dyads: A cross sectional study of psychometric properties of the QualCare scale," *International Journal of Nursing Studies*, 69, pp. 41–46. doi: 10.1016/j.ijnurstu.2017.01.012.

Platts-Mills, T. F. *et al.* (2018) "Development of the Emergency Department Senior Abuse Identification (ED Senior AID) tool," *Journal of Elder Abuse and Neglect*, 30(4), pp. 247–270. doi: 10.1080/08946566.2018.1460285.

Power, M., Fell, G. and Wright, M. (2013) "Principles for high-quality , high-value testing," *BMJ Evidence-Based Medicine*, 18(1), pp. 5–10.

Reis, M. and Nahmiash, D. (1995) "Validation of the Caregiver Abuse Screen (CASE)," *Canadian Journal on Aging / La Revue canadienne du vieillissement*, 14(S2), pp. 45–60. doi: 10.1017/S0714980800005584.

Reis, M. and Nahmiash, D. (1998) "Validation of the indicators of abuse (IOA) screen," *Gerontologist*, 38(4), pp. 471–480. doi: 10.1093/geront/38.4.471.

Ruelas-González, M. G. *et al.* (2018) "Development and validation of a Screening Questionnaire of Family Mistreatment against Older Adults for use in primary care settings in Mexico," *Health and Social Care in the Community*, 26(1), pp. 102–112. doi: 10.1111/hsc.12466.

Santos, E. J. and King, D. A. (2010) "The Assessment of Elder Abuse," in *Handbook of Assessment in Clinical Gerontology*, pp. 229–242. doi: 10.1016/B978-0-12-374961-1.10009-0.

Schmeidel, A. N. *et al.* (2012) "Health Care Professionals' Perspectives on Barriers to Elder Abuse Detection and Reporting in Primary Care Settings," *Journal of Elder Abuse and Neglect*, 24(1), pp. 17–36. doi: 10.1080/08946566.2011.608044.

Schofield, M. J. and Mishra, G. D. (2003) "Validity of self-report screening scale for elder abuse: Women's health Australia study," *Gerontologist*, 43(1), pp. 110–120. doi: 10.1093/geront/43.1.110.

Simmons, J. *et al.* (2020a) "Validation of REAGERA-S: a new self-administered instrument to identify elder abuse and lifetime experiences of abuse in hospitalized older adults," *Journal of Elder Abuse and Neglect*, 32(2), pp. 173–195. doi: 10.1080/08946566.2020.1737614.

Simmons, J. *et al.* (2020b) "Validation of REAGERA-S: a new self-administered instrument to identify elder abuse and lifetime experiences of abuse in hospitalized older adults," *Journal of Elder Abuse and Neglect*, 32(2), pp. 173–195. doi: 10.1080/08946566.2020.1737614.

Speechley, M. *et al.* (2017) "Screening in Public Health and Clinical Care: Similarities and Differences in Definitions, Types, and Aims - A Systematic Review," *Journal of clinical and diagnostic research : JCDR*. 2017/03/01, 11(3), pp. LE01–LE04. doi: 10.7860/JCDR/2017/24811.9419.

Swagerty, D. (2003) "Elder mistreatment identification and assessment," *Clinics in Family Practice*, 5(1), pp. 195–211. doi: 10.1016/S1522-5720(02)00086-7.

Teresi, J. A. *et al.* (2019) "Methodological approaches to the analyses of elder abuse screening measures: Application of latent variable measurement modeling to the WC-RAPS," *Journal of Elder Abuse and Neglect*, 31(1), pp. 1–24. doi: 10.1080/08946566.2018.1523766.

Touza, C., Martínez-Arias, R. and Prado, C. (2018) "Psychometric Properties of the Spanish Adaptation of the Indicators of Abuse (IOA) Screen," *Spanish Journal of Psychology*. doi: 10.1017/sjp.2018.38.

Touza, C., Prado, C. and Segura, M. P. (2012) "Detection Scales for the Risk of Domestic Abuse and Self-Negligent Behavior in Elderly Persons (EDMA)," *Journal of Elder Abuse and Neglect*, 24(4), pp. 312–325. doi: 10.1080/08946566.2012.661682.

Wang, B. *et al.* (2020) "A Vulnerability Risk Index of Self-Neglect in a Community-Dwelling Older Population," *Journal of the American Geriatrics Society*, 68(4), pp. 809–816. doi: 10.1111/jgs.16285.

Wang, J.-J. J. J.-J., Tseng, H.-F. H.-F. F. and Chen, K. M. K.-M. K.-M. (2007) "Development and Testing of Screening Indicators for Psychological Abuse of Older People," *Archives of Psychiatric Nursing*, 21(1), pp. 40–47. doi: https://doi.org/10.1016/j.apnu.2006.09.004.

Wang, J., Lin, J.-N. and Lee, F.-P. (2006) "Psychologically Abusive Behavior by Those Caring for the Elderly in a Domestic Context," *Geriatric Nursing*, 27(5), pp. 284–291. doi: 10.1016/j.gerinurse.2006.08.016.

Wang, X. M. *et al.* (2015) "Elder abuse: An approach to identification, assessment and intervention," *CMAJ*, 187(8), pp. 575–582. doi: 10.1503/cmaj.141329.

Wilber, K. H. and McNeilly, D. P. (2001) *Elder abuse and victimization.* 5th ed. Edited by J. Birren and K. Schaie. San Diego: Academic Press.

World Health Organization (2002) "The Toronto Declaration: the Global Prevention of Elder Abuse," *Geneva: WHO.*

World Health Organization and International Network for the Prevention of Elder Abuse (2002) *Missing voices : views of older persons on elder abuse.* Geneva.

Yaffe, M. J. *et al.* (2008) "Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI)©," *Journal of Elder Abuse and Neglect*, 20(3), pp. 276–300. doi: 10.1080/08946560801973168.

Yaffe, M. J., Weiss, D. and Lithwick, M. (2012) "Seniors' Self-Administration of the Elder Abuse Suspicion Index (EASI): A Feasibility Study*," Journal of Elder Abuse and Neglect*, 24(4), pp. 277–292. doi: 10.1080/08946566.2011.652930.

Yon, Y. *et al.* (2017) "Elder abuse prevalence in community settings: a systematic review and meta-analysis," *The Lancet Global Health*, 5(2), pp. e147–e156. doi: 10.1016/S2214-109X(17)30006-2.

Zawisza, K. *et al.* (2020) "Validity of a self-reported neglect scale among older adults in Poland," *Gerontologist*, 60(3), pp. E117–E126. doi: 10.1093/geront/gnz014.

Annex I

List of elder abuse screening instruments

Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) - (Hwalek and Sengstock, 1985)

Elder Abuse Suspicion Index (EASI) - (Yaffe *et al.*, 2008)

Vulnerability to Abuse Screening Scale (VASS) - (Schofield and Mishra, 2003)

Emergency Department Senior Abuse Identification (ED Senior AID) - (Platts-Mills *et al.*, 2020)

Responding to Elder Abuse in GERiAtric care-Self-administered (REAGERA-S) - (Simmons *et al.*, 2020)

Geriatric Mistreatment Scale (GMS) - (Giraldo-Rodríguez and Rosas-Carrasco, 2013)

Korean Elder Abuse Scale - (Oh *et al.*, 2006)

Weinberg Center Risk and Abuse Prevention Screen (WC-RAPS) - (Teresi *et al.*, 2019)

Client Assessment and Risk Evaluation (CARE) - (Burnett *et al.*, 2014)

Detection Scales for the Risk of Domestic Abuse and Self-Negligent Behavior in Elderly Persons (EDMA) - (Touza, Prado and Segura, 2012)

Elder Assessment Instrument - Reviewed (EAI - R) - (Fulmer *et al.*, 2012)

Elder Assessment Instrument (EAI) - (Fulmer *et al.*, 2000)

Expanded Indicators of Abuse (E-IOA) - (Cohen *et al.*, 2006)

Indicators of Abuse (IOA) - (Reis and Nahmiash, 1998)

QUALCARE - (Phillips, Morrison and Chae, 1990)

Risk on Elder Abuse and Mistreatment Instrument (REAMI) - (De Donder *et al.*, 2018)

Signs of abuse inventory - (Cohen *et al.*, 2007)

Caregiver Abuse Screen (CASE) - (Reis and Nahmiash, 1995)

Family Members Mistreatment of Older Adults Screening Questionnaire (FAMOASQ) - (Ruelas-González *et al.*, 2018)

Caregiver Psychological Elder Abuse Behavior Scale (CPEAB) - (Wang, Lin and Lee, 2006)

Elders' Psychological Abuse Scale (EPAS) - (Wang, Lin and Lee, 2006)

Older Adult Psychological Abuse Measure (OAPAM) - (Conrad *et al.*, 2011)

Perceived Emotional Abuse Scale for Adults (PEASA) - (Aslan and Erci, 2020)

Financial Exploitation Vulnerability Scale (FEVS) - (Campbell and Lichtenberg, 2020)

Older Adult Financial Exploitation Measure (OAFEM) - (Conrad *et al.*, 2010)

Signs of neglect inventory - (Cohen, 2008)

Self-Reported Neglect Scale (SRNS) - (Zawisza *et al.*, 2020)

Self-Neglect Severity Scale (SSS) - (Kelly *et al.*, 2008)

Vulnerability Risk Index of Self-Neglect - (Wang *et al.*, 2020)

References

Aslan, H. and Erci, B. (2020) "The incidence and influencing factors of elder abuse and neglect," *Journal of Public Health (Germany)*, 28(5), pp. 525–533. doi: 10.1007/s10389-019-01071-7.

Burnett, J. *et al.* (2014) "Community-based risk assessment of elder mistreatment and self-neglect: Evidence of construct validity and measurement invariance across gender and ethnicity," *Journal of the Society for Social Work and Research*, 5(3), pp. 291–319. doi: 10.1086/677654.

Campbell, R. J. and Lichtenberg, P. A. (2020) "A Short Form of the Financial Exploitation Vulnerability Scale," *Clinical Gerontologist*. doi: 10.1080/07317115.2020.1836108.

Cohen, M. *et al.* (2006) "Development of a screening tool for identifying elderly people at risk of abuse by their caregivers," *Journal of Aging and Health*, 18(5), pp. 660–685. doi: 10.1177/0898264306293257.

Cohen, M. *et al.* (2007) "Elder abuse: Disparities between older people's disclosure of abuse, evident signs of abuse, and high risk of abuse," *Journal of the American Geriatrics Society*, 55(8), pp. 1224–1230. doi: 10.1111/j.1532-5415.2007.01269.x.

Cohen, M. (2008) "Research assessment of elder neglect and its risk factors in a hospital setting," *Internal Medicine Journal*, 38(9), pp. 704–707. doi: 10.1111/j.1445-5994.2008.01630.x.

Conrad, K. J. *et al.* (2010) "Self-report measure of financial exploitation of older adults," *Gerontologist*, 50(6), pp. 758–773. doi: 10.1093/geront/gnq054.

Conrad, K. J. *et al.* (2011) "Self-report measure of psychological abuse of older adults," *Gerontologist*, 51(3), pp. 354–366. doi: 10.1093/geront/gnq103.

De Donder, L. *et al.* (2018) "Risk on Elder Abuse and Mistreatment - Instrument: Development, psychometric properties and qualitative user-evaluation," *Educational Gerontology*, 44(2–3), pp. 108–118. doi: 10.1080/03601277.2017.1417810.

Fulmer, T. *et al.* (2000) "Elder neglect assessment in the emergency department," *Journal of Emergency Nursing*, 26(5), pp. 436–443. doi: https://doi.org/10.1067/men.2000.110621.

Fulmer, T. *et al.* (2012) "Screening for elder mistreatment in dental and medical clinics," *Gerodontology*, 29(2), pp. 96–105. doi: 10.1111/j.1741-2358.2010.00405.x.

Giraldo-Rodríguez, L. and Rosas-Carrasco, O. (2013) "Development and psychometric properties of the Geriatric Mistreatment Scale," *Geriatrics and Gerontology International*, 13(2), pp. 466–474. doi: 10.1111/j.1447-0594.2012.00894.x.

Hwalek, M. A. and Sengstock, M. C. (1985) "A Screening Instrument for Identifying Elderly at Risk of Abuse and Neglect."

Kelly, P. A. *et al.* (2008) "Exploring self-neglect in older adults: Preliminary findings of the self-neglect severity scale and next steps," *Journal of the American Geriatrics Society*, 56(SUPPL. 2), pp. S253–S260. doi: 10.1111/j.1532-5415.2008.01977.x.

Oh, J. *et al.* (2006) "A study of elder abuse in Korea," *International Journal of Nursing Studies*, 43(2), pp. 203–214. doi: https://doi.org/10.1016/j.ijnurstu.2005.03.005.

Phillips, L. R., Morrison, E. F. and Chae, Y. M. (1990) "The QUALCARE Scale: developing an instrument to measure quality of home care," *International Journal of Nursing Studies*, 27(1), pp. 61–75. doi: https://doi.org/10.1016/0020-7489(90)90024-D.

Platts-Mills, T. F. *et al.* (2020) "Multicenter Validation of an Emergency Department–Based Screening Tool to Identify Elder Abuse," *Annals of Emergency Medicine*, 76(3), pp. 280–290. doi: 10.1016/j.annemergmed.2020.07.005.

Reis, M. and Nahmiash, D. (1995) "Validation of the Caregiver Abuse Screen (CASE)," *Canadian Journal on Aging / La Revue canadienne du vieillissement*. 2010/11/29, 14(S2), pp. 45–60. doi: DOI: 10.1017/S0714980800005584.

Reis, M. and Nahmiash, D. (1998) "Validation of the indicators of abuse (IOA) screen," *Gerontologist*, 38(4), pp. 471–480. doi: 10.1093/geront/38.4.471.

Ruelas-González, M. G. *et al.* (2018) "Development and validation of a Screening Questionnaire of Family Mistreatment against Older Adults for use in primary

care settings in Mexico," *Health and Social Care in the Community*, 26(1), pp. 102–112. doi: 10.1111/hsc.12466.

Schofield, M. J. and Mishra, G. D. (2003) "Validity of self-report screening scale for elder abuse: Women's health Australia study," *Gerontologist*, 43(1), pp. 110–120. doi: 10.1093/geront/43.1.110.

Simmons, J. *et al.* (2020) "Validation of REAGERA-S: a new self-administered instrument to identify elder abuse and lifetime experiences of abuse in hospitalized older adults," *Journal of Elder Abuse and Neglect*, 32(2), pp. 173–195. doi: 10.1080/08946566.2020.1737614.

Teresi, J. A. *et al.* (2019) "Methodological approaches to the analyses of elder abuse screening measures: Application of latent variable measurement modeling to the WC-RAPS," *Journal of Elder Abuse and Neglect*, 31(1), pp. 1–24. doi: 10.1080/08946566.2018.1523766.

Touza, C., Prado, C. and Segura, M. P. (2012) "Detection Scales for the Risk of Domestic Abuse and Self-Negligent Behavior in Elderly Persons (EDMA)," *Journal of Elder Abuse and Neglect*, 24(4), pp. 312–325. doi: 10.1080/08946566.2012.661682.

Wang, B. *et al.* (2020) "A Vulnerability Risk Index of Self-Neglect in a Community-Dwelling Older Population," *Journal of the American Geriatrics Society*, 68(4), pp. 809–816. doi: 10.1111/jgs.16285.

Wang, J. J., Lin, J. N. and Lee, F. P. (2006) "Psychologically Abusive Behavior by Those Caring for the Elderly in a Domestic Context," *Geriatric Nursing*, 27(5), pp. 284–291. doi: 10.1016/j.gerinurse.2006.08.016.

Yaffe, M. J. *et al.* (2008) "Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI)©," *Journal of Elder Abuse and Neglect*, 20(3), pp. 276–300. doi: 10.1080/08946560801973168.

Zawisza, K. *et al.* (2020) "Validity of a self-reported neglect scale among older adults in Poland," *Gerontologist*, 60(3), pp. E117–E126. doi: 10.1093/geront/gnz014.