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The Elder Abuse Suspicion Index: Results of a Pilot Study

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Elder abuse is a significant challenge in global societies. As we experience a demographic ageing transition, it is imperative that appropriate safeguarding systems are in place, which include the ability to identify elder abuse. This paper presents the piloting of the Elder Abuse Suspicion Index (EASI) in Ireland. It presents how the EASI was adapted to the Irish context by multi-disciplinary healthcare professionals in different settings. Findings from 716 older respondents demonstrate a suspicion of elder abuse in eleven percent of the sample. Findings also demonstrate that it is a challenge to convince older people to access formal safeguarding services. Conclusions point to the need for additional research to further establish the EASI positive predictive value and the need to empower older people to access appropriate services.

***Key words**: elder abuse, older people, safeguarding, screening tools.*

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Introduction

Elder abuse has been defined as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (WHO, 2008: 1). In many cases, such abuse also represents a crime being perpetrated. Elder abuse can be perpetrated in a number of ways, for example, physical abuse, psychological abuse, financial/material abuse, sexual abuse and neglect (either by omission or commission). There is also some debate on whether self-neglect constitutes an additional category of elder abuse, with some jurisdictions recognising it as abuse and others excluding it (Phelan, 2013). For example, in Ireland's first policy document on elder abuse (WGEA, 2002), self-neglect was explicitly identified as not being a form of elder abuse, although more recent policy has included self-neglect in safeguarding policy (Health Service Executive, 2014). In addition, there is a growing association of elder abuse as a human rights issue (WGEA, 2002; WHO 2015; Purser et al., 2017). Addressing cases of elder abuse can be complicated and often involves complex presenting issues in the older person's physical and mental health, capacity, family dynamics and self-determination. The impact of elder abuse is substantial, in terms of psychological distress (Comijs, 1998), increased rates of depression (Dyer, 2000), increased mortality rates (Dong et al., 2009) and increased admissions to hospital (Dong, Simon, 2013).

Many prevalence studies consider elder abuse a significant public health issue, with a pooled prevalence rate of 15.7 per cent in 52 studies involving 28 countries (Yon et al., 2017). As most older people live at home, elder abuse is more common in that environment, although it can occur in any other setting, such as in residential care or hospital (Cohen et al., 2007; Drennan et al., 2012). Prevalence studies have been identified as representing an under-estimation of the true figures on elder abuse. For instance, as early as 1998, an incidence study in the United States (National Centre on Elder Abuse in collaboration with Westat Inc., 1998) described the iceberg theory, meaning that not all cases are recognised or reported with many being hidden. This theory is also borne out in a prevalence study in New York, where research found that just 1 in 24 cases were identified through formal services like health and social care, police or within the legal system (Lifespan of Greater Rochester Inc., 2011). Similarly, in Ireland, a comparison between cases within health care elder abuse services

and a 2010 national prevalence study indicated that at least 1 in 5 cases were not being brought to the attention of formal services (Phelan, 2013). In addition, it is important to note that most prevalence studies are generally undertaken with older people who have cognitive capacity, yet studies which attempt to estimate elder abuse in populations of older people who have capacity challenges demonstrate prevalence figures ranging from 30 percent to 70 per cent (Cooper et al., 2008; Dong et al., 2011; Downes et al., 2013).

The identification of elder abuse is complicated. For example, it may not even be recognised by the older person him or herself (Phelan, 2013). This is particularly the case where the older person has a dependency on the perpetrator, or where the older person rationalises or normalises the abuse. For example, the older person may see the abuse as justified because they perceive themselves as a burden on the perpetrator. Other influencing issues in recognition include ageism (Gutman, Spencer, 2010), cognitive status (Laumann Leitsch, Waite, 2008), a lack of training to recognise abuse (Reingle-Gonzalaz et al., 2016), general complacency (WHO, 2008) and ethical issues (Donovan, Regehr, 2010). In addressing elder abuse, the use of screening tools has been useful (Phelan, Treacy, 2011; Gallione et al., 2017). However, there are some reservations on the universal use of these screening tools as screening is usually based on identified disease trajectories yet elder abuse has multi-contextual influencing factors which do not neatly fit to epidemiological screening standards (Rabin et al., 2009; United States Task Force on Family Violence, 2013). Notwithstanding these commentaries, screening tools offer an opportunity to bring the topic into the open with the older person and enable a targeted enquiry into their potential experience of abuse. However, such tools are only valid with older people who have cognitive capacity and their use in different countries must incorporate issues of culture and vocabulary used in the questions (WHO, 2008; Yan, Kwok, 2011).

In 2011, Phelan and Treacy conducted a review of published validated screening tools and suspicion indexes and identified two which were suitable for piloting in Ireland, the Older Adult Financial Abuse Measure (OAFEM) (Conrad et al., 2010) and the Elder Abuse Suspicion Index (EASI) (Yaffe et al., 2008). The OAFEM was considered very relevant, since the Irish national prevalence study (Naughton et al., 2010) identified financial abuse as being the most common form of abuse of older people (see Phelan et al., 2017). The EASI was also considered useful as it demonstrated positive psychometric

testing (Yaffe et al., 2008). Other advantages included its cultural transferability (WHO, 2008) and its brevity (Yaffe et al., 2008). In addition, the EASI has the potential for self-completion and created an increased awareness of elder abuse in both staff and older people (Yaffe et al., 2012).

The EASI tool (Yaffe et al., 2008) is a suspicion index which was developed in Canada and piloted with physicians only. Preliminary drafts of the EASI included nine questions which elicited information on possible abuse experiences. Further work within inter-disciplinary focus groups resulted in a reduction in the number of questions to five (Yaffe et al., 2009). The EASI was designed to be included in a direct discussion with the older person and was based on his/her experiences within the previous twelve months. The Canadian researchers also added a sixth question to enable physicians to record their objective evaluation of the older person (Table 1).

Table 1: *The Elder Abuse Suspicion Index (Yafee et al., 2008)*

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

The EASI tool was used in the initial assessment of 953 cognitively-intact older Canadians who were attending physicians' practices (Yaffe et al., 2008). Three weeks later, social workers, who were blinded to the EASI result, undertook a standard social work evaluation of the older person's risk of abuse. Psychometric results demonstrated that the sensitivity of each of the six EASI tool questions ranged from 0.03-0.23 and specificity ranged from 0.72-0.99

(Yaffe et al., 2008). Correlations between the EASI and the social workers' evaluation demonstrated a sensitivity rate of 0.44 and a specificity rate of 0.77 (Yaffe et al., 2008). When the first question was removed, the sensitivity was reduced (0.47-0.32) and this was attributed to the fact that question 1 acted as a primer to the subsequent questions (Yaffe et al., 2008). Given the potential of the EASI as a useful and brief suspicion index that could be easily incorporated into an older person's assessment, the tool was selected for piloting in Ireland. This pilot study sought to evaluate the tool in order to identify its transferability to the Irish context.

Methods

The study was part of a funded research programme on elder abuse conducted by the National Centre for the Protection of Older People (NCPOP) in University College Dublin. Full ethical approval was obtained from the Human Subject (Sciences) Committee, University College Dublin (LS-12-98).

Establishing content validity

In order to establish the content validity of the tool as it is transferred to an Irish setting, the pilot study evaluated face validity and also content validity. Face validity was tested using cognitive interviewing with six older people to ensure the clarity and accuracy of the tool for use with an Irish older population. In addition, content validity was evaluated through a bespoke survey instrument completed by 18 healthcare professionals who examined the tool for clarity of language and clarity of meaning for each of the six items. The healthcare professionals were comprised of a geriatric physician (n=1), nurses (n=8), general medical practitioners (n=5) and social workers (n=4) who were actively involved in safeguarding and therefore in a position to assess the tool's content. These healthcare professionals were purposively recruited through the National Centre for the Protection of Older People (NCPOP) mailing list with the inclusion criteria of being involved in care of older people and having experience of elder abuse cases.

As a result of the comments by the older people through cognitive interviewing and the health care professionals, the research team made minor

amendments to the wording of the EASI items; for example, as older people could have financial accounts in post offices and credit unions, these institutions were included as well as 'banking' in question 1. In addition, the phrase 'relying on another person' was further clarified to indicate 'unable to do independently'. Having adapted the tool in order to maintain content validity as it is transferred to the Irish setting, the primary aim of this study was to pilot the tool in Ireland. We aimed to recruit healthcare practitioners from across the disciplines to act as data collectors. The EASI could be incorporated by these data collectors into their routine assessment of older people in their practice area (Table 2).

The research team targeted one rural hospital and one urban hospital and recruited one consultant geriatrician who gave medical team support (non-hospital consultant doctors). Subsequent to recruitment and prior to data collection, the rural hospital withdrew due to the departure of the geriatrician and a large urban hospice was recruited. General medical practitioners were recruited through the University College Dublin general practitioner training scheme and five agreed to pilot the EASI.

Through the Health Service Executive public services, the research team recruited day care centres (which older people attended) and local health offices to allow access to older people using their services. Thirty day care centres participated in the study. Thirty-two local health areas (LHAs) who delivered community based health care were forwarded information on the study; twelve expressed interest in participating in the study. For pragmatic reasons, two LHAs were recruited.

In addition, through information sent to the Institute of Community Health Nursing, three community based nurses in other LHAs volunteered to implement the pilot tool and were recruited to participate in the study as data collectors. In addition, two members of the NCPOP research team, who were nurses with experience of older person care, also acted as data collectors in the day care centres. The pilot tool was piloted over a six-month period in all the sites.

Table 2: *Data collection participating sites and individual caseloads with associated HSE region*

Data collection participating sites	Number of cases
Hospital	1
Hospice	1
Local health office (community)	2

Care of the Older Person Day Centres*	30
General Practitioners' caseload	5
Individual Community Registered Nurse's caseload	3

*Members of the NCPOP research team undertook data collection in day centres

Procedures for implementing the tool

A protocol handbook, tailored to each site and discipline, was developed in collaboration with the healthcare staff, which gave instructions on how and in which circumstances the EASI tool should be administered. Participating healthcare practitioners were offered face-to-face training on the topic of elder abuse, how to obtain informed and voluntary consent, confidentiality and cognition screening. Information was also provided on how to administer the tool, complete the survey instrument and to ensure that local guidance/policy on referrals was followed. Participating staff could also avail of an online training programme (accessed via password protected e-portal in the NCPOP webpage for the data collection period and delivered through the Vimeo platform), which replicated the face to face training. Healthcare staff were also encouraged to contact the research team at any point to clarify any issues of concern. In total, thirty-eight face to face training sessions were delivered with the remaining data collectors availing of the on-line training and NCPOP telephone follow up for clarification and guidance through the protocol handbook.

Acting as data collectors, the participating health care professionals invited English-speaking patients aged 65 years and over to participate in the study. Those with a confirmed diagnosis of altered cognitive capacity, those living in a nursing home or in a distressed state were excluded. Older people who met the inclusion criteria were invited to participate in the study, and allowed time to review the participant information leaflet and ask questions. If consent was given, the data collector performed a cognitive assessment using either the Mini-Mental State Examination (Folstein, M. F., Folstein, M. R., 1975) (eligible score >/= 24) or the 6-item Cognitive Impairment test (6-CIT) (Brooke, Bullock, 1999) (eligible score 0-7). The choice of assessment tool was based on pragmatic reasons. Cognitive assessment was provided within the training as some healthcare staff had not undertaken this activity. In considering length of time for completion, the 6-CIT was given as the screening tool

within the survey documentation as it has a completion time of 3-4 minutes (Sheehan, 2012) as opposed to 10-12 minutes for the Mini-Mental State Examination (MMSE) (Sheehan, 2012). The 6-CIT has been used in research studies and deemed suitable for primary and specialist settings (Etgen et al., 2010; Mitchell, Srinivasa, 2010; Tuiji et al., 2011). However, when discussing the process, in particular with medical staff, a familiarity with and preference for the MMSE was noted, and the option of completing either test was enabled as both are approved as cognitive assessments (NICE, 2006).

Where cognitive capacity to participate was determined, the data collector administered the EASI tool. If an older person's responses to the six questions triggered a suspicion of elder abuse, according to local protocols, he or she was then offered a referral to the safeguarding service. As Ireland does not have mandatory reporting of elder abuse, the older person could decline this referral or change their mind after initial agreement. Where a suspicion of abuse was indicated, details of the case were recorded in narrative form, including the identity of the suspected alleged perpetrator of the abuse, the form of the abuse, and whether the older person refused referral to the safeguarding service and, if refused, the reasons for refusal. Other information was also recorded, including the person to whom the referral was made. If consenting, referrals for a suspicion of elder abuse were then forwarded to safeguarding services. To reduce the risk of bias, the referral documentation did not identify the EASI study as the trigger to referral. If an NCPOP staff member identified the suspicion of abuse and the older person consented, the team member would approach the nurse in charge in the day care centre and meet in a private room to indicate that the older person had triggered a suspicion of abuse and had consented to a referral. The nurse in charge would subsequently meet the older person in private the same day and complete a referral.

As part of the EASI validation procedure, each case of suspicion of abuse that was referred to the safeguarding service was subsequently tracked by the research team to determine the outcome of the safeguarding service assessment. The tracking was achieved through a procedure whereby the research team, with the older person's consent, temporarily recoupled the coded participant consent form with the coded EASI tool so that details (name, date of birth and safeguarding staff for that geographical area) were identified. The name of the individual was then placed in a sealed envelope along with the individual's unique identifier code number and a second

member of the research team met with the safeguarding case-worker two months later when the primary assessment of the case had been completed by safeguarding staff. The safeguarding case-worker opened the sealed envelope and then completed a report, which only identified the older person by their code and this was immediately returned to the research team member. For the purpose of the study, the outcomes of the referred cases were categorised as follows: a) no record of the referral, b) substantiated case, c) unsubstantiated case, d) continuing case, or e) case closed.

Analysis

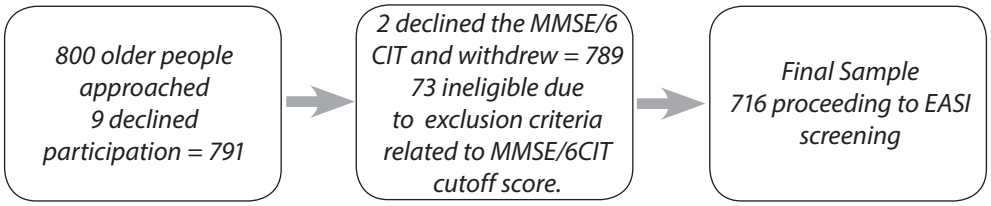
We conducted statistical analysis of all referrals to the safeguarding service using SPSS v. 20, to ascertain how the tool could be feasibly transferred to the Irish setting and to gather the information necessary to plan a further study measuring predictive value of the EASI.

Results

This study aimed to adapt the EASI tool to an Irish context and then to have multi-disciplinary professionals in multiple settings pilot the tool in their clinical practice. The content validity of the tool was first assessed and demonstrated the need to make minor amendments. This indicates the importance of examining the transferability of tools to different populations, where subtle differences may impact on understandings. In order to support the inter-rater reliability of data, a collection, bespoke training (face to face and on line) and a written protocol were developed.

The research team then proceeded to gather information which would assist in making a recommendation for the further more nuanced testing of the tool in Ireland to ascertain predictive value. Eight hundred people were deemed eligible for inclusion in the study and the final sample was 716 (Figure 1).

Figure 1: *Sample recruitment*



Most respondents were female (67%, n=473) and were in the age category of 80 years or above (55%, n=388). The majority of screenings were undertaken by nurses from the NCPOP (57%), followed by the general practitioners (17%), specialist nurses in gerontology (11%), community nurses (7%), day centre nurse co-ordinators (6%), social workers (1%), practice nurses, non-consultant hospital doctors and medical consultants (0.8%) (missing data 0.2%).

A suspicion of some form of elder abuse was identified in 79 older people (11%) who were screened. Of this number, 41 (52.6%) were aged between 64–79 years, while 37 (47.4%) were aged 80 years and over. More females (n=46) than males (n=32) generated a suspicion of elder abuse; however, there were no statistically significant relationships between a suspicion of elder abuse and either age (p=0.170) or gender (p=0.110). The identity of the suspected alleged perpetrator of the abuse was recorded in 52 of the 79 cases in which a suspicion of elder abuse was indicated (Table 3).

Table 3: *Perpetrators identified in EASI and numbers*

Perpetrator	Number
Son	10
Spouse	10
Daughter	6
Other family	6
Healthcare professional/worker	10
Friend/neighbour/acquaintance/ social group	6
Service professional/worker	6
Fellow patient	2
Salesperson/door caller	2
Not clear/not indicated	22
Total	**80***

* One older person identified 2 perpetrator sources

Of the 79 suspicions of elder abuse, only nineteen (24.1%) older people consented to a referral to the safeguarding services. A further six indicated they were already receiving formal assistance from other services, including police, solicitors, general practitioners, social workers and/or nurses. In the cases where the details of the suspected abuse were recorded by the data collector, the descriptions included the type of abuse; this included being spoken to in a threatening, aggressive or belittling manner, financial abuse, physical abuse and enforced social isolation. Most of these instances of suspected abuse were recorded as ongoing in the older person's life. Other descriptions of suspected abuse recorded by the data collectors included poor interactions with healthcare staff, local authority or transport services, a robbery in the home, being placed in a day care facility that was unsuitable or being hounded for payment of a utility bill. Data collectors also recorded details of older people's reasons for refusing a referral to the safeguarding services. Reasons included not wishing to get their relative in trouble, being fearful of exacerbating the situation, wanting to deal with the issue him/herself and a fear of the situating escalating.

Two months later, the referrals were tracked in the safeguarding service using the blinded method described above. The tracking procedure yielded just 13 of the 19 cases, suggesting that six of the older people who had initially indicated consent had subsequently withdrawn it, or that the suspected abuse had been resolved. For the identified 13 referrals that were tracked, a member of the research team met with the individual safeguarding case manager, who confirmed that ten (76.9%) out of the thirteen were substantiated for abuse and concurred with the type of abuse identified in the EASI screening process. For the remaining three cases, two were continuing cases without a case decision, while the third had voluntarily withdrawn from safeguarding services before substantiating evidence was collected.

Discussion

In Ireland, elder abuse training has been delivered to almost 44000 people in multiple care settings and training included staff in the Health Service Executive (residential, acute, community based), private/voluntary organisations and the business sector (Health Service Executive, 2014). Since 2009,

such training has been mandated by the Health Information and Quality Authority for staff working in residential care services. However, challenges persist in identify and responding to elder abuse and this study aimed to pilot a screening tool which could assist in case-finding.

The findings in this study relate to the use of the EASI with older people who use a variety of health settings and who interface with a variety of healthcare disciplines. Elder abuse is a multi-faceted and complex phenomenon which is impacted not only by the immediate dyadic relationship between the victim and the perpetrator but by complex ecological systems (O'Donnell et al., 2014). As such, its identification can be challenging and research demonstrates that issues such as power relations, culture, ethnicity, lack of recognition, sense of entitlement, taboo status and ageism have all impacted on obscuring recognition and identification. The importance of increasing health care professionals' ability to case find through assessment such as the EASI is borne out by the discrepancy of elder abuse cases within formal response services as opposed to prevalence studies' figures (Lifespan of Greater Rochester Inc., 2011; Phelan, 2013). Consequently, raising both public and professional awareness and optimising identification are central to addressing elder abuse as well as having appropriate response systems in place. Although the EASI has been used in many countries (Perel-Levin, 2008; Pérez-Rojo, 2010; Carmona Torres, 2018), its potential use by various health care disciplines in multiple setting in Ireland was piloted. In Yaffe et al.'s study (2008), the EASI was used by physicians only in primary care settings, however, this research represents the first published study known to the authors, which examined the use of the EASI tool within a multi-disciplinary and multi-setting context.

A notable issue in the study was that although sites agreed to participate in the study, there were challenges in data collection due to staff shortages and job relocations. Moreover, in contrast to Yaffe's et al.'s (2008) original study, the healthcare professionals who acted as data collectors for the EASI were also conducting a cognitive assessment and obtaining consent, which represented a significant time commitment within their busy clinical areas. These issues impacted on a decision to extend the time for data collection and additional outreach involvement in data collection by NCPOP staff.

In this study, there were more female (67%) respondents than males (33%). This is higher than the gender breakdown in the 2016 Census (CSO, 2017), where females over 65 years represent 53.44 percent of the population. How-

ever, there is an increasing longevity in females, which may have impacted the gender proportions, particularly in the over 80 years age group (CSO, 2017). Within data collection, it is notable that only older people who were deemed to have cognitive ability by the healthcare professional were offered participation. When NCPOP researchers were data collecting, local staff identified potential respondents. However, of those judged as having capacity to consent, 73 (9.9%) did not reach the required capacity scores' cut-off. This supports the argument that cognitive impairment itself may be undiagnosed and unrecognised in older people for a period of time (Jackson et al., 2016). Furthermore the descriptive studies in this study point to the case response difficulties, with only a rate of 16.5% consenting to referral to safeguarding services (13 from 79 suspected). This is an important finding as it points to the challenge in getting older abuse victims to accept help. Furthermore, in terms of the practicality of doing a study which would measure predictive capacity of the tool, both these figures provide the information that would be needed to ascertain what sample size would be required for a future study. So in calculating that 100 referred cases are needed to have the power to make a conclusion about predictive capability of the tool, it would be possible to further estimate that a sample of 6500 older people screened for elder abuse using the tool should provide approximately 650-715 people with a suspicion of elder abuse (10-11%). Of this number, it would be expected that 100-118 would be willing to be referred (16.5%) to safeguarding services. Consequently, it can be concluded that the feasibility of ascertaining the predictive power of the tool would require a hugely resourced study to screen a sample of that size.

The sample population was one where there were existing health challenges. For example, the majority of respondents were in receipt of day care services (n=454) and were 80 years or over. Increasing age is a risk factor for increased health utilisation (McNamara et al., 2013). Our sample, therefore, differs from the general population of older people over 65 years of age as dependency is much higher (with 55% indicating a reliance on someone else), and poor health and disability have a strong evidence base in relation to being risk factors for elder abuse (WHO, 2018). This may explain the difference in a suspicion of elder abuse in just 11 percent of the sample in this study with a prevalence rate in the community of 2.9% in Ireland (Naughton et al., 2010). However, in this study, being reliant on another person was not statistically significant in the context of a suspicion of elder abuse.

Of the 79 older people with a suspicion of elder abuse, only 19 agreed to a referral. In most cases, relatives and friends were identified as the perpetrator, which concurs with the prevalence literature (Yon et al., 2017). The study had the advantage of an optional recording of the experience of abuse as well as reasons for referral refusal. Some suspicions included a blurring of abuse definitions or once off experiences, such as receiving a letter to pay a bill after the bill was settled or detailing an account of a bus driver being rude. In six records, the case was already being reviewed by the appropriate professional (safeguarding, public health nurse, solicitor, police), or in four cases, the issue had been resolved. However, there were some instances where referral was declined based on kinship loyalty, fear of reprisal or withdrawal of care, or the spousal abuser being in both day care and at home with the older person (so there was no opportunity to meet safeguarding without arousing the spouse's suspicion). Only three older people indicated that they would consider referral in the future. This again reiterates the discrepancy between suspected abuse experience and formal service investigation which is noted in other studies (Lifespan of Greater Rochester Inc., 2011) and such underreporting has been used to justify mandated reporting of elder abuse (Bernal, 2017). The taboo status of family violence and, for elder abuse, the fact that the perpetrator is commonly a relative or friend impacts on the decision to disclose, while threats of nursing home admission or other negative repercussions may also be influencing factors. This is compounded by the invisible and hidden nature of abuse.

Although 19 older people out of the 79 people who generated a suspicion of abuse agreed to referral to safeguarding services, in the tracking phase of the study, only 13 were located. We hypothesize that this is due to subsequent resolution or subsequent withdrawal of consent to a referral after data collection. For those that were tracked, all were deemed to have been appropriate referrals by the safeguarding teams. In ten cases, abuse was substantiated and the typology matched the suspicion identified in the EASI. In the remaining three cases, one older person who met with the safeguarding team member indicated that abuse was occurring and withdrew from the service, not wanting any further interaction. For the other two older people, the safeguarding team members advised that the cases were very complex and demonstrated elements of potential abuse, warranting their intervention. Consequently, all EASI referrals were deemed appropriate.

There are a number of limitations to the study. Firstly, the EASI is only suitable for older people with cognitive capacity, thus eliminating a particularly vulnerable sub-group. Secondly, the number of onward referrals was limited which impacted a more robust statistical analysis. A larger sample would have been more conclusive in generating findings, particularly related to the EASI's predictive value. Furthermore, evaluating the use of the EASI with the healthcare professionals acting as data collectors would have contributed to understanding about experiences of discussing elder abuse and using the tool. Finally, a blanket blinding of the tool to safeguarding services was not always possible as some participating social workers were also the local safeguarding referral point. However, only eight EASIs were undertaken by these social workers, thus, limiting this issue.

Conclusion

Elder abuse is a significant challenge in global societies. Moreover, it is important to increase public awareness, identification and early intervention. This study has demonstrated that the EASI can be routinely used by multiple professionals in different settings and enables a gateway to discussions on the topic of elder abuse, which can increase awareness and using the EASI has potential to streamline appropriate cases to safeguarding services. However, the reluctance of older people to engage with safeguarding services is noted and issues of normalisation of abuse, power dynamics, kinship relationships, culture, and fear of consequences remain as barriers and warrant further investigation. Consequently, a sensitive approach is important and targeting public awareness to reduce the taboo nature of elder abuse would help in diminishing the reluctance to agree to referral to safeguarding, while further research on the EASI tool would demonstrate its predictive value in safeguarding practice.

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Indeks sumnje na nasilje nad starijim osobama: Rezultati pilot istraživanja

Nasilje nad starijima predstavlja značajan izazov savremenih društava na globalnom nivou. Kako se suočavamo sa trendom starenja stanovništva, neophodno je da postoje odgovarajući sistemi zaštite starije populacije, koji uključuju mogućnost blagovremenog identifikovanja nasilja nad starijima. Ovaj rad ima za cilj predstavljanje rezultata pilot istraživanja primene Indeksa sumnje na nasilje nad starijim osobama (EASI) u Irskoj. Prikazano je kako su zdravstveni radnici različitih specijalnosti prilagodili EASI kontekstu irskog društva. Rezultati primene EASI na uzorku od 716 starijih ispitanika pokazuju sumnju na nasilje u 11% slučajeva. Istraživanje je, takođe, pokazalo koliki je izazov ubediti starije osobe da prihvate zvanične oblike pomoći i zaštite. U zaključku se ističe potreba za dodatnim istraživanjima kako bi se potvrdila vrednost EASI u ranom otkrivanju nasilja nad starijim osobama i potreba da se stariji ljudi osnaže da u slučaju viktimizacije potraže pomoć i zaštitu.

Ključne reči: nasilje nad starijim osobama, starije osobe, zaštita, instrumenti za skrining.

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