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Review of screening and assessment tools for abuse of older people

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An intertwining graphic motif has been developed for this report to represent the gathering of information and its dissemination into the public discourse.

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Contents table

Executive summary

Context

The World Health Organization (WHO) estimates that around one in six people over the age of 60 years experience some form of abuse or neglect each year (Yon, Mikton,Gassoumis, 2017) .

Only a small portion of these cases of abuse are reported (World Health Organization, 2008). The number of actual cases of abuse of older people (AOP) in Aotearoa New Zealand as reported by Elder Abuse Response Services is increasing – 2852 cases across all the Age Concerns with an Elder Abuse Response Service in 2022/2023, with 11 new cases reported every workday (Age Concern 2023). Perpetrators of abuse were primarily reported as family members.

Abuse may be suspected (stress, distress, injuries, neglect), but definitive abuse is challenging to identify due to personal and professional barriers and some overlap between indicators of abuse or neglect and normal age-related changes. The presence of dementia adds further complexity to identifying abuse.

There is no consensus in Aotearoa New Zealand about how to measure and identify abuse of older people. The Ministry of Social Development (MSD) funds Elder Abuse Response Services, which focus on response and intervention. Aged care, health services and community organisations such as the New Zealand Police may use formal or informal approaches when assessing abuse.

Overview of this project

This review aimed to provide an overview of the tools and measures currently being used across Aotearoa to screen for and assess AOP. This includes the availability of tools, how they are currently being used, and what practices of screening and assessment are taking place in the absence of tools being used.

To achieve this, overall the project had two focus areas:

1. **Conduct** a systematic literature review to identify screening and assessment tools developed for AOP, both in Aotearoa New Zealand and internationally.
2. **Interview** a cross-section of practitioners in a variety of healthcare settings about their current practices in detecting and intervening in AOP and their views of AOP screening tools.

This report summarises the findings from this research and aims to contribute to the development of evidence-based recommendations for the use of these tools to detect and manage AOP.

Overview and findings from systematic literature review

We used a systematic literature review methodology to search, assess and integrate relevant literature between 1970 and 2023. We identified more than 100 tools that have been developed for the identification of AOP. Of these, 38 tools were analysed and reviewed in detail.

The overarching research goals for the literature review were to:

1. **describe** general approaches to screening and assessment,
2. **describe** and evaluate the characteristics and usage of available screening and assessment tools, and
3. **discuss** how AOP is currently assessed in Aotearoa New Zealand.

Initially, 1122 potential articles were found. After screening, the review ultimately comprised 39 journal articles. Many articles were excluded based on the research questions; irrelevant topics included reports on intimate partner violence only, child abuse, self-neglect or neglect in other spheres of life. Several articles were excluded because they were not written in English, and other articles were excluded because the full article was unavailable, or the article missed details of either tool development or psychometric analysis.

The review unveiled a spectrum of screening tools for detecting AOP, showcasing varying degrees of sensitivity and specificity. Some screening tools were designed to screen for only one type of abuse – such tools primarily focused on financial abuse – while other tools encapsulated several types of abuse and one also included carer burden questions. Notably, no single tool universally excelled in detection of AOP, and there was an absence of tools developed or in use in Aotearoa New Zealand. The literature has suggested that screening tools should have some level of risk assessment included. Some health professionals interviewed in this research had already devised some form of risk assessment while others relied on intuitive recognition and observation.

Overview and findings from key stakeholders interviews

To provide insights into current practices, we interviewed practitioners from a variety of healthcare and social service settings. These include practitioners who work closely in the field of AOP and those who provide healthcare but are less directly involved in the field of AOP. Fifteen participants participated in a semi-structured interview.

The narratives and review information found that detecting and preventing abuse demands a comprehensive response. This response should consider hidden internal and external factors contributing to vulnerability and risk among older people.

Development of a national screening tool

The research participants expressed a shared interest in the development of a national screening tool. They felt this could facilitate collaboration and data collection to inform policy decisions, ensuring consistent services across varied workplace settings. However, they also identified challenges that might hinder a national screening implementation, including validation, acceptability and non-disclosure.

Current barriers and enablers in practice

Barriers and enablers significantly influence the effectiveness of detection of AOP and subsequent interventions. Collaborative, strength-based approaches yielded better outcomes and emphasised the importance of building trust and rapport. Some participants adopted various strategies including using a traffic light system or following the Ministry of Health guidelines (Ministry of Health, 2016). While not ideal, these strategies supported practitioners in navigating complex cases and making informed decisions.

However, challenges such as confirmation of abuse, risk assessment and consent underscored the necessity for clear protocols and ethical guidelines. Training, awareness and knowledge emerged as pivotal enablers, yet their absence contributes to underreporting of suspected cases.

Cultural relevance and diversity

Cultural relevance and diversity emerged as pivotal discussion points, both in the review material and interviews, emphasising the need for culturally adapted tools and services that align with cultural understandings and sensitivity. Collaborative design and the inclusion of cultural needs in the assessment process was emphasised in stakeholder narratives. The absence of tools that incorporate wairua/spiritual dimensions of abuse was noted as an area for future development and understanding.

The role of interdisciplinary teams

Embracing interdisciplinary collaboration emerged as vital for effective detection and intervention. For support to be effective and comprehensive, it is crucial that social workers, legal experts and community organisations work together.

Overall findings

Despite one of the key aims of the project being to explore current global screening tools, none was found to meet the gold standard in terms of validity, reliability and other criteria. Several important issues were identified that address the current needs of AOP services in Aotearoa New Zealand. By implementing the recommendations listed below, services can work towards a more effective response to AOP that ultimately will improve the safety of older people in the community.

Recommendations

- **Explore further** how development and implementation of screening tools have been adapted internationally. Focus initially on the six screening tools highlighted in the report.
- **Build on the evidence** and information from this scoping review to improve cultural sensitivity and competence to help professionals understand and respect the cultural differences of AOP.
- **Establish and strengthen support networks** for older people including access to resources, peer support groups and safe housing options.
- **Develop comprehensive educational resources** and training toolkits for relevant professional groups on AOP awareness, assessment, and intervention, including culturally specific frameworks.
- **Foster collaboration** among healthcare professionals, social services, law enforcement agencies and community organisations to create comprehensive support systems for older people experiencing abuse and neglect.

List of tables

List of figures

Glossary

Term	Description
AOP	Abuse of older people Cruelty or mistreatment of older people has been known by many names including elder abuse and elder mistreatment. The World Health Organization uses the term abuse of older people and includes acts of neglect. For the purposes of this report, references to AOP also include neglect.
ARC	Aged residential care, excluding retirement villages.
Assessment tools	Tools that include a measure of heightened level of risk.
Dimensions of abuse	The types of abuse Unidimensional tools – measure one type of abuse Multidimensional tools – measure more than one type of abuse
Domains of abuse	The areas of abuse identified in the tool (see Table A).
Elder abuse	Although the term AOP is used in this report, the term elder abuse is retained where it was used specifically by others; for example, in a direct quote.
EPOA	Enduring power of attorney
NZLSA	New Zealand Longitudinal Study of Ageing
Multidisciplinary teams	A multidisciplinary team is a group of professionals from diverse backgrounds, areas of expertise and disciplines who collaborate to achieve a common goal or solve complex problems.
Multi-part tools	Tools that measure abuse in more than one way. In general, the parts are risk factors, direct questions and signs of abuse.
Screening tools	Tools that assess potential for abuse or enquire about experiences of mistreatment.
Supported decision-making	Helping someone with affected decision-making capacity, such as mild cognitive impairment, to decide on a course of action. Support involves communicating what is being asked, exploring options, and communicating their decision to the agency involved.
Substituted decision-making	Deciding for someone else because they are unable to make their own decision, even with support.
VIP	a violence intervention programme

Background

Te Aorerekura | The National Strategy to Eliminate Family Violence and Sexual Violence (Te Puna Aonui, 2021) highlights that many older people experience abuse, and furthermore, that the abuse experienced by them is often not visible. This is often due to limited understanding of the abuse of older people (AOP), unmet support and care needs (commonly termed neglect), social isolation and a lack of respect, resulting in the abuse being minimised or ignored. Raising awareness of potential abuse and neglect for older people is therefore critical.

AOP is a serious health and social concern (World Health Organization, 2022) with consequences that include short- and long-term physical and psychological effects, social disruption and, in extreme cases, mortality (Lachs et al., 1998; Perel-Levin, 2008; Podnieks & Smith et al., 2017; Thomas 2017; Waldegrave, 2015).

This project is part of a wider prevention of abuse of older people work programme which is being led by the Ministry of Social Development (Ministry of Social Development, 2022). The work programme focuses on building the foundations needed to better understand and prevent AOP in Aotearoa New Zealand. The work programme has four focus areas:

- **Reviewing** what is known and what is already happening to prevent abuse of older people.
- **Understanding** the abuse of older people happening in Aotearoa New Zealand: prevalence, impacts and drivers.
- **Investing** in opportunities to grow the prevention system around abuse of older people.
- **Testing** what works (and doesn't work) in initiatives aiming to prevent abuse of older people.

This project contributes to the Reviewing focus area.

MSD commissioned this project to provide insights into the current state of screening for and assessment of AOP in Aotearoa. The findings from this review are intended to support future work in this area, including policy and practice improvements, and the development and design of screening and assessment tools appropriate for Aotearoa New Zealand.

Project objectives

The overall objective of this project was to provide of an overview of the tools and measures currently being used across Aotearoa to screen for and assess AOP. This would include the quality and availability of tools, how they are currently being used, and what practices of screening and assessment are taking place in the absence of tools being used.

In order to achieve this objective, the project had three broad focus areas:

- **Conduct a systematic literature review** to identify screening and assessment tools developed for AOP, both in Aotearoa New Zealand and internationally.
- **Interview a cross-section of key stakeholders** in a variety of healthcare settings about their current practices in detecting and intervening in AOP and their views of AOP screening tools.
- **Explore the value of new screening tools** for Aotearoa New Zealand.

The report summarises the findings from these three areas of research and identifies insights from the intersections of research and practice in AOP. It aims to contribute to the development of evidence-based recommendations for the use of tools to detect and manage AOP.

The report is likely to be of interest to policymakers and practice leads, health professionals and clinicians, and organisations and practitioners working to support the well-being of older people.

Introduction to the abuse and neglect of older people

This section provides an overview of abuse to give context to the main body of the report. It covers:

- What is the abuse of older people?
- Risk factors and influences
- Cultural conceptions of abuse in Aotearoa New Zealand
- Barriers to reporting and measuring abuse

What is the abuse of older people?

Definition

This research report uses the World Health Organization's (WHO) definition of abuse of older people, which is the most widely accepted definition of AOP internationally:

> **Abuse of older people 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. (World Health Organization, 2022)**

This definition is used by most services working with older people in Aotearoa New Zealand, including Age Concern New Zealand, the lead community organisation working in the AOP area at a national level.

Forms of abuse

The definition of AOP covers many of the different forms of harm that older people experience. In order to simplify the discussion of these different forms of harms, and provide common reporting frameworks, AOP is commonly broken down into different types of abuse. The five most common types are psychological abuse, financial abuse, physical abuse, sexual abuse (these four types are acts of commission inflicted by a perpetrator on a victim) and neglect (an omission of basic human rights) (World Health Organization, 2021). The parameters of each of these are briefly described below.

Psychological abuse is behaviour that causes anguish, stress or fear. Behaviours that demonstrate psychological abuse include verbal assault, intimidation and harassment, threats of physical or sexual harm, control over decision-making and damage to property. Psychological or emotional abuse is often evident when other abuse is also present.

Financial abuse is the illegal or improper exploitation and/or use of other people's funds or resources. Behaviours that demonstrate financial abuse include theft, appropriation of assets by fraud, abuse of enduring powers of attorney (EPOA) for personal gain, or failure to act in the best interests of the older person.

Physical abuse is the infliction of physical pain, injury or force. Behaviours that demonstrate physical abuse include inappropriate use of physical restraints or confinement, and deliberate misuse of medication to cause sedation or harm.

Sexual abuse is non-consensual sexual contact of any kind. Behaviours that demonstrate sexual abuse include forced, coercive or exploitive sexual behaviour or threats. Sexual activity with an adult without the capacity to understand is also considered sexual abuse.

Neglect is the failure to meet the health and safety needs of another person when there is a reasonable obligation to do so. Behaviours that demonstrate neglect include inadequate provision of food, healthcare and a safe environment, and abandonment (desertion by a person who has assumed responsibility for someone's care). Neglect can be intentional or unintentional, such as when a care partner is stressed or lacks skills in caring. It can also be self-inflicted; however, self-neglect may occur outside an abusive relationship so is often excluded from reports of AOP.

There are many examples of variations or additions to these types of abuse. For example, institutional abuse is also now commonly recognised as another type of AOP.

Institutional abuse occurs in places where older people receive care; for example, in aged residential care (ARC) or hospital settings (e.g. Ministry of Social Development, 2019). Although all types of abuse can be perpetrated within an institution, particular forms of abuse, such as inappropriate custodial control and inadequate consenting, can be unique to these settings. Internationally, more than 60% of staff in residential facilities admit to AOP (Yon et al., 2018), making this setting one of high importance.

In some contexts, more specific subtypes of abuse have been identified by studies. These are not usually reported on individually and are reported on within one of the main types. These include abuse by a partner; abuse by discrimination, disrespect and ageist attitudes; and structural/societal or systemic abuse, which involves marginalisation of older people within society (Glasgow & Fanslow, 2007). Also, although spiritual abuse has often been assimilated with other forms of abuse, several commentators argue that spiritual identity is sufficiently inherent to one's cultural identity, particularly in indigenous cultures, to be considered vital to health and respect. They suggest

that harm to one's spiritual integrity, lack of access to spiritual resources, and/or an inability to pursue spiritual growth should be understood as a distinct form of abuse (Gray et al., 2021; Thaggard et al., 2023).

Impact of abuse

The physical effects of abuse can be wide and include physical pain, broken bones and bruises, nutrition and hydration issues, sleep disturbances, impacted immune system, gynaecological issues, increased hospitalisations, decreased quality of life, and exacerbation of other health problems (Centres for Disease Control and Prevention, 2019; Podnieks & Thomas 2017).

Financial abuse resulting in significant financial losses may have an impact on health decline, with older people going without buying food, seeking medical help, or heating their home in order to give money to their abuser (Jackson, Shelly, Hafemeister and Thomas, 2013).

Psychological effects on a victim of AOP include depression and anxiety (in up to 20% of sufferers), loneliness and post-traumatic stress disorder (Lachs et al., 1998; Perel-Levin, 2008; Waldegrave, 2015). Other victims may suffer feelings of guilt, shame, fear and embarrassment, helplessness and insecurity (Dow et al., 2020).

AOP also affects the broader community through the costs of prevention and intervention services, and diminished engagement of the victim with society in general. Abuse can also affect the ability of an older person to live independently, with some older people seeing an increased need for home supports and others needing to move into long-term care (Dong & Simon, 2013).

Cases and types of abuse in Aotearoa New Zealand

In Aotearoa New Zealand, it is estimated that there will be around 1.2 million people aged 65 and over by 2034,[1] and nearly 180,000 people aged 85 and over (Office for Seniors, 2019). If one in six older people experiences abuse annually, that will amount to 200,000 people.[2] Overall population ageing means that, even if the prevalence of AOP does not rise, the actual number of people experiencing abuse is likely to grow substantially.

However, because there has been no national prevalence study, the current extent to which AOP affects New Zealanders has been hard to establish (Hall et al., 2022; Hynds & Leonard, 2023; Waldegrave, 2015). The closest population-level estimates of AOP come from an examination of interRAI assessment data which, depending on the threshold used, places the incidence of AOP at either 2% or 4.6% (Hall et al., 2022).[3] Research conducted as part of the 2010 and 2012 waves of the New Zealand Longitudinal Study of Ageing (NZLSA) reported

1 Although the WHO defines older age as starting at 60, this is not formally defined in Aotearoa New Zealand. Older age is most commonly understood as starting at 65, as this is when citizens become eligible for New Zealand Superannuation.
2 It should be noted that age-related conditions such as Parkinson's Disease or early-onset dementia can affect younger people as well as older people and may increase their vulnerability to abuse and neglect.
3 Assessment of AOP through the interRAI assessments is described on page 40.

the incidence of AOP to be around 10% in people over 65 years (Waldegrave, 2015). That study also reported that older Māori may suffer abuse considerably more often than older non-Māori (Waldegrave, 2015), although it is generally perceived that the abuse of older Māori, Pacific, Asian and older people of other ethnicities in Aotearoa New Zealand is still under-researched (Hynds & Leonard, 2023). Anecdotal data for older Pacific Peoples living in Aotearoa (Thaggard et al., 2023) suggests that abuse is more likely for older Pacific women and those with chronic illnesses (Glasgow & Fanslow, 2006).

Table 1 provides a summary of case report data from Age Concern's Elder Abuse Response Services (EARS)[4]. Age Concern New Zealand deals with some, but not all, cases of AOP. The figures show the high level of abuse within families. Formal carers of older people also make up a small proportion of perpetrators. Although these figures show that reported referrals about financial abuse have decreased compared with other types of abuse, the Family Violence Study reports an increase in controlling behaviours and economic abuse overall between 2003 and 2019 – 8% versus 13% and 5% versus 9%, respectively (Ministry of Justice, 2022).

Table 1: AOP referrals to Age Concern EARS providers from 2016 to 2022

Year	Total referrals
2021–2022	2,768
2020–2021	2,452
2019–2020	2,411
2018–2019	2,420

Table 1.1: AOP referrals to Age Concern EARS providers from 2016 to 2022: By perpetrator

Year	Adult child or their partner	Other family member	Friend or neighbour	Formal carer
2021–2022	46	37	15	2
2020–2021	48	36	14	2
2019–2020	46	38	14	2
2018–2019	46	35	16	3
2017–2018	46	34	17	3
2016–2017	44	32	20	4

Source: Age Concern New Zealand At a Glance reports (2017, 2018, 2019, 2020, 2021, 2022).
Note: Age Concern reports intervening in an average of 73% of cases where abuse was identified.

4 Elder Abuse Response Services (EARS) providers are contracted by MSD to address the immediate needs of older people experiencing or at risk of experiencing abuse or neglect.

Table 1.2: AOP referrals to Age Concern EARS providers from 2016 to 2022: By case

Year	Psychological	Financial	Physical	Neglect	Institutional	Sexual
2021–2022	89	37	18	12	4	1
2020–2021	83	40	20	13	3	1
2019–2020	88	44	19	14	5	1
2018–2019	84	51	17	15	5	1
2017–2018	78	49	16	14	5	1
2016–2017	79	54	19	17	2	1

Risk factors and influences

No single factor explains why individuals become perpetrators of harm. It is useful to perceive the risk factors and influences using a socioecological framework (Krug et al., 2002). Using this framework, abuse lies at four levels, ranging from those that are personal (individual and family level influences) to those less personal but with broader influences (i.e., community and societal level influences).

Individual and family level risk factors and influences

While older people are a heterogenous group with varying levels of ability, health and vibrancy (Kerse et al., 2016), general age-related factors can place some people at greater risk. Age-related declines in physical and mental health mean that some people rely heavily upon others for personal support, including, for some, managing their money. By itself, health decline does not lead to abuse, but it places some older people in a more precarious situation. For example, higher levels of cognitive impairment may increase vulnerability to coercion and exploitation (Fraga Dominguez et al., 2022). Dementia also provides a challenge in identifying abuse. Loss of physical strength and balance, in addition to being a risk factor, diminish an older person's ability to defend themselves. Physical impairment may also contribute to falls and injuries and makes it hard to know whether injuries are related to physical abuse or age-related change.

Large sample longitudinal population-based data from people aged 65 and over enrolled in the Canadian Longitudinal Study of Ageing (Burnes et al., 2021) found a heightened risk for abuse for older people with:

- health and functional impairments, including functional capacity and chronic health conditions
- lower or declining mental health (purported to be related to depression, life satisfaction, post-traumatic stress disorder and perceived mental health.

Mental health may also have an impact on self-worth, self-blame and isolation factors that could reduce a person's ability to protect themselves)
- a decline in cognitive status over time
- childhood maltreatment, and
- household cohabitation.

Most cases of AOP involve someone known to the older person where a reasonable expectation of trust has been violated (Hynds & Leonard, 2023; Peri et al, 2008; Woodhead, 2018). Perpetrators are often family members who have the responsibility of caring for their older relative and this is the case in Aotearoa New Zealand as well as overseas (Age Concern New Zealand, 2022). Older people are the largest recipients of informal care in Aotearoa New Zealand and difficulties in accessing home care and respite services (Synergia New Zealand, 2019) may create challenges for family members who are ill-prepared for the responsibility. Caregiver anxiety, depression and stress contribute to the elevated level of family abuse (Burholt et al., 2022; Valimaki et al., 2020). Informal carers also often receive little support through the caring process (Tough et al., 2022).

Other individual and family level risk factors include a poor relationship between the carer and care recipient (Valimaki et al., 2020), the older person's mental well-being and levels of loneliness (Yeung et al., 2015), social isolation, which may offer a perpetrator greater opportunity to abuse as well as the ability to conceal abuse (Pillemer et al., 2016), alcohol and drug abuse by either the perpetrator or the victim (Pillemer et al., 2016), and family greed (Peri et al., 2008), which can stress and undermine usually supportive relationships.

Community and societal risk factors and influences

Social structures are thought to facilitate AOP through ageist attitudes (Burnett et al., 2014; Hynds & Leonard, 2023; Ministry of Social Development, 2019; Perel-Levin, 2008). A stereotypical perspective of older people as frail and dependent continues to affect society's vision of ageing despite the vital contributions older people make to society (World Health Organization, 2021, 2022). The changing nature of families and Western values becoming more widespread across traditional societies are seen as contributing factors to abuse in Aotearoa New Zealand (Ministry of Social Development, 2019). Attitudes that undervalue or disrespect older people can also make older people themselves feel that they have less to contribute and feel like less-worthwhile citizens (Peri et al, 2008). Other societal level risks include social pressures that increase individual stress, such as housing and employment instability (Ministry of Social Development, 2019; Peri et al, 2008).

A New Zealand study by Peri et al (2008) discussed increased institutional risks for people living in residential care. Perceived influences on abuse included staffing issues related to training, funding, staff-to-resident ratios and organisation culture (Peri et al., 2008). Relative to individual and family level risk factors, more work needs to be done to understand community and societal level risks (World Health Organization, 2022).

Cultural conceptions of abuse in Aotearoa New Zealand

Family violence for Māori, Pacific and other older people of non-Western ethnicity in Aotearoa New Zealand is a more complex social construction. Cultural shifts away from traditional beliefs and concepts of village and family relationships and support, role conflicts, and social and linguistic isolation have been identified as culturally related drivers of harm (Hynds & Leonard, 2023; Park, 2014; Peri et al, 2008; Taranaki District Health Board, 2019; Thaggard et al., 2023).

Māori and Pacific peoples models of health

The cultural understanding of what constitutes abuse is also nuanced by context (Woodhead, 2018), and abuse can be understood alongside cultural models of health. For example, in Te Whare Tapa Whā, the most widely referenced Māori model of health, well-being is perceived to be four dimensional (Durie, 1985). Taha tinana represents physical health, taha hinengaro represents mental health, taha whānau represents family health, and taha wairua represents spiritual health. The four dimensions are symbolised by the four walls of a wharenui (house) and imbalance between them or a deficiency in any dimension, as can occur with abuse, is seen to compromise overall well-being. Pacific peoples similarly view health holistically (Thaggard et al., 2023). In the Fonofale model, one of several Pacific models of health, the self is represented by the fale (house), and different aspects of the self are represented by the house's foundation and pou (walls); the four walls represent mental, physical, spiritual and other aspects of health, such as economic means (Pulotu-Endemann, 2009).

Older Māori and Pacific peoples have traditionally been seen as leaders and holders of wisdom and knowledge and treated with respect (Durie, 1999). Disrespect, for example, of a person's spiritual needs, is a key concern for older people (Muru-Lanning et al., 2021; Thaggard et al., 2023). Muru-Lanning's qualitative study about what constituted good health found that older Māori prioritise wairua (the spirit and spiritual health) over physical health in relation to wellness (Muru-Lanning et al., 2021).

Cultural qualitative research about abuse

There has been little research conducted investigating cultural conceptualisations of abuse in Aotearoa New Zealand, but two research projects can offer insight. Thaggard et al. (2023) investigated what abuse meant for older Pacific peoples of Niuean, Tokelauan, Tuvaluan, Samoan, Tongan, Cook Island and Fijian heritage living in Auckland, and Park (2014) investigated a common conceptualisation of abuse as it applied to older Korean immigrants.

In Thaggard et al.'s (2023) work, the older people who were interviewed expressed that disrespect by the younger generation was a key concern of theirs as it violated the culturally normative values that they expected the younger generation to observe, such as obedience, courtesy, reverence and tradition. Using the Fonofale model as the viewing lens, psychological, neglectful, spiritual, financial and cultural disrespect, as interwoven with the fale's walls and roof, were interpreted by Thaggard et al. as acts of abuse to the older person's self-integrity. In using a culturally appropriate methodology, the study uncovered these deeper meanings of abuse from the normally reticent Pacific older generation. Thaggard et al. present their research as a breaking of the 'silence' under which abuse in Pacific Island culture is usually perceived.

Park (2014) interviewed ten older Korean immigrants to Aotearoa New Zealand to understand their psycho-social experiences of elder mistreatment. This study specifically looks at Korean migrants in New Zealand, examining how cultural factors and migration stress contribute to the abuse and its impacts. AOP in this context often involves physical, emotional, psychological and social mistreatment by family members. The term hwa-byung, which means "anger syndrome," describes a condition resulting from the suppression of anger. This syndrome is characterised by significant health issues, including both physical symptoms like headaches and chest pain and psychological issues such as anxiety and depression. Park's study highlights the severe consequences of elder mistreatment, underscoring the need for better support systems and protective measures for elderly migrants to ensure their health and well-being.

Barriers to reporting and measuring abuse

Despite the high number of known cases, many cases of AOP are not reported so the full extent of the problem may be much higher than believed (Pillemer et al., 2016). Non-disclosure of AOP in healthcare or community settings is affected by victim, tool user and instrument factors.

Victim factors

Older people may not perceive the harm being done to them if they do not understand abuse well enough to see it as a problem (Naughton et al., 2013). Other older people may know they are being mistreated but feel that it is the result of their own failure for being sick or dependent (Shugarman et al., 2003). Reporting abuse by someone they know requires significant courage of the older person and they may be influenced by guilt or a desire to protect the perpetrator, or by fear of retaliation (Brijnath et al., 2020). In other cases, an older person may feel shame in filing a report against a family member, which could delay seeking help until the abuse is so extreme that the victim faces no other option (Dow et al., 2020).

Tool user factors

Despite being in a position to witness the effects of abuse, health and other professionals are not necessarily consistent in reporting it. They may have varying levels of understanding about AOP or inadequate training on the signs of abuse, particularly financial abuse, so may miss important cues (Cohen, 2013). They may also be disinclined to get involved in legal issues, feel uncomfortable talking about mistreatment, or have limited access to usable screening and assessment tools or inadequate organisational support to aid the reporting of identified cases of abuse (Age Concern Auckland, 2023; Brijnath et al., 2020; Friedman et al., 2017).

Instrument factors

Although standardised screening and assessment tools can be an important aid to identifying abuse, they are not always used (Ries & Mansfield, 2018) as some are time-consuming or impractical in a clinical setting. Even when formal structured and guided assessment is available, abuse of older nonfluent English speakers may not be well captured as tools written in English, that make Western cultural assumptions, may be a poor fit for people of other cultures (Woodhead, 2018).

A consequence of underreporting abuse is that many older people who have suffered abuse will not receive the support they need. A better understanding of AOP is imperative. The WHO's advice to "generate more and better data on prevalence and risk and protective factors" includes a strong call to develop and use an effective detection instrument (World Health Organization, 2022). The next section introduces and discusses tools for assessment of AOP.

Section one: Literature review

The goals for the systematic literature review were to:

- **Identify and map** the available literature on screening and assessment tools for abuse and neglect of older people.
- **Assess the quality and validity** of the identified tools and identify any gaps or limitations in the literature.
- **Compare the identified tools** in terms of their validity, reliability, feasibility and cultural appropriateness, including for Māori, Pacific, Indian, Chinese and other ethnic groups residing in New Zealand and overseas.

An informal search uncovered more than 100 tools that assess some aspect of AOP. It is not feasible to review all of these, so the evaluation part of this section focuses on a systematic database search to find articles that include relevant properties of tool design and quality.

Methods approach

Grey literature search

An initial search of grey literature was undertaken to scope the literature on the topic.[5] The search sourced: a) agency webpages, policy and guideline documents, and commissioned reports, b) published articles including journal tables of contents and reference lists, and c) recommended readings and supplied references. Information from the grey literature was used to inform the following sections of the report: General approaches to screening and assessment; Guidelines and frameworks to guide measurement of AOP in Aotearoa New Zealand.

Grey literature was also used to supplement the comparison of tools returned in the database search. This supplementary material includes tool reviews and research papers and commentary about how tools have been adapted to other settings and populations.

Database search

Following a standard review methodology (Peters et al., 2015) the PsycINFO, MEDLINE, CINAHL and PubMed Central databases were searched to identify primary, peer-reviewed articles that had abstracts available. The search included Medical Subject Headings (MeSH) terms and keywords chosen for their similarity to terms used in other reviews (Table 2). The search terms are similar to those used by dos Santos-Rodrigues et al. (2022) in their review of validated AOP tools. All the main types of abuse are included, but selfneglect is excluded.

5 Grey literature is material found outside non-commercial or academic publications.

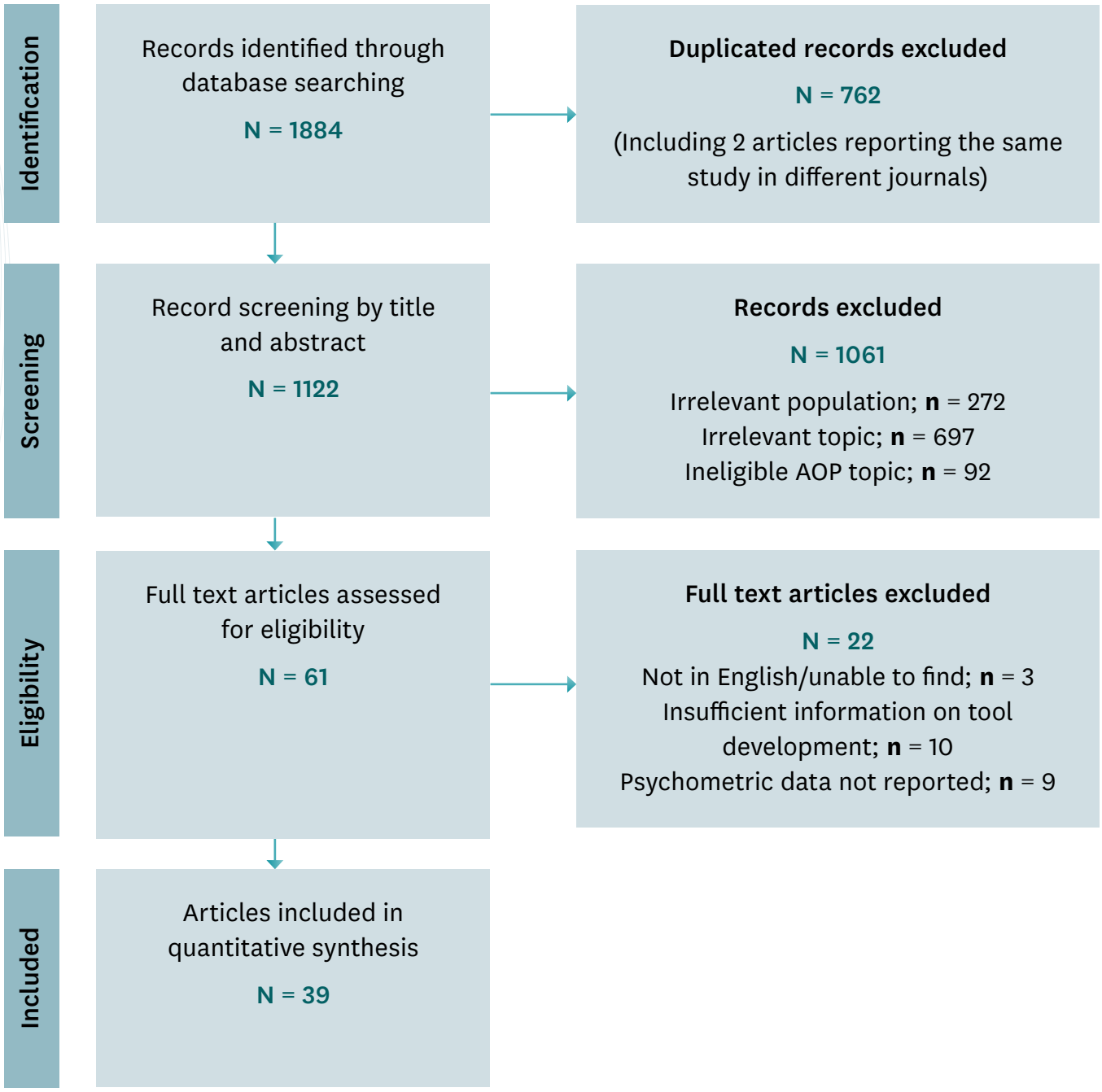
Table 2: Key concepts, MeSH terms and keywords

Key concepts:			
Older people in the community or residential care	Tools for screening or assessing	Abuse of older people	Assessment of quality
MeSH terms:			
Aged Aged, 80 and over Older Adulthood Geriatrics	Surveys Questionaires Screening	Elder Abuse	Psychometrics
Keywords:			
In title only	**In title only**	**In title only**	**In title, abstract, keyword**
"older adult*" "older people" elder* geriatric* resident* "long term" "long-term" institution*	OR tool* screen* assess* measure* tool* scale* question* identif* survey	OR abus* mistreatment violen* maltreatment* exploitation* negl* "psychological abuse" "financial abuse" "physical abuse" "verbal abuse" "emotional abuse" "sexual abuse" "domestic abuse" NOT "self neglect" "self-neglect"	OR quality psychometric reliability valid* sensitivity specificity predictive review translation culture

Eligibility criteria for the search were that the article included details of development of the tool, administration methods and quality indicators. The aim was to assess tool quality rather than article quality. Once duplicates were excluded, the search identified 1122 potential articles (see Figure 1). One thousand and sixty-one articles were excluded based on an irrelevant research topic or population, which left 61 articles to read in full. Irrelevant topics and populations included reports of intimate partner violence only, child abuse, self-neglect or neglect in other spheres of life. Further reduction was made for articles unavailable or not written in English (n = 3), and those missing details of either tool development. (n = 19).

Thirty-nine articles met the eligibility criteria and were peer reviewed to confirm eligibility status. Eligibility was considered to be met for one tool because, although development and psychometrics were reported separately in two articles, both articles were returned in the search and appeared as companion papers in the same journal issue. The final articles reference 38 AOP tools and are listed in the Appendix. Table A lists the tool name, year of development, first author surname, country of origin, original language, recommended setting, number of items, administration method, and aim of the tool. Unidimensional and multidimensional tools are listed separately and are ordered by year of development.

Figue 1: PRISMA diagram of search strategy



General approaches to screening and assessment

A recent review suggests that screening and assessment tools for AOP align with primary and secondary prevention strategies (Van Royen et al., 2020); that is, align with approaches to understanding the level of risk and prevention of further abuse through early detection. Standardised tools can also be an aid to initiating a conversation about abuse (Ries & Mansfield, 2018) and, when used appropriately, they can improve detection of AOP (Cohen, 2008).

The terms 'screening' and 'risk assessment' have been used synonymously in the literature but may be defined slightly differently. A screen is a process for examining potential for harm, whereas a risk assessment is a more comprehensive process that evaluates the likelihood of abuse and determines the level of risk. Neither assumes that abuse is present. Instead, they are precursors to case finding and intervention and are fundamental actions within a wider identification protocol. This section outlines current approaches to screening and assessment.

Risk assessment, questions and signs

Cohen (2013) has identified a three-part typology for screening which comprises: 1) identifying risk factors and precursors, 2) directly questioning the older person or an informant about experiences or behaviour, and 3) assessing signs and symptoms of abuse. Abuse may be invisible, yet directly questioning an older adult about the presence of abusive behaviour or assessing for signs of abuse may be confronting. Consequently, risk assessment is often a more common initial approach.

Risk assessment often bases questions upon known precursors or conditions that might suggest a risk of harm for an older person or might predispose a carer to abuse. Some assessments also measure the older person's decision-making ability. Moreover, assessing risk factors is important as abuse can develop as environmental conditions worsen. If the measurement of risk is considered to be a graduated process where greater risk (more factors or a more profound experience of abuse) implies a heightened likelihood of AOP (Glasgow & Fanslow, 2006), risk assessment can be envisaged as a component of enquiry within an assessment tool. Multiple sources suggest that screening also identifies 'at-risk' individuals (e.g., see Perel-Levin, 2008).

Direct questioning involves asking questions about the presence of abusive behaviour. Other types of questions might try to elicit the older person's perceptions and feelings but not directly question what might or might not have

happened. This second approach is often described as routine enquiry and can be an effective approach before formal screening. Eliciting admission of abusive experiences has been the mode of enquiry for most brief screening tools as a way to quickly assess potential for harm and has been advocated as the best approach for older people who present with alert features in a general enquiry (Glasgow & Fanslow, 2006). Signs of abuse are usually assessed from a physical examination or reports of harm such as bruising, fractures or burns.

In her typology, Cohen (2013) noted overlap between the three parts as, for instance, an older person can be asked directly about risk factors within their environment. This multi-part enquiry could be beneficial as it may improve identification of cases (Beach et al., 2017; Cohen, 2013). According to Cohen (2013), evaluating behaviour during risk assessment benefits the enquiry by inviting professional judgement of the person's behaviour. In healthcare settings, this accommodates a healthcare practitioner's years of skill and training. The professional assessor can also utilise their knowledge of behaviours that are normal for the person and their culture.

Universal, selective and opportunistic screening

Although screening is population-based, it can be universal, selective or opportunistic. Universal screening, also known as routine screening, of all older people in the absence of signs and symptoms has been widely debated but with no consensus reached. The arguments against routine screening are largely ethical. For routine screening to be most effective, detection tools need to be used by professionals who are aware of the risk factors, signs and effects of abuse, and who have empathy and the confidence to follow up their concerns; these professionals must also be supported by protocols and an intervention process to follow up positive cases (Glasgow & Fanslow, 2006). The lack of sufficiently compelling evidence that abuse screening tools are more likely than not to identify positive cases means that they are not, apart from in certain environments such as in emergency departments in the USA (see Burnett et al., 2014), recommended in any country for routine use. Given the degree of debate on this topic, this position is likely to continue to come under scrutiny and will be advanced by access to good quality data about tool usage.

Without routine screening, selective and opportunistic screening take advantage of the normal vigilance that professionals and health practitioners use in client or patient encounters. The need to enquire or delve further into an older person's situation may arise from signs, indirect evidence of risk, or 'gut instinct'. Progression to selective screening, also known as targeted screening, would be triggered by sufficient concern raised from initial indirect questioning, such as by asking the older person to describe how things are at home, for example, in a general way. Alternatively, opportunistic screening occurs when

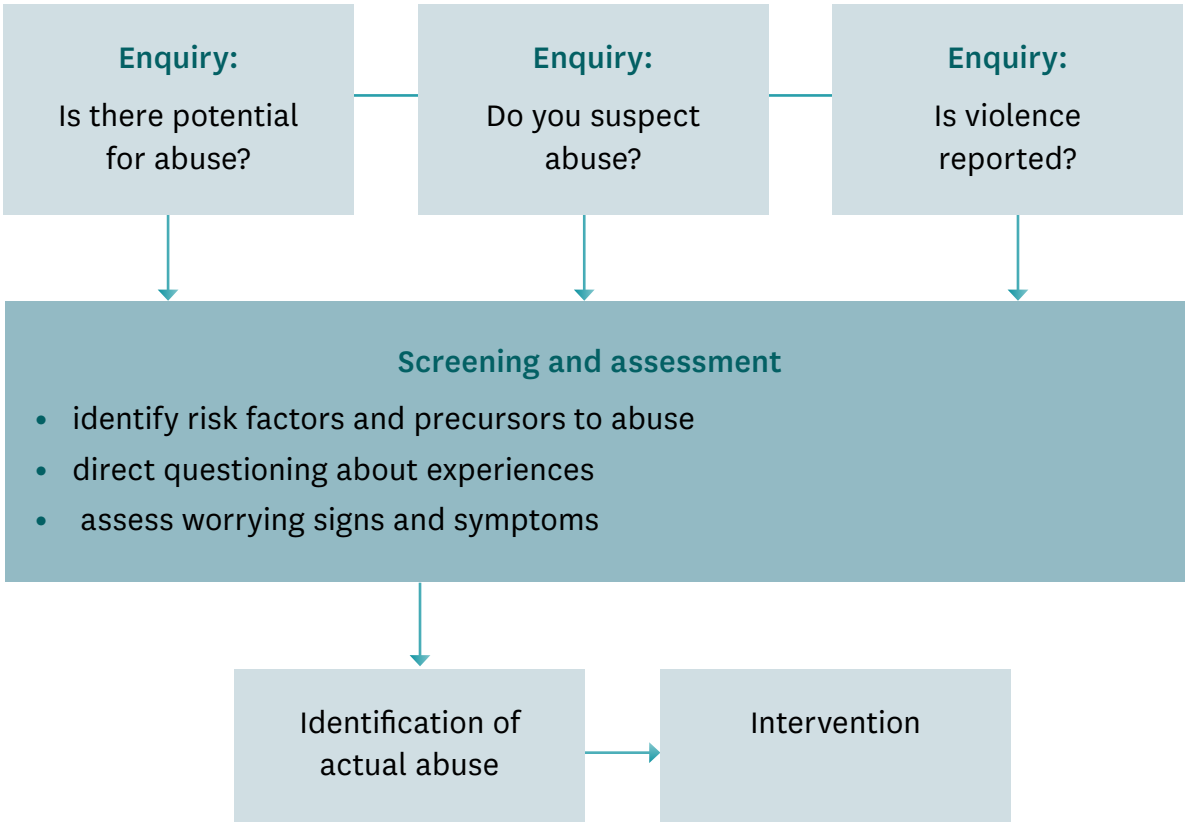
professionals or practitioners see individuals for other purposes. Examples of this are during standard health assessments such as the Comprehensive Geriatric Assessment used in the United States and the interRAI assessments used in Aotearoa New Zealand.

Screening and assessment are part of a system

Screening built into a formalised process has the benefit of setting up meaningful flow-on to assessment and intervention if it is needed. It also provides a tangible and reproducible record of contact. For older people who do not agree to further intervention, or who may need time to feel comfortable reporting abuse or accepting that they have faced abuse, a documented assessment can provide reference material for a future revisit if it is appropriate.

The main imperative is that people who screen positive are followed up by further testing or treatment to determine the actual presence of abuse and/or who perpetrated it. Screening and assessment, therefore, become part of the system of suspicion prompting formal identification that, when present, necessitates intervention that then leads to an outcome (Keys, 2003). Figure 2 provides a simple graphic representation of a process approach to identification of AOP.

Figure 2: Approach to screening, assessment and identification of AOP



Consent in the assessment process

Informed consent should be obtained prior to direct measurement of AOP (Glasgow & Fanslow, 2006). By obtaining informed consent, it is understood that the older person knows the reasons for and intention of the assessment and any potential risks they might encounter by answering questions about potential abuse or abusive behaviours. The ability to provide informed consent requires both the capacity to decide and the competence to communicate that decision (National Ethics Advisory Committee, 2019).

While a standard consent process is possible for most people, almost any person with the right support will be capable of making decisions about matters that affect them (National Ethics Advisory Committee, 2019). Aotearoa New Zealand currently has two methods to assist someone who cannot make a decision easily on their own and both methods may be applied in cases of suspected abuse.

- **Supported decision-making** retains the person's autonomy and choice by facilitating their own decision-making with the help of a support person. Rather than making decisions *for* the older person, the role of a supporter is to communicate full information about what is being asked, including the risks involved, in a manner that the older person can comprehend, to explore options with them about whether to act, and then help them to communicate their decision. Supported decision-making is an ethical and consumer right (Health and Disability Commissioner, 1996). Many older people with diminished decision-making capacity are informally supported by family members already.
- **Substituted decision-making** is used to obtain consent from a person who cannot give consent themselves, even with support. In this situation, someone else makes the decision on the older person's behalf. Utilisation of substituted decision-making requires finding out who is legally approved to make such decisions; often that will be the person who holds enduring power of attorney (EPOA) for the older person.

Supported decision-making is recommended over substituted decision-making because it does not remove the person's rights (Mental Health Foundation of New Zealand, 2023). However, supported decision-making is not currently embedded in New Zealand law. According to the current law, if a person wholly or partially lacks decision-making capacity, their decisions may not have legal effect. Striking the appropriate balance between human rights and undue influence is also potentially problematic as, for example, someone with EPOA may be the abuser. Over 2022/2023, the New Zealand Law Commission sought submissions on a review of the Adult Decision-Making Capacity Law with the intention of removing some of the perceived barriers to inclusion in decision-making, recognising te ao Māori principles (principles important in the Māori

world such as values, kin relationships, respect, compassion and spirituality),[6] and better facilitating the dynamic nature of decision-making across mental health, addiction, protection, common law and other areas of law (Law Commission, 2022). The review hopes to strengthen the safeguards within this area.

Supported and substituted decision-making will be required for more people as cognitive impairment and dementia are increasing in prevalence worldwide. In Aotearoa New Zealand, dementia is expected to increase from almost 70,000 people in 2021 to 170,000 people by 2050. People with cognitive impairment are both more vulnerable to abuse (Dong, 2015) and present more barriers to interviewing due to memory problems and their ability to comprehend and answer questions clearly. But respect for the rights of an older person with dementia to disclose abuse is no less important than for any other person. If there is any doubt about a person's ability to consent to measurement of AOP, health professionals are advised to assess the person's cognitive capacity before asking any questions.

Tools to assess AOP

Initial examination of the grey and published literature showed that AOP is a topic that remains current and important, including how, when and where abuse should be assessed. Since the first tools to assess AOP came out in the 1970s, over 100 tools have been developed. At least 40 of these were released in the last ten years. As yet, there is no gold standard assessment tool (Van Royen et al., 2020) and ongoing debate about the acceptability and quality of tools shows that usability consensus has not been achieved (dos Santos-Rodrigues et al., 2022; McCarthy et al., 2017; Perel-Levin, 2008; Ries & Mansfield, 2018). No tools have been developed in Aotearoa New Zealand and there are very few reports on measurement of AOP here. The international literature, therefore, provides a necessary context for the measurement of abuse in older New Zealanders.

The following data synthesis and discussion is based on the 38 tools found in the database search. Data synthesis is presented under six headings: setting and population, dimensionality, tool specifics, acceptability, psychometric properties, and adaptability. The numbers used in the tables in this section are reference numbers that can be found in the first column in Table A in the Appendix. To enhance readability, tool acronyms are used in the text. The full names of the tools and their acronyms are presented in Table 3.

6 Concepts relevant to te ao Māori and the law are defined in the Law Commission's 2022 review.

Table 3: Screening and assessment tools identified in the database search & acronyms

Name	Acronym
Abuser Risk Measure	ARM
Assessment Tool for Domestic Elder Abuse	ATDEA
Clinical Signs of Neglect Scale	CSNS
Elder Abuse Decision Support System (also short forms)	EADSS (OAFEM, OAEAM,OAPAM, OANM)
Elder Abuse Emotional Consequences Scale	EACS
Elder Abuse Suspicion Index Questionnaire about the attitude and exposure to abuse and neglect*	EASI
Elder Mistreatment Measure	EMM
Elders Psychological Abuse Scale	EPAS
Emergency Department Senior Abuse Identification	ED-Senior AID
Expanded-Indicators of Abuse	E-IOA
Family Members Mistreatment of Older Adults Screening Questionnaire	FAMOASQ
Family Violence Against Older Women Scale	FVOW
Family Violence Scale	FVS
Financial Exploitation Vulnerability Scale – Short Form	FEVS-SF
Financial Exploitation Vulnerability Scale	FEVS
Geriatric Mistreatment Scale three-part tool for the identification of abuse*	GMS
Hospitalized Elder Abuse Questionnaire	HEAQ
Hwalek-Sengstock Elder Abuse Screening Test	HS/EAST
Indicators of Abuse	IOA
Lichtenberg Financial Decision Screening Scale	LFDSS
Litchenberg Financial Decision Rating Scale - Short Form	LFDRS- SF
Native Elder Life Scale	NELS
Older Adult Financial Exploitation Measure	OAFEM
Older Adult Psychological Abuse Measure	OAPAM
Potentials and Risk of Family Care for the Elderly	PURFAM
Resident-to-Resident Elder Mistreatment - Staff version	R-REM-S
Responding to Elder Abuse in GERiAtric care-Self-administered abuse and neglect scale*	REAGERA-S
Risk on Elder Abuse and Mistreatment Instrument Questionnaire to assess elderly abuse by family caregivers*	REAMI
Self-Reported Neglect Scale	SRNS
Social Vulnerability Scale	SVS15
The Five-Item Victimization of Exploitation Scale	FIVE
Tool for Risk, Interventions, and Outcomes	TRIO
Vulnerability Abuse Screening Scale	VASS
Weinberg Centre Risk and Abuse Prevention Screen	WC-RAPS

For more detail about these tools, see Table A in Appendix page 106

Notes: 1. * These tools were unnamed in the development papers; the name given to them is a description.
2. See also Table A in the Appendix.

1. Setting and population

Although the majority of tools were developed in English-speaking countries, 15 were developed in countries with a non-English first language (see Table 4). Five tools were developed initially in two languages: the IOA in English and Hebrew, the EASI in English and French, the GMS in Spanish and English, the WC RAPS in English and Spanish, and the EACS in German and English. A review of screening tools by Perel-Levin reported that up until 2008, most tools were limited to North American origin (Perel-Levin, 2008). With the recent increase in tool development overall, culturally relevant tools are also starting to become available.

Recommended setting

Healthcare settings are often seen as the most appropriate places to screen for abuse as health practitioners see older people regularly and multiple times, and are trusted professionals (Burnett et al., 2014; Glasgow & Fanslow, 2006). Of 12 tools developed for healthcare settings, two were developed for use in clinical community services, four for use in primary care, and six for use in hospital settings (see Table 4). Tools targeted for the busy healthcare environment are some of the shortest in this review; for example, the EASI – one of the most widely used primary care tools – has only six items.

Table 4: Population for the screening and assessment tools

Population	Reference from Table A	Total #
Cognitive status mentioned		
In financial abuse tools	2, 5, 7, 8, 10	5
Embedded in the screen	5, 6, 8, 15, 27	5
Use with cognitively intact older people recommended	1, 2, 3, 7, 10, 16, 19, 20, 25, 30, 34, 36	12

Table 4.1: Country of origin of the screening and assessment tool

Country of origin	Reference from Table A	Total #
USA and Canada	2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 16, 18, 22, 23, 24, 25, 26, 30, 33, 34	20
Central America	17, 19, 29	3
Europe	9, 21, 27, 32, 36	5
Asia, including West Asia	1, 15, 20, 28, 31, 35	6
Australia	4, 14	2
Africa	33	1

Table 4.2: Settings for the screening and assessment tools

Recommended setting	Reference from Table A	Total #
Community	1, 3, 9, 11, 17, 18, 23, 33, 35, 36	11
Healthcare	6, 10, 15, 16, 21, 25, 27, 29, 30, 32, 34, 37	12
Aged residential care	22	1
Professional service agency (e.g., financial institutions and AOP services)	2, 5, 7, 8, 24, 26, 28, 31	8
Multiple settings	4, 12, 13, 14, 19, 20, 38	7

While the safety of a clinical setting means the older person can speak freely, screening for abuse in someone's home is another option because in the home, there is often more time available to develop trust. Home is also where most abuse happens. Social services and informal carers have been seen as potential yet underutilised users of a screening tool (Van Royen et al., 2020). Other non-clinical settings such as financial institutions have quite different requirements for an abuse screening tool and tools developed for financial institutions have commonly been brief (Lichtenberg, Gross et al., 2020). A small number of tools were developed for use across multiple settings. Tools such as the EASI that rely on clinical judgement as well as questioning the older person, limit their usefulness to other settings.

Population

Cognitive status or ability to make decisions was mentioned in 17 articles. Cognitive ability is linked to greater likelihood of financial exploitation (Lichtenberg, Campbell et al., 2020) and other mistreatment (Giraldo-Rodríguez & Rosas-Carrasco, 2013), so it is not surprising that unidimensional tools measuring financial abuse often include a measure of ability to make decisions – five out of the seven unidimensional financial screening tools included an item on ability to make decisions. Twelve tools had either an embedded item to measure cognitive status or ability to make decisions or recommended measurement of cognitive ability prior to using the tool.

More of the available tools are recommended for use with cognitively intact older adults. However, given the increasing prevalence of dementia in the oldest-old (those aged over 85) compared with the younger-old, the usability of many of these tools will be limited in the oldest-old age group. The EACS was developed specifically to address the challenges of interviewing people with age-related health vulnerabilities and dementia. For example, these people might have a greater need for assistance or to have a third-party informant to report abuse for them. Results of that study showed the structure of the EACS was appropriate for people with mild cognitive impairment. While it did not resolve a methodological issue that third-party proxies reported more abuse than older people who

answered for themselves, the authors suggest that proxy usage, consistent with greater health and cognitive impairment, might also be consistent with greater risk for abuse. Conversely, pilot testing showed that third-party presence during an assessment did not improve reporting, leading the authors to recommend that vulnerable people continue to be interviewed alone.

2. Dimensionality

Type of abuse and measurement tools

All types of abuse are measured in at least one tool and more tools are multidimensional than are unidimensional (see Table 5). Financial abuse was the most common type of abuse measured in a unidimensional tool, although psychological abuse and neglect were also measured separately. While unidimensional tools can devote effort to a single domain of enquiry in a parsimonious way (Wang et al., 2007), multidimensional tools have the advantage of screening for multiple risk factors at once, any of which can then be further assessed more comprehensively (Beach et al., 2017; Hwalek & Sengstock, 1986).

It is more common for older people to experience multiple types of abuse; for example, physical and psychological abuse often occur together (dos Santos-Rodrigues et al., 2022). Almost all the multidimensional tools assess neglect alongside other types of abuse, and this may be due to the increasing inclusion of neglect in modern definitions of abuse. The prevailing nature of neglect means that it is an important area to assess (Zawisza et al., 2020). Of the two tools that do not measure neglect, one is a measure of resident-to-resident abuse in ARC (the R-REM-S), so measurement of neglect would be inappropriate.

Although many tools assess sexual abuse, this form of abuse is purposefully excluded from some item analyses due to low reported prevalence in old age. Neise et al. (2022) and Wong et al. (2021) suggest sexual abuse is better examined by qualitative approaches. Where sexual abuse is assessed, few questions are asked, and where they are asked, they are direct; for example, “Have you been forced to have sex even if you did not want to?” (Giraldo-Rodríguez & Rosas-Carrasco, 2013). In the development article for that tool, the authors report a prevalence of sexual abuse less than 1% in the pilot sample. In other tools, institutional abuse was also difficult to measure reliably due to low prevalence (e.g., the EACS).

Table 5: Which tools are used to screen for and assess different types of abuse

Key: **P/E** = psychological/emotional abuse, **F** = financial abuse, **P** = physical abuse, **N** = neglect, **I** = institutional abuse, **S** = sexual abuse

Tool name	P/E	F	P	N	I	S	Other
EPAS	Yes	No	No	No	No	No	N/A
OAFEM	No	Yes	No	No	No	No	N/A
OAPAM	Yes	No	No	No	No	No	N/A
SVS-15	No	Yes	No	No	No	No	N/A
LFDSS	No	Yes	No	No	No	No	N/A
CSNS	No	No	No	Yes	No	No	N/A
FEVS	No	Yes	No	No	No	No	N/A
LFDRS-SF	Yes	Yes	No	No	No	No	N/A
SRNS	No	No	No	Yes	No	No	self-neglect
FEVS-SF	No	Yes	No	No	No	No	N/A
FIVE	No	Yes	No	No	No	No	N/A
H-S/EAST	Yes	Yes	Yes	Yes	No	Yes	N/A
IOA	Yes	Yes	Yes	Yes	No	No	N/A
VASS	Yes	No	Yes	Yes	No	No	N/A
E-IOA	Yes	Yes	Yes	Yes	No	Yes	N/A
EASI	Yes	Yes	Yes	Yes	No	Yes	N/A
Questionnaire about the attitude and exposure to abuse and neglect	Yes	Yes	Yes	Yes	No	No	N/A
FVOW	Yes	Yes	Yes	Yes	No	No	N/A
GMS	Yes	Yes	Yes	Yes	No	Yes	N/A
Three-part tool for the identification of abuse	Yes	Yes	Yes	Yes	No	Yes	N/A
PURFAM	Yes	Yes	Yes	Yes	No	Yes	N/A
R-REM-S	No	No	Yes		No	Yes	verbal, other
NELS	No	Yes	No	Yes	No	No	N/A
TRIO	Yes	No	Yes	Yes	No	Yes	N/A
FVS	Yes	Yes	Yes		No	No	N/A
EADSS short forms	Yes	Yes	Yes	Yes	No	No	N/A
ED-Senior AID	Yes	Yes	Yes	Yes	No	No	N/A
REAMI	Yes	Yes	Yes	Yes	No	Yes	N/A
Questionnaire to assess elderly abuse by family caregivers	Yes	Yes	Yes	Yes	No	No	control
FAMAOSQ	Yes	No	No	Yes	No	No	N/A

Tool name	P/E	F	P	N	I	S	Other
ARM	Yes	Yes	Yes	Yes	No	No	N/A
ATDEA	Yes	Yes	Yes	Yes	No	Yes	self-neglect, social
WC-RAPS	Yes	Yes	No	Yes	No	Yes	N/A
REAGERA-S	Yes	Yes	Yes	Yes	No	Yes	N/A
Abuse and neglect scale	No	No	Yes	Yes	No	No	Yes
EMM	Yes	Yes	Yes	No	No	No	N/A
HEAQ	Yes	No	Yes	Yes	Yes	No	Yes
EACS	Yes	Yes	Yes	Yes	No	Yes	Yes

Refer to acronym chart Table 3, page 33

3. Tool specifics

Measurement approach

Just over half the tools use known risk factors to screen for the potential for abuse. Thirteen of these question risk factors related to the older person or their environment, such as having poor sleep, mobility issues or a strained relationship with their carer, and five tools assess carer risk factors such as substance abuse or financial dependence. Greater assessment of the level or extent of abusive factors is included in a further 6 tools (sometimes prompted by risk in the same tool), also making them generally more comprehensive and longer. Choosing items based on risk presents the problem that not all risks will be present for an older person who has been abused, and nor will all risk factors that are present be related to abuse. The IOA, for example, exclusively measures risk factors, and the authors recommend caution when interpreting non-discriminating problem variables such as needing help with activities of daily living, having financial difficulties other than financial dependency, having physical or cognitive impairment, the caregiver's desire to institutionalise the care receiver and caregiver stress, as they do not always signal abuse (Reis & Nahmiash, 1998).

Of the eight tools that measure objective signs of abuse, six are multi-part assessment tools. The multi-part tools returned in this search utilise direct questioning plus observed physical signs (E-IOA, three-part tool for the identification of abuse, ED-Senior AID), separate nurse and team assessments (PURFAM), and assessment of risks, outcomes and interventions (TRIO). In general, assessing abuse in multiple ways did not necessarily take longer to administer than tools that asked direct questions only.

Nine tools incorporate questions that require stating the name of a potential perpetrator (EADSS short forms, OAFEM, OAPAM) or identifying a potential

perpetrator by kin or other relationship (FIVE, FVOW, GMS, NELS, questionnaire to assess elderly abuse by family caregivers, ARM). Measurement of the relationship between the older person and the perpetrator allows researchers to understand abuse in the wider social context (Wong et al., 2021). Despite the importance of identifying a potential perpetrator, the ARM is the only tool that assesses carer risk factors at the same time.

Administration method

Some tools have been developed for administration by interview; others have been developed for respondents to complete in privacy (see Table 6.1). There is some research to say that self-administered tools are preferred when responding to questions about violence (Yaffe et al., 2012).

Of the two tools that can be completed electronically, the CSNS is a clinical assessment of signs of neglect and does not consult the older person, and the TRIO uses electronic system prompts to facilitate further investigation of potential cases of abuse. Electronic recognition of AOP is a parsimonious method of data collection that can be automated, integrated with existing health records, linked to clinical advice (Friedman et al., 2017), and improves inter-rater consistency (Sommerfeld et al., 2014). A disadvantage is the lack of inclusion of independent observation (Sommerfeld et al., 2014).

Table 6: Measurement

Measurement approach	Reference from Table A	Total #
Risk screener	4, 5, 6, 8, 10, 11, 12, 13, 14, 16, 17, 21, 23, 25, 28, 29, 30, 31, 33, 34, 36, 37	22
Older person and environmental risks	1, 4, 7, 9, 12, 13, 14, 15, 20, 21, 24, 28, 33	13
Carer risks	13, 15, 24, 28, 31, 33	6
Assessment	1, 2, 3, 7, 9, 15, 18, 19, 20, 22, 24, 26, 27, 32, 35, 38	16
Objective signs of abuse	6, 13, 15, 21, 22, 24, 27, 28	8
Multi-part	1, 15, 20, 21, 24, 27	6

Table 6.1: Administration method

Administration method	Reference from Table A	Total #
Self-report older person	3, 7, 8, 9, 10, 11, 12, 14, 17, 18, 19, 23, 25, 30, 33, 36	16
Self-administration possible	12, 14, 25, 34, 35, 37	5
Interview older person	1, 2, 5, 13, 15, 16, 20, 24, 26, 27, 29, 31, 38	13
Self-report or interview completed in whole or part by a third-party	4, 6, 13, 15, 21, 22, 28, 32	8
Case notes or electronic	6, 24	3
Multi-part	1, 15, 20, 21, 24, 27	6

Eight tools can be completed with the assistance of a third-party – either staff in a hospital or ARC setting by observation at the time of assessment (CSNS, IOA, E-IOA, PURFAM, R-REM-S), or a knowledgeable informant such as a caregiver on behalf of an older person living in the community (SVS15, REAMI, ATDEA). The SVS15 was developed to assess the older person's gullibility to financial abuse and was developed to improve reporting for people with cognitive impairment. The ATDEA was developed for home visit nurses in Japan and assesses the older person's social vulnerability as well as vulnerability to abuse but it does not justify the tool's use by nurses rather than self-reportingby the older person.

Response format and tool length

The most common method of scoring for screening tools is to assign a positive screen if positive responses from yes/no questions reach a threshold. Seventeen of the tools use a yes/no format (see Table 7). Although yes/no questioning is common and quick (depending on the number of questions), Likert-type scales, where the respondent chooses the closest answer on a scale of, generally, 3–5 options and which offer greater granularity in measurement (Brijnath et al., 2020), are preferred by health professionals. Likert scales are used in 13 of the tools in this review. Checklists are an alternative, usually quick, scoring method utilised in an interview or self-report questionnaire.

Finally, this section reports on the length of time to administer the tools. Ten tools are reported to be brief or can be administered in under five minutes. The results are hampered by missing time-to-complete in some of the articles but, based on the average administration time for similar tools, another four appear to be part of this brief set (abuse and neglect scale, LFDSS, SVS15, R-REM-S). Some tools are purposefully shortened adaptations of long-form tools (EADSS short forms, FEVS-SF, OAFEM, OAPAM, LFDSS, LFDRS-SF, SVS15, questionnaire about the attitude and exposure to abuse and neglect). The longest tools tend to be face-to-face home interviews or tools that assess abuse in more than one way. Tools that are brief as well as assessing abuse in more than one way are potentially most useful, although rarer, because they are both brief and comprehensive; for example, Cohen's three-part tool for the identification of abuse and the ED-Senior AID.

Table 7: Response values

Response format	Reference from Table A	Total #
Yes/no response	1 ,2, 3, 5, 11, 12, 14, 16, 17, 19, 24, 25, 26, 30, 31, 33, 34, 36	17
Likert response	4, 8, 9, 10, 13, 15, 18, 23, 24, 28, 35, 37, 38	13
Checklist	13, 15, 21, 22, 32	5

Table 7.1: Length of the tool

Response format	Reference from Table A	Total #
Brief (under 5 minutes)	10, 11, 14, 16, 20, 21, 27, 34, 36, 38	10
5-15 minutes	1, 12, 25, 26, 28, 30	5
15-30 minutes	8, 37	2
Lengthy (over 1 hour)	13, 15, 19, 24	4
Not reported	2, 3, 4, 5, 6, 7, 9, 17, 18, 22, 23, 29, 31, 32, 33, 35	16

4. Acceptability

Data gathered about development of the tool items and evaluation of the tool's use can inform acceptability. The acceptability for both the older people and the professionals administering the tool in whatever way it was measured is reported below.

Item development and review

The items contained in the tools were developed from known risk factors or obtained from literature reviews or other research studies, or from a panel of experts – usually gerontologists or nurses and abuse professionals (see Table 8). Representatives from psychology and law were included in the multidisciplinary review team for the CSNS and psychometric academics were included in the team that assessed the ED-Senior AID. Soliciting expert clinical or field knowledge enhances the validity of the item content as a representation of abuse. However, inviting older peoples' perceptions of what they think abuse feels like or how they would want to be asked about abuse may grant the tool greater overall acceptability because older people can then suggest terminology they are comfortable with. Focus groups or interviews with older people to suggest or agree to item content were used in the development of the 18 tools, with a few of these specifically using cognitive interviews where older people assessed question grammar and comprehensibility before the tool was piloted. Thirteen articles report both expert and user evaluations.

Both qualitative and quantitative methodologies were used in the development of 24 of the tools. Of the others, three tools were developed using only literature review, three used only qualitative interviews, six brief tools were based on other tools and used statistical methods or author choice to reduce the number of items. Three articles did not report the item development process.

Table 8: Question item development and review

Item selection and review	Reference from Table A	Total #
Literature or research review	1, 2, 3, 4, 6, 9, 12, 13, 16, 17, 18, 19, 21, 22, 23, 28, 29, 31, 32, 33, 35, 36, 38	23
Based on a previous tool	5, 7, 8, 10, 11, 15, 20, 24, 25, 26, 34	11
Evaluation of questions expert panel	1, 2, 3, 4, 6, 8, 9, 11, 12, 15, 16, 18, 19, 21, 23, 27, 28, 31, 33, 34, 35, 38	22
older adult	1, 2, 3, 16, 18, 19, 23, 27, 29, 30, 31, 33, 34, 37, 38	15
user	2, 3, 22, 24, 27, 30, 31, 32, 33	9
Not reported	14, 30	2

Table 8.1: Tool evaluation

Tool evaluation	Reference from Table A	Total #
Consumer	1, 21, 29, 33, 34, 37	6
Expert or tool user	6, 21, 24, 25, 28, 33	6

Tool evaluation

While content, face validity and focus group assessment of questions prior to their confirmation as a tool item can provide assurance of comprehensibility, the acceptability of a tool in a real-world situation may be different. Below is a description of the way items were evaluated for acceptability. Overall, very few articles reported acceptability to older people or tool users (see Table 8).

Evaluation by older people

- Four tools were rated as comprehensible and readable by older people (PURFAM, Mahmoudian et al.'s (2018) questionnaire to assess elderly abuse by family caregivers, HEAQ, and FAMAOSQ). Readability of the WC-RAPS was formally assessed using readability software.
- Three tools were assessed as user friendly – the EPAS, PURFAM and HEAQ.
- Older people also rated the PURFAM checklist items for relevancy, finding them useful for dealing with problematic care situations.

Evaluation by users

- Four tools were evaluated positively in terms of features such as its length – the REAMI used by social services staff, the FVS used in primary care, the WC-RAPS used by long-term support services for older people, and the PURFAM used in outpatient's clinics. The experience of using the REAGERA-S in ARC was rated moderately overall.

- Moderate to good ratings of the tool's fit into busy workloads were given by staff using the PURFAM (78% rated the tool as realistic to use in their everyday work), the CSNS used in ARC (rated as feasible), and the TRIO (Adult Protection Service (APS) case workers found the electronic version of the tool not overly burdensome to administer).
- Two articles reported that using a screening tool increased the user's knowledge and awareness of abuse. For the EASI, 97.2% of primary care doctors thought the tool would have a positive impact on their practice. Formal caregivers reported the REAMI to have increased their knowledge of AOP and they became more alert for signals.
- The articles for the TRIO and REAMI also reported on work satisfaction. Social workers using the TRIO said they felt better because the tool improved client risk assessment and the tailoring of interventions within the service, while REAMI users felt that the tool enhanced their confidence to report abuse because of the evidence it provided when reporting positive cases.

Few authors mentioned training requirements to administer their tool; however, when training is required, it can add significant complexity to a tool and impact the setting and profile of who would be an appropriate user. The LFDSS, for example, was developed to reduce the training demands of the longer tool it was based upon to improve usability. On the other hand, Reis and Nahmiash (1998) recommend that training the users of screening tools to identify possible abuse cases is vital for ethical reasons. The TRIO requires substantial training as it is intended to be used collaboratively to report client outcomes to social workers, supervisors and administrators. As such, a requirement is that it contributes to the older person's management plan. Users expressed that any burden in terms of training and tool complexity were outweighed by the tool's thoroughness and its impact on workflow and work satisfaction.

A review by Brijnath et al. (2020) adds further context to the usability of AOP screening tools in a healthcare setting. Australian health professionals were asked to assess the relevance to their practice of five tools, chosen from a previous literature review as having high internal rigour. They were asked to comment on readability, time required for completion and acceptability of the VASS, EASI, EAI, CASE and BASE. The tools were overall rated poorly. Brijnath et al.'s final evaluation was that a successful AOP screening tool should be concise, easy to use, account for the older person's health and social vulnerabilities, and outline a referral pathway if abuse suspected.

5. Psychometric quality comparison

Tool quality is often assessed by its psychometric, or measurement, properties as well as properties related to its usability. Important aspects of a tool's psychometric quality are its validity, reliability and ability to identify positive cases. Previous reviews have highlighted a lack of psychometric assessment, as can be seen by gaps in the data in Table 9.

Validity is the extent to which the items in the tool measure what they propose to measure (abuse). Face and content validity assess the appearance of the items as a measure of the construct, while criterion validity measures the construct against a reference standard measure. Concurrent and predictive validity are measures of criterion validity (de Souza et al., 2017). Construct validity is the degree to which the items measure the construct using a statistical test. Convergent and discriminant validity are measures of construct validity (de Souza et al., 2017).

Reliability is the consistency of the tool to measure the construct in different situations. Internal reliability measures how closely related the items are as a group. Cronbach's alpha is a common measure of reliability, and the general rule is that a Cronbach's alpha of 0.70 and above is good, 0.80 and above is better, and 0.90 and above is best. Having fewer items in the assessment will tend to lower the Cronbach's alpha (de Souza et al., 2017). The Kuder-Richardson test also measures reliability with values close to 1.00 considered ideal (Souza et al., 2017).

High sensitivity and specificity provide greater assurance of detection. Sensitivity refers to correctly detecting the construct when it is present (a true positive), and specificity refers to correctly identifying people without the construct (a true negative). As a measure of quality, both should be reported, and both should be over 80% for the tool to have high utility. Sensitivity over 50% is preferred.

Table 9 reports the validity, reliability, sensitivity, and specificity for the tools returned in this database search on the pilot population. The tools are ordered according to their main method of administration – self-report, self-administration, interview, and by other methods where the older person is not consulted.

The tools highlighted in Table 9 are discussed in more detail in the data synthesis section.

Table 9: Psychometric properties of the screening and assessment tools / Administration by self-report

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
3	Older Adult Psychological Abuse Measure	not reported	31-item 0.92 18-item 0.87	not reported	not reported
7	Financial Exploitation Vulnerability Scale	Construct	0.82	not reported	not reported
8	Lichtenberg Financial Decision Screening Scale - Short Form	Construct, predictive, convergent	not reported	25%	99%
9	Self-Reported Neglect Scale	Construct	Total 0.91 Domains 0.81-0.92	not reported	not reported
10	Financial Exploitation Vulnerability Scale – Short Form	Construct, predictive	0.85	75%	70%
11	The Five-Item Victimization of Exploitation Scale	Construct, convergent	0.35	not reported	not reported
12	Hwalek-Sengstock Elder Abuse Screening Test*	Construct, content, concurrent	0.29	94%	High false negative rate
17	Questionnaire about the attitude and exposure to abuse and neglect	Discriminant	Attitude 0.87 Exposure 0.89	not reported	not reported
18	Family Violence Against Older Women	Construct	0.97	not reported	not reported
19	Geriatric Mistreatment Scale		Total 0.83 Psychological 0.82 Physical 0.72 Economic 0.55 Neglect 0.80 Sexual 0.87	not reported	not reported
23	Native Elder Life Scale	Construct, criterion	NELS-FE 0.65 NELS-N 0.78	not reported	not reported
30	Family Members Mistreatment of Older Adults Screening Questionnaire*	Construct, concurrent	0.89	86%	90%
33	Weinberg Centre Risk and Abuse Prevention Screen	Content, face	Risk 0.82 Abuse 0.90	not reported	not reported

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
36	Elder Mistreatment Measure	Face	Psychological 0.59 Coercion 0.21 Financial 0.42 Physical 0.43	not reported	not reported

Notes: 1. Cronbach's alpha is reported unless stated otherwise; K-R20 = Kuder-Richardson test 2. nr = not reported

Table 9.1: Psychometric properties of the screening and assessment tools / Administration by Self-administration

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
14	Vulnerability Abuse Screening Scale	Construct, content, face, predictive	0.31-0.74	Positive correlation with abuse factors	
25	Family Violence Scale		0.95	not reported	not reported
34	Responding to Elder Abuse in GERiAtric care-Self-administered*	Construct, face	not reported	Lifetime 72% Current 88%	Lifetime 92% Current 92%
35	Abuse and neglect scale	Discriminant, concurrent, convergent	0.90	not reported	not reported
37	Hospitalized Elder Abuse Questionnaire	Construct, content, face, convergent	0.89	not reported	not reported

Notes: 1. Cronbach's alpha is reported unless stated otherwise; K-R20 = Kuder-Richardson test 2. nr = not reported

Table 9.2: Psychometric properties of the screening and assessment tools / Administration by Interview

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
1	Elders Psychological Abuse Scale	Content, criterion	K-R20 of 0.82	nr	nr
2	Older Adult Financial Exploitation Measure	Construct	Full form 0.97 54-item 0.95 30-item 0.93	nr	nr
5	Lichtenberg Financial Decision Screening Scale	Criterion	nr	nr	nr
13	Indicators of Abuse	Criterion, construct	0.92	nr	nr

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
15	Expanded-Indicators of Abuse*	Construct, criterion, discriminant, content, face, concurrent, predictive	0.78-0.91	93%	98%
16	Elder Abuse Suspicion Index	Criterion	nr	47% (71% with a supporter)	75%
20	Three-part tool for the identification of abuse*	Discriminant, predictive	0.88	92%	86%
24	Tool for Risk, Interventions, and Outcomes	Face, concurrent, predictive	High inter-rater agreement of overall and scale scores	nr	nr
26	Elder Abuse Decision Support System (EADSS) – short forms	Construct, criterion, predictive	OAFEM 0.89 OAEAM 0.88 OAPAM 0.86 OANM 0.66	OAFEM: 20-58% OAEAM: 34-73% OAPAM: 25-71% OANM: 25-30%	OAFEM 96%+ OAEAM 97%+ OAPAM 95%+ OANM 97%+
27	ED-Senior AID*	Predictive	100% inter-rater agreement of suspicion of abuse	94%	90%
29	Questionnaire to assess elderly abuse by family caregivers	Construct, content, face	0.98	nr	nr
31	Abuser Risk Measure	Construct, predictive	21-item 0.91 9-item 0.84	75-80%	75-80%
38	Elder Abuse Emotional Consequences Scale	Construct	nr	nr	nr

Notes: 1. Cronbach's alpha is reported unless stated otherwise; K-R20 = Kuder-Richardson test 2. nr = not reported

Table 9.3: Psychometric properties of the screening and assessment tools / Administration without the older person present

Reference Number	Tool name	Validity	ReliabilityΩ	Sensitivity	Specificity
4	Social Vulnerability Scale	Construct	Total 0.90 Gullibility 0.85 Credulity 0.86	nr	nr
6	Clinical Signs of Neglect Scale	Criterion, predictive	nr	unweighted 69% weighted 90%	unweighted 51% weighted 23%
21	Potentials and Risk of Family Care for the Elderly	Face	Insufficient information in English to report psychometrics		
22	Resident-to-Resident Elder Mistreatment - Staff version		0.74 Verbal 0.73 Physical 0.65	nr	nr
28	Risk of Elder Abuse and Mistreatment Instrument	Construct, content	0.74-0.89	nr	nr
32	Assessment Tool for Domestic Elder Abuse	Content, face	nr	nr	nr

6. Adaptability

Revisions to better fit tools to other settings include shortening the tool to simplify administration, modifying the item content or structure to improve the tool's quality rating, and adapting the tool to improve cultural acceptability. Using the tools returned in the database search as a basis, the purpose of this section of the report is to demonstrate the breadth of adaptation that has occurred.

Shortening the tools

Development papers recommend either revision, or adaptation and validation in other settings to widen a tool's usage. The EADSS suite of tools is a collection of questionnaires that together assess financial, psychological and physical abuse, as well as neglect. They were used successfully together by APS case workers to substantiate reports of alleged abuse, but case workers reported in follow-up interviews that they were too time-consuming to administer. The brief versions were created to address the need to systematically collect comprehensive and reliable information on each abuse type in less time. The number of items were reduced based on high correlation with APS case workers' substantiation (conclusion that abuse had occurred) and the authors comprehensively validated the resulting scales (Beach et al, 2017)They concluded that the ability

to detect subtler forms of abuse made them a useful balance between detecting abuse and minimising time burden, but the longer forms provide a bank of items that may be useful if a comprehensive AOP assessment is warranted. The EADSS domains can also be used individually.

Similarly, Irizarry-Irizarry's (2008) questionnaire about the attitude and exposure to abuse and neglect is a multi-part tool that includes measurement of risk factors for the older person and their caregiver, signs of abuse, and the older person's self-disclosure of abuse.[7] The tool was developed to capture both subjective and objective indicators of abuse in a brief yet complementary way. The author suggests using one of the three sub-tools if time is short and the setting is appropriate.

The LFDRS was shortened from 68 items to 34 to create the LFDRS-SF. Good convergent validity and clinical utility were found (Lichtenberg & Gross, 2020). Because of its brevity, the authors promote the tool as a more efficient financial decision rating scale. The LFDRS was also adapted in 2020 to the FEVS, which is a 17-item unidimensional measure of financial decision-making that used just the contextual factors from the LFDRS (Lichtenberg & Gross, 2020). The authors found that the three domains of the scale (financial awareness, financial vulnerability, and susceptibility) were internally consistent and correctly predicted financial exploitation. To extend the usability of the tool in clinical gerontology settings, the FEVS was shortened again to create the FEVS-short form, in which the items were reanalysed with factor analysis to obtain a valid measure. The authors concluded that the FEVS-short form is a better predictor of exploitation than demographic factors and several measures of cognitive functioning.

Overall, the shortening of a tool has shown that validity can be maintained with fewer questions.

Modifying the item content and structure

Yaffe et al. (2012) has shown that self-administering an AOP tool is acceptable to older people and also improves general practitioner and patient awareness of abuse. The 6-item EASI has been a popular screening tool and was subsequently adapted by the original authors to improve its usability. A version for self-administration (5 items) was developed in 2012 (Yaffe et al., 2012) and a version for use in long-term care facilities (8 items + 1 user item) was developed in 2019 (Ballard et al., 2019). The self-administered version removed the user item and simplified the coding. Initial administration demonstrated it to be acceptable and comprehensible to older people due to its brevity. The original EASI works well in primary care as it raises doctors' levels of suspicion about the presence of abuse by increasing their awareness of what AOP might look like. Patients who self-administered the tool in their doctor's waiting rooms reported increased awareness of abuse and improvements in levels of understanding the manifestations of abuse.

7 This tool was unnamed in the development paper, so the title used here is a description.

The long-term care version of the EASI adapted the questions for relevance to institutional care and includes additional guidelines for administration with institutionalised older people. Overall, the ability for a tool to be self-administered may enable professionals to expediently assess a situation for safety.

Developed as one of the first screening tools to assess AOP, the H-S/EAST is a multidimensional screening questionnaire that can be administered fairly quickly by interview. Despite common usage, the tool's quality has come under criticism by some (e.g., Buri et al., 2009) but high face validity has led to the use of some of the items in other tools. Two notable adaptations of the H-S/EAST are the VASS, which uses ten H-S/EAST items and has become a well-used tool itself, and the NELS, which uses the financial abuse and neglect items of the H-S/EAST in a culturally specific approach.

Culturally specific tools

The simplest approach to cultural adaptation is to translate an existing tool. Many tools have been successfully translated from English. For example, the EASI is available in ten languages and the HS/EAST has been translated for Turkish and Portuguese populations. Cross-cultural validation has been conducted for translated versions of the LFDSS, FEVS, H-S/EAST, IOA, E-IOA, VASS, EASI, EADSS short forms, and the ED-Senior AID.

Two other approaches include adapting the items of an existing tool for a different population and creating a tool specifically for the population it is intended for. Adapting a tool to serve another population and setting might be easier than creating a new tool. Two of the domains of the H-S/EAST were adapted by Jervis et al. (2014) to better measure financial abuse and neglect experienced by older American Indians as it was considered that items on the existing tool such as banking scams were not applicable to the local people. Extensive community consultation was sought to improve comprehensibility of the questions and highlight salient aspects of potential abuse. The resulting NELS questionnaires was validated for Northern Plains and South Central older American Indians.

Tools developed from the start for a particular cultural setting will be better suited there and may avoid some of the issues with response reticence or denial of a problem and non-compliance with referrals or intervention that may occur if the original tool does not adequately fit behaviours in a different population (Beach et al., 2017; Struthers et al., 2009; Wang et al., 2022). Using a collaborative approach that consults with older people as well as staff who work in the area when developing questions will enhance culturally relevant content. First Nations commentary suggests that it is more than the questions asked, however, but the approach to asking about abuse that must be ethical for it to be culturally safe (Struthers et al., 2009). Thus, the contextual understanding of abuse is

an important consideration. For example, the older people who informed the FAMAOSQ tool defined mistreatment according to their culture as "to not have support from one's family and to not be cared for, and especially when one is sick or when one needs assistance with everyday life tasks" (Ruelas González et al., 2021). The GMS also defined abuse according to the phenomenon's contextualisation in the Mexican population (Giraldo-Rodríguez & Rosas-Carrasco, 2013). Although consultation with older people was commonly undertaken, it was less common for adapted tools to be evaluated after development.

Data synthesis of six high quality tools

As previous literature reviews have consistently highlighted the inadequacy of psychometric measurement (Gallione et al., 2017; McCarthy et al., 2017; Perel-Levin, 2008; Reis & Nahmiash, 1998; Van Royen et al., 2020), six tools with high reliability, sensitivity and specificity, as shown in subsection 5 and Table 9, were selected as case examples and are now discussed below. Advantages and disadvantages of the tools from subsections 1–6 are also discussed.

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

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) (Gallione et al., 2017; Hwalek & Sengstock, 1986; McCarthy et al., 2017; Neale et al., 1991; Perel-Levin, 2008; Reis & Nahmiash, 1998; Van Royen et al., 2020) is one of the earliest and most widely used tools to assess all types of abuse and risk for abuse. Fifteen items fit three conceptual categories: overt abuse, risk for vulnerability and situational factors. The tool is recommended for use in a health or social services setting where further assessment can follow up positive cases. Tool design and validation were tested with people identified as abused or not abused by aged care service providers. The low internal reliability shows that the HS/EAST is not homogeneous, but this was deemed reasonable due to the variety of abuse types that the tool measures. Although internal reliability was improved in two later studies (Buri et al., 2009; Moody et al., 2000), the ability to discriminate AOP remained low. Advantages of the tool are that it is brief, can be used in multiple settings, can be self-administered and has been used and validated cross-culturally. Even though the high false negative rate means more people will be identified as abused who are not, at the time the tool was developed it was a good option because other tools had not been validated at all. Evaluation of the tool by older adults was not assessed.

Expanded – Indicators of Abuse (E-IOA)

The E-IOA test (Cohen et al., 2006) was developed from Reis and Nahmiash's IOA screen to identify risk factors for signs of abuse where the abuse may not be evident. The IOA was translated from English to Hebrew and validated in Hebrew, then used as the basis for the E-IOA. The E-IOA operationalises 15 indicators of abuse and standardises administration by including 47 sub-indicators based on widely known physical and mental disorders. Evident signs and symptoms of abuse are also measured to differentiate probably abused from probably not abused individuals. Face validity during development demonstrated the appropriateness of the items and rigorous psychometric testing shows high validity and reliability of the tool. The tool was piloted in two-hour interviews with patients in two major hospitals in Israel. The tool user was trained in identification of signs of AOP prior to assessment. In summary, although the tool is comprehensive and well validated, its length and complexity suggest that older adults may find the interview tiring and assessment for people with cognitive impairment will be limited. For the same reasons, the E-IOA is inappropriate for busy healthcare environments and community settings. Additionally, care must be taken when assessing only risk factors as risk does not equate with actual abuse.

Three-part tool for the identification of abuse[8]

Cohen (2013) combined direct questions to the older person, a list of risk factors that were based on the E-IOA, and a measure of signs of abuse in a brief tool set that could be used by social welfare or health services in a short time to optimise identification of cases. The tool is standardised to minimise differences in health practitioner interviewing and diagnostic skills. It was piloted across four studies and included participants from various types of communities and cities and different socioeconomic and ethnic groups, as well as those in long-term care. The final version was validated in a large sample of older people receiving care at home. Cohen recommends that the tool set be used as a combination; however, the tool components can also be used independently as well, according to the requirements of the available time or the setting. At face value, this tool has good psychometric properties; however, as validity was focused on a community sample, wider validation would be required. The assertion that together the tool components are more able to identify abuse than a tool focused on one mode of enquiry also needs further testing. On the other hand, the tool is brief and easy to score and the ability to administer one part of the tool alone makes it useful in different environments.

8 This tool was unnamed in the development paper, so the title used here is a description. Access to authorship to obtain more information about the tool was unsuccessful. Nevertheless, we include it in this section because it has some appealing features.

Family Members Mistreatment of Older Adults Screening Questionnaire (FAMAOSQ)

The FAMAOSQ (Ruelas-González et al., 2018) is culturally and socially tailored to older adults in Mexico. It is aimed at firstline health practitioners as an early alert to potential abuse. Development of the tool specifically incorporated advice on tool design and item type from the intended end-users – older adults, health service providers and legal experts. The final 15-item tool asks older adults direct questions about abuse and their emotional well-being in relation to mistreatment. Overall, the FAMAOSQ has advantages of brevity, and ease of answering and administering. There are fewer items than the GMS, which was also developed for older Mexicans, but the FAMAOSQ has better internal consistency. Disadvantages include no assessment of financial or sexual abuse and a lack of post-development evaluation with older adults.

Emergency Department Senior Abuse Identification (ED-Senior AID)

The ED-Senior AID tool (Platts-Mills et al., 2018) is a multidimensional, multi-part tool that includes a brief cognitive screen (four items) and six items to assess abuse. A 12-item physical examination is included if the tool user judges the individual to be unable to report abuse, or for those for whom the presence of abuse is uncertain or suspected, in which case the collection of additional information can support a report to elder abuse services. Following use of the screen, the tool user provides their clinical judgement by answering the question: "Based on all information available including the answers the patient provided, patient's chief complaint, and any observations you have made, do you suspect an ongoing problem of elder abuse?" The tool was developed for a busy emergency department, and while it could be administered in a community health practice, it may be unsuitable for use by anyone without professional experience of AOP. On the other hand, clinical intuition can be an aid in abuse detection (dos Santos-Rodrigues et al., 2022). Also, although the ED-Senior AID is very good at identifying cases and non-cases of abuse, its acceptability to older people as a complete tool has not been assessed. The authors noted some administration and patient limitations in the development work, including lack of assessment with people with severe cognitive impairment and psychiatric conditions, inter-rater and clinical judgement biases, and small sample size. At the time of piloting, a multi-site validation study was planned.

Responding to Elder Abuse in GERiAtic care – Self-administered (REAGERA-S)

The REAGERA-S (Simmons et al., 2020) was intended to be multidimensional (including five types of abuse), acceptable and brief. It is a 9-item self-administered questionnaire for hospitalised older people that measures experiences of abuse. The tool was developed in Sweden using wording acceptable to the Swedish population and the selected items were reviewed by geriatric experts and older people. A robust translation process ensured an English version of the tool was the same as the Swedish version. The tool was further developed throughout the piloting phase. In contrast to other tools, the final item wording, yes/no response format and layout is reported to be acceptable to older people and the Swedish version of the tool seems psychometrically sound. While the tool itself is brief, it is intended to be supplemented with a standardised clinical follow-up of positive cases to determine actual abuse and lifetime experience of abuse. However, this would be the case for many tools so may not limit REAGERA-S's use. A valid, acceptable, self-administered tool that older people can complete in private is uncommon and is obviously promising for a busy hospital environment. The use of the REAGERA-S with people who have greater cognitive impairment is planned, but further validation in other settings and with other cultures also needs to be done.

Measurement of AOP in Aotearoa New Zealand

No tools have been developed in Aotearoa New Zealand or specifically designed for older New Zealanders. Measurement here is largely achieved through selective or opportunistic screening. Although individual agencies may have their own internal guidelines, protocols or approaches, two publicly available approaches may guide practitioners to navigate the issue and two tools that have been used to assess abuse.

Frameworks and tools

Family Violence Intervention Guidelines: Elder abuse and neglect, 2006

The **Family Violence Intervention Guidelines: Elder abuse and neglect** (Glasgow & Fanslow, 2006) was written to support the Ministry of Health's response plan to reduce family violence. Designed as a practical resource to improve health providers' understanding of AOP and their confidence to act, the guidelines provide an expert-driven approach and framework under which to generate an intervention process for identified cases. The guidelines offer a six-step model with pointers on ways to:

1. **identify** abuse using questioning
2. **support/empower** the older person and validate their storytelling
3. **assess** the level of risk and urgency to act
4. **plan,** with the older person, how to keep them safe
5. **document** the discussion and any actions taken, and
6. **refer** cases for intervention.

To identify abuse in Step 1, general open-ended questions are recommended first, with progression to direct questioning about abuse when a combination of alert features or signs of abuse are found. Although there is no scoring recommendation, nine direct questions are suggested. The questions are derived from the American Medical Association guidelines (Aravanis, 1994) and ask about all types of abuse, including neglect:

- Has anyone at home ever hurt you?
- Has anyone ever taken anything that was yours without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone ever touched you without consent?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you to take care of yourself when you needed help?

Questioning the older person's caregiver is also recommended but only if the tool user thinks it is safe to do so. Effectiveness of the guidelines revolves around embedding them in an approach that includes training for providers about the risks and effects of abuse as well as cultural competency and empowering approaches they can take when working with older people; local policy and protocols to support all persons involved; and connection with effective follow-up. EARS are an important step in the framework.[9]

The Family Violence Intervention Guidelines: Elder abuse and neglect framework is an active document. Within the family violence programme, the Ministry of Health funds, resources, trains and monitors violence intervention programmes (VIPs) run through the district health boards (DHBs). These programmes were set up to improve identification and management of partner abuse and child abuse and neglect and can also utilise the guidelines for AOP screening (e.g., Violence Intervention Programme; Taranaki DHB, 2019)

9 For further information about EARS, see MSD publications on the current state and future strategy for EARS in Aotearoa New Zealand (Ministry of Social Development, 2019, 2020).

Safeguarding Adults From Abuse (SAFA)

The SAFA programme is a multi-agency response framework that originated as a guide for the disability sector. The programme is described in a review of a pilot initiative conducted between Waitematā DHB and Waitematā Police in 2016 (Appleton-Dyer & Soupen, 2017). The SAFA format does not separate the abuse of older adults from that of other vulnerable adults, but it does aim to better equip first-line response agencies with a process to deal with concerns about people who are experiencing abuse. Also, as the programme is focused on actions beyond assessment, there is minimal content in the framework on screening or assessing for abuse. Nevertheless, the review of the pilot found that Police felt more confident in recognising and responding to vulnerability. The review recommended greater education and training for Police to enhance their recognition of potential abuse and also placed strong emphasis on the need for interagency engagement and embedded referral pathways.

The interRAI assessments

The interRAI assessments (Morris et al., 2013) are a suite of clinical instruments used across the world for assessing health and social indictors for older people who are perceived to be vulnerable to adverse health outcomes. Aotearoa New Zealand uses five of the 20 available instruments. Measurement of risk of abuse is part of the comprehensive assessment for home-dwelling residents (interRAI-HC) but cannot usually be administered separately to the other questions in the assessment. The abuse-related Clinical Assessment Protocol trigger items (A-CAP) include: fear of a family member or carer; unexplained injuries, broken bones or burns; appearance of neglect or mistreatment; or signs of physical restraint (e.g., limbs restrained, bed rails used, or being constrained to a chair when sitting). The advantages of assessing for abuse within a widespread existing comprehensive assessment are that it takes advantage of multidisciplinary input and that people with no other indications might be picked up through symptom measurement (Hall et al., 2022). Including questions about abuse within an integrated process also minimises the need for repetition by the older person (New Zealand Guidelines Group, 2003). Amendment of the interRAI-HC to broaden the scope of abuse detection by including items coded as “unable to determine” has been proposed (Hall et al., 2022).

Measurement of AOP in Aotearoa New Zealand research

The Vulnerability Abuse Screening Scale (VASS; Schofield & Mishra, 2003) was developed for the Australian Longitudinal Study of Women’s Health and was used in the NZLSA (Waldegrave, 2015; Woodhead, 2018, Yeung et al, 2015). Twelve items assess four domains of abuse: vulnerability and coercion, which are linked to physical abuse, and dependence and dejection, which are linked to psychological abuse (Office for Seniors | Te Tari Kaumātua, 2016). The VASS

is derived from the HS/EAST and uses 10 of the 15 H-S/EAST items with two new items added. It is brief to administer as the questions only require yes/no answers. Data from the NZLSA study have informed understanding of the prevalence of AOP in Aotearoa New Zealand. The tool was developed to improve construct validity of the H-S/EAST and has been further improved by adaptations made during the NZLSA study. Moderate internal consistency was improved by reducing the number of items from 12 to 7, modifying the subscales and adapting the risk threshold (Woodhead, 2018).

In a population-based study, the Family Violence Study (Ministry of Justice, 2022) interviewed 2888 New Zealanders from Northland to the Waikato between 2017 and 2019. Although the study assessed violence against women, people over 60 years were over-represented (33%). Data were gathered on exposure to physical, sexual and psychological abuse, controlling behaviour and economic abuse. The questions about prevalence and risk of abuse were based on the WHO Multi-Country Study on Violence Against Women. Overall family violence has declined since 2003. Data from this study contribute prevalence data for Aotearoa New Zealand.

Literature review summary

The goal of this literature review was to identify and map the tools that are currently available to assess AOP and compare their quality. While screening is an aid to improve detection of AOP, screening for abuse should be part of a broader systemic response to the identification of AOP. The MOH's **Family Violence Intervention Guidelines** for elder abuse and neglect were written for this purpose. Effective management of abuse should include an understanding that disclosure is complicated for the older person, recognise the weight of the tool user's decision to ask about abuse, and highlight the imperative that both the assessor and the older person are surrounded by systems of support and process. A clear referral pathway that informs, guides and supports all staff engaged in abuse screening is important.

There are significant variations in the type and degree of abuse experienced by older people. Some types of abuse are more visible than others (dos Santos-Rodrigues et al., 2022). Screening is an early detection approach but may not be the first step. When abuse is suspected, informal questions that ask about the home situation, for example, can be a sensitive way to broach the topic and are often generated by a 'gut instinct' or clinical intuition.

The literature review and data synthesis has highlighted diversity in both the usability and quality of tools. Standardised screening and assessment tools can be used not only for a more directed identification of abuse but have several additional benefits:

- They improve case-finding (Cohen 2008) and increase healthcare provider sensitivity (Yaffe et al., 2008).
- They reduce measurement variability within their sphere of use (Gallione et al, 2017; New Zealand Guidelines Group, 2023).
- They can improve the confidence of informal caregivers to report abuse by providing back-up documentation (De Donder et al., 2018).

A tool should be fit for purpose

Type of tool

As abuse can occur in any setting, choosing a tool in response to a particular situation or to suit a particular environment has been seen as a reasonable approach. Nevertheless, within any setting, there are many tools to choose from. Reviews on the usability and validity of AOP tools from the last ten years have focused on emergency departments and clinical settings where older people visit at higher rates than other age groups (Kayser et al., 2021; Mercier et al., 2020), as well as residential care where there is a duty of care imperative (Malmedal et al., 2020; Schultes et al., 2021).

Greater focus now needs to be placed on tools that can be used in the community where in-home care providers may see more subtle signs of abuse and where financial exploitation is more evident (Jackson, 2018; Ries & Mansfield, 2018; Sooryanarayana et al., 2013; Van Royen et al., 2020), and, by community-based health services where older people are seen regularly and changes in their health or demeanour may be noticed (Burnett et al., 2014; Caldwell et al., 2013; McCarthy et al., 2017).

The consensus of these reviews is that short but multidimensional tools are preferable. Short screening tools may enable periodic measurement if abuse has not been identified but where there is suspicion, or screening for an increasing level of risk (Age Concern Auckland.,2023; Burnett et al., 2014; Cohen et al., 2013). Tools that are multidimensional are preferrable for most settings because of the interlinked nature of types of AOP (Yi et al., 2019) and their association with health outcomes (e.g., New Zealand Guidelines Group, 2023).

The rise of financial scams in an increasingly digital world has seen banks put more effort into keeping their customers safe. Screening specifically for financial abuse within the financial industry is not only useful to detecting financial exploitation but may be able to raise general awareness of this sort of abuse.

In other settings, when unidimensional tools are used, complementary tools that can assess other forms of abuse at the same time may also be needed (dos Santos-Rodrigues et al., 2022; Gallione et al., 2017). To improve the scope of identification of abuse, Cohen (2013) and Beach et al. (2017) developed tool sets

that assess multiple aspects of abuse (three-part tool) or dimensions of abuse (EADSS short form) and that can be delivered in parts depending on the needs of the situation. As well as being comprehensive, both tool sets are brief so may speed up intervention time for positive cases.

Overall, fitting the tool characteristics to the environment may be more useful than having a gold standard tool (Gallione et al., 2017; McCarthy et al., 2017). For example, tools that are very brief may be suited to busy hospital environments like the emergency department, while other hospital departments may be able to use a tool that includes a physical examination. Tools that ask direct questions, which may be confronting, are better suited to primary care where the person is known and abuse is suspected rather than seen. The ability to build rapport and trust is imperative to effective assessment (Brijnath et al., 2020; Simmons et al, 2020).

Institutional abuse, which encompasses specific behaviours unique to settings such as aged care facilities, necessitates the use of a specially designed assessment tool. As noted by Neise et al. (2022), institutional abuse includes dynamics and forms of mistreatment that are not readily applicable to other environments. These may involve neglect, inadequate medical care, inappropriate use of restraints and financial exploitation, among others.

Training

Training opportunities include basic education about AOP that is included in formal curricula for tool users, examination by users of their feelings about abuse to address ethical issues, and training programmes that are interdisciplinary and include older people's perspectives about abuse (Perel-Levin, 2008). Fewer tools are designed for community delivery and, although members of the general public lay people may not "sufficiently know how to recognise risk factors or potential cases of abuse" (Ministry of Social Development, 2019), others highlight the public awareness value when tools, and hence the topic of AOP, are made visible (De Donder et al., 2018; Yaffe et al., 2012). Lawyers and home care workers could be enabled to screen for abuse (Ries & Mansfield, 2018). Judges and schoolteachers could be better equipped to advocate for intergenerational solidarity by receiving training and resources that emphasise the importance of fostering connections and understanding between different age groups (Perel-Levin, 2008).

Tool quality and acceptability

While there is compelling evidence to tailor a tool to a particular setting, tool reviews commonly highlight the need for more work to be done around tool quality. Important aspects of tool quality are the tool's validity, reliability and ability to identify positive cases. All tools have advantages and disadvantages. Overall, further psychometric and sensitivity/specificity testing of AOP tools

is needed to improve user confidence that AOP is correctly identified and erroneous assumptions are not made about the existence of abuse (McCarthy et al., 2017; Perel-Levin, 2008; Ries & Mansfield, 2018).

The current review findings support previous reviews that highlight a lack of acceptability of AOP tools by older people (Perel-Levin, 2008; Ries & Mansfield, 2018; Van Royen et al., 2020).

Even tools designed to address the challenges of interviewing the most vulnerable older people – with features like brevity, adaptability across settings, and inclusion of ability to make decisions – have not been adequately evaluated with older respondents. For older people to feel confident in reporting abuse, especially from a trusted family member, the tool must effectively facilitate this process.

Understanding what is acceptable to older people in terms of the questions and approach to asking them, as well as what is acceptable for tool users, will improve interprofessional practice on referrals and interventions (Perel-Levin, 2008).

Adaptation of tools

This review found a limited cross-sectoral usability of tool design (Van Royen et al., 2020). A cultural approach to measurement of AOP might include developing a culturally relevant conceptualisation of abuse (Giraldo-Rodríguez & Rosas-Carrasco, 2013; Ruelas-González et al., 2018) and choosing items that reflect the local understanding of abuse (Wang et al., 2007). Collaborative design is imperative for both new tool development and adapting an existing tool to a new environment (Jervis et al., 2014; Ruelas-González et al., 2018).

Cultural sensitivities that would play a part in any health consultation should also be factored into the consent and administration process; for example, considering the person's language, having the assessment administered by someone from the same culture, allowing whānau or family support in the interview if the older person would like them to be there, and allowing time for relationship building and trust. In some cases, an interpreter or cultural advocate may be necessary (National Ethics Advisory Committee, 2019).

In all cultures, establishing a positive relationship between the person being assessed and the assessor is crucial for the quality of the measurement, leading to potentially better outcomes. Despite critical commentary advocating the separation of cultural and spiritual dimensions of abuse from other forms, and qualitative research highlighting the importance of spirituality to Indigenous populations, no assessment tools currently incorporate spiritual items. To address this gap, there needs to be a better understanding of how integrating "sacred justice" (Gray et al., 2021) can prevent cultural "unsafety" (Struthers et al., 2009). This understanding should be prioritised in the development of new assessment tools.

Section two: Key stakeholders narratives

Abuse of older people, including kaumātua, and their safety are sensitive issues, with research hampered by concerns about the safety of participants simply for speaking up. People involved with the care of older people include a range of community members, specific organisations tasked with responding to abuse, and those tasked with keeping the peace and safety of the public.

Objectives

The second part of this project involved interviewing a cross-section of practitioners in a variety of healthcare settings about their current practices in detecting and intervening in AOP and their views of AOP screening tools. The interviews were designed to:

- **identify** any potential barriers or facilitators to the use of these tools in clinical and community settings, in order to
- **develop recommendations** for the use of screening and assessment tools in the detection and management of abuse and neglect of older people.

Interview methods

Research design and approach

A qualitative research methodology guided this stakeholder engagement project.[10]

Qualitative methods

Recruitment of participants for this project involved snowball sampling, a non-probability sampling technique. The process involved identifying initial participants through the research team's existing contacts and networks and then asking these participants to refer other potential participants. This method was beneficial for the project due to the limited time frame available, as the snowball method allows for relatively quick recruitment. All potential participants contacted were willing to be interviewed.

Ethical considerations included seeking and gaining approval from the University of Auckland Research Ethics Committee: Reference No AH26170.

Data collection procedures

For this project, semi-structured interviews were the most appropriate method because they provide a robust and insightful way to gather valuable information on stakeholder views (Patton, 1998).

Thus, semi-structured interviews were chosen as the preferred data collection method because they would provide understanding of current practices to prevent and detect abuse and neglect of older people in community and healthcare settings. Specific cultural norms, societal dynamics and regional challenges may also be illuminated during semi-structured interviews.

10 This report uses the term 'abuse of older people/person' (AOP), although the term 'elder abuse' is also used if captured in quotes of participants.

The development of the semi-structured interview questions was informed through various lenses, including the objectives of the project, from experts who work in the field of AOP, and from evidence gained during a preliminary scan of the literature about the abuse and neglect of older people.

Fifteen participants consented to and participated in interviews. Interviews were conducted at a time and place selected by the participants and lasted between 30 and 60 minutes. Twelve participants preferred to be interviewed via Zoom, with three preferring in person. The demographics of the participants are given in Table 10.

The semi-structured interview schedule provided flexibility to adapt questions based on participants' responses and allowed for open-ended conversations that enabled participants to express their views in detail. The schedule also allowed the researcher to follow up on interesting or unexpected insights, delving deeper into specific aspects of the conversation. All interviews were audio recorded and transcribed verbatim, and video recordings were deleted after completing online interviews.

Table 10: Participants' demographics

Participant type	Number of participants	Organisation
Social workers (SW)	4	NGOs and Te Whatu Ora
Gerontology nurse specialist (GNS)	1	Emergency Department, Te Whatu Ora
Elder Abuse Response Service (EARS) provider	3	Te Whatu Ora and NGO
Geriatrician	1	Te Whatu Ora
Nurse practitioners (NP)	2	Primary care (1); mental health and old age Te Whatu Ora (1)
Dentist	1	Private practice
General practitioner (GP)	1	Primary healthcare
Community service manager (CSM)	1	NGO

Data analysis

Analysing the de-identified interview data involved systematically examining, organising and interpreting the information collected to uncover patterns, themes and insights. This required a stepped approach. First, transcribed transcripts were read several times to gain a broad understanding of the data. Following this, notes were made on initial impressions, patterns and potential themes. This open coding approach began to identify patterns in the participant narratives.

Initial coding and recoding

Code segments of text that represented significant meanings or concepts were highlighted, and a descriptive label assigned. These descriptive narratives and codes were shared with co-researcher team member (KH) and reviewed to see how the research findings sat within the broader scholarship (Dow et al., 2020). During these discussions, differences were compared and resolved by consensus. This process also allowed similar codes to be grouped into preliminary categories and sub-themes. For example, education and training were grouped within the 'needs required in a screening tool' catgeory, and also informed the theme 'enablers and barriers'. It was crucial to stay close to the data during this stage of initial analysis to process the material consistently (Strauss & Cobin, 1994).

Iterative process

Coding and categorising continued until no new insights were obtained. This reflective and iterative process provided the vehicle to deliver the emerging themes.

Creating categories and themes

On completing this iterative process, several group-related codes were confirmed, and the final categories and themes and sub themes were formed.

Results

Table 11 presents the main themes and sub-themes from the rich data provided from the research participants.

Results from the stakeholder interviews provided illuminating information about screening and assessment for abuse and neglect of older people, as well as comprehensive insights into current practices and challenges encountered. The stakeholders worked across a range of healthcare settings. Six main themes were identified during the qualitative analysis: 1) current practices to identify abuse and neglect of older people, 2) current barriers and enablers in practice, 3) collaborative efforts, 4) future needs and a national screening tool, 5) considerations for tool design and implementation, and 6) cultural considerations.

Table 11: Key themes and sub-themes

Key themes	Theme context	Sub-themes
Current practices to identify abuse and neglect of older people	Discusses and explores existing assessment process for AOP	• Knowing but at a distance • Clinical assessment and routine inquiry • Risk assessment frameworks beyond screening • Risk assessment from a secondary source • Beyond current practices
Current barriers and enablers	Introduces the numerous benefits and significant barriers that may be encountered	• Barriers: stigma complexity limited resources, legal and ethical implications, and training • Enablers: standardisation, early detection, increased awareness, training, and education
Collaborative efforts	The significance of a collaborative approach to ensure provision is both timely and appropriate in service delivery	• Multi-level approach • Multidisciplinary rather than sole practitioner • Family-supportive collaborators
Future needs and a national screening tool	Encompasses dimensions to ensure the effectiveness of a screening tool	• Views regarding a national screening tool
Considerations for tool design and implementation	Introduces key factors that might be important during tool design	• Co-design including older people • Unidimensional or multidimensional tool
Cultural considerations	Describes the diverse factors and perspectives to ensure the screening process is accessible and relates to the ethnic diverse Aotearoa New Zealand population	• Language • Training • Vulnerable special populations

Current practices to identify abuse and neglect of older people

Ways of detecting abuse and neglect

Ensuring the safety and well-being of older people within the community is perceived as a key role for everyone. Healthcare staff have an important role in detecting and reporting AOP ("Health professionals need support to target elder abuse", 2023). Detection and identification of abuse is the first essential step for any intervention (Yan, 2022). A recent Swedish study that involved abused older people found that the victims wanted healthcare staff to show interest and ask questions to enable them to disclose their situations (Simmons et al., 2022). Although aware of the possibilities of abuse or neglect, participants in this project found that it was often not at the forefront of their interaction with an older person. For example, for those working in day programmes for older

people, identifying and addressing a potential abuse or neglect case might be through a secondary source such as a van driver transporting older people to a day centre. The clinical manager from a day programme reinforced this sentiment, saying:

> **We probably don't think enough about it, you know. Like if this is a change in someone's behaviour, you know is there something going on here – is it a challenging behaviour or are they receding into themselves because of abuse going on at home? (Clinical manager, day programme)**

This participant felt that bi-annual training updates on abuse and neglect of older people might significantly improve the under-detection by those in the community of potential abuse of older people situations. This is supported by several reviews that found that education should be provided with in-depth training to improve both skills and confidence in detection and reporting of abuse (Gama, 2017; "Health professionals need support to target elder abuse", 2023).

Clinical assessment and routine enquiry, or "a gut feeling"

For the participants who worked more closely with older people, identification of potential abuse or neglect relied on more traditional approaches, including clinical assessment and routine enquiry.

For several experienced participants, the terms clinical assessment or routine enquiry was called "a gut feeling" and commonly referred to as professional clinical "intuition". This is supported by studies that state that the situation is often complicated by the unwillingness or inability of the victim to disclose abuse. It was also reported that a general increased suspicion by practitioners experienced in working with older people who have been abused is more likely than a screener to increase detection rates in primary care settings (Walling, 2005).

One practitioner described working alongside a community district nursing team and stated that "the district nurse would often go into the home and discover something is going on – or get a gut feeling and bring it back to the social workers to action" (NP, Te Whatu Ora). These factors were found in other studies that noted the importance of community-based nurses' reliance on intuition and on-the-spot observations when identifying elder abuse (Brijnath et al., 2020).

Intuitive recognition of a situation is based on previous experience and is described as "a direct apprehension and response without rationale"(Erlingsson, 2012). Yaffe et al. (2009) found that approaches to questioning were discernible between social workers, nurses and doctors. The social workers' approach was based on the need to advocate for clients, nurses' questions were influenced by practical concerns in relation to the present situation, and doctors' concerns tended to be holistic and tempered by practicalities.

In support of Yaffe et al.'s (2009) findings, gut feeling in this study went a lot deeper for one of the participating social workers who stated: "You have that gut feeling that things aren't right for that person? Right? You don't discuss any of these signs or feelings straight away. We're not looking for blame or anything like that" (SW, NGO).

Routine enquiry for the more experienced was seen as a standard and acceptable practice, as expertly explained by one social worker who said, "I think working with older people is important. Yes, it's the rapport and the trust that you need to build. You know those questions first up for anyone is confronting" (SW, community based). Engaging in open and honest conversations with the older person can sometimes reveal instances of abuse. However, this approach may be challenging, as abuse victims may be hesitant or fearful of disclosing their experiences.

Although challenging, Yan et al. (2022) highlighted the importance of inquiring into AOP when providing routine services, alongside the need to build rapport and trust. Building a relationship of trust and strong client–practitioner relationships lead to desirable outcomes (Brijnath et al., 2020; Burnes et al., 2016). Regardless of the detection process, active listening and respecting client autonomy and privacy were considered essential in both this research and the international literature (Joubett & Posenelli, 2009).

Risk assessment goes beyond screening

Detecting and preventing elder abuse requires the involvement of professionals and community partners from many disciplines. It is a community problem, a legal issue, a social concern and a medical matter (van Royan, 2020). Risk assessment is seen as a process of balancing the potential benefits and harms of alternative actions and based on the 'do more good than harm' ethical principle (Gambril, 2011).

Risk assessment and management was perceived by participants to increase positive outcomes and reduce potentially poorer outcomes, and in turn, make something fit for purpose for the organisation and those working with potential abuse cases. To support this, in some workplaces, elder abuse providers have developed their own risk assessment tools, which assist the team in understanding the level of risk and support a triage process that ensures urgent and complex cases are coordinated in a timely manner.

As one social worker stated, "We use a structured framework that helps us work out the risk and complexity when we receive a referral" (SW, NGO). Risk assessment in this context refers to both risk and complexity implying the possibility of an adverse outcome or injury. Both internal and external factors can contribute to vulnerability and risk. An awareness of what constitutes intolerable risk can help determine when immediate intervention is warranted, and implementing a risk assessment framework ensures that this matter is addressed.

Referrals from external agencies can be assessed for risk complexity as 'tolerable' or 'intolerable', 'actual' or 'potential'. The presence of intolerable risk will necessitate an assessment of decision-making capacity, which will be addressed later in this report. Other participants described protocols they followed to detect and refer suspected abuse to appropriate services. Having clear procedures in place for how to act and how to report abuse has better outcomes for victims and healthcare staff (Garma, 2016). However, Sandmoe et al. (2011) stress the importance of an individualised approach for any case of suspected abuse.

By drawing on their previous experience in working in family violence and/or those who had completed a violence intervention programme (VIP) credential training, participants described how they would incorporate VIP questions into their routine enquiry or clinical assessment with the older person. The emergency department (ED) gerontology nurse specialist (GNS) "considered this an ideal way to ensure the older person felt safe while utilising both observational and interview style enquiry during the ED visit to detect any signs of elder abuse or neglect" (GNS, Te Whatu Ora). However, using VIP screening in older people remains controversial (Beach et al., 2017). Several reasons have determined this view. Firstly, the lack of established reliability and validity among screening, as well as low levels of psychometric testing in the older population and the tools' lack of cultural sensitivity. Secondly, as addressed previously in this report, building rapport requires time, which is something that ED settings fail to provide for both the victim and healthcare staff (Beach et al., 2017).

Some of the participants said they followed Ministry of Health guidelines to guide referral processes. In the case of Te Whatu Ora staff, this might involve the "vulnerable elder abuse expert, particularly if legal issues such as protection orders, EPOA [enduring power of attorney] action was required" (Senior SW, Te Whatu Ora). These processes are often reactive and did not always lead to the best outcome due to current pressures on the overall health and community system.

Risk assessment from a secondary source

Support workers who act as the eyes and ears of the community are a valuable secondary source for identifying potential abuse and a good avenue of additional risk assessment. The value of support workers was highlighted by a clinical manager of a home-based support service, who stated that any indication of suspected abuse or neglect by a support worker would trigger a clinical incident form prepared by the attending support worker and actioned by a service coordinator. This clarifies the support worker's responsibility as "they act as our eyes and ears for the clinical team" (CSM, NGO).

This collaborative approach has been documented in the literature on detection and prevention of abuse and neglect in older people as an efficient strategy within a case management service delivery model (Blowers, 2012; Rizzo et al., 2015; Ulrey & Bandl, 2012).

Some of the participants said that working collaboratively across specific sectors, such as the Police and other external providers, was very helpful as it enabled sharing of risk assessments and routine inquiry information. As one experienced social worker highlighted:

> **We have got a strong multi-agency response which the Police are part of. We also get a lot of referrals from these safety action meetings that involve the Police. Some of these police [officers] are quite junior, so working collaboratively is very helpful for them to learn about the complexity of elder abuse. (Senior SW, Te Whatu Ora)**

Clearly, early detection of AOP and prevention is important. A recent review indicated that "service exposure" pertains to the degree of connection or accessibility victims of abuse have to a range of services and resources, encompassing multiple factors such as housing, legal assistance, social support and Police involvement, which collectively had a substantial positive influence on victims of abuse. Among the 52 studies reported in the review, service exposure was the factor that delivered the most significant outcome in terms of abuse of older person interventions (Burnes et al., 2021).

Culture plays a crucial role in shaping the perception, reporting and prevention of abuse. From a life course perspective, understanding and overcoming culturally related detection issues requires a different approach. In this context, the use of Te Whare Tapa Whā model of health underpinned several participants' practice. An example of this was a social worker stating that "we build a relationship with them before we do anything" (Māori SW, NGO).

Generally, lack of support and poor health literacy "puts the whānau under stress" (Māori SW, NGO). This was reinforced by another participant as she described the effects of a lack of cultural awareness for a particular victim and family:

> **With the potential lack of understanding due to language barriers, the health worker failed to recognise the cultural expectations of this community and individual. There is a strong tradition of respecting and caring for elders from this Asian community, which I didn't see in the case. (SW, community based)**

Another important part of the risk assessment process for some vulnerable older people must be an initial assessment of common medical conditions and complaints such as falls, weight loss, medications (including blood thinners) and other ageing biomarkers that are part of the normal physiological changes that occur in ageing (Collins & Presnell, 2007).

Participants were cognisant that gathering this important information assisted their clinical decision-making in detecting potential neglect situations alongside potential AOP situations, and the mention of victims with a diagnosis of dementia was foremost in this discussion.

To effectively address potential victims with cognitive impairment or dementia, is crucial to conduct standardised cognitive assessments, employing tools like the Mini-Addenbrooke's Cognitive Examination (MACE). This approach facilitates a delicate balance between the caregivers' requirements and the older individual's rights, especially in complex situations. Detecting instances of abuse and neglect in community and ARC settings poses a considerable challenge for participants. Detection necessitates is a compassionate and supportive approach from healthcare practitioners to encourage caregivers to acknowledge and address abusive behaviours (Wigglesworth et al., 2010).

Moving beyond current practices

Despite the overwhelming sense that some of the research participants had systems in place for both detection and risk assessment, there was also an appetite among the participants to improve exposure of abusive situations, which would require different approaches, including screening and assessment processes.

For example, a dentist with little knowledge of AOP suggested that education may remove a barrier to screening for abuse in a dental practice:

> **I believe that we are in the position to be able to identify some elder abuse, especially as we treat a lot of the elderly population. We are not looking for it necessarily; however, there are some situations that ring alarm bells but there are not many steps that I know to take. I wouldn't know how to manage it. (Dentist)**

Other participants went further in their call for wider community education and involvement in screening for AOP. For example, an EARS provider said, "Let's get everyone in the community involved in screening for AOP services such as community laboratory and banks" (EARS Provider). A recent Cochrane review by Baker et al. (2016) suggested that a two-pronged approach for screening was appropriate. This approach could include programmes that have "aged friendly" policies to strengthen and improve older people's welfare, economic and social position, and secondly, could be used to monitor closely vulnerable older people for early detection of abuse and/or neglect. Monitoring activities could include regular screening, helplines and home visits to detect those most at risk (Baker et al., 2016).

Current barriers and enablers in practice

The following section reveals some key themes that emerged related to specific barriers and enablers to screening for AOP encountered in the participants' work practices.

Barriers

One of the barriers included a lack of training and knowledge alongside the lack of implementation of the VIP screening tool currently in use in other identified vulnerable populations in their regions. One participant, who manages a hospital-at-home service within a highly intergenerational social housing mix, stated:

> **We are in and out of the patients' homes as part of the community health services and I don't understand why we are not part of the violence intervention [programme]. Currently it's for maternity, maternal and paediatric areas only. And at the moment, we are just using our clinical judgement – with no routine screening. We have had cases and had to rescue them out. (NP, lead community care)**

Cultural attitudes and myths about the nature of intimate relationships among older couples also need consideration. Older couples are living longer, are healthier and may still be sexually active (Beach et al., 2020). The myth that these couples are no longer intimate may be why some practitioners have not been trained in VIP screening. Expanding on this comment, a senior nurse manager felt that:

> **It's just our judgement and then let's talk about. There is no routine screening, which would be ideal … Furthermore, new staff aren't given any information about abuse or training in violence screening, and they go out and work in the community. They are very vulnerable. (SNM, community based)**

Clearly lack of training and knowledge features heavily in the AOP research space. Removing this barrier requires a combination of activities regardless of how detection is currently undertaken. Without adequate training and tools, healthcare professionals cannot be expected to act.

The cultural context of abuse and neglect is woven throughout this report. Participants recognised that a diverse cultural context can act as a barrier to defining what abuse means. Older people from different ethnic backgrounds could have different needs and expectations. For example:

> **It was noted within some Asian communities [that] the language of abuse and the activities that might be considered abuse or neglect in a New Zealand context is not the case for this community and getting the definition right would be helpful. (SW, NGO)**

Cultural hierarchies and power dynamics within families can influence the occurrence and reporting of abuse. Patriarchal norms, the high value of family cohesion, and language barriers can all contribute to underreporting (Blundell, 2012; Office of Seniors, Te Tari Kaumātua, 2023; Wang et al., 2007).

Older people from different cultural backgrounds may immigrate to Aotearoa New Zealand with their families and face challenges related to acculturation. Limited knowledge of their rights, social services and legal systems is problematic. Practitioners described how they must educate families about the human rights of older people. This lack of awareness can be extremely stressful, and participants articulated that they struggled to find easy solutions to such problems. One provider stated: "I need to provide education according to the different cultural backgrounds … its quite necessary … otherwise, they will do nothing" (EARS provider).

Several of the participants reported that poor cultural understanding of AOP and lack of culturally sensitive education for practitioners and families from varying cultures often reduces their ability to protect these vulnerable individuals. The participants provided several examples of abusive situations, highlighting significant financial exploitation. They also noted instances where they missed important cues due to a lack of awareness. Tensions around inheritance norms amplified by the loss of traditional family values were likely to precipitate financial exploitation of older family members (Blundell & Clare, 2012; Brijnath et al., 2020).

There is a lack of public awareness regarding both what constitutes AOP and the identification of appropriate channels for reporting suspected cases of abuse and/or neglect of an older person.

There are many reasons why people might not be aware of AOP (Baker et al., 2016). At a societal and community level, participants blamed ageism and ignorance. As one participant explained:

> **I don't think we acknowledge it enough, that there is the amount of abuse that is happening. I don't think people want to notice – I think people just think, 'Old people are sweet and innocent.' Nobody thinks it sort of happens. (SW, Te Whatu Ora)**

Established public health prevention initiatives have demonstrated efficacy in facilitating the early identification of abusive situations (Hermoso, 2006; Sanders, 2008).

It has been suggested that the older person may themselves put up barriers to talking about being abused because they feel uncomfortable talking about it, shame about the abusive situation, or because of intergenerational dependency. Disclosure of abuse by older people is complex and often involves their own children, adding to the reluctance to disclose being abused (Brijnath et al., 2020).

Subsequently, as noted by one of the social worker participants, older people may withdraw and refuse to enter a therapeutic relationship that may assist them to be in a safer place or reduce family conflict.

The competency of the older person and their consenting to assessment and/or intervention were considered by practitioners as both barriers and an enablers. For instance, those participants working in the mental health area considered competency an enabler and critical to supporting the practitioner's decision-making alongside the most appropriate intervention. An older person refusing to consent to an assessment, however, would be a serious barrier and a successful outcome would be contingent on the knowledge and skills of the attending practitioner.

A scoping review of AOP research literature revealed that outcomes such as time spent on cases with abuse confirmation, safety risk reduction, and goal accomplishment reduce the barrier of refused consent (Baker et al., 2016).

Enablers

Enablers involving access to other resources, services or peer support have effectively facilitated successful outcomes. Being supported by strong partnerships with community partners contributes to effective outcomes in planning and implementation (Dow et al., 2020; Hafford & Nguyen 2016; Pillemer et al., 2016).

One participant, a gerontology nurse specialist, noted that they had:

> **... visited an older person in the community who disclosed that a family member was psychologically and financially abusing them last week – in this case I sent a referral to the local EAR provider. Now I am working with the social worker from this service very closely. Of course, with the patient's consent. (GNS, Te Whatu Ora)**

In certain instances, disclosing instances of abuse may necessitate skilled interventions, such as relocating the client to a safe house. Studies detailing shelter programmes indicate positive outcomes, as they can prevent permanent placement in residential aged care facilities while ensuring safety and enabling strategic planning (Pillemer et al., 2016). This solution, albeit complex, was perceived as beneficial by participants. However, it relied heavily on the presence of a key worker, as expressed by one respondent:

> **We are so busy, and when an older person is placed in a safe house and doesn't speak any English, this makes it very challenging. I often struggle to engage interpreter services, meaning I have to act as the intermediary when someone like Kāinga Ora visits the client. (EARS provider)**

Another approach that aligns with the partnership concept was described by a nurse practitioner for Te Whatu Ora, who said that two individuals might visit together while implementing various safety measures to ensure the well-being of both patients and staff. A social worker from an NGO also noted that, in some cases, individuals living in unsafe environments have the support of security guards when clinical staff visit. Another example of an enabler are effective interventions that form alliances between different parties (Owusu-Addo et al., 2020). Collaborative practices will be further explored in the following section.

Collaborative efforts

The accessibility of collaborative services may provide a safety net for some victims. The research participants discussed the need for everyone to be aware of the vulnerable individuals who are often hesitant to report the abuse initially.

> **Keeping a watching eye becomes the task of many and the disclosure of abuse may take time. (Senior SW, Te Whatu Ora)**

Connections to community resources that are culturally appropriate, initiation of home-based support services, and community social worker visits may provide alternatives to minimise the stress during periods of abuse. AOP studies have also reported that older people may be more willing to disclose the abuse to another older person.

Furthermore some participants felt that because their own workloads meant they were time-poor, working collaboratively and sharing the load would be beneficial and that "to work effectively we need to connect with the NASC [Needs Assessment and Service Co-ordination] team, the geriatrician – how do we involve other professionals such as the legal services and the police?" (SW, NGO). Another participant stated, "We only have protocols and some guidelines but little else to assist us once we have found a case" (GNS, Te Whatu Ora).

There was agreement between the participants who work in primary health that general practitioners (GPs) are often very time-poor, with 15-minute consultations being extremely limiting for the older person, and that collaboration and supportive frameworks are needed for effective communication, in order:

> **... to support the ability for older people to disclose abusive and neglect situations; it doesn't always have to happen with the GP. Practice nurse and nurse practitioners may also be key players during the detection and disclosure phase. (NP, primary healthcare)**

Being alert to the life circumstances of an older person can be a game changer. 'Being alert' in this context means having awareness of AOP. Participants spoke of this in several ways. First, they noted the importance of providing mentorship to "junior practitioners who engaged actual and potential elder abuse cases and ensure they are well supported" (GP, primary healthcare), and secondly, with a more didactic approach to training programmes. Training programmes to increase awareness must include types of abuse and neglect, as well as the signs and symptoms of each type, in order to improve and manage suspected cases effectively (Beach et al., 2017; Shefet, 2007). Beach et al.'s (2016) review stated that no evidence currently supports awareness-raising or changing attitudes. However, there is emerging evidence that education on interventions for health professionals may improve the detection and management of AOP cases.

The importance of education is supported by an observation from Burnes et al. (2021), who found that self-efficacy of the victim was a driver of successful outcomes alongside eventual victim disclosure. A knowledgeable community and front-line personnel may be important facilitators, and in our own study, healthcare staff highlighted that:

> **You know from my experience not everyone sees the GP. Very often they might have more interaction with an ambulance driver or a hospital staff member. You can't discount these people as they might be the person the older person might finally disclose a potential/actual abusive situation [to]. (SW, Te Whatu Ora, mental health team)**

Collaboration should also involve the family. Building relationships with whānau has been identified as being essential, as noted earlier by a Māori social worker who works for an NGO: "We build a relationship with them before we do anything else." Reducing negative labelling and encouraging help-seeking

behaviour for caregivers has produced good outcomes. Pillemer et al. (2016) suggest that caregiver interventions that focus on prevention (education) have been shown to have the most positive results in research on AOP. Introducing a collaborative approach such as support groups may prevent revictimisation and reduce the onset of abuse. Caregiver training in cognitive behaviour therapy, a manual-based coping strategy and an educational support group could improve psychological outcomes for caregivers (Gama, 2017). Using a socioecological model will encapsulate these approaches better and more clearly. What essentially is being proposed is an all-round ecology that will enable wraparound support services that identify, assess and support victims and also prevent violence and abuse.

Future needs and a national screening tool

The definition of abuse types and the accuracy of health professionals' knowledge and their expectations about reporting have been shown to have an impact on both the victim's and health professional's outcomes (Gama, 2017).

Having reliable assessment tools that allow for early identification of potential AOP may be one way of addressing some of these issues. Prevention or early intervention can prevent further harm and address issues before they escalate. As mentioned in a previous section, there appeared to be an appetite for easy detection and prompt disclosure from the participants. When prompted by the question "How important do you feel it is to develop and put into your practice a new tool or tools for assessing risk of elder abuse?", the research participants provided rich and revealing information.

There is compelling evidence that implementing a standardised screening tool for detection of AOP could have far-reaching benefits, ranging from improved protection of older people to better data collection and resource allocation, which ultimately will enhance the well-being of older people in the community.

One participant, a senior social worker from Te Whatu Ora, believed that a potential benefit of a national screening tool for detecting and encouraging disclosure from older people would be ensuring that health professionals and others would be "singing from the same song sheet". Using a national screening tool would result in more consistent, reliable data and address the issue of currently limited reporting mechanisms. Additionally, it would offer an objective, rather than an inquiry-based, approach (Beach et al., 2017).

A systematic method of screening and gathering data was overwhelmingly perceived as valuable. For example, a nurse practitioner in primary care stated that "screening [is] going to make a huge difference because it's really screening and will help us get more information that might be used to help provide better resources for the AOP services." This assertion was further supported by

another participant who suggested that "having access to a screening tool will make people more aware what is acceptable and what is right at all levels, and we might get better funding if we have good evidence to show how busy we are" (EARS provider).

Other participants wondered what the process would involve if a national screening tool were to be implemented. For example, "Okay, so if you had a suspicion and I used that tool as an indicator, then what would be the next step?" (Māori SW, NGO). For this participant, ensuring that services are in place to provide culturally appropriate support for her community was paramount. This means that any conversation between the older person and the person inquiring about abuse needs to be conducted in a culturally sensitive manner; that is, in a way that involves understanding and respecting the cultural context, values and communication styles of the older person. Culturally responsive support ensures that the older person feels safe, respected and understood, which is crucial for encouraging disclosure and providing effective assistance (Brijnath et al., 2020). A culturally sensitive approach helps to build trust and rapport, which are essential for accurate assessment and meaningful intervention.

Participants emphasised that without a foundation of trust, older adults might be reluctant to disclose abuse, rendering any screening tool less effective. The participants stressed that the initial focus should be on building a trusting and respectful relationship, which can create a safe environment for disclosure. Only then should the formal assessment take place, ensuring it is conducted in a way that is sensitive to the older person's emotional and psychological state, and their cultural background. This approach aims to mitigate potential harm and increase the likelihood of accurate and honest disclosure.

Many participants wondered: "Where and when should the tool be used?" and "How much disclosure would occur if the trusting relationship was not established?" Beach et al. (2017) note that establishing mutual rapport to facilitate meaningful and compassionate screening may be difficult and produce unintended adverse consequences. In other words, developing a relationship appeared to be more relevant initially than conducting a screening assessment, as highlighted in Beach et al: "A false positive when screening may have lasting effects on the older person and may result in a reluctance to seek medical help in the future." Likewise, health professionals may feel guilty for wrongly accusing the older person and a caregiver (Beach et al., 2020). One possible solution to this is to ensure that the screening tool adheres to STARD and TRIPOD reporting standards (Beach et al., 2020).

One of the challenges that participants raised was related to the frequency of screening and whether it should be opportunistically or routinely carried out. There was no real consensus on this point, and views were mainly linked to the

participants' work areas. For example, day service programme healthcare staff felt that screening could be conducted as part of regular client reviews and caregiver indicators would be extremely useful. As one participant stated:

> **You perhaps haven't noticed anything. When you interpret the definition of screening and risk assessment, it's a very blurred area now. Once we understood what the screening might be like, we could add it to our review/reassessment. (CSM, Te Whatu Ora)**

Healthcare staff are already integrating VIP questions into their initial assessments and follow-ups indicated a desire to continue; however, they also understood the merit of a standardised AOP screening tool.

Overall, participants generally felt that upskilling and improving knowledge would be an additional outcome if a national screening tool were to be introduced. Training would provide the opportunity to improve knowledge on what is and what might not be abuse and neglect in older people and consequently support more accurate early detection. One participant posited that having a national screening tool: "this alone would raise the awareness across many sectors and hopefully provide a means to prevent or provide a mechanism for early detection" (EARS Provider). Furthermore, a national screening tool could be a valuable early preventative measure. As noted by one participant: "We are often at the bottom cliff and a screener may just see us more at the top" (Senior SW, Te Whatu Ora).

Considerations for tool design and implementation

This section explores the key considerations discussed by participants for the design and implementation of a national screening tool. It highlights several suggested essential aspects to address and safeguard older people. Several aspects were raised that will require careful consideration in the design. Paramount to the design are the unique needs and challenges older people face, such as cognition, health and well-being; ethical considerations, such as consent and human rights; and cultural sensitivities (Perel-Levin, 2008).

Paramount was the idea of co-design involving older people to ensure acceptability and cultural appropriateness. Other relevant information suggested by participants regarding the information on a screening tool should include relevant family structure, medical history, ethnicity and level of cognitive competency. Furthermore, a consensus was clearly reached on the length of the tool: "short and snappy" was the key message – something that could be completed in five minutes and consisting of no more than two to three pages. Several participants vocalised that: "It needs to be a quick-fire screener."

Accessibility of screening information must ensure privacy and confidentially. Although currently underdeveloped, an online screening tool should be considered for several reasons. First, a online screening tool would provide standardised information, and secondly, an online tool would enable the screened data to be captured anonymously and effortlessly at a national level. An online tool would also be consistent with current trends as most health and social services are "moving towards a paperless environment, in part to support sustainability" (Senior SW, Te Whatu Ora). Furthermore, an online tool could help to future-proof online patient health information files. And finally, an online tool is inherently accessible, as noted by a senior social worker at Te Whatu Ora: "It is really important if it could also be an online tool anybody can use it and then it's accessible."

Preference between a uni- or multidimensional tool was discussed, and support for a multidimensional tool was unanimous. Emphasis was placed on the need to capture family/carer issues. Several primary health participants proposed the novel idea of a self-reporting tool for healthy older people; however, this could have limitations such as "shame, stigma, cognitive ability and the inability to complete due to abuser being present" (NP, PHO), problems that were also suggested in a systematic review by Baker et a.l (2016).

Training in the use of the tool was considered essential. Participants suggested that training could be provided to meet the learning needs of individuals, as "you need good training, especially when it's something like … that you don't do day in or out" (CSM, NGO). Some suggested workshop-style training, while others felt a self-directed online training programme would be adequate. As noted by one nurse practitioner, "An online self-learning education programme … this has been a popular method of upskilling and credentialing in recent years and I see as an ideal way to learn" (NP, mental health team).

In summary, the critical considerations discussed by participants regarding the development and implementation of a national screening tool for AOP was the need for the tool to address the diverse needs and challenges of older adults; encompass their diverse cognitive abilities and statuses of health and wellbeing; include ethical considerations such as consent; and to be culturally sensitive. Codesigning the tool with input from older people is crucial to ensure its cultural appropriateness and acceptability.

The participants advocated the inclusion of key information such as family structure, medical history, ethnicity and cognitive competency levels in the tool, which should ideally be concise (completed within five minutes and limited to two to three pages). The accessibility of the tool, particularly through an online version, is seen as vital for standardised information provision and anonymous national data collection.

Moreover, there is an acknowledgement of the transition towards a paperless environment in healthcare, supporting sustainability and the future-proofing of patient health records. Lastly, training in tool usage is considered essential, with suggestions ranging from workshop-style sessions to selfdirected online programmes, highlighting the effectiveness of online self-learning programmes in enhancing skills.

Cultural considerations

Woven throughout this report is the key theme that a national screening tool must be built upon a foundation that acknowledges the rich tapestry of cultural diversity, addresses inequalities in access, and provides culturally appropriate interventions. This section explores the critical intersection of cultural considerations and equity as proposed by a senior social worker: "Yes, it's all about equity, isn't it? It's about getting the right outcomes for everyone. We have a very diverse culture in New Zealand."

Another participant strongly felt that:

> **It is clear that for Māori and Pacific people, we have a real thrust for equity at the moment [and] you know that the diversity of cultures in New Zealand will have their own lens around how they see abuse and what they want to do about abuse. So, having some knowledge about that in a screening tool would be really valuable and useful. (CSM, NGO)**

One important point highlighted by the participants is the significance of incorporating abuse of wairua (spirituality) into both the Aotearoa New Zealand definition of abuse and any national screening tool. Wairua (spiritual) abuse can cause a disconnect between kaumātua, culture and family identity. Addressing wairua abuse, ensuring screening questions are woven from a te ao Māori lens, and capturing Te Whare Tapu Whā principles in a training programme would drive this approach. One suggestion was to design the training programme in a similar way to He Waka Kākarauri (advanced care planning).

Participants felt that language was a major barrier to getting it right for the culturally diverse communities of Aotearoa New Zealand. As a nurse practitioner aptly explained: "The language you know, it's important you know. Translate the words 'elder abuse' in Chinese – in my mind, I have quite a few words, but again I don't know which is a better one. But this needs to be considered" (NP, MHOA). This concern was reinforced by another participant, who noted that "otherwise people will misinterpret or misunderstand it" (SW, Te Whatu Ora).

The growing concern about language was raised by several of the participants. For example:

> **... some of individuals that we see that don't speak English. They are incredibly vulnerable. They just don't speak any English and they are so much more vulnerable because they can't ask for help when they want to. People from other cultures are more at risk because of cultural expectations and cultural barriers. We have had to bring in different cultural support people when we have an issue of an older person from an Eastern European country. (SW, Te Whatu Ora)**

Access to interpreters was deemed beneficial to some extent; however, research indicates that working through an interpreter may impede practitioners in their efforts to engage and build trust. Instead, training and employing an ethnically diverse workforce has proven effective in working with abused women. While participants felt having a more ethnically diverse workforce would be helpful, albeit complex solution, it would still require the involvement of a key worker. As expressed by an Elder Abuse Response Service (EARS) provider, "We are so busy, and when an older person is placed in a safe house without English proficiency, it becomes challenging. Often, I struggle to engage interpreter services, forcing me to act as the intermediary when someone from an organisation like Kāinga Ora visits the client."

Routine enquires are also easier if the workforce is culturally diverse, as long as the screening is conducted by trained, empathic and non-judgemental health professionals rather than a standardised screening (Quigley, 2000).

Capacity and resources were paramount when participants explored the implementation of a national screening tool. Some were concerned about "who was going to do all the work if a screener was introduced" (SW, Te Whatu Ora), stating that services were already under pressure and facing ongoing workforce issues, especially a shortage of experienced practitioners in the family violence space.

Overall, this section underscores the critical role of cultural considerations in developing effective screening tools and interventions for identifying and addressing AOP, particularly in Aotearoa New Zealand's diverse cultural landscape.

The central theme of cultural considerations emerged prominently, with participants consistently emphasising the importance of incorporating cultural diversity and addressing disparities in access and care when developing a national screening tool. These views highlighted the intersection of cultural

considerations and equity. Participants acknowledged that achieving equity in AOP detection was paramount, with one participant noting that it is about "getting the right outcomes for everyone". There was a widely held view among the participants of the importance of adopting a rights-based approach, one that emphasised the right to equal opportunity and treatment for all individuals as they age, regardless of their ethnic origin or socioeconomic status.

Aotearoa New Zealand's rich cultural diversity was also recognised as a significant factor in this context. Language was seen as a major obstacle in communication and understanding. Participants stressed the importance of accurately translating terms such as 'abuse of older people' into different languages to avoid misinterpretations and misunderstandings, especially among individuals who do not speak English. The vulnerability of individuals who do not speak English and the need for cultural support and interpreters is important. Cultural expectations and barriers could put older people from different cultural backgrounds at higher risk of abuse, requiring the involvement of cultural support personnel.

Future considerations

The absence of a screening tool for AOP means that current detection primarily relies on traditional methods such as clinical assessments, routine inquiries, or even a gut feeling for experienced practitioners. For many of our participants, building rapport and trust with older individuals was crucial to initiating open and honest conversations, which could sometimes reveal instances of abuse. However, victims might be hesitant or fearful of disclosing their experiences. Some professionals, particularly those in day services, relied on informal notifications from sources such as van drivers to identify potential cases of AOP, highlighting a lack of proactive detection.

In some workplaces, providers who support older people who have been abused have developed their own risk assessment tools to understand the risk level and to support a triage process for urgent cases. Cognitive assessments, such as MACE, are being used in Aotearoa New Zealand to gather information for clinical decision-making, particularly for older people with health concerns such as dementia. Participants with experience in family violence and VIP credential training incorporate VIP questions into routine inquiries or clinical assessments, especially in ED settings, to detect signs of abuse or neglect of older people. For home-based support services, suspected abuse triggers the completion of a clinical incident form, emphasising the role of support workers as the eyes and ears for the clinical team. The participants reported that collaboration with external providers, such as the Police, was also helpful for information sharing

and addressing the complexity of cases involving AOP. Despite existing screening and risk assessment efforts, there was a desire among the participants to improve exposure of abusive situations, especially in primary healthcare settings. Challenges highlighted during the interview included time constraints in GP practices and the presence of inexperienced junior GPs who might miss cues or lack rapport with older patients. The narrative suggests that as the health system shifts towards a broader primary healthcare and community focus there is a need for AOP service delivery models to adapt. Providers such as pharmacies, dental services and NGO's can all play a role in managing the challenges an ageing population poses.

Current barriers and enablers in practice

This report highlights the complex landscape of addressing AOP with numerous barriers and enablers influencing the effectiveness of interventions. The report findings underscore the importance of training, cultural sensitivity, public awareness and support networks in improving the response to AOP and ensuring the well-being of older people in the community.

Barriers

- **Lack of training and knowledge:** Participants identified lack of training and knowledge as a significant barrier, particularly regarding the use of the VIP screening tool for older people. This tool was reported to be primarily used for other vulnerable populations, creating a gap in assessment and intervention in cases of AOP.
- **Cultural differences:** Cultural diversity presents challenges as individuals from different cultural backgrounds might perceive and/or experience abuse and neglect differently. Educating families about human rights and providing cultural sensitivity training was considered necessary to bridge this gap.
- **Public awareness:** Participants noted a lack of public awareness about AOP and where people could report suspected cases. Ageism and societal ignorance were identified as contributing factors to this issue.
- **Personal barriers:** Older individuals sometimes erect barriers because they feel uncomfortable talking about their abusive situations, experience shame, or are reluctant to disclose abuse, especially when it involves their own children. The need for privacy and the closed-door culture of the older generation were cited as factors.
- **Gaining consent and assessing competency:** Gaining consent and assessing cognitive competency could be both a barrier and an enabler. While assessment of competency can facilitate appropriate interventions, refusal by older individuals to consent to assessment can be a significant barrier.

Enablers

- **Access to resources, services and peer support:** Access to resources, services and peer support was seen as a significant enabler. Collaborating with other professionals and services, such as social workers, enhances the support network for practitioners and older people who are being abused.
- **Safety measures:** Having safety measures in place, such as a safe house policy and security guards in high-risk areas, enables practitioners to support older people who are being abused without compromising their safety.
- **Multidisciplinary team environment:** Working in a multidisciplinary team environment was mentioned by the participants as an enabler, allowing for better coordination of efforts, and ensuring that various aspects of AOP cases are comprehensively addressed.
- **Clinical supervision:** Ensuring that junior practitioners engage with actual and potential cases of abuse and receive clinical supervision was considered an enabler. Supervision support helps junior practitioners to navigate complex cases of AOP and make informed decisions.

Effective collaboration

Various strategies and challenges raised by the participants emphasisethe need for comprehensive support systems and protocols to ensure the well-being of older people. Without a dedicated screening tool, participants have adopted various strategies to address AOP cases. For instance, EARS providers use a traffic light system to determine the level of intervention required and to allocate a skilled practitioner. Others follow MOH guidelines to decide whom to refer cases to. This could involve engaging a person experienced in working with older victims of abuse and neglect when legal issues such as protection orders or EPOA actions were necessary. These strategies are often reactive, however, and not always conducive to the best and most prompt outcomes due to the overall strain on health and community systems.

Several challenges were identified by participants in their efforts to address AOP cases effectively. Limited time constraints within their own workloads and insufficient organisational support for interventions were noted as significant barriers. Some participants expressed the need to connect with various professionals and services, such as the NASC team, geriatricians, legal services and the Police. The participants lamented a lack of comprehensive protocols and guidelines to assist them once a case of abuse or neglect of an older person had been identified.

In contrast, participants in more developed service settings, such as tertiary hospitals, have established procedures for dealing with AOP cases. They use clinical notification forms and policies based on MOH guidelines to assess the level of risk and coordinate interventions. Senior social workers play a pivotal role in gathering information, coordinating efforts, and establishing outcomes in these settings. From a primary health perspective, GPs often face time constraints with limited 15-minute consultations, which hinder their ability to address AOP comprehensively. Collaboration and supportive frameworks were deemed by the research participants to be essential to facilitate effective communication and support for older individuals in disclosing abusive and neglectful situations. The participants also emphasised that not all older people interact primarily with GPs; some interact more with ambulance services or hospitals. Therefore, it is important not to discount these areas in addressing cases of AOP.

National screening tool

Importance of a national screening tool

The participants were prompted to discuss the significance of developing and implementing a new national screening tool, or tools, for screening and assessing risk for AOP. There was a consensus that implementing a standardised screening tool for AOP could deliver several benefits. These benefits ranged from improved protection for older people to better data collection and resource allocation, ultimately enhancing the well-being of older people in the community. The participants emphasised that having reliable assessment tools for the early identification of potential AOP cases is extremely important because early intervention can prevent further harm and address issues before they escalate. Having everyone using the same tool would ensure consistency and alignment in the assessment process.

From a Māori perspective, the participants offered clear guidance and direction regarding the design of a screening tool. They made it explicit that tool development must be done ‘by Māori, for Māori’. One of the Māori participants spoke very strongly, stating: “There are some brilliant kaumātua throughout the motu who would really sink their teeth in this mahi. They are aware that is becoming more of a problem in their hapū and iwi” (Māori SW, NGO).

Challenges and considerations

Questions were raised about the next steps after using the tool and what established procedures would be in place if the tool indicated a suspicion of abuse. Another concern related to the level of disclosure that could be expected, especially if a trusting relationship had not been established. Despite these concerns, participants recognised the value of a national screening tool, which could help highlight potential issues for further investigation. For day

service programmes, the tool could be integrated into regular client reviews and include caregiver indicators. This systematic approach to gathering information is seen as a significant reason to value the introduction of a screening tool. The potential for the tool to raise public awareness about what is acceptable – and what is not – and to effectively educate the community about AOP was deemed important. There was no consensus among the participants about screening frequency, and views on whether screening should be opportunistically or routinely carried out often reflected the participants' specific areas of work.

Upskilling and improving knowledge

Overall, the research participants saw the introduction of a national screening tool as an opportunity for upskilling and improving knowledge within the healthcare sector. Training would be essential, covering topics such as definitions of abuse and neglect, family factors, and other relevant material to support accurate information gathering. In turn, screening could raise awareness in the community and provide a mechanism for early detection and prevention of AOP. Considerations for tool design and implementation included co-design, the length and format of the tool, its multidimensionality, the use of technology, capacity, resources for implementation, and the need for effective training. Thoughtfully addressing these aspects is vital to ensure the tool's success in identifying and preventing AOP while also being sensitive to older people's unique needs and cultural diversity.

Design considerations

The participants emphasised the importance of co-designing the screening tool and involving older people and stakeholders in the process. This collaborative approach would ensure acceptability and cultural appropriateness. Additionally, the tool should capture essential information such as family structure, history, ethnicity and cognitive competency. The length of the screening tool was a unanimous concern among participants. They advocated a "short and snappy" tool that could be completed quickly in five minutes and consisting of no more than two to three pages. Furthermore, the tool should be multidimensional and capable of capturing information about family and carer issues. The tool could even be a self-reporting tool for some older people. However, participants acknowledged potential limitations, including issues related to shame, stigma, cognitive ability of the person being screened and the presence of the abuser during the screening process. The use of technology was deemed essential by the participants, with a preference for the tool to be available online. Many health and social services are transitioning to paperless environments to support sustainability, and an online format would both enhance accessibility and have the possibility of future-proofing patient health information files.

Implementation considerations

Capacity and resources were a primary concern regarding implementation of a national screening tool. For example, the additional workload that might result from introducing such a tool concerned some participants. Services are already under pressure and face ongoing workforce issues, including a shortage of experienced practitioners in violence prevention. The participants considered training in using the tool to be essential if a national screening tool were to be introduced. The participants discussed various approaches to training, including workshop-style sessions and online self-learning education programmes, which have gained popularity in recent years.

Cultural considerations

The central theme of cultural considerations emerged prominently, with participants consistently emphasising the importance of incorporating cultural diversity and addressing disparities in access and care when developing a national screening tool for AOP. These views highlighted the intersection of cultural considerations and equity. Participants acknowledged that achieving equity in detection of AOP was paramount, with one participant noting that it is about "getting the right outcomes for everyone". Cultural expectations and barriers could put older people from different cultural backgrounds at higher risk of abuse or neglect, requiring the involvement of cultural support personnel.

Final summary and recommendations

Synthesis of insights from the literature review and stakeholder narratives

Drawing on the key findings from the systematic literature review and the participant narratives, four themes were identified: 1) the importance of an interdisciplinary approach to the management of AOP; 2) prevention and awareness of AOP; 3) cultural competence and adaptation of screening and assessment processes; and, 4) screening tool insights.

Interdisciplinary approach and collaboration

The importance of an interdisciplinary approach to managing abuse and neglect of older people is a prominent theme. The systematic literature review and stakeholder narratives both underscore the necessity of health professionals working closely with social workers, legal experts and community organisations. This collaboration is recognised for its potential to provide comprehensive support and improve outcomes for older individuals facing abuse. The literature review highlighted that collaborative, strength-based approaches yield better results in terms of detection and intervention. The proposed introduction of a national screening tool is seen as a mechanism to enhance this collaboration, standardising practices across different settings and reinforcing a holistic approach to AOP detection and intervention.

Prevention and awareness

Another significant theme is the need for a strong commitment to the prevention of AOP by addressing barriers and supporting enablers. The systematic literature review identified a range of screening tools with varying sensitivity and specificity, and concluded that no single tool is universally effective. The lack of a standardised tool in Aotearoa New Zealand means health professionals often rely on their own risk assessment methods or intuitive recognition of abuse. The stakeholder narratives and literature review both emphasise the importance of building rapport and trust with older individuals, as this is essential for effective risk assessment and intervention. Raising awareness and providing education and training for health professionals are highlighted as crucial enablers, while the lack of training and knowledge is identified as a major barrier contributing to the underreporting of abuse. Better education and guidance can help health professionals stay informed about the latest developments in detection of AOP, thereby improving their effectiveness.

Cultural competence and adaptation

The centrality of local and community-level involvement is another key theme, particularly concerning the cultural relevance of services and screening tools. The systematic literature review and stakeholder narratives highlight the importance of developing tools that are culturally sensitive and reflect local understandings of abuse. Such tools would incorporate culturally appropriate language and consider spiritual dimensions of abuse, especially for Indigenous populations. The absence of tools that incorporate wairua/spiritual dimensions of abuse is noted as an area for future development. The discussion points to existing cultural frameworks like Te Whare Tapa Whā, Faonofale and Hwa-Byung as potentially beneficial in improving the identification and understanding of abuse in culturally diverse populations. The research participants indicated that the lack of culturally relevant tools is a significant gap that needs to be addressed to ensure effective and inclusive detection and intervention strategies.

Screening tool insights

The insights from the systematic literature review provide a comprehensive overview of the challenges and considerations related to screening tools for AOP. The review did not identify any screening tool currently being used that was developed in Aotearoa New Zealand, highlighting a critical gap in the existing framework. The systematic literature review identified a range of screening tools with varying sensitivity and specificity and concluded that no single tool is universally effective. Many health professionals have developed their own risk assessment tools, and some rely on intuitive recognition and observation. The main imperative is that people who screen positive are followed up by further testing or treatment to determine the actual presence of abuse and/or who perpetrated it.

The review identified several barriers to effective detection of AOP and intervention, such as the complexity and impracticality of some tools, and the need for tools to be culturally relevant. The review also emphasised the necessity for better education and training to improve the accuracy and effectiveness of detection of AOP.

The stakeholder narratives support the literature review findings and highlight the workforce's interest in a national screening tool, which would require validation, cultural adaptation and training for effective implementation. The participants emphasised the need to address the diverse needs and challenges of older adults, including their cognitive abilities, health status and well-being, as well as ethical considerations like consent and cultural sensitivity. Co-designing the tool with input from older people was seen as crucial to ensure its cultural appropriateness and acceptability.

Screening and assessment, therefore, becomes part of the system of suspicion, prompting formal identification of abuse, which when present, necessitates intervention (Keys, 2003).

In conclusion, these four themes collectively underscore the complexity of addressing AOP and the need for a multifaceted and culturally informed approach that leverages interdisciplinary collaboration.

This review offers the following recommendations to support the overall strategic direction of AOP services in Aotearoa New Zealand.

Recommendations

- **Explore further** how development and implementation of screening tools have been adapted internationally. Focus initially on the six screening tools highlighted in the report.
- **Build on the evidence** and information from this scoping literature review to promote cultural sensitivity and cultural competence to help professionals understand and respect the cultural differences of AOP.
- **Establish and strengthen support networks** for older individuals, including access to resources, peer support groups and safe housing options.
- **Develop comprehensive educational resources** and training toolkits for relevant professional groups on AOP awareness, assessment and intervention including culturally specific frameworks.
- **Foster collaboration** among healthcare professionals, social services, law enforcement agencies and community organisations to create comprehensive support systems for older people experiencing abuse and neglect.

Limitations of this report

The report has several limitations, which require discussion. First, time constraints prevented expanding the scope of the review and the opportunity to interview older people who have been abused and those who have not. This would have provided greater insight into the potential development of a national screening tool and older people's views of current practices. Secondly, the cultural narrative could have been enriched by including the voices of practitioners from other ethnic cultures and other diversities such as the rainbow and disability communities.

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Appendix

Table A: Screening and assessment tools identified in the database search - Unidimensional tools

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
1	Elders Psychological Abuse Scale (EPAS)	2007	Wang	Taiwan	Chinese	Community – home, institution	32 (3 domains)	Q: structured interview with older adult and caregiver S: yes/no (≥ 10) T: 5–10 minutes	Assessment – to detect actual psychological abuse and identify individuals at elevated risk
2	Older Adult Financial Exploitation Measure (OAFEM)	2010	Conrad	USA	English	Professional – social	79, 54 and 30 item versions	Q: interview S: yes/no/suspected/unknown (≥ 12 for the 30-item version) T: nr	Assessment – to assess cognitively intact older adult's vulnerability to financial exploitation and demonstrate levels of severity
3	Older Adult Psychological Abuse Measure (OAPAM)	2011	Conrad	USA	English	Community	31 and 18 item versions	Q: self-report S: yes, suspected, no 0–62 (≥ 12 for the 31-item version) T: nr	Assessment of cognitively intact older people by multiple agencies
4	Social Vulnerability Scale (SVS15)	2011	Pinsker	Australia	English	Multiple – clinical, non-clinical	15 (2 domains)	Q: self-report with knowledgeable informant S: Likert, 0–88 (higher more vulnerable) T: nr	Screen – a short form of the 22item informant report of vulnerability
5	Lichtenberg Financial Decision Screening Scale (LFDSS)	2016	Lichtenberg	USA	English	Professional – any financial setting, APS staff	10	Q: structured interview, decisional ability measured S: yes/no/don't know or inaccurate, interviewer rating using five items (higher greater risk) T: nr but includes discussion	Screen – to assess financial decision-making capability and prevent financial exploitation
6	Clinical Signs of Neglect Scale (CSNS)	2017	Friedman	USA	English	Healthcare – hospital, aged residential care	26	Q: utilises clinical data, including cognition, from electronic health records S: algorithm (≥ 5) T: automated delivery maximises staff time	Screen – to identify potential neglect cases in cognitively intact older adults
7	Financial Exploitation Vulnerability Scale (FEVS)	2020	Lichtenberg	USA	English	Professional – medical, social, mental health	17 (3 domains)	Q: self-report S: variety of question types T: nr	Assessment – to differentiate cognitively intact victims and non-victims of financial exploitation

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
8	Lichtenberg Financial Decision Rating Scale – Short Form (LFDRS- SF)	2020	Lichtenberg	USA	English	Professional – social, mental health	34 (4 domains) + follow-up questions	Q: self-report, decisional ability measured S: scale score (≥ 24) T: 20-25 minutes (online version)	Screen – to assess decisional ability and susceptibility to financial exploitation
9	Self-Reported Neglect Scale (SRNS)	2020	Zawiska	Poland	Polish	Community	12 (2 domains)	Q: self-report S: scale score (higher greater neglect) T: nr	Assessment – to recognise the presence and level of neglect in community-dwelling older adults
10	Financial Exploitation Vulnerability Scale – Short Form (FEVS-SF)	2021	Campbell	USA	English	Healthcare – clinical gerontology	9	Q: self-report S: Likert-type (≥ 5) T: brief	Screen – to assess risk for exploitation of cognitively intact older adults
11	The Five-Item Victimization of Exploitation (FIVE) Scale	2022	Hancock	USA	English	Community	5	Q: self-report S: yes/no (≥1) T: brief	Screen – to screen for elder abuse

Table B: Screening and assessment tools identified in the database search - Multidimensional tools

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
12	Hwalek-Sengstock Elder Abuse Screening Test (HS/EAST)	1986	Hwalek	USA	English	Multiple – healthcare, social services	15 + review of case notes	Q: self-report (can be self-administered) S: yes/no (≥ 3) T: 5–10 minutes	Screen – to identify people at high risk of the need for protective services
13	Indicators of Abuse (IOA)	1998	Reis	Canada	English	Multiple	29 (2 domains)	Q: checklist interview with older adult and caregiver S: Likert (≥ 16) T: items are rated following a 2–3 hour home visit	Screen – to identify risk factors for abuse
14	Vulnerability Abuse Screening Scale (VASS)	2003	Schofield	Australia	English	Multiple	12 (4 domains)	Q: self-report (can be self-administered) S: yes/no (≥ 1) T: brief	Screen – to identify older women at risk of abuse
15	Expanded-Indicators of Abuse (E-IOA)	2006	Cohen	Israel	Hebrew	Healthcare – primary care	15 indicators + 47 sub-indicators	Q: semi-structured checklist interview of older adult + caregiver, cognition measured + signs of abuse S: Likert (total score ≥ 16) T: up to 2 hours	Assessment – to locate older adults at high risk of abuse
16	Elder Abuse Suspicion Index (EASI)	2008	Yaffe	Canada	English and French	Healthcare – primary care	6 (2 domains)	Q: interview, includes professional rating S: y/n (≥1) T: 2–5 minutes	Screen – to raise a doctor's suspicion about elder abuse in cognitively intact older adults

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
17	Questionnaire about the attitude and exposure to abuse and neglect*	2008	Irizarry-Irizarry	Puerto Rico	Spanish	Community	57 (2 domains)	Q: self-report S: y/n/neutral T: nr	Screen – to measure the opinion, attitude and exposure to abuse, mistreatment, and neglect
18	Family Violence Against Older Women (FVOW)	2009	Paranjape	USA	English	Community	29 (2 domains)	Q: self-report S: Likert 0-4 (higher greater risk) T: nr	Assessment – to measure the presence and severity of family violence in older African American Women
19	Geriatric Mistreatment Scale (GMS)	2013	Giraldo-Rodríguez	Mexico	Spanish and English	Multiple – community, clinical	22 (5 domains)	Q: self-report S; yes/no (≥1 for mistreatment or type) T: lengthy	Assessment – to assess and measure mistreatment of older adults
20	Three-part tool for the identification of abuse*	2013	Cohen	Israel	Hebrew	Multiple – community, clinical	Not reported	Q: interview covering risk + signs of abuse + self-disclosure of abuse S: (score of 3.5 in the screen) T: brief	Assessment – a multi-part tool for identifying older adults experiencing abuse or at risk of abuse
21	Potentials and Risk of Family Care for the Elderly (PURFAM)	2013	Heidenblut	Germany	German	Healthcare – outpatients	Unable to obtain description in English	Q: objective nurse/team completed checklists S: Unable to obtain in English T: brief	Screen – to assess the potential and risk of abuse and neglect
22	Resident-to-Resident Elder Mistreatment - Staff version (R-REM-S)	2014	Teresi	USA	English	Aged residential care	12	Q: staff completed checklist S: witnessed/not witnessed (high aggressiveness) T: data collected over a 2wk period	Assessment – to measure specific acts of violent behaviour over the past 2 weeks
23	Native Elder Life Scale (NELS)	2014	Jervis	USA	English	Community	30 (2 domains)	Q: self-report S: Likert (higher greater exploitation) T: nr	Screen – to capture culturally salient aspects of mistreatment
24	Tool for Risk, Interventions, and Outcomes (TRIO)	2014	Sommerfeld	USA	English	Professional - APS service in the community	Risks 68 Interventions 17 Outcomes 20	Q: interview - electronic administration S: yes/no + Likert (nr) T: lengthy interview	Assessment – a multi-part tool to advance a cohesive and comprehensive approach to assessment for APS staff

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
25	Family Violence Scale (FVS)	2014	Préville	Canada	Not reported – tool available in English	Healthcare – primary care	21 (2 domains)	Q: self-report (can be self-administered) S: yes/no + frequency of event T: easy to administer	Screen – to assess violence perpetrated by spouse or child
26	Elder Abuse Decision Support System (EADSS) –short forms: OAFEM, OAEAM, OAPAM, OANM	2017	Beach	USA	English	Professional – APS service in the community	36 (4 domains) OAFEM (11) OAEAM (11) OAPAM (6) OANM (8)	Q: interview + interviewer-coded neglect S: yes, some, no/don't know (≥1) T: 10–15 minutes	Assessment – to obtain information about elder mistreatment within the past 12 months
27	Emergency Department Senior Abuse Identification (ED-Senior AID)	2018	Platts-Mills	USA	English	Healthcare or emergency department	22 (3 domains)	Q: Interview, cognition measured S: yes/no, physical assessment, nurse rating (suspicion of abuse) T: 1–3 minutes	Assessment – a three-part tool to identify abuse of older adults
28	Risk of Elder Abuse and Mistreatment Instrument (REAMI)	2018	De Donder	Belgium	Not reported – tool available in English	Professional – healthcare, social	22 (3 domains)	Q: self-report completed by a professional who knows the patient S: Likert (nr) T: < 15 minutes	Screen – to assess three levels of risk (personal, environment and signals of abuse)
29	Questionnaire to assess elderly abuse by family caregivers*	2018	Mahmoudian	Iran	Not reported – tool available in English	Healthcare and research	57 (7 domains)	Q: interview S: Likert 1–228 (medium risk 76–152, severe risk 15–-228) T: nr	Screen – to assess abuse by family caregivers
30	Family Members Mistreatment of Older Adults Screening Questionnaire (FAMOASQ)	2018	Ruelas-González	Mexico	Spanish	Healthcare – primary care	15	Q: self-report S: yes/no (≥ 3) T: 10-15 minutes	Screen – to detect the familial mistreatment of older adults in Mexico
31	Abuser Risk Measure (ARM)	2019	Conrad	USA	English	Professional ––APS workers (urban, suburban, rural)	21 and a 9-item short form	Q: interview S: yes/no (cautiously suggest ≥ 4 for 21-item and ≥ 2 for 9-item) T: nr	Screen – to measure abuser risk characteristics
32	Assessment Tool for Domestic Elder Abuse (ATDEA)	2019	Yi	Japan	English	Healthcare - community nurses	34 (7 subscales)	Q: checklist completed by a professional S: severity rated 1–5 (rating of 2–5) T: nr	Assessment – to assess the presence, subtypes, and severity of elder abuse
33	Weinberg Centre Risk and Abuse Prevention Screen (WC-RAPS)	2019	Teresi	USA	English and Spanish	Community	13 (2 domains)	Q: self-report S: yes/no T: nr	Screen – to assess risk and abuse of older people applying to long-term abuse prevention services

Reference #	Tool name (acronym)	Year	First author surname	Country of origin	Original language	Setting	Number of items	Administration	Aim of the tool
34	Responding to Elder Abuse in GERiAtric care-Self-administered (REAGERA-S)	2020	Simmons	Sweden	Swedish and English	Healthcare – inpatient setting	9	Q: self-administered or assisted for people with physical limitations S: yes/no (≥ 1) T: brief	Screen – to identify elder abuse in cognitively intact hospitalised older adults
35	Abuse and neglect scale*	2021	Asiamah	Ghana	English	Community	11 (2 domains)	Q: self-administered S: Likert, 11–33 (nr) T: nr	Assessment – to measure abuse and neglect of older adults
36	Elder Mistreatment Measure (EMM)	2021	Wong	USA	English	Community – research setting	10 stem questions + 2 questions about severity for each	Q: self-report S: y/n/dk: stem questions; Likert: severity questions (nr) T: brief	Screen – to solicit self-reports of mistreatment experiences
37	Hospitalized Elder Abuse Questionnaire (HEAQ)	2022	Naderi	Iran	Persian	Healthcare – acute care	27 (5 domains)	Q: self-administered or assisted interview S: Likert, 27–135 (moderate abuse 64–99, severe abuse 100–135) T: 15-20 minutes	Screen – to assess abuse by staff
38	Elder Abuse Emotional Consequences Scale (EACS)	2022	Neise	Germany	German and English	Multiple – inpatient, home	16 (6 domains)	Q: interview S: Likert (nr) T: < 3min	Assessment – to assess abuse in the oldest-old with mild cognitive impairment

Notes:1. Administration: Q = question format; S = scoring (indicator of risk); T = time to administer 2. nr = not reported 3. *these tools were unnamed in the development papers; the name given to them is a description

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

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