MEDICINE, LAW & SOCIETY
Vol. 16, No. 2, pp. 267–286, October2023

MEDICINE, LAW & SOCIETY

SCREENING THE OLDER FOR ABUSE

Accepted
27. 5. 2023

Revised
15. 8. 2023

Published
27. 10. 2023

MARTA SJENIČIĆ, SOFIJA NIKOLIĆ POPADIĆ
Institute of Social Sciences, Belgrade, Serbia
msjenicic@idn.org.rs, snikolic@idn.org.rs

CORRESPONDING AUTHOR
msjenicic@idn.org.rs

Abstract Many countries are developing instruments to help prevent and recognize violence against the older. In the area of older abuse and its consequences, different screening methods have been developed and adapted to the country in which they are applied. Professionals are often not trained to detect signs of abuse, much less screen for the same, and therefore need continuous training in geriatrics and geriatric medicine. In order to draw attention to the older in the near future, specific measures should be prescribed not only within the framework of current legal regulations and bylaws, but also through guidelines, guides and other professional documents (soft-law), to be taken by state bodies, non-governmental organizations and other actors, for the purpose of screening violence, prevention of violence against the older, treatment of the older who have been subjected to violence and measures against its perpetrators, including forensics in cases of violence against the older. Instruments for organized screening for violence should be introduced in all sectors, but especially in the health and social care sectors, because primary health care and social work centers, in fact, are the gateway to the health and social system and make initial contact with service users, including the older.

Keywords
older,
abuse,
neglect,
screening,
multidisciplinary

https://doi.org/10.18690/mls.16.2.267-286.2023
CC-BY, text © Sjeničić, Nikolić Popadić, 2023
This work is licensed under the Creative Commons Attribution 4.0 International License.
This license allows reusers to distribute, remix, adapt, and build upon the material in any medium or format, so long as attribution is given to the creator. The license allows for commercial use. https://creativecommons.org/licenses/by/4.0

University of Maribor Press

1 Intrudaction

According to the World Health Organization (WHO), the older people abuse "is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (WHO, 2022). Older abuse is not a new phenomenon. However, it is necessary to undertake additional actions to prevent its increase in absolute terms, considering the speed of population aging in the world. Consequences of older abuse (hereinafter: OA) are devastating for older persons. They can lead to poor quality of life, multiple health problems, psychological distress, and increased mortality (Perel-Levin, 2008, p. 8).

The American Medical Association recommended that all geriatric patients should receive OA screening. Multiple researchers have recommended screening as a way to help prevent and detect OA. Despite that, the U.S. Preventive Services Task Force concluded in 2013 that "current evidence is insufficient to assess the balance of the benefits and harms of screening all older or vulnerable adults for abuse and neglect. Additionally, a universal screening tool does not exist without challenges for screening" (National Center on Elder Abuse, 2016, p. 1).

Screening is usually defined as "the preliminary identification of an unrecognized disease in an apparently healthy, i.e., asymptomatic population" (Žujković & Anđelković, 2017, p. 553). It refers to a "standardized test or question that does not change from place to place and that has the ability to identify a condition with good sensibility and to provide an effective response" (Perel-Levin, 2008, p. 17). Due to the high level of sensitivity and complexity involved in the screening process, screening is related to the very important issues of confidentiality, autonomy, and reporting. Having that in mind, the question might not be whether to screen for abuse, but rather what method of screening would provide the optimal way to strike an appropriate balance between opposing points of view, through the application of proper communication and through compromise (Perel-Levin, 2008, p. 18). While the term "screening" may have a specific meaning in public health, it also implies a stronger attitude involving follow-up. The critical point, therefore, is that screening is only a first step, not an end in itself, and that consequent actions are also necessary. An important and justified objective of universal routine screening is to name and

accept the problem as well to assist in destigmatizing the issue. The most relevant advantage of screening older adults for abuse is that without its identification, there can be no intervention on abuse (Fundinho et al., 2021, p. 57).

The authors used the comparison and analysis method to review the existing screening tools and the analysis method to draw conclusions on the following issues: setting where the screening tools can be used and therefore the potential abusers; challenges in implementing screening tools; and, alternative approaches to OA screening. The authors then used the dogmatic legal method to display positive Serbian legislation related to older adults and to try to develop further steps to introduce higher quality screening abuse tools in Serbia.

2 Barriers to Screening of OA

Interpersonal violence is a critical health problem. Its complexity affects the creation of a variety of views, and concerns about how, when and who should tackle this issue (Perel-Levin, 2008, p. 20). Even though the effects of OA can be devastating, numerous barriers to screening for it exist, including: "lack of a simple, short, universal screening and assessment methodology; lack of time for screening and intervention; lack of knowledge regarding intervention and resources; fear of retaliation or escalating violence; lack of knowledge regarding mandatory reporting requirements; a desire to honor the wishes of the elder or family not to report OA; lack of knowledge regarding OA, what comprises abuse, and how to recognize it; difficulty in determining elder capacity; and, fear of the consequences of involving government agencies in the elder's life" (Caldwell et al., 2013, p. 21). The lack of a reference standard or "gold standard" for comparison with which to determine the validity of OA screening instruments is another current issue affecting the development and research of these instruments (Caldwell et al., 2013, p. 21).

Merely recommending the introduction of detection tools for OA or domestic violence, while critical, is in itself insufficient (Perel-Levin, 2008, p. 21). The basis of effective screening is the "development of valid and reliable screening measures with low measurement error," which is a very challenging task, both from the methodological side, but also because OA, like other forms of domestic violence, is a rather hidden phenomenon that occurs both in home and in institutions, most

often without witnesses to the abuse (Schofield, 2017, p. 161). There are various reasons why victims are unwilling to disclose the abuse. Some of them are shame, fear of judgment, inability of the older adults to identify behavior as abusive, feeling that the abuse is their fault, dependence of the older adults on the abuser etc. Additionally, OA is poorly recognized and understood within the community, especially given the different forms of OA. Members of the community may also be reluctant to interfere in family relationships (Schofield, 2017, p. 161). Besides the challenges in "regular situations", this issue was especially emphasized during the Covid-19 pandemics (Nikolić Popadić & Milenković, 2021, p. 188). There has been an increase in domestic violence in general, and the older were at particular risk, often not having the possibility to leave their homes or institutions where they were placed (Nikolić Popadić et al., 2021, p. 234).

3 Solutions for Screening of OA

In order to use the screening tools effectively, professionals must be trained so that they can detect the problem and signs of its existence, symptoms, consequences that the problem causes and so that they are adequately prepared and ready for intervention once the case of abuse or neglect is discovered. It is essential for professionals to have confidence to overcome the barriers that can obscure the detection of OA and necessary intervention. One of the aggravating circumstances is that there are other, more established health care issues which compete with older and domestic abuse, such as "cardiovascular diseases, cancer and acute care, adding to the difficulty for health care providers in dealing with a social chronic problem while medicalizing it" (Perel-Levin, 2008, p. 21). Changing attitudes toward violence/OA have a potential to help primary health care practitioners better understand how important and relevant screening is to recognize and perceive their patients' emerging and/or recurring conditions that would otherwise go undetected. Namely, one of the proposed solutions that can alleviate this situation and help the primary health care practitioners is to "see violence as a risk factor for a long list of diseases, in the same way that tobacco and alcohol are viewed" instead of seeing violence as a disease (Perel-Levin, 2008, p. 21).

Related to acceptability of screening-by-screening subjects, researchers suggest that "providers should be sensitive to the generational taboos around domestic violence and pick up on hints or clues to assist elder women (patients – authors comment) to disclose abuse. They should also avoid ageist assumptions and screen elder women (patients – authors comment) as well as younger patients" (Perel-Levin, 2008, p. 20). In order to break the cycle of abuse it is imperative for there to be a trusting relationship between the health care practitioner and the patient (Perel-Levin, 2008, p. 22). As doctors see their older patients five times per year on average, they play a key role in identifying OA and also in promoting awareness of this issue (National Center on Elder Abuse, 2016, p.1).

Instruments to help prevent and recognize violence against the older are better established in common law systems. These instruments are adapted to the country in which they are applied, but mostly to the setting in which they are implemented.

The screening instruments will be described in the following text.

4 Existing Tools for Screening of OA

Screening instruments for OA currently adhere to the standards for disease screening tests. In order to be valid, they should meet the following criteria: "(1) are sensitive (effectively identify individuals with the disease); (2) are specific (effectively identify individuals who do not have the disease as not having the disease); (3) demonstrate a positive predictive value; and (4) demonstrate a negative predictive value. It should also be understood that, as with all disease screening tests, the screening process results in the label of "positive" or "negative" but is not diagnostic and warrants additional testing and assessment before conclusions are drawn" (Caldwell et al., 2013, p. 20).

Over the past three decades, there has been growing interest in developing screening instruments that are valid, reliable, and designed to detect risk of OA and neglect in a variety of contexts (Schofield, 2017, p. 162). There are different ways to categorize screening instruments. Based on both the method and intention of the screening instrument, they were categorized into three groups (Cohen et al., 2006, pp. 664–667). The direct questioning tools about the olders' experience were in the first

group; tools that assess signs of actual abuse were included in the second group; while the third group was comprised of measures designed to assess risk of abuse. It was concluded that all three forms of screening measures should be incorporated into the screening model, having in mind that each of them has limitations and strengths, so that it would be beneficial to have a comprehensive approach (Schofield, 2017, p. 162).

Screening instruments can also be further categorized based on where the abuse has taken place and on the basis of who the abuser is.

The following text will describe some of these tools, drawing crucial distinctions between those applied in the community and those applied in the institutional setting.

Several tools have been identified for various reasons, such as their potential to assess several types of abuse, their specificities and their particular focus. Trained professionals in institutional settings plan to use the following tools (National Center on Elder Abuse, 2016, p. 2).

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) (Neale et al., 1991) addresses the various types of OA. The instrument consists of 15 questions with items in three domains: violation of personal rights or direct abuse; characteristics of vulnerability; and, potentially abusive situations (Perel-Levin, 2008, p. 14). Its purpose is to identify people at high risk of the need for protective services by interested service providers. All questions should be answered by the people that might be at risk and in need for protective services, so it is either self-report or through interview by a professional. It seems to be suitable in emergency or outpatient setting (National Center on Elder Abuse, 2016, p. 2).

The Elder Abuse Suspicion Index (EASI) tool was developed to "raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents, for in-depth assessment. The EASI was validated for asking by family practitioners of cognitively intact seniors seen in ambulatory settings" (Yaffe et al., 2008, p. 276). "The theory behind this is that a simple tool can grant the patient

permission to talk and can generate a level of suspicion and not necessarily a diagnosis. It is also aimed at general internists and geriatricians with the intention to expand and test it also with social workers and nurses" (Perel-Levin, 2008, p. 15). EASI is a short five-question tool directed at the older adult, with one observation item to be completed by the doctor. It should assess risk, neglect and abuse over a 12-month period and requires two minutes to complete (National Center on Elder Abuse, 2016, p. 2).

The Brief Abuse Screen for the Elderly (BASE) is a simple tool comprising five brief questions that help practitioners assess the likelihood of abuse. Practitioners should respond to every question (as well as they can estimate) concerning all clients over a certain age as well as caregivers (give regular help of any kind) or care receivers. Therefore, it is rough tool, which assesses abuse from both sides – caregiver and care receiver, and which provides certain proposals for further measures (Reis & Nahmiash, 1998, pp. 473–474).

The Elder Assessment Instrument (EAI) comprises the general assessment of the older person together with specific social, physical, and medical assessments (including neglect, abuse, exploitation, abandonment) and also a level of independence in lifestyle (Perel-Levin, 2008, p. 15). It is conducted in a clinical setting. For this instrument there is no "score" and it is quite descriptive. The EAI tool is not designed to question the patients, but instead is used by clinicians so they might independently assess the potential abuse of their patient. A patient should be referred to social services if the following exists: "1) any positive evidence without sufficient clinical explanation, 2) a subjective complaint by the elder adult of mistreatment, or 3) whenever the clinician deems there is evidence of abuse, neglect, exploitation, or abandonment" (Fulmer, 2003, p. 4–5).

The purpose of the Health, Attitudes Toward Aging, Living Arrangements, and Finances Assessment (HALF) tool (Ferguson & Beck, 1983) is to identify olders at risk in a health service setting and, therefore, it is a clinician-based tool. Questions are answered by the interviewer following a meeting with both the caretaker and older adult. Items are categorized on a three-point Lickert scale (Ferguson & Beck, 1983, p. 302). With this tool it is significant to notice that the dynamic between caretaker and older adult is recognized and determined, and thus, also potential causes of certain behavior.

The purpose of the Partner Violence Screen (PVS) tool is a brief screening for use in emergency departments or other urgent care settings. It is conducted through interviewing of the patient alone and through only few direct questions: "a) Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?, b) Do you feel safe in your current relationship?, and c) Is there a partner from a previous relationship who is making you feel unsafe now?" (Feldhaus et al., 1997, p. 1357).

Specific tools developed for use in the community setting will be described in the following text. The purpose of the Vulnerability to Abuse Screening Scale (VASS) tool (Schofield & Mishra, 2003, p. 116) is to identify specifically older women at risk of abuse, mostly within the family, through a self-report instrument. The questionnaire can be mailed to subjects with instructions to answer "yes" or "no". The individual self-reports on matters pertaining to dependency, dejection, coercion, and vulnerability (National Center on Elder Abuse, 2016, p. 2).

The Caregiver Abuse Screen (CASE) (Reis & Nahmiash, 1995) consists of eight questions to caregivers and does not address the patient directly. This tool aims to detect abuse in cognitively impaired adults. It can be used to assist in interviewing a suspected abuser, but unfortunately it ignores the autonomy of the patient and assumes only the caregiver model (Perel-Levin, 2008, p. 14). The tool is designed specifically for community use. The answers to all eight CASE questions should be "yes" or "no". If the score on the CASE is four or more, this may be "conservatively considered as suggestive of a higher risk for abuse", although "even a score of one can be indicative of abuse" (Reis & Nahmiash, 1995).

The Indicators of Abuse Screen (IOA) (Reis & Nahmiash, 1995) is a "48-point checklist of problem indicators for abuse that is completed by trained health care professionals in the context of a comprehensive home assessment" (Perel-Levin, 2008, p. 15). This tool builds on the professional's assessment skills, and it addresses the patient directly. Among the things that need to be checked are whether the patient has problems with alcohol, medication, behavior or poor relationships. It should be noted that "this is clearly not a screening tool for the clinical setting, but it has been recognized as a potentially good research instrument" (Perel-Levin, 2008, p. 15). It is a tool for screen for abuse and neglect at the client's home. It is also to be completed by social service agencies. The IOA is completed by administering the form, usually after a 2–3-hour comprehensive in-home assessment. The researchers

use a cutoff score of 16 to indicate abuse. Indicators of abuse are numbered in order of importance. After the assessment, each of the items should be rated on a scale of 0 to 4 and the scores summed. Items should not be omitted, and the rating should be done in line to the current opinion. Both caregiver and care receiver are being assessed, and thus therefore the dynamic of their relationship is determined and potential causes for certain behavior and consequences revealed (Reis & Nahmiash, 1995).

The purpose of the Risk of Abuse Tool (Bass et al., 2001) is to identify common risk factors associated with cases of older abuse and/or domestic violence. It indicates "whether the problem is likely to occur in a possible victim, a possible perpetrator, or both." A question intended for a possible victim is shaded in the column referring to the possible perpetrator and vice-versa. A question intended for both possible victim and possible perpetrator is identified by non-shaded columns next to the corresponding screening question. Service providers are encouraged to place a check mark in the appropriate row/question if they identify a particular problem/risk factor in either one or both columns.

There are also other tools for assessing the existence of domestic violence as Questions to Elicit Elder Abuse (Carney et al., 2003) and Suspected Abuse Tool (Bass et al., 2001).

There are also tools used in any setting, as, for example Australian Elder Abuse Screening Instrument (AUSI) (National Ageing Research Institute, 2020). AUSI is a quite comprehensive screening tool, designed with funding from the State Trustees Australia Foundation, by National Ageing Research Institute together with health, aged care, and legal services. Data obtained in the pilot testing showed that this tool was easy to use. It proved helpful to frontline providers such as nurses and medical personnel who do not usually perform a routine screening for OA, and it improved their confidence in screening. Some downsides are that the AUSI did not show impact on the detection of OA cases and did not affect staff's already high knowledge of OA. Accordingly, the tool is still in development. It can be conducted by any assessor; it comprises screening of all kinds of abuse; it provides instructions how to use the tool, and puts special emphasize on vulnerable population groups; it provides instructions for every level of neglect/abuse determined; it provides referral contacts for situations where abuse exists (National Ageing Research Institute, 2020).

Different tools have varying approaches concerning screening and assessment. Several tools (for example, H-S/EAST, VASS, EASI) target the older person with direct questions. However, it is evident that the caregiver model has a great influence in the design of other tools. It is important to note that "evaluations of the general acceptability of the tool were performed only with the professionals who participated in the studies", while "no study evaluated the acceptability of the tool by elder persons" (Perel-Levin, 2008, p. 15). There are certainly benefits of using screening tools. One of them is raising awareness of OA among service providers. However, not assessing acceptability by patients themselves is inconsistent with both the principle of screening and a rights-based approach (Perel-Levin, 2008, p. 15).

5 Challenges in Implementation of Screening Tools

There are several identified challenges in implementing screening tools: designing a screening tool – a simple, brief screening and assessment methodology is needed (Caldwell et al., 2013, p. 21); the lack of criterion standard for the diagnosis or validation of OA (Yaffe et al., 2008); the lack of a "gold standard" which should serve as a comparison to establish the validity of OA screening tools (Caldwell et al., 2013, p. 21); the lack of a "good-quality randomized, controlled trials focusing on both screening and interventions" (National Center on Elder Abuse, 2016, p. 4).

The challenges for physicians in determining OA are: normal aging changes can mimic signs of older abuse; screening tools that take more than an hour to administer meet with increased resistance which decreases screening quality; differences between unintentional and intentional injuries; challenges in screening of olders with mental or intellectual disabilities; older victims may reject disclosing evidence of abuse and neglect to professionals out of fear, shame, or a sense of hopelessness; concerns of OA may create significant additional work for clinicians that they are not familiar with; service providers may be skeptical about the possibility of making a change once OA is identified and reported (National Center on Elder Abuse, 2016, p. 4).

6 Different Thoughts and Approaches to OA Screening

OA screening may significantly benefit through utilization of a team-based approach in order to identify OA in emergency departments, which would include "emergency medical providers, triage providers, nurses, radiologists, radiology technicians, social

workers, and case managers" by capitalizing on their unique perspectives (National Center on Elder Abuse, 2016, p. 4). Radiology technicians and other staff who are involved in transportation of patients could incorporate the detection of OA into their practice as they spend time alone with the patients, which can give them an opportunity to receive reports on OA (National Center on Elder Abuse, 2016, p. 4).

The most common modes of assessment are self-report questionnaires or interviews by a health professional, either in the health setting or home environment (Schofield, 2017, p. 186). Benefits of self-report are: it's economical; the potential for mass screening; more honest answers when completed in private. Disadvantages of self-report could be: it may be unsuitable for those who are cognitively impaired, or illiterate; (if it is national survey, there is often no strategy to follow up those who are identified as at risk of OA (Schofield, 2017, pp. 186–187).

There are positives and negatives associated with screening for OA that is undertaken by professionals. Positives are: professional motivation; thorough screening/assessment; follow-up of screening if needed; screening can be followed by the intervention or referral to the appropriate service, for the purpose of mitigating the abuse or abuse risk. Negatives include: professionals often lack time to screen thoroughly; lack of training and comfort in asking highly sensitive questions; potential bias in scoring and interpretation; and, sometimes, lack of referral and intervention options (Schofield, 2017, pp. 186–187).

Observational screening tools are relevant for assessing neglect and self-neglect when the older person may be unable or unwilling to reliably report on these aspects. Observational measures are viewed as more objective, but on the other side, one should be cautious with the conclusions. For example, poor nutrition is a key feature of self-neglect. However, the amount and quality of food identified in the home of the person during the visit may vary dramatically depending on various factors including when the last shop was conducted, or whether the older person may have already prepared food brought in by others on a regular basis. The older person can also be on a diet which influences screening scoring system (Schofield, 2017, pp. 186–187).

7 Steps Towards Screening of OA in Serbia

The estimated population in the Republic of Serbia in 2020 was 6,899,126.11. Observed by sex, 51.3 percent were women (3,538,820) and 48.7 percent were men (3,360,306). In Serbia, 16 percent of older women aged 65 to 74 experienced some form of violence after reaching the age of 65. According to the research conducted in 2018, the most prevalent form is psychological violence, which was experienced by seven percent of women after turning 65, during one year before the research (Babović et al., 2022, p. 18). Based on the research of the small sample from one of the centers for social work in Serbia, obtained from victims that reported the abuse, it was concluded that elder women are more often the victims of violence. Men more frequently appear to be perpetrators of violence. Elder adults without a spouse were more exposed to violence compared to those who lived with a partner (Marinčević, 2018, p. 69).

Although violence obviously exists everywhere, unlike in common law systems, screening of violence against older persons (in Serbia, but also in many European countries) has in principle, so far, been a non-governmental initiative, but it is also mentioned in strategic documents.

In order to draw attention to the safety of the older population in the near future, specific measures should be prescribed within the framework of current legal regulations, bylaws, but also guidelines, guides and other professional documents (soft-law), to be taken by state bodies, non-governmental organizations and other actors, for the purpose of screening violence, prevention of violence against the older, treatment of the older who have been subjected to violence and measures against its perpetrators, including forensics in cases of the OA.

Instruments for organized screening for violence should be introduced in all sectors, especially in the health and social care sector, since primary health care – selected physician, and social work centers – department for protection adults and older– case manager are, in fact, the gatekeepers to the health and social system since they make the first contact with service users, including the older. These institutions, (i.e., their employees), should conduct screening for violence on the basis of screening protocols, after training for their application (Sjeničić & Vesić, 2018, p. 358). Professionals (health and social) are often not trained to detect signs of abuse, much less screen for the same. It is necessary that the workers of health and social services

have greater skills and knowledge that would enable them to effectively manage OA. In this sense, practice can be improved by targeted educational seminars that would fill the existing knowledge gaps. It is necessary to bear in mind that the distribution of printed materials is not efficient and does not produce the desired results. Also, many articles devoted to the signs and symptoms of OA have been published but they have had almost no impact (Perel-Levin, 2008, p. 25).

Workers in the judicial system must also be trained regarding appropriate protocols to be used in cases of OA. Although national legal regulations are applicable to everyone, regardless of age (except minors where there is specific incrimination for minor abuse) – special registers for OA cases should be introduced in the prosecutor's offices and criminal courts practice, and special prosecutors/court councils established that are tasked specifically to deal with cases involving abuse.

The first recipients of information should, if they determine there is evidence of the existence of possible abuse or neglect, according to the established algorithm, inform other actors in the multidisciplinary team so that they may undertake the necessary preventive measures to curb the abuse/neglect. Screening for abuse should be implemented on the population 65 and up.

Although early identification of abuse is crucial, it should be emphasized that the effectiveness of routine screening will eventually depend on effective interventions, which do not mean solving the problem, but "naming and accepting it together with limitations of the PHC level, leading to referral and interprofessional cooperation" (Perel-Levin, 2008, p. 24).

There are several criteria that an OA assessment instrument should meet in order to be successful. It needs to be "concise, easy to use, consider frailty of elder people, and give direction to a pathway if there is a suspicion of elder abuse" (Van Royen et al., 2020, p. 1804). Also, framing questions in a narrative and qualitative format and in a safe and calm environment can help assessors build trust and rapport with elder persons. In addition to enabling detection of OA, "assessment tools should include clear referral pathways on what to do when potential abuse is found - when to report, who to contact, and how to involve the elder person in the referral process" (Van Royen et al., 2020, p. 1804).

The assessment tools should be adaptable to risk groups as well. A disease-sensitive assessment tool specifically adapted to OA in persons with dementia is needed in order to seize the specific characteristics of abuse that would involve older persons with different stages of dementia as well. This is very important considering that dementia and cognitive impairment constitute one of the most important risk factors for OA. Additionally, there is a need to educate healthcare professionals regarding the nature and prognosis of dementia. This education will enable them to be alert of the potential risks which are related to symptoms associated with different stages of dementia, when they provide care at home (Van Royen et al., 2020, p. 1804).

8 National Legal Framework

Currently in Serbia there are not many national regulations in the field of aging, and there are none that exclusively regulate issues of prevention of violence against the older adults and reactions to violence. In the regulatory sense, the issue of aging has only been in focus for the last couple of decades (as in other European countries) and regulation mainly refers to healthy aging and the improvement of the environment that affects it (Sjeničić, 2020, p. 63).

In addition to general provisions related to intergenerational solidarity and the need for support to the older adults and their families, the National Strategy on Ageing (2006) (hereinafter: Strategy) deals indirectly with the system of detecting neglect of the older adults, and directly refers to the development of assistance services for the older and their families, in the community, and potentially, with the aim of preventing abuse and neglect (Sjeničić, 2020, p. 66).

One of the goals envisaged in the Strategy is to promote and support intergenerational solidarity. The activities foreseen for the realization of this goal are: "2.1. Organizing various activities and measures within the system of education, culture, social and health policy and actions, the aim of which will be to promote the value of mutual respect, understanding and tolerance for the different needs of generations, as well as respect and positive evaluation of the contribution of older generations in the overall development and functioning communities; 2.2. Engagement in the prevention of various forms of family violence (especially latent abuse of olders' family members, such as financial or psychological abuse, neglect of existential needs, etc.), through clearer definition and familiarization of the population with the forms and characteristics of these behaviors, more effective

application of existing ones and introduction of new ones legal measures; ensuring the most efficient functioning of the support network for potential victims, as well as other activities" (Sjeničić, 2020, p. 68).

Although the Strategy is comprehensive, none of the proposed measures are specifically related to screening tools, and many of them are not implemented in practice, although the Strategy has now expired.

There are a number of legal and by-laws that indirectly relate to the older adult population, for example: Law on Social Protection, Family Law, Law on Health Care, Law on Misdemeanors, Criminal Code, Law on Prevention of Discrimination of Persons with Disabilities, Law on Prevention domestic violence, the Law on Ratification of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, etc.

In addition to the Constitution, laws and by-laws, the following regulations are also relevant to this topic to a greater or lesser extent: National Strategy on Aging, Social Protection Strategy, National Strategy for the Prevention and Suppression of Violence against Women in the Family and in Partnerships, General Protocol on the behavior and cooperation of institutions, bodies and organizations in situations of violence against women in the family and in partner relationships.

Although all create an environment relevant to the prevention of OA, only a few may be specifically applicable to such situations, while none of them define and develop screening instruments for OA.

9 Conclusion

There currently are numerous screening tools available to detect OA, the majority of which are designed to be used by health care providers and some of them in other institutional settings, or community use. However, the gold standard screening mechanism for OA screening does not currently exist and there is no certain pathway which would point to the OA. If the screening results for OA are positive, the screening mechanism should indicate that additional information must be collected. This suggests that the pathway from identification of risk to successful improvement of outcomes is fraught with many difficulties, and will require more innovative approaches.

Care providers in the home environment play a crucial role in detecting the abuse and responding to it, having in mind the large number of older people who stay at home and depend on formal and informal care or assistance. OA is a community problem, a social concern, but also a legal and medical matter, and therefore detection and prevention requires the involvement of professionals from different disciplines, i.e., a multidisciplinary approach. Since the tool or tools should be effective in every surrounding, they should be built on the basis of multidisciplinary research and with the participation of different stakeholders, including the final beneficiaries – older adults. This will eventually reduce the stigma associated with the application of OA screening tools and improve their acceptance from both final beneficiaries, and the persons/social services implementing the tools.

Since this article has provided an overview of different screening tools, created for use in different surroundings (institutional or home) and for the different social milieus, it could provide the theoretical basis for further brainstorming for the adequate screening tool in the national frame and for changes in the legislation and soft regulations in that direction.

The next steps, following the screening and its results, are: development of individual plan/strategy for each abused person; development of spectrum of services for older; and development of focused interventions for abusers.

Acknowledgment

This paper was written as part of the 2023 Research Program of the Institute of Social Sciences with the support of the Ministry of Science, Technological Development and Innovation of the Republic of Serbia.

References

Babović, M., Brownell, P., Vračević, M. & Todorović, N. (2022). *Exploring violence against older women in the Western Balkans, Moldova and Ukraine. Red Cross of Serbia.* Retrieved from https://serbia.unfpa.org/sites/default/files/pub-pdf/final_report_005.pdf (25 March 2023).

Bass, D. M., Anetzberger, G. J., Ejaz, F. K. & Nagpaul, K. (2001). Screening tools and referral protocol for stopping abuse against elder Ohioans: A guide for service providers. *Journal of Elder Abuse and Neglect*, 13(2), pp 23–38. Retrieved from https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/Suspected_Abuse.pdf (20 March 2023).

Caldwell, K. H., Gilden, G. & Mueller, M. (2013). Elder Abuse Screening Instruments in Primary Care: An Integrative Review, 2004 to 2011. *Clinical Geriatrics*, 21(1), pp. 20–25.

Carney, M. T., Kahan, F. S. & Paris, B. E. C. (2003). Elder abuse: Is every bruise a sign of abuse? *The Mount Sinai Journal of Medicine*, 70(2), pp. 69–74. Retrieved from

https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/Questions.pdf (24 March 2023).

Cohen, M., Halevi-Levin, S., Gagin, R. & Friedman, G. (2006). Development of a screening tool for identifying elderly people at risk of abuse by their caregivers. *Journal of Aging and Health*. 18, pp. 660–685. doi: 10.1177/0898264306293257.

Constitution, Official Gazette RS, no. 98/2006 and 115/2021.

Criminal Code, Official Gazette RS, no. 85/2005, 88/2005, 107/2005, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016 and 35/2019.

Family Law, Official Gazette RS, no. 18/2005, 72/2011 and 6/2015.

Feldhaus, K. M., Koziol-McLain, J., Amsbury, H. L., Norton, I. M., Lowenstein, S. R., & Abbott, J. T. (1997). Accuracy of 3 Brief Screening Questions for detecting partner violence in the emergency department. *Journal of the American Medical Association*, 277(17), pp. 1357–1361. doi: 10.1016/S1075-4210(97)90044-4.

Ferguson, D. & Beck, C. (1983). H.A.L.F.-A tool to assess elder abuse within the family. *Geriatric Nursing*, 4(5), pp. 301–304. doi: 10.1016/S0197-4572(83)80195-5.

Fulmer, T. (2003). Elder abuse and neglect assessment. *Journal of Gerontological Nursing*, 29(6), pp. 4-5.

Fundinho, J. F., Machado, M. M., Petronilho F. A. & Ferreira-Alves, J. (2021). *What we know about screening elder adults for mistreatment: Results from the SAVE project, Literature review*. Retrieved from https://repositorium.sdum.uminho.pt/handle/1822/78276 (20 March 2023).

General Protocol on the behavior and cooperation of institutions, bodies and organizations in situations of violence against women in the family and in partner relationships. (2014). Retrieved from http://demo.paragraf.rs/demo/combined/Old/t/t2014_10/t10_0035.htm (20 March 2023).

Law on Health Care, Official Gazette RS, no. 25/2019.

Law on Misdemeanors, Official Gazette RS, no. 65/2013, 13/2016, 98/2016, 91/2019, 91/2019 and 112/2022.

Law on Prevention of Discrimination of Persons with Disabilities, Official Gazette RS, no. 33/2006 and 13/2016.

Law on Prevention of Domestic Violence, Official Gazette RS, no. 94/2016.

Law on ratification of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Official Gazette RS, no. 12/2013.

Law on Social Protection, Official Gazette RS, no. 24/2011 and 117/2022.

Marinčević, A. (2018). *Fenomenološke i etiološke karakterisitke zlostavljanja starih osoba* (master rad). Univerzitet u Nišu, Pravni fakultet. Retrieved from http://www.prafak.ni.ac.rs/files/master-radovi/andrea-marincevic-002-16.pdf (8 August 2023).

National Ageing Research Institute (2020). *The Australian Elder Abuse Screening Instrument (AUSI)*. Retrieved from https://www.nari.net.au/ausi (24 March 2023).

National Center on Elder Abuse (2016). Elder Abuse Screening Tools for Healthcare Professionals. Retrieved from http://eldermistreatment.usc.edu/wp-content/uploads/2016/10/Elder-Abuse-Screening-Tools-for-Healthcare-Professionals.pdf (24 March 2023).

National Strategy for the Prevention and Suppression of Violence against Women in the Family and in Partner Relations, Official Gazette RS, no. 27/2011.

National Strategy on Aging, Official Gazette RS, no. 76/2006.

Neale, A. V., Hwalek, M. A., Scott, R. O. & Stahl, C. (1991). Validation of the Hwalek-Sengstock elder abuse screening test. *Journal of Applied Gerontology*, 10(4), pp. 406–415. doi: 10.1177/073346489101000403.

Nikolić Popadić, S. & Milenković, M. (2021). Uvođenje mera za zaštitu javnog zdravlja stanovništva tokom pandemije Kovid 19. In: *Primena prava i pravna sigurnost: zbornik radova 34. susreta Kopaoničke škole prirodnog prava - Slobodan Perović*, Tom 1. Beograd. Kopaonička škola prirodnog prava - Slobodan Perović, pp. 183–197.

Nikolić Popadić, S., Milenković, M. & Sjeničić, M. (2021). The Covid-19 Epidemic in Serbia – the Challenges of Finding an Appropriate Basis for Responding to a Health Crisis. *Medicine, Law & Society*, 14(2), pp. 229–246. doi:10.18690/mls.14.2.229-246.2021.

Partner Violence Screen (PVS). Retrieved from https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/PVS.pdf (4 August 2023).

Perel-Levin, S. (2008). *Discussing Screening for Elder Abuse at Primary Health Care level.* Geneva. WHO.

Reis, M. & Nahmiash, D. (1995). Validation of the caregiver abuse screen (CASE). *Canadian Journal on Aging*, 14, pp. 45–60. Retrieved from https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/CASE.pdf (24 March 2023).

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

Risk of abuse tool. (2001). Retrieved from https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/Risk_of_Abuse_Tool.pdf (24 March 2023).

Schofield, J. M. (2017). Screening for Elder Abuse: Tools and Effectiveness. In Dong, X. (Ed.). (2017). *Elder Abuse: Research, Practice and Policy*, Springer, pp. 161–199. doi: 10.1007/978-3-319-47504-2_9.

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

Sjeničić, M. (2020). *Pravni aspekti nasilja nad starijim osobama*. Beograd: Institut društvenih nauka.

Sjeničić, M. & Vesić, Z. (2018). Zlostavljanje starijih: Istraživanja i prevencija. *Temida*, 21(3), pp. 345–362. doi: 10.2298/TEM1803345S.

Social Protection Development Strategy, Official Gazette RS, no. 108/2005.

Van Royen, K., Van Royen, P., De Donder, L. & Gobbens, J.R. (2020). Elder Abuse Assessment Tools and Interventions for use in the Home Environment: a Scoping Review. *Clinical Interventions in Aging*, 15, pp. 1793–1807. doi: 10.2147/CIA.S261877.

World Health Organisation (2022). *Abuse of elder people.* Retrieved from: https://www.who.int/news-room/fact-sheets/detail/abuse-of-elder-people (22 March 2023).

Yaffe, M. J., Wolfson, C., Lithwick, M. & Weiss, D. (2008). Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI). *Journal of Elder Abuse and Neglect*. 20(3) 000-000. Retrieved from: https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/EASI.pdf (3 August 2023).

Žujković, S. & Anđelković, M. (2017). Organizacioni aspekt sprovođenja programa skrininga raka. *Zbornik radova: Međunarodna konferencija Pravo, ekonomija i menadžment u savremenim uslovima* (Ed.Radosavljević, Ž.). Beograd: Univerzitet "Union-Nikola Tesla", Fakultet za poslovne studije i pravo i Fakultet za strateški i operativni menadžment.

Povzetek v slovenskem jeziku

Številne države razvijajo instrumente za preprečevanje in prepoznavanje nasilja nad starejšimi. Na področju zlorabe starejših in njenih posledic so bile razvite različne metode presejanja, ki so bile prilagojene državi, v kateri se uporabljajo. Strokovnjaki pogosto niso usposobljeni za zaznavanje znakov zlorabe, zato potrebujejo nenehno izobraževanje na področju geriatrije in geriatrične medicine. Da bi pritegnili pozornost k starejšim v bližnji prihodnosti, bi morali biti predpisani posebni ukrepi, ne le znotraj obstoječih zakonodajnih predpisov in podzakonskih aktov, temveč tudi prek smernic, vodnikov in drugih strokovnih dokumentov (soft-law), ki jih morajo sprejeti državni organi, nevladne organizacije in drugi akterji, za namene presejanja nasilja, preprečevanja nasilja nad starejšimi, zdravljenja starejših, ki so bili izpostavljeni nasilju, in ukrepov proti storilcem, vključno s sodnimi preiskavami v primerih nasilja nad starejšimi. Orodja za organizirano presejanje nasilja bi morala biti uvedena v vse sektorje, zlasti v sektorjih zdravstva in socialne oskrbe, saj so osnovno

zdravstvo in centri za socialno delo, dejansko vhod v zdravstveni in socialni sistem ter vzpostavljajo prvi stik s uporabniki storitev, vključno s starejšimi.

Ključne besede: starejši, zloraba, zanemarjanje, presejanje, multidisciplinarnost