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Assessing Elder Mistreatment: Instrument Development and Implications for Adult Protective Services

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Assessment of elder mistreatment is hindered by a myriad of factors, including inconsistent definitions, divergent and untested theories of causation, and limited research attention to the problem. In addition to these difficulties, professionals encounter complex situations requiring considerable clinical assessment skills and decision-making capacity. Adult Protective Services (APS) workers, as well as mandated reporters such as healthcare providers and social workers, need an assessment tool that can reliably and accurately assess for elder mistreatment. Based on a structured review of screening and assessment instruments, this article discusses the psychometric properties of 15 instruments and the relevance to APS. Implications of the findings for future research, practice, and policy are discussed.

KEYWORDS *Elder mistreatment, elder abuse, APS, assessment, screening tools*

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In the United States, elder mistreatment is a growing social and public health problem. Adult Protective Services (APS), the state and county programs responsible for investigating allegations of elder mistreatment and arranging for necessary intervention services, received 565,747 reports of elder mistreatment in 2004, a 19.7% increase from 2000 (National Center on Elder Abuse [NCEA], 2006). The National Research Council (NRC) to review Risk and Prevalence of Elder Abuse and Neglect reported that between 1 and 2 million adults aged 65 years and older have been mistreated by a caregiver (NRC, 2003). An increasing number of professionals in such settings as financial and healthcare institutions encounter cases of suspected abuse, neglect, or exploitation. In fact, in the State of California, officers and employees of financial institutions and clergy now are mandated reporters of suspected elder abuse.

Elder mistreatment is largely a hidden problem, with only an estimated 16% of all cases of mistreatment reported (NCEA, American Public Human Services Assn., & Westat, 1998). Although elder mistreatment has received national attention from the Institute of Medicine (2002) and the Centers for Disease Control and Prevention (National Center for Injury Prevention and Control Division of Violence Prevention, 2002), considerable debate remains as to the specific causes of elder mistreatment, how best to identify instances of mistreatment, and the most effective interventions to reduce occurrence of abuse and risk factors for abuse.

An increasing need exists for psychometrically sound instruments to assist practitioners in a variety of settings to screen, detect, and assess elder mistreatment (Fulmer, Guadagno, Dyer, & Connolly, 2004). However, efforts to create assessment instruments are hindered by complex factors, such as a lack of consensus about definitions of mistreatment, divergent theories of causation, and insufficient funding to develop such instruments (Summers & Hoffman, 2006). Therefore, the primary purpose of this review of the literature is to summarize the current progress in developing screening and assessment instruments for elder mistreatment and the implications for APS and mandated reporters.

ELDER MISTREATMENT: A GROWING SOCIAL AND PUBLIC HEALTH CONCERN

Elder mistreatment includes physical, sexual, and emotional abuse; neglect and abandonment; and financial exploitation and is defined as “(a) intentional actions that cause harm or create a serious risk of harm (whether or not the harm was intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm” (NRC, 2003, p. 1). Self-neglect is defined as an adult’s inability to perform necessary

self-care tasks due to physical or mental limitations (National Association of APS Administrators, 1993). Although there is considerable disagreement about what should be included in the definition of elder mistreatment, Table 1 highlights the major categories found in the literature. State statistics (substantiated reports) suggest that neglect is the most common form of elder mistreatment (37.2% for self neglect and 20.4% for caregiver neglect), followed by emotional/psychological/verbal abuse (14.8%), financial exploitation (14.7%), physical abuse (10.7%), sexual abuse (1%), and other (1.2%; NCEA, 2006).

APS originally was created as part of federal legislation; however, states and counties have the responsibility of designing and implementing reporting systems and intervention strategies. In 1975, the passage of Title XX of the Social Security Act allowed states to allocate a portion of funds from the Social Services Block Grants for advocacy and services for vulnerable older adults (Nerenberg, 2006). However, federal funding remains inadequate to address the growing number of reported elder abuse cases, and it lags behind funding for other types of abuse. In 2002, the federal government

TABLE 1 Definitions of Elder Mistreatment

Type of abuse	Definition
Abandonment	Desertion by an individual who has assumed responsibility for providing care for an older adult, or by a person with physical custody of an older adult.
Emotional and psychological	Infliction of pain or distress through verbal or nonverbal acts, including verbal assaults, insults, threats, intimidation, humiliation, harassment, being treated like an infant, and isolation.
Financial/material exploitation	Illegal or improper use of funds, property, or assets, including cashing checks without authorization or permission; forging a signature; misusing or stealing money or possessions; coercing or deceiving into signing a document; and improper use of conservatorship, guardianship, or power of attorney.
Neglect	Refusal or failure to fulfill any part of one's obligations or duties to an older adult, including failure to provide food, water, clothing, shelter, personal hygiene, medicine, comfort, or personal safety.
Physical	Physical force that may result in bodily injury, physical pain, or impairment, including striking, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, burning, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.
Self-neglect	An adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including obtaining essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, or general safety; and /or managing one's own financial affairs.
Sexual	Any kind of nonconsensual sexual contact, including unwanted touching, sexual assault, and battery.

Note. Adapted from National Center on Elder Abuse (1999; 2006).

spent \$153.5 million on elder abuse, only 30% of that spent for domestic violence (\$520 million) and 2% of that spent for child abuse (\$6.7 billion; Nerenberg, 2006). In addition, there exists no federal agency that oversees elder abuse reporting, establishes practice guidelines, or sets standards for service delivery. As a result, significant variation exists between states in terms of APS systems and funding and in definitions of elder abuse, guidelines for service eligibility, reporting requirements, assessment instruments, and prevention and intervention services. State APS also differ in terms of quality, with many programs severely understaffed with inadequately trained workers (Nerenberg, 2006).

As the American public has become more aware of elder mistreatment, the federal government has increased efforts to provide oversight of elder abuse programs. In 1990, the US Department of Health and Human Services commissioned an Elder Abuse Task Force to develop a strategic plan to identify and prevent elder abuse; and, in 1991 the Administration on Aging established the National Center on Elder Abuse as part of its Elder Care Campaign (American Medical Association [AMA], 1992). In 2002, Senators Breaux and Hatch proposed the Elder Justice Act, which would have created an office to coordinate federal and state elder abuse programs, provide technical assistance, and offer financial support for research (Nerenberg, 2006). Although Congress has not yet passed this legislation, it was reintroduced on April 2, 2009.

CHALLENGES TO RESEARCH AND PRACTICE IN ELDER MISTREATMENT

The absence of national coordination and leadership in the area of elder mistreatment creates numerous challenges for policymakers, APS workers, and researchers. One consequence is the lack of uniformity in elder abuse definitions between federal agencies, state legislation, and research investigations (Quinn & Tomita, 1997). For example, the National Center on Elder Abuse and the Administration on Aging list physical abuse, sexual abuse, neglect, abandonment, financial or material exploitation, and self-neglect as the major types of elder abuse. However, the Elder Abuse and Dependent Adult Civil Protection Act of California also includes isolation and abduction as major types of abuse. Most other state abuse laws differ slightly from the federal definition (NCEA, 2006). Further, despite the reported frequency of self-neglect (49,809 reports to APS in 2004), considerable debate exists about including self-neglect in definitions of elder abuse (Brandl et al., 2007; Teaster et al., 2006). Unlike other types of elder abuse, self-neglect does not involve an act or omission by a caregiver or other trusted individual.

Research studies often fail to include all major types of elder abuse in their investigations, focusing on only one type of abuse, such as neglect

(Fulmer et al., 2005) or physical abuse (Coyne, Reichman, & Berbig, 1993), or examining only a few select types. In addition, state elder mistreatment statistics are not consistently collected and a mechanism for collecting official national statistics does not exist (NCEA, 2005). Therefore, determining the prevalence, incidence, and causes of the various types of elder mistreatment is a nearly impossible task.

Using only a list of the major types of elder abuse, APS workers and researchers also encounter difficulties in their efforts to identify instances of mistreatment. Federal and state legislators and administrators provide descriptions of each type of abuse; however, they give little guidance to APS workers, who need specific criteria for determining elder mistreatment. Some organizations, such as the California Medical Training Center (CMTC, 2006), compile lists of indicators of the various types of elder abuse, but many of these indicators also are symptoms of disease and age-related cognitive and functional impairments. *Indicators of physical abuse* include bruising, fractures or broken bones, and numerous hospitalizations; possible *indicators of verbal or psychological abuse* include such stress-related conditions as depression, confusion, elevated blood pressure, and withdrawal (CMTC, 2006). *Indicators of neglect* are challenging to identify and assess given subjectivity about some aspects of self care and personal choice. It is critical to rule out alternative explanations when examining possible indicators of abuse. The lack of precise indicators of abuse increases the risk that APS workers will falsely accuse a family member of committing elder abuse, and increases the risk that APS workers and other professionals will attribute signs of abuse to the normal aging process and fail to intervene when necessary (Kosberg, 1988).

Since elder mistreatment gained national attention in the 1970s, researchers have proposed several theories of causation. Ranging from theories focusing on the characteristics of the victim, particularly the older adult's dependence on the caregiver to characteristics of the perpetrator such as substance abuse problems, early theories largely ignored the socio-cultural context of elder mistreatment and lacked empirical support (Quinn & Tomita, 1997). Although more recent theoretical models such as the preliminary model proposed by the Panel to Review Risk and Prevalence of Elder Abuse and Neglect (NRC, 2003) seek to address the sociocultural context, such theories still require evaluation. Currently, no single theory explains the existence of elder mistreatment, and many of the theories have not been empirically tested (Fulmer et al., 2004). Research studies that support each respective theory are based on small samples, have limited generalizability, use questionable or imprecise outcome variables, and are difficult to compare. This lack of theoretical and empirical precision makes it difficult to determine the usefulness of elder mistreatment instruments that are based on one or more of these theories.

Studies have also identified potential risk factors for elder mistreatment. However, the ability to predict elder abuse via studies of risk factors is hindered by imprecise definitions and untested theoretical models. Consequently, risk factors cited in the literature often lack empirical support and merely reflect assumptions of the theoretical models. The risk factors for victims of elder mistreatment, as well as perpetrators, include the following domains: (a) individual characteristics, (b) physical and mental health, (c) social/relational factors, and (d) economic factors. The commonly cited risk factors for victims are summarized in Table 2, and those for perpetrators in Table 3.

TABLE 2 Elder Mistreatment Victim Risk Factors

Domain	Risk factor
Individual characteristics	Advanced age (over 75) Gender (women)
Physical and mental health	Diminished mental capacity (i.e., Alzheimer's disease and other forms of dementia) Mental disorder Functional and cognitive impairment Chronic disease Difficulty with activities of daily living (ADLs) Increasing care needs
Social/relational factors	Social isolation Dependency on caregiver Living with potentially abusive or exploitative caregivers Lack of close family relationships Lack of community support or access to resources
Economic factors	Inadequate housing or unsafe conditions in the home Evidence of financial exploitation

Note. Adapted from Jones, Holstege, and Holstege (1997); Quinn and Tomita (1997).

TABLE 3 Elder Mistreatment Perpetrator Risk Factors

Domain	Risk factor
Individual characteristics	Younger age than victim Family member (son/daughter more likely, followed by spouse)
Physical and mental health	Drug and alcohol use and/or abuse Untreated psychiatric problems Dementia History of violence or antisocial behavior Poor impulse control
Social/relational factors	Personal family stress Caregiver stress Living with victim Dependence on victim for housing, transportation, or money Severe external stress (i.e. loss of job, personal illness, etc.)
Economic factors	Financial stress

Note. Adapted from Jones, Holstege, and Holstege (1997); Quinn and Tomita (1997).

Few studies examine cultural influences in either contributing to or preventing elder abuse. Specifically, cultural beliefs about how family matters are handled and the acceptance of outside involvement when a problem arises, culturally defined roles within relationships and families, and familiarity with different governmental services can directly impact an elder's vulnerability (National Committee for the Prevention of Elder Abuse, 2003). Further, cultural differences in definitions of elder abuse and language barriers can complicate the assessment process. Investigations into the influence of culture, as well as more accurate accounts of the ethnic composition of elder abuse victims, are needed (NCEA, 2006).

APS workers and mandated reporters, including health care providers and social workers, need an assessment tool that can reliably and accurately assess for elder abuse. However, due to a lack of consensus about the causes and indicators of abuse, assessment instruments vary considerably. Even if APS workers and other mandated reporters were armed with valid and reliable instruments to assess the presence of elder abuse, intervention strategies must balance the ethical obligation to protect the vulnerable adult with respect for the individual's right to self-determination. Although Child Protective Services workers can intervene without the consent of the minor child (such as removal from the home), APS workers lack such power. Victims of elder abuse who are deemed competent have a right to refuse intervention; a recent study of APS workers in Canada suggests that a respect for autonomy is often given a higher priority than the safety of the older adult (Bealieu & Leclerc, 2006). The question is, therefore, whether a victim of elder abuse is truly exercising autonomy and self-determination by refusing to initiate legal proceedings against the perpetrator or accept assistance from APS. According to Bergeron (2006), the duty of the APS worker is to protect vulnerable adults from harm, actions that may sometimes outweigh respect for self-determination. APS workers need clear guidelines to make the judgments about self-determination and mistreatment.

Finally, a number of additional factors may complicate the reporting process. Victims may refuse to report mistreatment by their family members because they fear retribution from the perpetrator, do not want outsiders to interfere with family matters, blame their own physical dependency for the abuse, or believe the only alternative to an abusive home situation is admission to a nursing home (Kosberg, 1988). In addition, older adults may be reluctant to report an abusive spouse or adult child out of feelings of love and allegiance (Bergeron, 2006).

In summary, multiple barriers complicate efforts to define, identify, and document elder abuse. These barriers limit assessment of abuse and accurate accounts of its prevalence. Efforts to explain the causes of elder mistreatment similarly suffer from a lack of clarity and a paucity of empirical evidence that would inform prevention and intervention efforts. APS workers encounter numerous challenges when assessing elder mistreatment, including a lack of

consensus on definitions and untested theoretical models and potential risk factors. Given the multidimensional and hidden nature of elder mistreatment, as well as the subjectivity and personal values involved in the decision-making process, valid and reliable screening and assessment instruments are needed to provide a structure for the assessment process (Fulmer et al., 2004; VandeWeerd, Paveza, & Fulmer, 2006).

METHODS

This review used predetermined search terms and search sources to identify research literature within a given topic. This method of searching can reduce the potential for bias in the selection of materials. Using specified search terms, numerous social science and academic databases available through the University of California library were searched. In addition, the search included Web sites of research institutes and organizations specializing in elder abuse (see Appendix for a description of the search strategy).

Using this search strategy, 15 screening and assessment instruments were located. Because of differences noted in purpose and evaluation criteria, these instruments were divided into two broad categories—*screening instruments* and *assessment protocols and guidelines*. Inclusion criteria for screening instruments included the following: (a) the instrument was developed to assess elder mistreatment, and (b) information regarding its psychometric properties was documented. Inclusion criteria for assessment protocols and guidelines included only the first of these criteria, given that very few have been evaluated.

MAJOR FINDINGS

Overview

Brief instruments to assess potential mistreatment generally are designed for fast-paced settings, such as emergency rooms. Such instruments also can be used to determine if further assessment is required. Alternatively, comprehensive assessment protocols and guidelines are designed for settings such as APS and ombudsman interviews when more in-depth assessment is indicated (Fulmer et al., 2004). Instruments designed to assess current abuse or risk for future abuse have utility in service provision and prevention efforts.

Screening Instruments

The six screening instruments meeting the inclusion criteria are summarized in Table 4. Psychometric information has been reported on each of these

instruments, however, overall validity and reliability is limited. None of the instruments has been validated adequately in diverse clinical settings; most have been evaluated only in emergency room settings. When an earlier version of an instrument has been tested and modified, only the final version is presented in Table 4. The three most frequently cited instruments offer additional information regarding instrument development and psychometrics and are described in the following paragraphs.

Elder Assessment Instrument (EAI). The EAI is a 42-item instrument designed as a comprehensive screen for suspected elder abuse in clinical settings (Fulmer, Paveza, Abraham, & Fairchild, 2000). Based on a 4-point Likert-type scale ranging from *no evidence* to *definite evidence*, the professional responds to items in five general categories: (a) general assessment, (b) possible abuse indicators, (c) possible neglect indicators, (d) possible exploitation indicators, and (e) possible abandonment indicators. General assessment includes items such as quality of hygiene and nutrition. Possible abuse indicators such as bruising or statements of older adults related to abuse are assessed, in addition to neglect indicators including dehydration and failure to respond to warning of obvious disease. Exploitation indicators include misuse of money and inability to account for money or property; abandonment indicators include evidence that a caretaker has withdrawn care precipitously without alternate arrangements. The professional completing the form indicates “unable to assess” when sufficient information is not available for any of the items.

A summary section is also included. No total score of items is computed. Instead, a referral to social services, or APS, occurs if assessment reveals any of the following: (a) positive evidence of mistreatment without sufficient clinical explanation; (b) a subjective complaint by the elder of elder mistreatment; and (c) high risk of probable abuse, neglect, exploitation, and abandonment (Fulmer, 2002).

In a study of 501 older adults in an emergency room setting, the EAI demonstrated internal consistency with a Cronbach’s alpha of 0.84 and test-retest reliability of 0.83 (Fulmer & Wetle, 1986). Further psychometric studies demonstrated a sensitivity of 71%, specificity of 93%, and a content validity index of 0.83 (Fulmer et al., 2004). The EAI takes approximately 12–15 min to administer and has been used by practitioners in busy settings such as emergency rooms.

Hwalek–Sengstock Elder Abuse Screening Test (H–S/EAST). The H–S/EAST is a 15-item screening tool designed to identify older adults who are being abused or who are at risk for abuse (Hwalek & Sengstock, 1986). The H–S/EAST developed out of a larger study that used a pool of more than 1000 items from several existing elder abuse protocols (Neale, Hwalek, Scott, Sengstock, & Stahl, 1991). From the larger pool, the authors selected items believed to be correlates of abuse; data reduction techniques were then used to shorten the final instrument. The H–S/EAST evaluates three specific

TABLE 4 Elder Mistreatment Screening Instruments

Name	Citation	Scales/subscales	Administration	Psychometrics
Brief Abuse Screen for the Elderly (BASE)	Reis, Nahmiash, & Schrier (1993)	5 items assess for physical, psychological, and financial mistreatment and neglect	Completed by trained professional	Evidence of face validity; reliability not reported
Caregiver Abuse Screen (CASE)	Reis and Nahmiash (1995)	8 items assess for physical, psychological abuse and neglect; purpose to identify caregivers who are more likely to be abusers	Completed by caregiver	Evidence of predictive, construct validity; alpha = 0.71
Elder Assessment Instrument (EAI)	Fulmer, Paveza, Abraham, and Fairchild (2000)	42 items; General, physical, social, medical assessment; level of independence in lifestyle; summary	Completed by professional	Evidence of content validity; sensitivity of 71%; specificity of 93%; alpha = 0.84 and test-retest 0.83
Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)	Hwalek and Sengstock (1986)	15 items; Direct abuse; vulnerability; situational characteristics	Self-report or interview	Evidence of construct and predictive validity; limited reliability analysis (one study reports weak internal consistency)
Indicators of Abuse (IOA) Screen	Reis and Nahmiash (1998)	29 items; Caregiver intrapersonal/interpersonal problems; Care receiver social support/past abuse	Completed by trained professional	Evidence of divergent, concurrent, construct validity; alpha = 0.91
Vulnerability to Abuse Screening Scale (VASS)	Schofield, Reynolds, Mishra, Powers, and Dobson (2002)	12 items; Dependency; dejection; vulnerability; coercion [comprised of 10 items from H-S/EAST and two items from Conflict Tactics Scale (Straus, 1979)]	Self-report	Support for stability of four factors and construct validity of factors

categories of abuse, including: “(1) overt violation of personal rights or direct abuse, (2) characteristics of the elder that make him or her vulnerable to abuse, and (3) characteristics of a potentially abusive situation” (Neale et al., 1991, p. 408). Items include questions such as “Can you take your own medication and get around by yourself?” and “Are you helping to support someone?” After reverse coding four items, responses to questions (*yes* or *no*) are summed. One item, “Who makes decisions about your life—like how you should live or where you should live?” involves an open response and the response of “someone else” is coded in the risk direction. According to Neale and colleagues (1991), a mean score of 3 or higher indicates higher risk of abuse, a trigger for further assessment.

Preliminary evidence of validity was reported in the initial instrument development (Sengstock & Hwalek, 1986) and supported in subsequent studies. For example, in a study using three groups of elders—abused ($n = 170$), nonabused ($n = 42$), and comparison ($n = 47$)—Neale et al. (1991) found preliminary evidence of the construct validity of the H-S/EAST. The authors caution that the instrument should only be used to identify cases warranting further investigation. In 2000, Moody, Voss, and Lengacher assessed the psychometric properties of the H-S/EAST with a convenience sample of 100 elders living in public housing, offering additional support for the construct validity. Psychometric data are limited by small, unrepresentative samples and low internal consistency. Although the H-S/EAST is a brief and easy to administer tool that appears to be useful for screening in community-based social service agencies (administration time is estimated to be between 5–10 min), further psychometric testing of the predictive, convergent, and concurrent validity, as well as the reliability, is needed (Neale et al., 1991).

Indicators of Abuse (IOA) Screen. The IOA is a 29-item instrument that includes 12 abuse risk items about the caregiver, 15 abuse risk items about the care receiver, and 2 demographic questions (Reis & Nahmiash, 1998). The IOA is designed to help professionals discriminate between abuse and nonabuse cases. Unlike the H-S/EAST and the EAI, an experienced, trained professional completes the IOA after an intensive 2–3 hr in-home assessment. The professional first indicates the caregiver’s age and relationship to the care receiver (spouse/nonspouse). Next, the caregiver and care receiver abuse risk items are rated on a scale ranging from 0 (*nonexistent*) to 4 (*yes/severe*). Items are grouped into three general categories: (a) caregiver intrapersonal problems/issues, (b) caregiver interpersonal problems, and (c) care receiver support issues and past abuse (Wolf, 2000a). Caregiver items include “Has unrealistic expectations” and “Is inexperienced in caregiving,” and care receiver items include “Has been abused in the past” and “Is socially isolated.”

In separate analyses, the IOA demonstrated internal consistency with Cronbach’s alphas of 0.91 and 0.92. Further, analyses demonstrated evidence

of divergent, concurrent, and construct validity in discrimination between abuse and nonabuse. The IOA correctly identified 78–84% of abuse cases coming into contact with a health and social service agency (Reis & Nahmiash, 1998). Fulmer et al. (2004) indicated the potential of the IOA as a research instrument, but noted that the time commitment required to complete the instrument prohibits its use in most practice settings.

Assessment Protocols and Guidelines

Unlike screening instruments, assessment protocols tend to consist of open-ended questions. Some protocols also incorporate a quantitative risk assessment. In general, protocols offer the opportunity to examine multiple data sources—and interview multiple respondents (e.g., caregiver, care recipient)—to assess mistreatment. The majority of assessment protocols have not been validated empirically. Nine assessment protocols and guidelines were located using the search strategy, and Table 5 summarizes their basic features. The instruments that appear to be most relevant to APS or are commonly cited in the literature (i.e., AMA guidelines) are described in the following paragraphs.

AMA Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

The AMA Diagnostic and Treatment Guidelines on Elder Abuse and Neglect were developed to help physicians and other medical professionals to identify elder abuse and neglect and to incorporate assessment into routine practice. The guidelines include facts about elder mistreatment and barriers to identification, and outline ways in which physicians can improve detection of elder abuse in clinical settings (AMA, 1992). The guidelines identify the following areas for assessment:

1. Safety (i.e., is the patient in immediate danger?),
2. Access (i.e., are there barriers preventing further assessment?),
3. Cognitive status (i.e., does the patient have cognitive impairment?),
4. Emotional status (i.e., does the patient manifest depression, shame, guilt, anxiety, fear, and/or anger?),
5. Health and functional status (i.e., what medical problems exist?),
6. Social and financial resources (i.e., does the patient have adequate financial resources for basic substantive needs?), and
7. Frequency, severity, and intent (i.e., has mistreatment increased in frequency or severity over time?; AMA, 1992, p.11–12).

In addition, the guidelines include flow charts for screening and intervention that outline a routine pattern for screening and assessment (i.e., steps to take if mistreatment is expected) as well as referral resources for physicians.

TABLE 5 Elder Mistreatment Assessment Protocols and Guidelines

Name	Citation	Description	Administration
Adult Protective Services (APS) Risk Assessment Protocol	Hwalek, Goodrich, and Quinn (1996)	Factors used to measure risk: client, environmental, transportation, and support systems, current and historical, perpetrator	Case worker completes
Akron General Medical Center Geriatric Abuse Protocol	Jones, Dougherty, Schelble, and Cunningham (1988)	Protocol developed for emergency room setting from retrospective medical record review; medical and psychosocial history, physical assessment, diagnostics	Completed by emergency room physician
American Medical Association (AMA) and Treatment Guidelines on Elder Abuse and Neglect	AMA (1992)	Screening flowchart, patient management flowchart	Checklist completed by diagnostic clinician
Comprehensive Geriatric Assessment	Siu, Reuben, and Moore (1994)	Integrated (combined qualitative/quantitative) approach to screening in multiple domains; time intensive	Conducted by multidisciplinary team (social worker, nurse, and physician); must be completed by trained gerontologic professionals Clinician reviews guidelines
Elder Abuse Diagnostic Tool	Bomba (2006)	One-page tool developed by clinician for practice settings; guidelines and screening questions to assist clinician in determining when referral to APS is needed; includes modified items from Hwalek-Sengstock Elder Abuse Screening Test	Completed by emergency room worker
Harborview Medical Center Elder Abuse Diagnostic and Intervention Protocol	Tomita (1982)	History (methodology & technique); presentation (signs and symptoms, functional assessment, physical exam)	Completed by emergency room worker
Occupational Therapy Elder Abuse Checklist	Lafata and Helfrich (2001)	Checklists used to uncover possible abuse or neglect; issues include health issues, caregiver attitudes, financial issues, support systems for caregiver and/or client, and safety	Elder and caregiver answer same questions; therapist completes
Screening Protocols for the Identification of Abuse and Neglect in the Elderly	Johnson (1981)	Protocol utilizes subjective and objective data; use of etiology statement	Completed by clinician with input from elder and caregiver
Screening Tools and Referral Protocol (STRP)	Bass, Anetzberger, Ejaz, and Nagpaul (2001)	Consists of several screening tools (Actual Abuse Screening Tool, Suspected Abuse Screening Tool, Risk of Abuse Screening Tool)	Completed by practitioner

Protocols such as the AMA Guidelines are based primarily on descriptive studies and have a limited ability to differentiate normal disease processes from elder mistreatment (Fulmer et al., 2004). In addition, the lengthy administration time limits utility in busy practice settings. Finally, these guidelines lack empirical data on essential characteristics such as sensitivity and specificity.

APS Risk Assessment Protocol. The APS Risk Assessment Protocol was developed by the Florida APS program and subsequently adopted for use in Illinois. The protocol seeks to record and track the risk for elder victims for future abuse. Developed using caseworker's experiences in assessing victims of elder abuse, the APS risk assessment protocol measures risk in the following content areas:

1. Client factors (e.g., age, gender, physical/functional health, mental/emotional health, chemical dependency or other special problems, and income/financial resources),
2. Environmental factors (e.g., structural soundness of the home, appropriateness of the environment to the victim, and cleanliness of the residence),
3. Transportation and support systems factors (e.g., availability, accessibility, and reliability of services, and adequacy of formal or informal supports),
4. Current and historical factors (e.g., severity of the physical or psychological abuse that is perpetrated; frequency or severity of exploitation; severity of neglect; quality and consistency of care; and previous history of abuse, neglect, or exploitation), and
5. Perpetrator factors (e.g., access to the client, situational response to stress or home crises, physical health, mental/emotional health or control, perpetrator-victim dynamics, cooperation with the investigation, financial dependency on the client, and chemical dependency or other special problems; Hwalek, Goodrich, & Quinn, 1996, p. 128-131).

The protocol is completed by the case worker, who uses clinical judgment based on the previously listed factors to determine a case risk status of no/low risk, intermediate risk, or high risk. To assist in this determination, a description of indicators in each risk group is provided. For example, for a client with the risk factor of chemical dependency or other special problems, the risk indicators include:

- No risk/low risk: no indication of substance abuse; no, or minor special problems,
- Intermediate risk: periodic episodes of alcohol or substance abuse, and
- High risk: active alcoholic or substance abuser; any change that places the client at high risk (Hwalek et al., 1996).

After assigning a risk level for each factor, the case worker continues to use her or his clinical judgment to approximate an overall abuse risk (Hwalek et al., 1996).

The reliability and validity of the Risk Assessment Protocol have not been tested formally. Hwalek and colleagues (1996) did, however, cite a study in Florida in which case workers completed the risk assessment protocol after viewing a videotaped case. Among the case workers, there existed a high degree of risk agreement; this and the use of caseworker experience in protocol development suggest reliability and face validity that should be confirmed by further evaluation.

Screening Tools and Referral Protocol (STRP). Developed by the Benjamin Rose Institute and multidisciplinary service providers in Ohio, the STRP contains three screening tools: (a) actual abuse screening tool, (b) suspected abuse screening tool, and (c) risk of abuse screening tool. The practitioner begins with one of the tools; then, based on the progress of this assessment, she or he may shift to one of the remaining tools.

The abuse screening tools attempt to operationalize elder abuse and domestic violence in late life by establishing clear definitions and recording observed indicators (Nagpaul, 2001). Service providers involved in elder abuse, including professionals in law enforcement, APS, and domestic violence, developed the STRP. The STRP is one of the few protocols developed for use in APS; however, like other protocols, the STRP involves a complex set of subjective decisions and requires further refinement and subsequent evaluation.

DISCUSSION

Elder mistreatment assessment, and the development of elder abuse assessment instruments, remains a slowly growing and underdeveloped field. The field is hindered by the lack of clarity about basic definitions of abuse, insufficient and incomplete incidence and prevalence data, and the limited empirical research attention given to the development and testing of instruments. Existing instruments require further refinement and testing and new instruments must be developed with theoretical and methodological rigor. The evolution of screening instruments and assessment protocols and guidelines provides a context for discussion about the next steps to address the problem of elder mistreatment.

Existing screening and assessment instruments tend to focus on indicators of physical abuse and exploitation that are readily observable. Probing for subtle signs of potential neglect or abuse is challenging. Although more prevalent, cases of neglect are difficult to assess for a number of reasons. Although extremes are more readily assessed, quality of care can sometimes be subjective. A lack of knowledge by the caregiver about the needs of the aging adult, a lack of resources, and other factors related to the caregiver's characteristics and life circumstances can contribute to neglect. Adding to this complexity, self-neglect attributable to the elder's inability to care for

themselves due to cognitive impairment and/or lack of caregiving resources can be difficult to distinguish from caregiver neglect. It also may be difficult to differentiate an older adult's lifestyle choices or living arrangements from self-neglect (NCEA, 2006). In addition to clarification of elder mistreatment definitions and indicators, screening and assessment tools addressing the unique considerations for neglect and self-neglect need to be developed and evaluated.

The screening and assessment instruments reviewed reflect the settings for which they were developed and typically rely on the knowledge and judgment of the assessing professional. For example, instruments may seek to provide professionals in busy settings, such as an emergency room or a physician's office, with a standardized tool to assess current abuse risk. However, such instruments fail to offer conclusive evidence of abuse. In fact, most screening instruments, such as the H-S/EAST, explicitly state that they only identify cases warranting further investigation. Because of differences in knowledge and assessment skills between various helping professions, the degree of consistency that can be expected in use of standardized tools, such as interpretation of questions and clinical judgments about results, will require more testing and research. Initial empirical findings about internal consistency and reliability bring hope that this is a barrier that can be handled. Interestingly, consistency has been demonstrated among APS workers in the Florida and Illinois APS Risk Assessment Protocol, which suggests the following: (a) that development of standardized measures may emerge further from assessment protocols, and (b) that there may exist elements in the knowledge and training of APS workers that will need to be disseminated and replicated with other professionals.

Because screening is a preliminary activity in assessment of elder mistreatment, screening instruments should remain broad, and be developed and evaluated based on their ability to detect multiple types of elder mistreatment. The challenge may be to train multidisciplinary professionals to administer and interpret such tools. There is a need for more research on assessing abuse and neglect to develop screening tools across disciplines and professional settings. Although one assessment tool may never meet universal professional standards, developing and testing tools reinforces the quest to delineate critical elements of professional knowledge and skills.

Further, in the development of screening instruments, it remains critical to evaluate general reliability and validity, assess validity in diverse clinical settings such as community care settings, and obtain confirmatory validation from other investigators (NRC, 2003). Although some of the screening instruments in Table 4 are referenced in multiple studies and reviews, these instruments are not widely utilized in any setting, including the emergency rooms for which most were created.

Designed for more comprehensive assessment environments, such as APS, the development of assessment protocols and guidelines appears to

lag behind that of screening instruments. In settings such as APS, there is a great need for comprehensive assessments that incorporate information from multiple perspectives and sources. Because comprehensive assessments develop in response to locality-based needs, they may include components specific to a community or state. Such regionally standardized tools may need to be altered for additional localities. However, these tools contain a significant subjective component that relies upon professional clinical judgment to identify risk. This may honor the professionalism of well-trained staff; and, as noted, at least one study has found that APS staff members show relative consistency in the assessment outcome when using such tools. However, these assessment protocols lack validated and well-tested risk assessment tools; incorporating such would undoubtedly increase the evidence-base of risk assessment techniques and tools. Such changes may further increase the already lengthy time involved to administer comprehensive protocols; however, with additional research scholars and professionals may identify effective assessment tools that increase efficiency.

The clinical judgment and training required to complete complex assessment tools and protocols present additional issues for consideration—the most important is training. The tools and protocols presented in this review described neither the content of required training nor how agencies assure that training is received. This leads back to the question of required training for the helping professions, such as doctors, nurses, and social workers—what must be the content of training in professional degree programs, and what must occur after? And, how much of this training should be required of other mandated reporters, such as employees of financial institutions and clergy? Clearly, the answers to these latter training questions go beyond the scope of this article. However, the need for universality in training of professionals, about an issue that affects all states—elder mistreatment—prompts speculation about the need for national policy standards in educational institutions and APS programs. Such global questions can only be answered with further development of assessment tools.

RECOMMENDATIONS FOR APS

Systematic approaches to assessment offer objective, and potentially standardized, criteria to a subjective process. The results of a risk assessment can be used to determine the need for more thorough and comprehensive assessments, thereby supporting a prudent allocation of resources. Screening and assessment instruments can guide investigations, facilitate case plan development, and inform intervention, while also supporting resource allocation and education and training needs. The challenges inherent in instrument development, as well as the psychometric limitations of existing measures, however, raise questions about the utility of screening and

assessment instruments for APS. Several recommendations emerge from the extant literature.

Increase Standardization of Assessment Processes

APS workers are faced with complex demands in the assessment process, including balancing values of self-determination and safety, evaluating imminent risk, navigating complex relationships between family members and care providers, and coordinating services between systems that are often disconnected. A survey of state APS programs commissioned by the National Committee for the Prevention of Elder Abuse found that only 18 states use a risk assessment tool, and only 3 of these states had tested the tool for reliability and validity (Goodrich, 1997). Further, although narrative assessments of elder abuse are frequently used in APS and other settings, such assessments involve considerable subjectivity and lack evaluation. In light of the inattention of researchers to the unique needs of APS in the assessment process, next steps for increasing standardization in the APS process include evaluating the utility of screening and assessment protocols/guidelines.

Implement Data Management Systems

The collection and management of elder mistreatment data varies considerably, however a number of states and counties have implemented data management systems to track case information and reporting requirements. Although the literature suggests that current systems do not generally incorporate standardized instruments, the systematic collection of basic information signals movement toward improved case management (including assessment processes) and service provision. In addition to providing a necessary structure for the investigation process, such systems may be a useful approach to quantifying risk and measuring outcomes (Wolf, 2000b).

Promote Multidisciplinary Approaches to Policy & Practice

Finally, the broad directive to reduce and eliminate elder mistreatment requires a collaborative effort from overlapping service sectors. Specifically, elder mistreatment detection is best assessed by the various professionals who encounter elders, including workers in APS, criminal justice and civil justice systems, medical settings, financial settings, and domestic violence advocacy groups. Given the common objectives of such service providers to address elder abuse and the complexity of cases requiring integrated intervention approaches, a number of professionals and professional entities

advocate multidisciplinary approaches to policy and practice at the local, state, and national levels (Brandl et al., 2007; NCEA, 2001; NRC, 2003). Similarly, the International Network for the Prevention of Elder Abuse (2007) seeks to engage the international community of stakeholders in recognizing and responding to elder abuse across diverse cultures. Results of this review suggest that screening and assessment of elder mistreatment must go beyond readily observable cases, given the hidden nature of this growing social and public health problem.

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APPENDIX: SEARCH PROTOCOL

Search Terms

1. elder abuse and assessment
2. elder mistreatment and assessment
3. elder abuse and evaluation
4. elder mistreatment and evaluation
5. elder abuse and measurement
6. elder mistreatment and measurement
7. adult protective services

Databases

Academic databases for books and articles

- Pathfinder or Melvyl
- Expanded Academic ASAP
- Family and Society Studies Worldwide
- PsycARTICLES
- PsycInfo
- PubMed
- Social Services Abstracts
- Social Work Abstracts
- Sociological Abstracts

Research institutes and organizations

- U.S. Administration on Aging
- National Center on Elder Abuse
- Urban Institute