

Instruments for Assessing Elder Mistreatment: Implications for Adult Protective Services

Reader Note: The essential feature of a literature review is its identification of the most recent, relevant, and rigorous research in order to categorize what is known, to date, about an area of interest. It focuses on the past in order to inform the future. It does not address the present in which emerging and promising practices are being implemented by practitioners. These current practices do not yet have the benefit of either formal evaluations or the availability of published reports on the nature of the activities, lessons learned, or research findings. As a result, a literature review is designed to foster critical thinking about current practices, but it is not designed to stop or derail current efforts to experiment with new approaches designed to meet the needs of children, adults, and families in areas where research is lacking.

A specific kind of search strategy was used for this review. Formal published and unpublished research studies were identified through a structured process that involved predetermined search terms and research resources. This type of review facilitates a more thorough and less biased selection of materials than does a standard narrative literature review.

Introduction

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 2000.¹ The National Research Council to review Risk and Prevalence of Elder Abuse and Neglect² reports that between 1 and 2 million adults aged 65 years and older are injured, exploited, or otherwise mistreated by a caregiver. An increasing number of professionals in such settings as financial and health care 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.

Further, elder mistreatment is largely a hidden public health problem, with only an estimated 16% of all cases of mistreatment reported.³ While elder mistreatment has received national attention from the Institute of Medicine (2002) and the 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.⁴ 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. Therefore, the primary purpose of this research review is to summarize the current progress in developing screening and assessment instruments for elder mistreatment and the implications for Adult Protective Services.

We begin with a brief history of the role of APS in addressing elder mistreatment in the United States. Next, we present the major challenges in assessing risk and detecting elder abuse, followed by a description of theories of causation and their relationship to elder abuse assessment. We then review the psychometric properties of existing screening and assessment tools (see the Appendix for a detailed description of the methods used to locate and assess relevant instruments). Next, we present results from a practice survey completed by 90 APS workers and supervisors responding to questions about existing instruments. Finally, we conclude our report with a discussion of the implications of the findings for future research, practice, and policy, including recommendations for Adult Protective Services.

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.”⁵ This definition excludes self-neglect, which is defined as an adult’s inability to perform necessary self-care tasks due to physical or mental limitations.⁶ While there is considerable disagreement about the definition of elder mistreatment, the definitions in Table 1 highlight the major categories found in the literature.

Adult Protective Services (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

Table 1. Definitions of Elder Mistreatment

Type of Abuse	Definition
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.
Sexual	Any kind of non-consensual sexual contact, including unwanted touching, sexual assault, and battery.
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.
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.
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.
Financial and 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, improper use of conservatorship, guardianship, or power of attorney.

Source: National Center on Elder Abuse (2006)

of funds from the Social Services Block Grants for advocacy and services for vulnerable older adults.⁷ 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 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).⁸ 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 services also differ in terms of quality, with many programs severely understaffed with inadequately trained workers.⁹

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 U.S. 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.¹⁰ 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.¹¹ While Congress has not yet passed this legislation, it was re-introduced in 2007.

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.¹² 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.¹³ Further, despite the frequency of reports

(49,809 reports of self-neglect to APS in 2004), considerable debate exists about including self-neglect in definitions of elder abuse.¹⁴ Research studies often fail to include all major types of elder abuse in their investigations, focusing on only one type of abuse, such as neglect¹⁵ or physical abuse¹⁶ or examining only a few select types. 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 (CMTTC, 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, while possible *indicators of verbal or psychological abuse* include such stress-related conditions as depression, confusion, elevated blood pressure, and withdrawal.¹⁷ 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.¹⁸

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. While child protective services workers can intervene without the consent of the minor child (such as removal from the home), adult protective service workers lack such power. Victims of elder abuse who are deemed competent have a right to refuse intervention; a recent study of adult protective service workers in Canada suggests that a respect for autonomy is often given a

higher priority than the safety of the older adult.¹⁹ 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 Adult Protective Services. 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.²⁰ In addition, older adults may be reluctant to report an abusive spouse or adult child out of feelings of love and allegiance.²¹

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 suffer similarly from a lack of clarity and a paucity of empirical evidence that would inform prevention and intervention efforts. The next section of our paper traces the development of theories of causation and the role that these theories play in assessment of elder mistreatment.

Theories of Elder Mistreatment

Elder mistreatment first gained national attention in the 1970s. Since then, researchers have identified several theories of causation; six frequently cited theories are summarized in Table 2. Researchers first began investigating the causes of elder abuse with a focus on characteristics of the victim, in particular the older adult's dependency on the caregiver for completion of activities of daily living.²² Collecting information from elder abuse victims, researchers discovered that victims are no more dependent upon caregivers than those who are not abused.²³ Thus, it seems clear that dependency of the victim, a common feature of child abuse research, fails to be a universally applicable component to research about the mistreatment of older adults.

In the 1980s, the focus of elder abuse research shifted to characteristics of the perpetrators; such

Table 2. Theories of Elder Mistreatment

Theory	Major Assumptions
The web of dependency	Caretaker is dependent on the elder for housing and money; elder is dependent on caregiver for daily activities due to poor health.
Psychopathology in the abuser	Alcohol or drug abuse by the abuser and or/mental illness among family members are risk factors for abuse.
Transgenerational violence	Children who are victims of abuse or witness abuse between their parents are more likely to become perpetrators of violence when they reach adulthood.
Caregiver stress	Increasing care needs (or problematic behavior) combined with caregiver feeling forced to care for unwanted elder or external stress for caregiver contribute to abuse.
Caregiving context	Factors such as social isolation, shared living arrangement, lack of close family ties, and lack of community support or access to resources contribute to abuse.
Sociocultural climate	Factors such as inadequate housing, recent relocation and adaptation to American culture, loss of support systems, and the decline of stature within the family create a climate that supports abuse.

Source: Jones et al. (1997)

theories emphasized individual factors in the perpetrator as the primary cause of abuse and were supported by studies reporting high rates of psychiatric illness and substance abuse problems in abusers.²⁴ However, critics of this approach believe it explains only a small percentage of all cases of elder mistreatment and offers a simplistic understanding of a complex phenomenon.²⁵ Similarly, the theory of transgenerational violence focuses on abuser characteristics and proposes that children who witness or experience violence while growing up may become perpetrators as adults. The theory of transgenerational violence similarly has little empirical support and many researchers believe that the theory provides an inappropriate model for elder mistreatment.²⁶ For example, the theory offers no explanation as to why the majority of children who experience or witness violence while growing up do not become adult perpetrators.

Researchers and practitioners have given the most attention to theories that connect caregiver stress and burden to elder mistreatment. As with all theories of elder mistreatment, however, only a few studies test the theory of caregiver stress and the results are somewhat mixed.²⁷ The majority of caregivers experience stress and burden, yet only a small percentage perpetrates some type of abuse against their older care recipient.²⁸ The equivocal findings have led researchers to search for alternative explanations to the stressed-caregiver model.

Finally, in an effort to move beyond models focusing solely on individual characteristics, other theories focus on the context of caregiving, including social factors such as isolation and limited social support, interpersonal relationships, and societal and cultural factors that can contribute to elder mistreatment.²⁹ Recently, the Panel to Review Risk and Prevalence of Elder Abuse and Neglect proposed a preliminary theoretical model that focuses on the sociocultural context of elder mistreatment.³⁰ The model describes a transactional process between the victim of mistreatment and the caregiver in the context of individual level factors from both individuals (i.e., physical health and beliefs and attitudes about aging), status inequality, relationship type, and power and exchange dynamics. This microprocess is rooted in the sociocultural context, including the living environment and ethnic or cultural factors that may be associated with risk for mistreatment.³¹ Given the limited testing of this and other theoretical models, the panel recommends “systematic, theory-driven longitudinal research, both qualitative and quantitative, exploring

the changing dynamics of elder people’s relationships and the risk of mistreatment, as they are affected by changing health status, social embeddedness, and caregiving and living arrangements, in both domestic and institutional contexts.”³²

As the array of theories about causation suggests, no single theory explains the existence of elder mistreatment. Many of these theories have not been tested in rigorous clinical research programs.³³ 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.

Risk Factors for Elder Mistreatment

Studies also have 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: 1) individual characteristics, 2) physical and mental health, 3) social/relational factors, and 4) economic factors. The commonly cited risk factors for victims are summarized in Table 3, and those for perpetrators in Table 4.

Finally, while certain cultural values, beliefs, and traditions may contribute to vulnerability for elder abuse, 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.³⁴ 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.³⁵

In summary, 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

Table 3. 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

Source: Jones et al. (1997); Quinn & Tomita (1997)

Table 4. 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 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

Source: Jones et al. (1997); Quinn & Tomita (1997)

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.³⁶

Major Findings: Literature Review

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.³⁷ 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 (see Appendix) are summarized in Table 5. 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 earlier versions of an instrument have been tested and modified, only the final version is presented in Table 5. The three most frequently cited instruments offer additional information regarding instrument development and psychometrics and are described below.

Elder Assessment Instrument (EAI). The EAI is a 42-item instrument designed as a comprehensive screen for suspected elder abuse in clinical settings. Based on a 4-point Likert type scale ranging from *no evidence to definite evidence*, the professional responds to items in five general categories: (1) general assessment, (2) possible abuse indicators, (3) possible neglect indicators, (4) possible exploitation indicators, and (5) possible abandonment indicators. General assessment includes items such as quality of hygiene and nutrition. Possible abuse indicators such as bruising or statement of older adult 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 while 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: 1) positive evidence of mistreatment without sufficient clinical explanation, 2) a subjective complaint by the elder of elder mistreatment, and 3) high risk of probable abuse, neglect, exploitation, abandonment.³⁸

In a study of 501 older adults in an emergency room setting, the EAI demonstrated internal consistency with a Cronbach’s alpha of .84 and test-retest reliability of .83³⁹ (Fulmer & Wetle, 1986). Further, psychometric studies demonstrated a sensitivity of 71%, specificity of 93%, and a content validity index of .83. The EAI takes approximately 12-15 minutes 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. 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.⁴⁰ 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 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.”⁴¹ 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

Table 5. Elder Mistreatment Screening Instruments

Name	Citation	Scales/Subscales	Administration	Psychometrics
Brief Abuse Screen for the Elderly (BASE)	Reis et al. (1993)	5 items assess for physical, psychological, and financial mistreatment; neglect	Completed by trained professional	Evidence of face validity; reliability not reported
Caregiver Abuse Screen (CASE)	Reis & 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 et al. (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 .83
Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)	Hwalek & 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 & 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 et al. (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

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, & 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. While the H-S/EAST is a brief (administration time estimated to be between 5-10 minutes) and easy to administer tool that appears to be useful for screening in community-based social service agencies, further psychometric testing of the predictive, convergent, and concurrent validity as well as the reliability is needed.⁴²

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. The IOA is designed to help professionals discriminate between abuse and non-abuse cases. Unlike the H-S/EAST and the EAI, an experienced, trained professional completes the IOA after an intensive 2-3 hour in-home assessment. The professional first indicates the caregiver age and caregiver and care receiver kinship (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: (1) Caregiver intrapersonal problems/issues, (2) Caregiver interpersonal problems, and (3) Care receiver support issues and past abuse.⁴³ 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 .91 and .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.⁴⁴ Fulmer et al. (2004) indicate the potential of the IOA as a research instrument but note 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 be qualitative in nature. Some protocols do incorporate a quantitative risk assessment.

In general, they 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 our search strategy, and Table 6 summarizes their basic features. The instruments that appear to be most relevant to APS or commonly cited in the literature (*i.e.* AMA guidelines) are described below.

American Medical Association (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, barriers to identification, and outline ways in which physicians can improve detection of elder abuse in clinical settings.⁴⁵ 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?)
- 7) Frequency, Severity and Intent (*i.e.*, Has mistreatment increased in frequency or severity over time?)

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.

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.⁴⁶ In addition, the lengthy

Table 6. Elder Mistreatment Assessment Protocols and Guidelines

Name	Citation	Description	Administration
Akron General Medical Center Geriatric Abuse Protocol	Jones et al. (1988)	Protocol developed for emergency room setting from retrospective medical record review; medical & psychosocial history, physical assessment, diagnostics	Completed by emergency 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 et al. (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
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 H-S/EAST	Clinician reviews guidelines
APS Risk Assessment Protocol	Hwalek et al. (1996)	Factors used to measure risk: Client, environmental, transportation and support systems, current & historical, perpetrator	Elder abuse case worker completes
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 & Heifrich (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 et al. (2001)	Consists of several screening tools (Actual Abuse Screening Tool, Suspected Abuse Screening Tool, Risk of Abuse Screening Tool)	Completed by practitioner

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, income/financial resources)
- 2) Environmental factors (e.g., structural soundness of the home, appropriateness of the environment to the victim, cleanliness of the residence)
- 3) Transportation and support systems factors (e.g., availability, accessibility, and reliability of services, 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, previous history of abuse, neglect, or exploitation)
- 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, chemical dependency or other special problems)

The protocol is completed by the case worker, who uses clinical judgment based on the factors listed above 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
- High risk: active alcoholic or substance abuser; any change that places the client at high risk.⁴⁷

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.⁴⁸

The reliability and validity of the Risk Assessment Protocol has not been tested formally. Hwalek and colleagues (1996) do, 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.

Screening Tools and Referral Protocol (STRP).

Developed by the Benjamin Rose Institute and multidisciplinary service providers in Ohio, the Screening Tools and Referral Protocol contains three screening tools: 1) Actual Abuse Screening Tool, 2) Suspected Abuse Screening Tool, and 3) 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.⁴⁹ 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.

Major Findings: Practice Survey

Ninety out of a possible 131 workers and supervisors (69%) completed the APS electronic survey, exceeding the goal of 60%. The majority of individuals completing the survey (75%) indicated that they are front line workers. Sixty-seven percent of respondents reported a Master's degree as their highest educational level and 52% indicated Social Work as the field of study, with Psychology as the second most common field of study (19%). The average amount of time working with Adult Protective Services was approximately 8 years, with responses ranging from 3 months to 24 years.

Items from the H-S/EAST, EAI, IOA, and APS Risk Assessment Protocol were included in the survey. In response to survey items reflecting general assessment, most respondents (90% or more) replied "I currently consider this item in my assessment" to

possible indicators of: physical/sexual abuse; psychological abuse; neglect; and exploitation. Exceptions to this high level of agreement largely fell into the indicators of possible neglect category and included items such as impaction and contractures. Other exceptions from indicators of possible exploitation included reports of demands for goods in exchange for services and overpayment for goods or services. Table 7 provides a summary of the items which the majority of workers (90% or more) agreed should be considered when assessing for elder mistreatment.

In summary, survey results indicate a number of items from existing instruments that appear to be useful in assessing for elder abuse. Responses to a case scenario additionally point to priority questions to ask in an assessment of possible neglect. According to survey results, many of these items are currently considered by workers when assessing for elder mistreatment, though not as part of a standardized assessment.

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 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.

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 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 amongst APS workers in the Florida and Illinois APS Risk Assessment Protocol, which suggests the following: (1) that development of standardized measures may emerge further from assessment protocols, and (2) that there may exist elements in the knowledge and training of APS workers that will need to be disseminated and replicated with other professionals. Results from the practice survey indicate current use of items in the APS Assessment Protocol by APS workers and supervisors, further supporting these conclusions.

Since 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 in order to develop screening tools across disciplines and professional settings. While 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.⁵⁰ While some of the screening instruments in Table 5 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. Interestingly, APS workers and supervisors indicate considering a number of these items in their current assessment, although this process is not standardized.

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.

Table 7. Possible Elements for Inclusion in an APS Assessment Tool

<p>1. INDICATORS OF PHYSICAL/ SEXUAL ABUSE</p> <ul style="list-style-type: none"> • Bruising, welts, cuts, or wounds, cigarette or rope burn marks or blood on person/clothes • Internal injuries, including broken or fractured bones, sprains, or muscle injuries • Various stages of healing of any bruises or fractures • Painful body movements, such as limping, trouble sitting/standing (not illness related) • Vague or indirect references to sexual assault or unwanted sexual advances • Statement of older adult related to abuse <p>2. INDICATORS OF PSYCHOLOGICAL ABUSE</p> <ul style="list-style-type: none"> • Sense of resignation and hopelessness with vague references to mistreatment • Behavior that is passive, helpless, withdrawn • Anxious, trembling, clinging, fearful, scared of someone/something • Self-blame for current situation or partner/caregiver behavior <p>3. INDICATORS OF NEGLECT</p> <ul style="list-style-type: none"> • Dehydration • Contractures • Decubiti • Diarrhea • Impaction • Urine burns • Unclean physical appearance, poor hygiene • Inadequate food or meal preparation supplies in household • Underweight, physically frail or weak • Under or overuse of, or confusion about, prescription or over-the-counter medications • Failure to respond to warning of obvious disease • Repetitive hospital admissions due to probable failure of health care surveillance • Inadequate utilities, including lack of heat, water, electricity, and toilet facilities • Unsafe or unclean environment, including insect infestation or poorly maintained animals • Neglected household finances, including unpaid bills or rent • Depression • Statement by older adult related to neglect <p>4. INDICATORS OF EXPLOITATION</p> <ul style="list-style-type: none"> • Misuse of money • Evidence of exploitation • Reports of demands for goods in exchange for services • Overpayment for goods or services • Inability to account for money/property • Unexplained changes in power of attorney, wills, or other legal documents • Statement by older adult related to exploitation <p>5. INDICATORS OF ABANDONMENT</p> <ul style="list-style-type: none"> • Evidence that a caretaker has withdrawn care 	<ul style="list-style-type: none"> • precipitously without alternate arrangements • Evidence that the older adult is left alone in an unsafe environment for extended periods of time without adequate support • Statement by older adult related to abandonment <p>6. ENVIRONMENT OR RESOURCE FACTORS</p> <ul style="list-style-type: none"> • Structural soundness of the home • Appropriateness of residence to the client • Cleanliness of residence • Availability of, access to, and reliability of transportation services • Availability of, access to, and reliability of home health services • Availability of, access to, and reliability of medical services • Adequacy of formal/informal support network • Quality/consistency of care • Previous history of violence, abuse, neglect, or exploitation <p>In their practice, APS workers and supervisors indicated that the following risk factors are frequently encountered for perpetrators of elder abuse:</p> <ul style="list-style-type: none"> • Physical health problems • Financial dependence • Mental/emotional difficulties • Alcohol/substance abuse problem • Unrealistic expectations • Blames others • Lacks understanding of care receiver's medical condition • Difficulty with or reluctance performing care-related tasks • Marital/family conflict • Caregiving inexperience • Caring for other dependent family members <p>Alternatively, frequently encountered risk factors for victims of elder abuse include:</p> <ul style="list-style-type: none"> • Physical deterioration • Cognitive deficits • Has been abused in the past • Marital/family conflict • Socially isolated • Lacks social support • Mental/emotional difficulties • Financial dependence • Unrealistic expectations • Poor current relationship • Behavior problems • Blames others • Emotional dependence • No regular doctor • Alcohol/substance abuse problem • Refuses needed services • Confusion
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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 above, 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—most importantly training. The tools and protocols that we examined 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 paper. However, the need for universality in training of professionals, about an issue that affects all states—elder abuse—prompts speculation about the need for national policy standards in educational institutions and APS programs. Such global questions only can be answered with further development of assessment tools.

Several issues are common to all assessment tools. First, all forms of assessment are limited by insufficient and incomplete incidence and prevalence data. Without understanding the magnitude of the problem, assessment tools may be suitable for the needs of only a subpopulation of those affected by elder abuse. The general consensus that many cases of elder mistreatment are unreported leaves researchers and professionals to guess about the assessment needs of these individuals. *Further investigation of the occurrence of elder mistreatment via population-based surveys is needed.*⁵¹ Second, inconsistency in definitions of elder mistreatment and theoretical approaches to measuring risk limit instrument

development. As the findings suggest, instruments are developed from a range of theoretical and discipline-specific perspectives. Instrument developers need to clearly *state the operational definition of elder mistreatment* used in the creation of the tool so that others may assess the value of the instrument for different settings and purposes.⁵²

Finally, in elder mistreatment assessment, *it is critical to obtain information directly from the elder, the caregiver, or both.* Instruments such as the H-S/EAST that interview the elder directly rely upon the ability of the abused victim to respond. An elder's ability to give reliable answers may be affected by fear, distrust, cognitive limitations, and emotional factors. Instruments such as the IOA require direct assessment of caregivers and may offer an advantage by gaining multiple perspectives and taking context into account. At the same time, caregivers may be limited in their ability to provide information; the caregiving context is complex and caregiver characteristics may play a role in the abusive situation. When obtaining multiple perspectives, the professional must then use her or his clinical judgment to sort discrepancies and inconsistencies.

Recommendations for Adult Protective Services

Systematic approaches to assessment offer objective, and potentially standardized, criteria to a subjective process. The results of 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 Adult Protective Services. A number of 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.⁵³ Further, while 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. While 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.⁵⁴

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 end elder abuse and the complexity of cases requiring integrated intervention approaches, a number of professionals advocate multidisciplinary approaches to policy and practice at the local, state, and national levels.⁵⁵ 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.

One approach to engaging multidisciplinary professionals involves organizing a symposium of local stakeholders to determine steps toward a comprehensive approach to elder abuse prevention and treatment. Such an effort may mirror larger national initiatives such as the National Policy Summit on Elder Abuse convened by the National Center of Elder Abuse (2001). The Summit brought together stakeholders, including representatives from legal advocacy services, the justice system, regional research and policy institutes, and APS administrators. Funded by the Administration on Aging and the Office for Victims of the Department of Justice, the Summit identified public policy priorities and action steps. A similar process conducted at the local or state level could identify public policy priorities and clarify practice concerns while simultaneously strengthening collaborations between overlapping service providers.

Appendix

Methods

This research review involved two components: 1) a structured review of the literature on instruments for assessing elder mistreatment and 2) a survey describing current practice in APS. The structured review of the literature used pre-determined search terms and search sources to identify research literature on assessing elder mistreatment. This method of searching can reduce the potential for bias in the selection of materials. Using the following specified search terms, we searched numerous social science and academic databases available through the University of California library. In addition, we searched the websites of research institutes and organizations specializing in elder abuse. Our review was limited to articles and studies printed in English.

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

Brookings Institute
RAND
Urban Institute

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: (1) the instrument was developed to assess elder mistreatment, and (2) information regarding its psychometric properties was documented. Inclusion criteria for assessment protocols and guidelines included only the first of the above criteria given that very few have been evaluated.

In addition, a web-based practice survey was administered in August 2007 to APS workers and supervisors in the Bay Area Counties.⁵⁶ All workers and supervisors were eligible to participate and the survey was provided to individuals on contact lists from the county ($N=131$). The goal for survey completion was 60%. A practice survey seeks to capture the perspectives of agency staff with respect to the issues identified in the literature review. Much like the way that literature reviews are designed to synthesize current research, practice surveys seek to identify the views of practitioners related to current practice, customs, rationales for professional activity, information gaps in current practice, and gaps in the knowledge base of practice.⁵⁷ The APS survey obtained demographic information (i.e., job classification, education level, field of study, work experience with APS) as well as workers' and supervisors' perspectives on elder abuse assessment items identified in the structured review of the literature.

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- 1 National Center on Elder Abuse [NCEA], 2006
2 NRC, 2003
3 NCEA, 1998
4 Fulmer, Guadagno, Dyer, & Connolly, 2004
5 NRC, 2003, p.1
6 National Association of Adult Protective Services
Administrators, 1993
7 Nerenberg, 2006
8 Nerenberg, 2006
9 Nerenberg, 2006
10 American Medical Association, 1992
11 Nerenberg, 2006
12 Quinn & Tomita, 1997
13 NCEA, 2006
14 Brandl et al., 2007; Teaster et al., 2006
15 Fulmer et al., 2005
16 Coyne, Reichman, & Berbig, 1993
17 CMTC, 2006
18 Kosberg, 1988
19 Bealieu & Leclerc, 2006
20 Kosberg, 1988
21 Bergeron, 2006
22 Quinn & Tomita, 1997
23 Quinn & Tomita, 1997
24 Jones, Holstege, & Holstege, 1997
25 Ansello, 1996
26 Quinn & Tomita, 1997
27 Coyne et al., 1993; Reis & Nahmiash, 1997
28 Pillemer & Finkelhor, 1988, 1989; Wolf, 2000a
29 Jones et al., 1997
30 NRC, 2003
31 NRC, 2003
32 NRC, 2003, p. 70
33 Quinn & Tomita, 1997
34 National Committee for the Prevention of Elder
Abuse, 2003
35 NCEA, 2006
36 Fulmer et al., 2004; VandeWeerd, Paveza, &
Fulmer, 2006
37 Fulmer et al., 2004
38 Fulmer, 2002
39 Fulmer et al., 2004
40 Neale, Hwalek, Scott, Sengstock, & Stahl, 1991
41 Neale et al., 1991, p. 408
42 Neale et al., 1991
43 Wolf, 2000a
44 Reis & Nahmiash, 1998
45 AMA, 1992
46 Fulmer at al., 2004
47 Hwalek, Goodrich, & Quinn, 1996
48 Hwalek et al., 1996
49 Nagpaul, 2001
50 NRC, 2003
51 NRC, 2003
52 NRC, 2003
53 Goodrich, 1997
54 Wolf, 2000b
55 Brandl et al., 2007; NCEA, 2001; NRC, 2003
56 Sue & Ritter, 2007
57 SCIE, 2005

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