# Elder Abuse Screening Tools for Healthcare Professionals

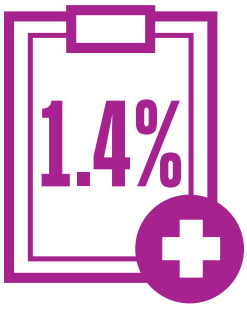
A number of instruments and protocols for elder abuse screening have been developed. Most have been created for use in hospitals, clinics, or home care. Although all share similar content and are directed toward assisting with the identification of various forms of elder mistreatment, there are key differences in the focus, format, structure, and type of data gathered by each instrument or protocol (Fulmer et al., 2004). Doctors have been ascribed a key role in elder abuse identification and in awareness promotion because they see their elderly patients, on average, five times per year (Yaffee, 2008).

The American Medical Association recommends that all geriatric patients receive elder abuse screening (Burnett et al., 2014) and multiple researchers have recommended screening as a way to help prevent and detect elder abuse. However in 2013, the U.S. Preventive Services Task Force concluded that current evidence is insufficient to assess the balance of the benefits and harms of screening all elderly or vulnerable adults for abuse and neglect (U.S. Preventive Task Force, 2013). Additionally, a universal screening tool does not exist without challenges for screening.

## KEY TAKEAWAYS

- Currently there is no gold standard for elder abuse screening.
- Many screening tools exist, with the majority designed for use by health care providers.
- There are differing opinions on whether screening presents more benefits or harms. Additional research is needed.
- A positive screen for elder abuse does not ubiquitously mean that elder abuse is occurring, but does indicate that further information should be gathered.

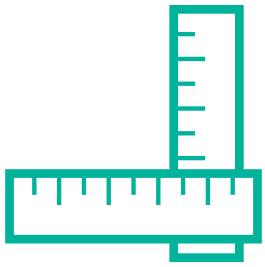
## *Background*




Identifying elder abuse has been a critical issue both in the community and within health care settings. While most abuse is identified in health care settings, studies have shown that rates of abuse identification by health care providers remain low (Burnett et al., 2014, Cohen, 2011, Yaffe et al., 2008). **Recent research suggests that only 1.4% of cases reported to Adult Protective Services come from physicians** (National Committee for the Prevention of Elder Abuse & The National Adult Protective Services Association, 2006).

Elder abuse screening instruments are currently held to the same standards as disease screening tests and are determined to be valid if they meet the following criteria: (1) are sensitive (effectively identify individuals with the disease); and (2) are specific (effectively identify individuals who do not have the disease as not having the disease). As with all disease screening tests, the screening process results in the label of "positive" or "negative" but a positive screen does not ubiquitously mean that elder abuse is occurring, but does indicate that further information should be gathered (Caldwell et al., 2013, Burnett et al., 2014).

## *Screening Tools*



At the Elder Mistreatment Symposium convened by the Centers for Medicare and Medicaid Services in 2013, three screening tools (presented in table below) were identified for increased use in practice for the screening of elder mistreatment. These tools were identified for their ability to assess multiple types of abuse, for the specifications of the measure, and for the focus of each tool when combined (McMullen et al., 2014).

These tools are intended to be used by trained professionals in healthcare settings.

| ASSESSMENT | ITEMS | ADMINISTRATION | PSYCHOMETRICS | SETTING |
|---|---|---|---|---|
| **ELDER ABUSE SUSPICION INDEX (EASI)** | 6 | Completed by health care professional to assess risk, neglect, verbal, psychological, emotional, financial, physical and sexual abuse over a 12 month period; 2 minutes to complete | Sensitivity: 0.77<br>Specificity: 0.44 | Validated in family practices and ambulatory care settings |
| **HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST (H-S/EAST)** | 6 | Self-report or interview by a professional | Construct and predictive validity, weak item reliability, but good cross-cultural adaptation | Suitable in emergency or outpatient setting |
| **VULNERABILITY TO ABUSE SCREENING SCALE (VASS)** | 12 | Self-report of dependency, dejection, coercion, and vulnerability | Moderate ranges of reliability and moderate to good construct validity | N/A |

(Burnett et al., 2014)

## *Other Elder Abuse Screening Tools:*

### WITH PSYCHOMETRICS:

- Brief Elder Screen for the Elderly (BASE) (Reis et al., 1993)
- Caregiver Abuse Screen (CASE) (Reis & Namiash, 1995)
- Elder Assessment Instrument (EAI) (Fulmer & O'Malley, 1987)
- Expanded Indicators of Abuse (E-IOA) (Cohen et al., 2006)
- Geriatrics Mistreatment Scale (GMS) (Giraldo-Rodríguez & Rosas-Carrasco, 2013)
- Indicators of Abuse (IOA) (Reis & Nahmiash, 1998)
- Older Adult Financial Exploitation Measure (OAFEM) (Conrad et al., 2010)
- Screening Tools and Referral Protocol Stopping Abuse Against Older Ohioans: A Guide for Service Providers (Bass et al., 2001)
- Self-disclosure tool (Cohen et al., 2007)
- Signs of abuse inventory (Cohen, 2011)

### WITHOUT PSYCHOMETRICS:

- Case Detection Guidelines (Rathbone-McCuan, 1980)
- Elder Abuse and Neglect Protocol (Tomita, 1983)
- Health, Attitudes towards aging, Living arrangements, and Finances (H.A.L.F.) (Ferguson & Beck, 1983)
- Screening Protocols for the Identification of Abuse and Neglect in the Elderly (Johnson, 1981)

## *Settings*

Studies of various elder abuse screening tools have been conducted in various health care settings. Basic justifications for screening in certain settings and findings of these studies are presented below. This list is not exhaustive. Other healthcare specialists such as orthopedic surgeons, optometrists, plastic surgeons, and dermatologists may also be effective in screening for elder abuse.

### PRIMARY CARE

Elders are seen in primary care settings for common conditions associated with aging. Therefore, primary care settings may provide a valuable opportunity for elder abuse screening. Caldwell et al. examined various tools used in primary care settings, and found two with good internal validity – the OAFEM and EASI. However, they note that external validity is difficult to measure because there is no 'gold standard' for comparison (Caldwell et al., 2013).

### DENTAL CLINICS

Fulmer and colleagues (2012) studied the feasibility of screening for elder mistreatment in busy clinics, including dental clinics, using an adapted version of the Elder Assessment Instrument (EAI). It was found that screening in dental clinics was feasible and study participants were willing to enroll in the study regardless of the sensitive nature of the survey questions (Fulmer et al., 2012).

### HOME HEALTH SETTINGS

Pickering et al. (2016) suggest that professionals working in home healthcare have an advantageous position to identify and report elder abuse and neglect because they directly observe most assessment criteria. Furthermore, this is an important setting for elder abuse assessment as older adults are receiving more services from home healthcare providers. They indicate that the use of a tool such as the QualCare scale – focused on identifying the met and unmet needs of the older adults regardless of the mechanisms causing them – can increase identification and reporting of abuse (Pickering et al., 2016).

### EMERGENCY DEPARTMENTS

Emergency departments (EDs) have become critical sites for detection of child abuse but the same has not happened for elder abuse despite its prevalence and the potential value of identifying it in the ED (Rosen et al., 2016). EDs serve an important role when older adults interface with healthcare services, and ED nurses may be able to recognize and identify abuse (Phelan, 2012).

### OB/GYN CLINICS

Given that women are at an increased risk for elder abuse, OB/GYNs may play a fundamental role in screening for elder abuse. In a study, Leddy et al. (2014) found that routine screening is not currently being conducted due to time constraints, uncertainty about where to call for help and lack of professional protocols on how to respond to abuse. The study indicated a need for greater education and training for elder abuse screening (Leddy et al., 2014).

### LONG-TERM CARE SETTINGS

Long-term care settings including nursing homes and skilled nursing facilities present opportunities for screening and detection of elder abuse. Cohen (2011) indicates studies have found that data on the prevalence of abuse or neglect in long-term care institutions is lacking, in part, due to inadequate procedures for its assessment and identification. While many tools have been suggested and tested for use in the long-term care setting, they need to be further validated to encompass possible abusive behaviors that may be characteristic of institutions (Cohen et al., 2010).

## *Potential Benefits and Potential Harms of Screening*

### POTENTIAL BENEFITS

- Screening is critical for early detection and prevention of elder abuse (Burnett et al., 2014).
- Similar to IPV screening for pregnant women, elder abuse screening does not present any noticeable harm. Even if potential benefits are unclear, they are possible (Dong, 2015).
- An encounter with a professional may be an elder's only chance to change an abusive situation and prevent its continuation or exacerbation (Cohen, 2011).
- Early detection and interventions as a result of screening may help ameliorate or stop elder abuse (Dong, 2015).

### POTENTIAL HARMS

- Screening poses an additional challenge for APS agencies, which are already overwhelmed and under-resourced (O'Brien in Dong, 2015).
- There is a perceived lack of response to screening, detection, and reporting, which may lead to even less reporting by healthcare providers (O'Brien in Dong, 2015).
- Initiatives to promote awareness of elder abuse are encouraging, but fail to meet threshold to justify screening (O'Brien in Dong, 2015).
- Existing tools are problematic because they don't detect common forms of abuse including financial and neglect (O'Brien in Dong, 2015).

## *Challenges and Future Directions*

### DESIGNING A SCREENING TOOL

- A simple, brief screening and assessment methodology is needed (Caldwell et al., 2013, Fulmer et al., 2004)
- A criterion standard for the diagnosis or validation of elder abuse is lacking (Fulmer et al., 2004, Yaffe et al., 2008, McMullen et al., 2014, Cohen, 2011)

### EVALUATION

- A "gold standard" comparison for establishing the validity of elder abuse screening tools does not exist (Caldwell et al., 2013). Good-quality randomized, controlled trials focusing on both screening and interventions are needed (U.S. Preventive Task Force, 2013).

### CHALLENGES FOR PHYSICIANS

- Normal aging changes can mimic signs of elder abuse (Fulmer et al., 2004, Lachs & Rosen, 2016, Cohen, 2011)
- Screening tools that take more than an hour to administer meet with increased resistance which decreases screening quality (Cohen, 2011, Yaffe et al., 2008, Fulmer et al., 2004). Differentiating between unintentional and intentional injuries and between illnesses that occurred despite appropriate care or as a result of neglect is also time consuming (Bond et al., 2013, Gibbs, 2014).
- Screening cognitively impaired elders can be challenging because physical findings and diagnostic results may be the only source of information to determine the presence of abuse (Rosen et al., 2016, McMullen et al., 2014).
- Elder victims may be reluctant to disclose evidence of abuse to professionals out of fear, shame, or a sense of hopelessness (Fulmer et al., 2004, Fulmer, 2008, Rosen et al., 2016).
- Concerns of elder abuse may create significant additional work and propel the clinician into a world that he or she is likely to be unfamiliar with (mandatory reporting statutes, adult protective service workers, and a criminal justice system) (Lachs & Rosen, 2016, Rosen et al., 2016).
- Providers may be skeptical about the possibility of making a change once elder abuse is identified and reported (Rosen et al., 2016, Yaffe et al., 2008)

### NEW APPROACHES TO SCREENING

- Research on a team-based approach to identifying elder abuse in emergency departments may be useful. This would involve leveraging the unique perspectives of emergency medical services providers, triage providers, nurses, radiologists, radiology technicians, social workers, and case managers (Rosen et al., 2016).
- Research on how diagnostic radiologists can incorporate detection of elder abuse into their practice may be beneficial. Radiology technicians and other employees such as nursing assistants who transport patients are uniquely positioned to receive such reports because they often spend time alone with the patient (Sidley & Southerland, 2015).
- NIJ has funded two projects related to elder abuse screening that are currently underway. For more information, visit: **http://www.nij.gov/topics/crime/elder-abuse/pages/addressing.aspx** (National Institute of Justice, 2016).

## *What to Do If Abuse Is Suspected*

Whenever a reasonable suspicion of abuse arises, including a positive screen, it should be reported to the appropriate agency to be further investigated. States vary in reporting laws and procedures. The Eldercare Locator (**http://www.eldercare.gov/eldercare.NET/Public/index.aspx**) can be used to identify the appropriate local elder abuse reporting agency and contact information.

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