Progress in Elder Abuse Screening and Assessment Instruments

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The responsibility of identifying elder mistreatment (EM) often falls on the healthcare professional. Many different screening and assessment instruments have been developed to aid healthcare professionals in making determinations about EM. The purpose of this article is to review existing EM screening and assessment instruments to examine progress in this field. The value and limitations of these instruments with regard to their use in different clinical and healthcare settings are discussed. The settings in which EM screening and assessment are conducted are also considered. The authors conclude that there is much to be done in terms of achieving consensus on what constitutes an appropriate screen or assessment instrument for detecting EM. Effort must be focused on instruments that can be used for brief, rapid screenings and those that can be used for more-detailed diagnostic assessments. J Am Geriat Soc 52: 297–304, 2004.

Key words: elder abuse; elder neglect; elder mistreatment; screening and assessment instruments

Elder mistreatment (EM) has been referred to 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.1

It generally includes abuse, neglect, exploitation, and abandonment of an older person by others and is distinct from violence by strangers. It has been recognized as a significant problem in the realm of family violence since the late 1970s. More recently, the field has been the subject of intensive debate in prominent national forums.1–3 Since the late 1970s, the prevalence of EM has been determined to affect from 1.3% to 5.4% of the elderly population, and a number of instruments, protocols, and guidelines have been developed to assist healthcare professionals in the screening, detection, and assessment of EM.4–6 Although the development of screening and assessment instruments and guidelines has been valuable for clinicians in identifying suspected victims of EM, the complexity of the matter is such that even the best-conceptualized instruments are problematic. The purpose of this article is to examine progress in the field of EM instrumentation, debate the value and the limitations of existing EM screening and assessment instruments,7–9 and extend the discussion begun in the National Research Council (NRC) report.1 There is now broad consensus that appropriate, conceptually consistent, and psychometrically sound EM instruments are crucial if there is to be progress in the practice and research of this significant health concern.1 The sheer variety, number, and specialized attributes of current instruments contribute to the difficulty in achieving any comparable quantitative or qualitative measurement of the phenomena. It is imperative that psychometrically sound instruments be developed for use in a variety of circumstances and settings. This article reviews existing instruments, provides a comparative analysis where possible, and discusses attributes and limitations of each.

THEORIES OF ELDER MISTREATMENT

Theories for EM causation have been debated in the literature for more than 25 years, but minimal progress has been made in supporting or refuting such theories. One problem in EM instrumentation rests in the flawed circularity of basing such instruments on theories, which may be erroneous or incomplete.10–12 For example, some of the EM theories and presumed physical indicators of abuse have been adapted from child abuse models, and the extent to which they accurately reflect the phenomenon of EM is unknown. The NRC report, Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America (three of the current authors, TF, CD, and MTC, were panel participants), explores the difficulties involved in proposing a
concrete theoretical model for the occurrence of EM. The existing literature documents general support for exploring the following theories for elder mistreatment: the situational theory, which espouses that an overburdened caregiver who cannot keep up with caregiver demands creates an environment for mistreatment; exchange theory, which addresses how dependencies between an older adult and the person who is committing the mistreatment is related to tactics and responses in family life that have long been established; social learning theory, which posits mistreatment as a learned behavior influenced by behavior in one’s environment; political economic theory, which focuses on the challenges faced by elders once they lose their role and must depend on others for well-being; and the psychopathology of the caregiver theory, which examines the role of the caregiver with a mental health problem and how that puts elders at risk for mistreatment. Few studies have empirically tested these theories, and the recent NRC report makes this point, as well as providing a new theoretical model for examining EM. New insights into these theories are imperative, because they form the foundation for the creation of appropriate screening and assessment instruments.

Development of Screening and Assessment Instruments

The need for EM assessment criteria has evolved from three major factors: the responsibility for identification of EM often falling to the healthcare professional, the unpreparedness of professionals to fulfill this role, and the need for more research on EM to inform practice. Because older adults are two to three times more likely to visit a healthcare professional than younger individuals, identification of mistreated or at-risk older adults, along with initiation of intervention in many cases, can be achieved in a healthcare setting.

Self-report of EM cannot be relied upon to identify and treat cases. Although one study found that older adults reported themselves as victims of EM, other studies refute this finding. Several studies have found that older adults are unlikely to report episodes of EM and that 70% or more of the identification of mistreated older adults comes from third-party observers and not the older person. Although some older adults may choose not to report EM, other studies refute this finding. Several studies have empirically tested these theories, and the recent NRC report makes this point, as well as providing a new theoretical model for examining EM. New insights into these theories are imperative, because they form the foundation for the creation of appropriate screening and assessment instruments.

Despite the pivotal role healthcare professionals hold relative to the identification and treatment of mistreatment, there is evidence that these groups experience difficulty fulfilling these roles. One study reported that only one out of five cases of EM is reported. This finding was reaffirmed in the 1985 report from the House Select Committee on Aging. Another investigator speculated that lack of detection of EM resulted from denial by health professionals of the existence of EM and from the absence of written guidelines for the identification of cases. A study reported that 90% of physicians believed that mistreatment in elders was difficult to detect; physicians accounted for only 2% of all reported cases of suspected EM in Michigan between 1989 and 1993. The difficulty nurses and social workers have in determining the presence of EM in the elderly is well outlined. Concern generated by a general lack of awareness that the problem might exist along with a paucity of instruments for detecting EM has served as the impetus for the development of screening and assessment instruments.

The American Medical Association (AMA) recommends EM screening for all geriatric patients. The Department of Health and Human Services and the 1992 Joint Commission on Accreditation of Health Care Organizations standards underscore the necessity of screening protocols for EM, as well as for domestic violence and child abuse. Still others have suggested that EM screening be included in the routine health assessment of all older persons. In addition to the medical and ethical obligations of geriatric clinicians to care for mistreated older adults, there are legal requirements in 44 states to report mistreatment to public agencies. In addition, a long-form assessment might be used for follow-up when screening with a short form indicates potential mistreatment.

Although instruments have primarily been developed in response to the needs of clinicians, the paucity of research in the field of EM has hindered their evolution and development. As far back as 1986, it was reported that additional research was needed to standardize the language and methods for case detection. In 2004, another study reported the same observation. Although limited progress has been made, some instruments have been developed to collect data in a standardized format, making them more versatile and useful in case detection and the collection of research data. The most significant barrier in the accurate development of screening and assessment instruments is the lack of a criterion standard for the diagnosis or validation of mistreatment. The absence of a conclusive biomarker or clinical test makes the diagnosis dependent upon an array of subjective and objective data that experienced clinicians must analyze along with appropriate team members and colleagues from APS and sometimes law enforcement. A National Institutes of Health consensus conference on this topic would be a welcome next step for the field. Colleagues from across the family violence arena should be included in such an effort.
Screening and Assessment Instruments and Protocols

A number of instruments and protocols have been developed and are currently available. Most have been created for use in hospitals, clinics, or home care. Nursing home residents are evaluated for EM through the use of the Minimum Data Set and appropriate resident instruments and protocols. Although all share similar content and are directed toward assisting with the identification of various forms of EM, there are key differences in the focus, format, structure, and type of data gathered by each instrument or protocol. This article will discuss instruments and protocols in terms of four approaches, including checklists and guidelines, qualitative assessments, quantitative assessments, and combinations of the above.

Checklists and Guidelines

AMA Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

This assessment guideline calls for clinicians to incorporate closed-ended questions about abuse into the history and physical examination to arrive at a diagnosis. It is a lengthy protocol and does not lend itself to rapid assessment. It has a useful screening flowchart and a patient management flowchart. State agencies, clinicians, and researchers have developed other checklists for a variety of settings such as emergency departments and outpatient clinics. These are mostly based on descriptive studies and often do not assess for neglect or address the difference between disease and mistreatment. They can be cumbersome, and due to time constraints, lack of empirical data regarding their sensitivity and specificity, and uncertainty regarding follow-up, practicing clinicians are not eager to use them.

Qualitative Approach to Assessment

Guidelines developed by other researchers are examples of qualitative approaches to assessment.

Subjective-Objective-Assessment-Plan Format

One investigator uses a Subjective-Objective-Assessment-Plan format to collect relevant data from the elder and the caregiver. The investigator identifies specific interview questions and suggested observations that the clinician should make regarding the patient, the caregiver, and the interaction of the two. The protocol directs the health professional to use subjective and objective data to determine the patient’s status, assessing, for example, the type of mistreatment and its probable etiology. The inclusion of an etiology statement is a strong advantage of this protocol because it can guide the type of intervention initiated. For example, interventions for neglect as a result of caretaker frailty are likely to be significantly different from interventions used when neglect stems from the caretaker’s lack of knowledge. This approach involves considerable subjectivity.

Elder Abuse Diagnosis and Intervention Model

This model is a more complex and eclectic approach to assessment. It combines structured interviews with the elder and caregiver; a functional assessment, including administration of a Mini-Mental State Examination and a standardized assessment of ability to perform activities of daily living; and a physical examination, including a graphic depiction of physical injuries. Collateral contacts with individuals who are familiar with the elder such as neighbors, friends, and visiting nurses are also suggested. The advantage of this protocol is its potential for generating a comprehensive picture of the elder and the caregiver and the specifics of the caregiving situation. A limitation is its length and the unwillingness of some practitioners to reach out to varied networks when they have uncertainty about the findings.

Rathbone-McCuan and Voyles

Rathbone-McCuan and Voyles use a less-structured format in their guidelines for in-home observations. The authors identify categories for assessment, including observable physical indicators, behavioral observation of the elder and caregiver, and environmental observations such as evidence of inadequate food supply or the presence of restraints and locks. General suggestions are made relative to the kind of interview questions to be asked, but specific content is left to the discretion and expertise of the individual clinician. This instrument has not been tested in a variety of settings, and the broad categories may not lend themselves to good interrater agreement.

Quantitative Approaches to Assessment

Instruments developed by many investigators are examples of quantitative approaches to assessment. None have gained widespread use.

H.A.L.F

Some view EM as a problem of family dynamics and have developed an instrument called the H.A.L.F. (an acronym for four factors: Health, Attitudes towards aging, Living arrangements, and Finances). The H.A.L.F. uses a Likert-type scale to assess areas such as the health status of the elder, family attitudes toward aging, living arrangements, and finances. The instrument directs the user to indicate the frequency (almost always, some of the time, never) that a specific event (e.g., unexplained injury) has occurred. The authors believe that the number and position of these check marks on the questionnaire can be used to determine the presence and severity of abuse. Use of the instrument has not been documented since 1983.

Elder Assessment Instrument

The Elder Assessment Instrument (EAI) was designed according to the categories that theories of EM generally cover (e.g., dependency) and state elder protection mandated reporting laws. It includes a general assessment of the elder, physical assessment, level of independence in lifestyle, social assessment, medical assessment, and a summary section. A Likert-type scale and an area for additional comments accompany each section. A summary section directs the user to indicate the likelihood of the presence of each type of EM. Although this instrument collects data in a quantitative format, unlike the H.A.L.F. instrument, no attempt is made to score or interpret the findings quantitatively. The summary assessment is derived from clinical interpretations of the findings in the previous sections. Psychometric studies show a content validity index of 0.83, interrater agreement of 0.83, a sensitivity of 71%, and a specificity of 93%. Because elder abuse teams...
and research nurses in the emergency department have used it successfully, the Elder Assessment Instrument may be appropriate for busy clinical settings.31,46

**Brief Abuse Screen for the Elderly**
The Brief Abuse Screen for the Elderly (BASE)43 contains five brief questions that take a only minute to complete. Those who administer the instrument must undergo training. The BASE is designed to screen elders who are caregivers or care-receivers and does not assess for any factors of self-neglect. The instrument has an 86% to 90% agreement by trained practitioners and a correlation between abusive and nonabusive caregivers. The BASE may be useful in busy clinical settings, but it is unclear how training is to be accomplished or evaluated.

**Indicators of Abuse Screen**
The Indicators of Abuse Screen (IOA) began as a 48-item checklist that was reduced to a 40-item survey.34 A multidisciplinary committee consensus panel reviewed the initial subsample of items. It is a subjective measure that requires 2 to 3 hours for an experienced, trained administrator to complete. Cronbach alpha tests demonstrated an internal consistency of 0.92 and 0.91 on two separate samples. The IOA identified 78% to 84% of elder abuse cases seen by a health agency and a social service agency.28 It appears to have great potential as a research instrument but is too lengthy to be used in most medical, social service, APS, or ombudsman practices.

**Conflict Tactics Scale**
The Conflict Tactics Scale (CTS),44,45 although not specific to the elderly, has long been used to determine whether individuals have been threatened or assaulted. Developed in 1978, the CTS is an interview used to detect the perception of upsetting or injurious circumstances in a person’s life. The original CTS is a 19-item self-report with a Cronbach alpha reliability of 0.88 and content validity of 0.80. A Spanish version has also been validated.57 There are now multiple additional versions that can be purchased from the authors. This is the most widely adopted instrument in the field and may approach a criterion standard for physical abuse and verbal assault, but it does not address neglect.

**Hwalek-Sengstock Elder Abuse Screening Test**
The Hwalek-Sengstock Elder Abuse Screening Test initially pooled and distilled more than 1,000 items into a 15-item instrument to measure physical abuse, vulnerability, and potential abusive situations.5 The instrument was further trimmed to six items based on discriminate analysis.35 A second analysis also yielded six questions similar to the first six that are suitable as a brief screening instrument.41,48 Discriminant function analysis determined that six of 15 were predictive of the presence of “abuse.” The instrument is easy to administer and can be completed quickly. This instrument shows promise for research but needs to delineate abuse from other types of EM.

Each of the qualitative and quantitative instruments is described in Table 1 and includes the method of screening or assessment, whether statistical analyses are documented, and the number of items contained in each instrument.

**Combined Qualitative and Quantitative Approaches**

**Comprehensive Geriatric Assessment**
Many have suggested that the Comprehensive Geriatric Assessment (CGA) is a strong approach for evaluation of abused or neglected individuals.21,49,50 It is an integrated approach to the screening of conditions in a variety of domains51 and requires the acquisition of a comprehensive history and physical examination and the use of validated instruments to quantify measures of psychosocial health and functional ability. A multidisciplinary team consisting of a social worker, nurse, and physician usually conducts the CGA. At the end of the assessment, the team arrives at a diagnosis based on a combination of test scores and clinical acumen.

The CGA can be performed efficiently in a variety of settings (hospital, outpatient clinic, nursing home, and private home). At least eight randomized trials in Sweden and the United States have shown it to be an effective procedure for evaluation and intervention of frail elders.52 Only trained gerontologic professionals can apply this approach, and it is time-intensive. Studies are underway to assess outcomes of the CGA in abused elders. Not all sites have the necessary personnel or resources to use this approach, and there is some debate as to whether CGA can detect EM.

**Screening Tools and Referral Protocol: Stopping Abuse Against Older Ohioans: A Guide for Service Providers**
A group of protective service and domestic violence providers, along with members of law enforcement and others involved in aging issues, developed this guide. In general, state agencies do not have resources available for research, and the Screening Tools and Referral Protocol (STRP) is one of only a few instruments that state agencies use that its developers have studied. Their goal was to improve the detection and referral of elder abuse cases in Ohio by combining educational information with screening and state-specific intervention strategies.53 The instrument is complex and combines an Actual Abuse Tool, a Suspected Abuse Tool, a Risk of Abuse Tool, and a referral protocol with 24 extended instruments that address matters such as functional or cognitive ability. Based on these studies, its developers are currently shortening and revising the instrument.54 The STRP may best be used when its respective parts are used independently depending on the circumstances of individual cases. This is also a complex instrument and needs further refinement.

**DISCUSSION**

**Value of Screening and Assessment Instruments**
EM screening and assessment instruments have a valuable potential role in the clinical and research arenas. Screening is important because EM, like other forms of domestic mistreatment, is often a hidden problem. Elders may be too fearful, ashamed, or cognitively impaired to report problems. Unlike child abuse, where the signs of neglect and physical abuse almost always indicate a problem, normal aging changes and symptoms and signs of disease states (e.g., cancer) can look like mistreatment. Clinicians must be vigilant for evidence of EM while accounting for multiple diseases and disorders that may cloud the assessment.
Table 1. Description of Screening/Assessment Instruments

<table>
<thead>
<tr>
<th>Authors (Year)</th>
<th>Name of Instrument</th>
<th>Method</th>
<th>Documented Psychometrics</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson D (1981)</td>
<td>Screening Protocols for the Identification of Abuse and Neglect in the Elderly</td>
<td>Checklist requiring interview and period of observation; 18 issues assessed</td>
<td>No</td>
<td>Used as a brief screen; setting not specified; victim and caregiver</td>
</tr>
<tr>
<td>Ferguson AD et al. (1983)</td>
<td>H.A.L.F.</td>
<td>37-item checklist requiring interview and period of observation</td>
<td>No</td>
<td>Requires a somewhat lengthy social history; for all clinical settings; victim and caregiver</td>
</tr>
<tr>
<td>Rathbone-McCuan E et al. (1982)</td>
<td>Case Detection Guidelines</td>
<td>Reference list of risk factors and physical findings</td>
<td>No</td>
<td>Aimed at practitioners with little experience with elder mistreatment (EM) cases; all clinical settings; victim and caregiver</td>
</tr>
<tr>
<td>Tomita SK (1982)</td>
<td>Elder Abuse and Neglect Protocol</td>
<td>Comprehensive outline describing an approach to abuse</td>
<td>No</td>
<td>In-depth assessment and intervention plan development; for social service agencies; victim and caregiver</td>
</tr>
<tr>
<td>Fulmer T et al. (1984) (Modified in 1992, 2000)</td>
<td>Elder Assessment Instrument</td>
<td>42-item checklist of selected common presentations of EM</td>
<td>Yes</td>
<td>Requires training, easily administered, suitable in home care, clinic hospital, emergency center; available in Spanish; victim only</td>
</tr>
<tr>
<td>Hwalek MA et al. (1986)</td>
<td>Hwalek-Sengstock Elder Abuse Screening Test</td>
<td>15-item questionnaire</td>
<td>Yes</td>
<td>Quick screen suitable in emergency or outpatient setting; victim only</td>
</tr>
<tr>
<td>Straus M (1978, 1979)</td>
<td>The Conflict Tactics Scale</td>
<td>19-item self-report or interview</td>
<td>Yes</td>
<td>Inpatient or outpatient settings; sensitive questions; available in Spanish; victim only</td>
</tr>
<tr>
<td>AMA (1992)</td>
<td>AMA Assessment Protocol</td>
<td>Checklist to use if abuse suspected</td>
<td>No</td>
<td>Depends on clinical acumen; all clinical settings; victim only</td>
</tr>
<tr>
<td>Reis M et al. (1995)</td>
<td>Brief Abuse Screen for the Elderly</td>
<td>Five standard questions</td>
<td>Yes</td>
<td>Quick screen suitable in emergency or outpatient setting; victim only</td>
</tr>
<tr>
<td>Reis M et al. (1998)</td>
<td>Indicators of Abuse Screen</td>
<td>40-item checklist</td>
<td>Yes</td>
<td>Requires in-depth interview; setting not specified; victim and caregiver</td>
</tr>
<tr>
<td>Bass DM et al. (2000)</td>
<td>Screening Tools and Referral Protocol Stopping Abuse Against Older Ohioans: A Guide for Service Providers</td>
<td>A combination of several instruments; includes a referral protocol</td>
<td>Yes</td>
<td>A series of qualitative and quantitative measurements of practitioner's change in understanding of abuse and violence: all clinical settings; victim only</td>
</tr>
</tbody>
</table>

Note: Estimated time to complete instruments is not documented.
All clinicians should be strongly encouraged to develop an approach for incorporating EM screening and assessment in their practices, and the use of these instruments may help support decisions regarding the diagnosis of EM, especially for those who have less experience with the problem. EM is a multidimensional phenomenon that encompasses a broad range of behaviors, events, and circumstances.17 A well-conceptualized assessment approach can serve to guide clinicians in reaching thoughtful, thorough, and balanced judgments about diagnoses and intervention. The relationship between subjectivity and personal values in reaching decisions about EM has been documented.17,55,56 Although screening and assessment instruments cannot eliminate bias, they can provide a framework that facilitates consistency in evaluative procedures.

A number of recent studies have demonstrated that medical disease plays a greater role in EM than previously thought. It has been determined that dementia, depression, and malnutrition are independent risk factors for mistreatment.37,58 Elders who experience self-neglect, physical abuse, or caregiver neglect have triple the mortality of those never reported as abused.57 Early detection and intervention by healthcare professionals in EM cases may lead to decreased morbidity and mortality, but simply reporting cases to APS may not improve outcomes. Reports of EM may be unjustified. Furthermore, reports may cause caregivers to withdraw from their roles and devastate social support. Older adults may be fearful of retribution or abandonment if a caregiver knows they have discussed mistreatment with a clinician. The AMA guidelines note that separating the victim from the perpetrator often gives the former the opportunity to speak freely, and clinicians must be reminded of how important it is to conduct any screening with the greatest degree of discretion. An ongoing dialogue with APS agencies in the community can help with prevention and follow-up strategies. Finally, EM takes place within a context, and without assessment of the biopsychosocial context of EM, any screening or assessment instrument has significant limitations.

Limitations of Screening and Assessment Instruments
A comparative analysis of EM assessment instruments can help users decide which instruments are appropriate and for what purpose. For clinicians in busy clinical settings, brief screens will often be the choice, whereas clinical researchers may need instruments with multiple imbedded constructs for theory testing and analysis.22 One investigator discusses the use of screening and assessment instruments for the elderly in clinical settings. Although EM assessment instruments are not addressed specifically, caution is expressed regularly about indiscriminate use of assessment instruments and that measurements of validity are crucial to the collection of quality data. EM assessment instruments can be valuable but must be accepted with reserve. It is likely that existing instruments will change markedly to reflect new conceptualizations of the problem. Finally, different disciplinary team members will select different instruments. Generalists, police officers, emergency medical technicians, and emergency room personnel may have a greater need for screening instruments. APS workers, prosecutors, and members of geriatric EM teams may require a more comprehensive assessment instrument. In certain circumstances, an individual practitioner may need to use both screening and assessment measures. EM takes place within a context, and without assessment of the caregiver and environment, any assessment has significant limitations.

Six of the instruments described involve direct assessment of the caregiver. The Elder Abuse and Neglect Protocol, the H.A.L.F, the BASE, and the IOA require caregiver interviews. The Screening Protocols for the Identification of Abuse and Neglect in the Elderly and the case detection guidelines by Rathbone-McCuan and Voyles also include caregiver assessments.52 These instruments evaluate the mental health and social situation and abusive or neglectful behaviors of the caregiver. The health and living circumstances of caregivers are often inextricably tied to those of the victims. Clinical experience suggests that recognizing this dyadic relationship and directing intervention to both the victim and the caregiver results in a greater likelihood of ending the cycle of abuse. The instruments that include caregiver assessment provide an advantage over those that focus solely on the victim. Context for an EM event is important, and a caregiver assessment helps provide context.

A second limitation exists for assessment instruments that use measurement scales. These scales direct the user to comply with a set response (e.g., very good, good, poor, etc.). Although this can be helpful in the collection and tabulation of data, there are problems associated with this approach. Unless well-defined criteria are established for selecting a specific category versus another (e.g., what distinguishes very good from good) the scale is likely to result in inconsistent and biased ratings. Additionally, the set response narrows the range of observations and, as such, may lack sensitivity to more minor differences in patient situations.22,53 This raises the concern of whether the scale selected will accurately reflect true variations in patient responses or circumstances. Finally, set responses may lead clinicians to inappropriately assign a score to instruments that are not meant for that purpose. In summary, measurement scales are useful in trying to quantify the degree of the problem but must not be overinterpreted.

A third limitation of assessment instruments relates to practicality issues. Instruments that take more than 1 hour meet increased resistance and decrease the quality of data.59 Although this does not pose a problem for checklists, interviews with open-ended questions or CGA may take extended periods of time. It has been reported that the Elder Abuse Diagnosis and Intervention Model requires interviews with both the elder and the caregiver of approximately 45 minutes, which makes its routine use in clinical settings impractical and unlikely.60

An additional limitation relates to norms for appropriate and adequate care. To date, the standards of the community still determine “ordinary and reasonable care,” and no uniform national standards of EM exist. Inappropriate and inadequate behaviors can be manifested in a number of ways, which are labeled “physical abuse,” “psychological abuse,” “physical neglect,” and so forth. A major conceptual problem lies with the inability to precisely define the attributes of normal, appropriate, and adequate
relationships. Hitting, biting, and burning are clearly outside of acceptable boundaries, but can the same be said so unequivocally about yelling or restraining behavior? Experts have not set a standard of care that clinicians can rely on to determine uniformly whether minimal care is being provided. The occasional inadvertent failure to provide a dose of medication or to adequately turn and position an older person may be defined as neglect, but many clinicians would disagree with such a conclusion. Self-neglect may be even more difficult to assess as a form of EM. Certain self-neglecting older persons may not recognize how detrimental their actions are or may prefer the lifestyle they have adopted. Because self-neglect is the failure to thrive in one’s environment, a self-neglect rating scale would necessarily involve a home assessment. This may not be possible or acceptable to the older person. Despite the recognized limitations of screening instruments, in states with mandatory reporting laws, clinicians are required to report even the suspicion of EM to designated agencies. The final decision concerning the validity of the allegations rests with trained protective service agency staff that generally follow legislative guidelines for case substantiation. (The National Center on Elder Abuse Website contains state-specific requirements at http://www.elderabusecenter.org/.) This, in itself, may be a serious flaw in the process.

Recommendations and Future Considerations
To develop a better understanding of the nature of EM and to identify persons requiring treatment and intervention, EM instruments must be improved. The addition of more senior researchers to the field will help make progress in instrumentation. The lack of empirically tested instruments constitutes a critical impediment to research and hinders the ability to detect, treat, report, and intervene in EM cases when they occur.

Setting specific considerations is important. Members of the healthcare team can use a short-format screening instrument for use in busy environments such as emergency centers and outpatient clinics with questions applicable to all elders. A short format suited to residents of institutions or residential care facilities, perhaps modified from Minimum Data Set instruments, is also needed. CGA may be readily modified to incorporate EM in appropriate settings.

CONCLUSION
EM screening and assessment instruments help provide a structure and format for collecting data, which aids in the decision-making process that surrounds EM detection and reporting. When EM is correctly identified, healthcare providers and social services agencies can help people who are at risk for or are victims of mistreatment. A number of instruments available for practitioners and researchers as they address EM have been identified. It seems wise, at this time, for clinicians to develop a protocol for use in their practices drawing from the existing instruments in the literature. The authors recommend the CTS, the BASE, or the Elder Assessment Instrument because all are easy to use and can be administered quickly. Changes in the older person’s condition must be monitored over time to provide context for the assessment. Clinical agencies should develop procedures and protocols for addressing EM case finding, documentation, and follow-up. The need for additional research cannot be overemphasized, and culturally sensitive instruments are an important next step in the development of appropriate EM assessment instruments. Senior, seasoned investigators must be drawn to the field to help address the current limitations in our EM knowledge base, and the aging of the population will force the issue. Excellence in screening and assessment instruments is an achievable goal.

REFERENCES