

# **Physician Screening for Elder Abuse in the Emergency Department: A Literature Review**

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*Division of Education*

*Research Scholar Program 2015*

## **Abstract**

Elder abuse (EA) and elder mistreatment (EM) are unseen but spreading viruses in our society that need to be prevented. The first step to prevention of elder abuse is spreading awareness of this epidemic to the public, more specifically to healthcare workers such as Emergency Medicine physicians who play vital roles in connecting victims and Adult Protective Services (APS). The Emergency Department screens, assesses, diagnoses, treats, and refers; the first step in improving the reporting of elder abuse cases by Emergency Medicine physicians is to educate them on the most pertinent screening instruments for elder abuse so that they can detect in order to provide further care. The purpose of this article is to review EA screening and assessment instruments that are currently at the disposal of both healthcare workers and those that are most appropriate to Emergency Medicine physicians and suggested for use in the Emergency Department. This review addresses the 7 types of abuse and risk factors; validated elder abuse screening and assessment tools; their categories, effectiveness and suitability for the Emergency Department; and future research recommendations. The literature review found one validated elder abuse screening tool in the Emergency Room setting and suggests three other validated screening tools for use in the Emergency Department. There is not enough research done in testing the validity of these suggested instruments in the Emergency Department. Future research should involve evaluating the applicability of this study's nine elder abuse instruments to different settings including the Emergency Department and how they apply to their user.

## **Objectives**

The purpose of this review article is to address validated elder abuse screening instruments and their applicability to the Emergency Department in order to spread awareness to LVHN Emergency Medicine physicians about their unique role in detecting abuse in their geriatric patients. A podcast will be developed based off this literature review and will educate LVHN physicians about suggested, validated elder abuse screening instruments for utilization in the Emergency Department.

## **Methodology**

Literature searches were performed in the bibliographic database Medline during June and July 2015 using the EbscoHost platform. The following keywords were used in the search: elder abuse, elder mistreatment, screening instruments, tools, Emergency Medicine physicians, Emergency Department, and assessment strategies. Articles in the English language with these keywords, ranging from 1991 to 2015, were included in the search on Medline.

## **Introduction**

### ***Background***

The World Health Organization defines elder abuse as a "single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, that causes harm or stress to an older person [1]. Elder abuse first emerged in Britain in the early 1970's as "granny bashing" and shortly after in the United States in the year 1978 at a hearing on family violence [2]. Since its initial publicity, seven billion dollars of federal funding has supported child abuse awareness, training and prevention programs, and education; and 500 million dollars of federal funding has helped spread awareness of younger women abuse. In 2005, a review that examined the policy issues of elder abuse stated that the government had not passed any federal elder abuse legislation [2], and ten years later, this is still the case. By the year 2030, 19.3% of the United States population will consist of people aged 65

years or older [3]. This statistic suggests more elder abuse cases and reports, with 1/12 currently being abused, a higher volume of patients 65 years or older visiting the Emergency Department, and a greater necessity for Emergency Medicine physicians to have effective, ER-validated elder abuse screening tools at their disposal so that they can detect, assess, treat, and refer these patients. Although screening for elder abuse is paramount, there are many other factors physicians consider when assessing the elderly. They consider elder patient's decision-making capacity, their competency, their most life threatening injuries, and chief complaint. Elderly patients take more time to evaluate, often have a host of medical problems, and usually have a higher admit rate [4]. Older people [>65 yrs.] frequent the ED more often with a higher level of urgency, 63% of elderly versus 34% of younger patients [4,5]. These emergent cases can mask signs of mistreatment, which is already elusive, and is one of the many reasons Emergency Medicine physicians often do not detect abuse. Evaluating the elder abuse screening and assessment instruments is a critical initial step in making the process of detection for elder abuse by Emergency Medicine physicians more simple.

### ***Seven types of Elder Abuse and their factors***

The National Center for Elder Abuse sub-divides elder abuse into seven categories. While there were federal guidelines written in the 1987 Amendments to the Older Americans Act, they are not statutes and for this reason, there are still discrepancies among the types and definitions of abuse because individual states enacted their own laws in defining elder abuse [3, 9]. Since each state has laws that define elder abuse differently, it is difficult to gather accurate multi-state data on types and numbers of elder abuse reports from APS [3]. **Table 1** lists the most current types and definitions of elder abuse *Adapted from* the National Center on Elder Abuse and from a recent review, "Prevention and Early Identification of Elder Abuse" by Burnett et al.

The most common type of abuse is financial exploitation followed by neglect, 95% of this occurring in the domestic setting [6]. Elderly patients that come into the Emergency Department often display signs that mimic abuse and vice versa. Emergency Room physicians must be able to differentiate these types of abuse from mimicking medical conditions. In one study, a 44 question national survey was taken by American Emergency physicians. 74% were not certain that definitions of elder abuse existed and 58% of the physicians believed they could not accurately identify cases of abuse [7]. If 3/5 of these emergency physicians could not even identify elder abuse, how could they differentiate elder abuse from mimicking medical conditions, i.e. physical abuse from an allergic reaction [8]? Emergency Medicine physicians must know and learn how to use screening instruments validated for elder abuse screening to detect and prevent EA.

### ***Risk factors***

All elderly patients are vulnerable to mistreatment [6, 13]. However, certain risk factors make some more vulnerable than others. Two studies on elder abuse and dementia display prevalence rates for abuse and neglect in the demented elderly presenting to the Emergency Department at values of 27.5% and 55% [10,11]. Caregivers often do not know how to care for the elderly suffering from dementia in the domestic setting and can become overwhelmed leading to care-giver neglect of the patient. This risk factor is one of three types of cognitive dysfunction: delirium, mild cognitive impairment, and dementia [14]. One study found a high prevalence of cognitive dysfunction (23% to 40% in all elderly ED patients) and the lack of previous detection of this dysfunction in 94% of those afflicted patients [14]. These issues complicate screening for elder abuse in the Emergency Department because these patients "impede effective emergency care" [14]. The lack of rapid, *ED-validated* screening tools for elderly cognitive dysfunction slows assessment of the elderly in the ED and will result in the physician not using elder abuse screening tools. Other risk factors for the abused elderly include: poor health and functional impairment, co-habitation with others, substance abuse, frailty, dependence on caregiver or fear of caregiver, and social isolation [6, 8, 13, 16]. There are few screening tools for elder abuse that suit the environment of Emergency Medicine and there are often barriers that prevent abuse from being detected.

### *Screening Tool Barriers*

Healthcare workers, more specifically Emergency Department physicians, are in a unique position in which they can not only screen and detect elder abuse in their patients, but also can “change the abusive situation and prevent its continuation” [17]. Although Emergency Medicine physicians are in these potentially impactful positions, one study surveyed family and Emergency Medicine physicians around the country and shed light on the reality of the average Emergency physician’s knowledge of his role in detecting elder abuse. One fourth of the respondents to the study’s survey could not identify one patient factor that would alert the Emergency Medicine physician to potential abuse [20]. There are multiple barriers that often hinder the Emergency Medicine physician in screening for elder abuse. The Emergency Medicine physician does not have adequate training in identifying elder abuse and the physician may not know the signs for abuse. The physician may know what signs of abuse to recognize in a geriatric patient, but the screening tool may be too time-consuming and may not give a definitive answer as to whether or not the physician should proceed with further assessment. Even if the tool is used to its full capacity, the patient may lie to the physician if he or she is highly dependent on the caregiver. According to many of the studies that validated the screening instruments, many of these tools have good sensitivity but lower specificity resulting in false-positive identification [6, 8, 13, 15, 17, 18, 20]. The last study to examine solely Emergency Medicine physicians and their knowledge of elder mistreatment stated frankly that Emergency Medicine physicians are not confident in identifying or reporting geriatric abuse [7]. The physician may know of an instrument and how to screen but not know to whom they should direct the case report and how they should direct it. EA screening instruments are not perfect and two studies state that 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 [18, 21]. Despite this fact, screening tools assist the physician by identifying some of the patient factors for potential abuse and have been shown to “elicit rate of abuse higher than those found in prevalence studies” [17].

### *Types of Screening Tools*

Recent review articles on EA screening instruments have distributed the various instruments among three different types of screening based on direct questioning, signs of abuse, and indicators of risk for abuse; or they have categorized the tools into qualitative or quantitative assessment types [17, 18, 21]. This review organizes elder abuse screening instruments into three categories delineated by Cohen et al [25]. Many studies have guidelines that list various signs for each type of abuse; however these signs are not validated through any procedure or attached to any screening instrument [17]. **Table 2, Table 3, and Table 4** display many current validated EA screening instruments available to healthcare providers in different settings and they provide the users’ agendas for assessing cognitively functional elderly adults. [17, 18, 21-24]

### **Discussion**

Although there are three types of screening for elder abuse according to Cohen et al, they all overlap with each other in some manner. The physician who follows EASI [21] may identify risk factors for elder abuse that the IOA would identify also. According to one of the most current literature reviews on elder abuse screening instruments, some of the screening instruments above were created for the Emergency Department setting, however, only one tool, the EAI, was actually tested in the setting [26, 30]. Many of the instruments in **Tables 2-4** are not suitable to the ER according to their validation studies and descriptions. The H-S/EAST is short and easy to administer, but it is recommended for use in the social service agency setting [30]. The IOA and E-IOA are highly reliable and have good specificity, but they are too time-consuming for the Emergency Department [17, 23]. In **Table 2**, the authors of the 2003 VASS validation study recommend further research on the sensitivity and specificity of the tool and 12 years later this recommendation is unanswered [27]. In **Table 3**, The Signs of Abuse Inventory tool is designed to be completed by a nurse or social worker [18, 25]. It is evident from these four instruments’ validation studies that they are not suitable for the Emergency Medicine physician. Although there is no standard for the “correct” elder abuse tool in the ER, past reviews and some validation studies have suggested which tools are suitable for the ER. The

EAI was the only tool tested in the ER and has been used successfully by research nurses in the ED and is appropriate for the Emergency Department [18]. The EASI was created to be easily accessible to family physicians in order for them to become more comfortable in screening for EA [21]. Although its authors validated the tool for family physicians, a more current literature study states EASI is for the “physician” [17] and quick enough that it could be used in the ER. CASE is a rapid direct questioning tool that was created for “all clients.” The Emergency Medicine physician can use this tool to interview the care giver in only 8 questions [24] detecting care giver abuse risk factors through positive results. The self-disclosure tool is another rapid assessment tool that has 10 questions covering all 7 types of abuse [28]. Of the 9 listed tools, 4 are suggested for use in the Emergency Department and only 1, the EAI, has been tested in the ER. This review cannot and does not validate the EASI, CASE, EAI, and the Self-disclosure tool for use in the Emergency Department but suggests their use in the Emergency Department based on their validation studies, intended use, and descriptions [21-24, 27, 29, 30]. In addition, it is beyond the scope of this article to address what the physician should do after assessing the geriatric patient with the four suggested ER-appropriate screening tools.

Although the IOA and E-IOA are time-consuming and not appropriate for the ER, their type of screening is important because it fills the “gap between the estimated number of elder persons suffering abuse and the actual figures for identified abuse among the elderly [17]. This gap occurs from the patient not reporting abuse and the “absence of evident signs of abuse” [17]. When the signs of abuse tools are used, such as the EAI, the physician must consider that often medical conditions can mimic signs of abuse and the fact that many signs for psychological abuse such as depression or fear can originate from other sources such as dementia [16, 17].

All the direct questioning instruments in **Table 2** cannot be used to assess patients with dementia and the other tools are not validated for screening patients with dementia [16]. Since these tools cannot be used to screen cognitively dysfunctional geriatric patients, it is essential that before screening for elder abuse in the Emergency Department, the Emergency Medicine physician evaluates the patient’s mental status with widely used mental screening tools such as the Mini-mental state examination (MMSE), the Mini-cog, or the Functional Assessment Staging Tool (FAST) [8, 10, 11, 16]. The Mini-cog is quick and has comparable sensitivity and specificity to the MMSE [16]. The Emergency Medicine physician can begin screening for elder abuse if the patient has a score of 3 or below on the FAST or a score of 24 or greater on the MMSE. If the patient does have cognitive dysfunction, the Emergency Medicine physician can use the only validated elder abuse screening tool for cognitively dysfunctional patients, the Conflicts Tactics Scale [17]. The CTS, which is given to the caregiver, has a very good sensitivity and low specificity. The CTS identified correctly 89% of demented patients in its validation study [17]. There is a significant problem if the average Emergency Medicine physician does not use or know how to use these mental status screening tools (in the presence of a geriatric patient) because they will most likely not screen for elder abuse or read false-positive/false-negative results from the EA screening test. These instruments only suggest the likely presence of abuse; they do not diagnose elder abuse and do not include geriatric elder abuse assessment models which are beyond the scope of this paper. The Emergency Medicine physician must remember to use sound clinical judgment in assessing geriatric patients for potential abuse.

## **Recommendations**

Emergency Medicine physicians simply do not know enough about current screening instruments because there is a lack of education regarding the identification and treatment of elder abuse, there is no standard for diagnosis of EA, and there are no standardized criteria by which an EA screening tool can follow to be validated for use in the Emergency Department. As many studies state, more research must be done on deriving a criterion standard for the evaluation and diagnosis of elder mistreatment. In addition, there is not enough research done in testing the validity of these suggested instruments in the ER. Future research should involve evaluating the applicability of these elder abuse instruments to different settings including the Emergency Department and how they apply to their user. The creation of a podcast educating Emergency Medicine physicians about the most rapid, ER-appropriate EA and EM

screening tools and their categories would likely increase the Emergency Medicine physician's suspicion level the next time they see a geriatric patient in the ER.

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## Appendix

**Table 1:**

Type	Definition	Prevalence
Physical abuse	Bodily injury, physical pain or impairment owing to use of physical force	1.6%
Sexual abuse	Any kind of non-consensual sexual contact	0.6%
Psychological/emotional abuse	Verbal or non-verbal acts that cause emotional and/or psychological anguish, pain or distress	3.2%
Financial exploitation	Improper or illegal use of an older adult's money, property or assets	5.2%
Caregiver neglect	Failure or refusal to fulfill one's caregiver obligation or duties to an older adult	5.1%
Self-neglect	Older adult failure to provide him/herself with appropriate care involving hygiene, diet, shelter, clothing, and medication	5.1%
Abandonment	Desertion of an older adult by an individual who assumed responsibility for their care	-

Note: The prevalence data comes from a review which found the “findings of the most recent US population-based study of elder abuse in cognitively intact community-dwelling older adults” [6].

**Table 2: Direct Question Screening**

Name	Description	Problems/ Benefits	Validity	Year
H-S/East- (Hwalek-Sengstock Elder Abuse Screening test)	Earliest direct question tool 15 items covering 3 domains: overt violation of personal rights or direct abuse, characteristics of vulnerability to abuse, or potentially abusive situation [29, 30].	Very high false-negative rate. Quick and easy to use. [29].	Validity data are small from unrepresentative samples and low internal consistency. Apt for a social service agency setting [30].	1991
VASS- (Vulnerability to Abuse Screening Scale)	H-S/East + 2 questions Self-report tool [27].	More validity tests needed. There were positive correlations with risk factors of abuse [27].	Tested in a 12,000 female group. Good construct validity [27, 30].	2002
Self-Disclosure Tool*	10-item tool for patient self-disclosure. Covers all 7 types of abuse [28].	High criterion validity [28].	Criterion and content validity determined [17].	2007
EASI- (Elder Abuse Suspicion Index)*	Most recent interview tool created for assisting physicians. Consists of 6 questions [21], 5 of them direct yes/no questions and the 6 <sup>th</sup> asks the physician if	Created to be accessible specifically to physicians [21].	Administered by physicians to 663 elder patients. Sensitivity of .47 and specificity of	2008

	he's noticed behaviors indicative of abuse.		.75 [21, 30].	
CASE- (Caregiver Abuse Screen)*	8-item questionnaire answered by caregivers. Identifies caregiver possibly guilty of physical, psychological abuse or neglect [24].	Good construct validity. Non-confrontational wording [24].	Tested among 139 caregivers. Good construct validity, concurrent, convergent validity and reliability [24, 30].	1995

**Table 3: Signs of Abuse Tools**

<b>Name</b>	<b>Description</b>	<b>Problems/ Benefits</b>	<b>Validity</b>	<b>Year</b>
EAI- (Elder Abuse Instrument)*	42-item screening tool covering 5 categories: general assessment, possible abuse, neglect, exploitation, and abandonment indicators [17, 30]. Based on a 4 pt. scale from no evidence to definite evidence.	Good internal and test-retest reliability. Good sensitivity, weaker specificity. Used efficiently by ER nurses [18,26]. Takes 12-15 minutes [30].	Tested in the ER. 71% sensitivity, 93% specificity, and content validity [30].	2004
Signs of Abuse Inventory	Tool that lists signs for each type of abuse. The severity of each sign is rated on a 0-4 scale, 4 being extreme [18,25].	Difficulty finding conclusive signs of psychological abuse. Good internal consistency [18,25].	Internal consistency ranging from 0.67-0.91 [17].	2007

**Table 4: Risk of Abuse Tools [17, 23, 30]**

<b>Name</b>	<b>Description</b>	<b>Problems/ Benefits</b>	<b>Validity</b>	<b>Year</b>
IOA- (Indicators of Abuse)	40-item survey First validated risk of abuse tool. Created for the trained professional.	Takes about 2-3 hours to complete. High internal reliability. High specificity.	Discriminant and convergent validity. Evaluated with 341 people via interview. Identified 84% abuse cases and 99% of non-abuse cases.	1998
E-IOA- (Expanded Indicators Of Abuse)	IOA items are broken down into a series of sub-indicators. Risk is rated on a 1-4 scale.	Takes about 2-3 hours to complete.	Content, criterion, and discriminant validity confirmed. Correctly classified 92.9% of the probably abused and 97.9% of the probably not abused of 731 participants.	2002