ACTUAL ABUSE TOOL

Name of Client: ______________________ Case Number: ______________________

The victim or a reliable party reports, or you directly observe the following acts of domestic violence, abuse, neglect or exploitation (this list is not exhaustive but contains some examples). A single check indicates the perceived presence of domestic violence or elder abuse.

	(check)
Examples of Physical Abuse	
• Hit, pushed, shoved, scratched or restrained.	
• Threatened with a knife, gun or other weapon.	
• Sexually assaulted, harmed or hurt.	
• Physically harmed in some other way (specify):	
Examples of Psychological Abuse	
• Yelled at, called names, insulted.	
• Threatened with physical injury.	
• Locked in a room.	
• Stalked or followed around.	
• Psychologically abused in some other way (specify):	
Examples of Neglect by Others or Self	
• Denied adequate care and supervision (especially in cases of physically or mentally impaired persons).	
• Not treated for physical health problems.	
• Isolated from others.	
• Inappropriately dressed for weather or environmental conditions.	
• Lacking adequate shelter.	
• Neglected in some other way (specify):	
Examples of Exploitation	
• Money, property, or other assets used, taken, sold, or transferred without consent.	
• Signature forged on checks or other financial and legal documents.	
• Large sums of money withdrawn from bank accounts (without her/his knowledge).	
• Exploited in some other way (specify):	

DECISION/ACTION SHEET
FOR ACTUAL ABUSE TOOL

Record Sources of Information/Observations Used to Complete (check all that apply):

Victim ☐ Perpetrator ☐ Family Member ☐ Specify relationship _______________ Friend ☐
Agency Staff (specify agency and staff member name) ☐__________________

Your own Direct Observation ☐

Comments____

____

____

Decision:

Circle the answers to the following questions:			
Victim in immediate danger?	YES	NO	DON'T KNOW
Victim willing to accept help?	YES	NO	DON'T KNOW
Perpetrator willing to accept help?	YES	NO	DON'T KNOW

If abuse is occurring, how soon do you estimate that intervention/action is needed (check off)?

Immediately ☐ Within 24 hours ☐ 24 -72 hours ☐ More than 3 days ☐________(specify)

Action:

Based on the above information, if a client is experiencing abuse as defined by this tool, **there is no need to evaluate the signs or risk factors of abuse,** since it is clearly evident that abuse is occurring. Follow the arrows in the Flow Chart directly to the diamond that asks whether the victim is mentally retarded or developmentally disabled (MRDD). If yes, refer to the designated (MRDD) agency. If the victim is not mentally retarded or developmentally disabled, follow the arrow to the diamond that helps to decide whether this is a case of elder abuse or domestic violence and refer to the identified agencies.

**Adapted from:* Adult Protective Services Indicators, Ohio Coalition for Adult Protective Services/Ohio Department of Human Services
Adapted from Reis, M. & Namiash, D. (1998). Validation of the Indicators of Abuse (IOA) Screen. The Gerontologist, 38 (4): 471-480.

SUSPECTED ABUSE TOOL

Name of Client: ______________________ Case Number: ______________

The Suspected Abuse Tool **is designed to help you recognize common signs or symptoms of abuse**. It does not contain all possible signs and is not intended to replace your own judgment. It is a supplement that assists in recognizing common signs of domestic violence, abuse, neglect, or exploitation. A single check indicates suspected abuse and requires an appropriate referral for further investigation.

Please check any signs reported to you or that you directly observe for this client.	(check)
Signs of Physical Abuse	
• Bruises, 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	
• Painful body movements, such as limping, trouble sitting/standing (not illness related)	
• Coded or vague or indirect references to sexual assault or unwanted sexual advances	
• Other signs of physical abuse (specify):	
Signs of Psychological Abuse	
• 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 and partner/caregiver behavior	
• Other signs of psychological abuse (specify):	
Signs of Neglect by Others or Self	
• Unclean physical appearance	
• Inadequate food or meal preparation supplies in household	
• Underweight, physically frail or weak, or dehydrated	
• Under or overuse of, or confusion about, prescription or over-the-counter medications	
• Inadequate utilities, including lack of heat, water, electricity, and toilet facilities	
• Unsafe or unclean environment, including insect infestation or unmaintained animals	
• Neglected household finances, including unpaid bills or rent	
• Other signs of neglect (specify):	
Signs of Exploitation	
• Overpayment for goods or services	
• Unexplained changes in power of attorney, wills, or other legal documents	
• Missing checks or money, or unexplained decreases in bank accounts	
• Missing personal belongings	
• Other signs of exploitation (specify):	

DECISION/ACTION SHEET
FOR SUSPECTED ABUSE TOOL

Record Sources of Information/Observations Used to Complete (check all that apply):

Victim ☐Perpetrator☐ Family Member☐ Specify relationship ________________ Friend ☐
Agency Staff (specify agency and staff member name) ☐___________________

Your own Direct Observation ☐

Comments____

____

____

Decision:

Circle the answers to the following questions:			
Victim in immediate danger?	YES	NO	DON'T KNOW
Victim willing to accept help?	YES	NO	DON'T KNOW
Perpetrator willing to accept help?	YES	NO	DON'T KNOW

If abuse is occurring, how soon do you estimate that intervention/action is needed (check off)?

Immediately ☐ Within 24 hours ☐ 24 –72 hours ☐ More than 3 days ☐______(specify)

Action:

Based on the information above, **if signs of suspected abuse are observed**, further investigation is required. Follow the arrow in the Referral Protocol to the diamond that asks whether the victim is mentally retarded or developmentally disabled (MRDD). If yes, refer to the county MRDD agency. If the victim is not mentally retarded or developmentally disabled, follow the arrow to the diamond that helps to decide whether this is a case of elder abuse or domestic violence and refer to identified agencies.

If no signs of suspected abuse are observed but you still have concern about the potential for abuse, follow the arrow to the diamond that includes the ***Risk Factor Screening Tool*** for domestic violence and elder abuse.

*Adapted from: Adult Protective Services Indicators, Ohio Coalition for Adult Protective Services/Ohio Department of Human Services
Adapted from Reis, M. & Namiash, D. (1998). Validation of the Indicators of Abuse (IOA) Screen. The Gerontologist, 38 (4): 471-480.

RISK OF ABUSE TOOL

Name of Client: ______________________ Case Number: ______________________

The Risk of Abuse Tool identifies common risk factors associated with cases of elder abuse and/or domestic violence. The Risk of Abuse Tool indicates whether the problem is likely to occur in a possible victim, a possible perpetrator or both. A question intended for a possible victim is shaded in the column referring to the possible perpetrator and vice-versa. A question intended for both possible victim and possible perpetrator is identified by non-shaded columns next to the corresponding screening question. Service providers are encouraged to place a check mark in the appropriate row/question if they identify a particular problem/risk factor in either one or both columns.

RISK FACTOR SCREENING QUESTIONS	Possible Victim (check)	Possible Perpetrator (check)
Past Neglect, Abuse or Criminal Offenses		
• Is there a history of past abuse, violence (including use of guns/weapons) or neglect?		
• Was the person convicted of abuse or another violent crime (including violation of a court order) in the past?		
• Is there current violence toward family members or pets, or access to guns?		
Relationship Problems Between Possible Victim and Perpetrator		
• Is there evidence of current or past relationship problems (including abuse/violence)?		
• Are there relationship problems specific to issues of power, control, dominance, coercion and manipulation?		
• Is there evidence of extreme jealousy and possessiveness?		
• Do the parties have unrealistic expectations of each other?		
Physical, Emotional or Mental Health-Related Problems		
• Are there problems with anger and hostility?		
• Are there problems with use of alcohol* or drugs or medications?		
• Are there mental health (including depression*) or emotional problems?		
• Is the person a "blamer"?		
• Are there problems in physical health or functional activities (ADLs or IADLs*)?		
• Is there evidence of cognitive or memory impairment*?		
• Does the possible victim lack a regular doctor?		
• Is the possible victim emotionally dependent?		
• Is there evidence of behavior problems?		
• Is there a lack of understanding of the medical condition?		
• Does the possible perpetrator have problems with employment or work?		
Caregiving and Social Support		
• Is there evidence of a lack of social support?		
• Is there evidence of social isolation?		
• Is there difficulty with or reluctance performing care-related tasks?		
• Is there stress or strain or inexperience with caregiving?		
• Is the possible perpetrator caring for other dependent family members?		
• Is financial dependency a problem?		
Environmental and Household Characteristics		
• Do the possible victim and perpetrator share a household?		
• Does the house have hazardous environmental conditions?		

DECISION/ACTION SHEET
FOR RISK OF ABUSE TOOL

DECISION:

Circle the answers to the following questions:			
Victim in immediate danger?	YES	NO	DON'T KNOW
Victim willing to accept help?	YES	NO	DON'T KNOW
Perpetrator willing to accept help?	YES	NO	DON'T KNOW

If abuse is occurring, how soon do you estimate that intervention/action is needed (check off)?

Immediately ☐ Within 24 hours ☐24 –72 hours ☐More than 3 days ☐_________(specify)

Action:

Based on your assessment of the severity and danger of the risk factors, if you believe that the client is a potential victim of elder abuse or domestic violence and could benefit from community services, consult with the Area Agency on Aging or County Department of Human Services for further investigation.

*These problem areas include examples of standardized instruments that may be useful for further evaluation of these risk factors. Selection of these problem areas for further evaluation was either based on project investigators' judgment or from the pretest phase of the project in which practitioners used instruments to further evaluate problem areas. The instruments are not meant to be exclusive and serve only as examples of standardized tools. The instruments may be used with either possible perpetrators or possible victims. See ***Appendix C*** for the standardized instruments included in this manual. Standardized instruments may be available for further evaluating the same and/or other problem areas in the literature.

Adapted from Reis, M. & Namiash, D. (1998). Validation of the Indicators of Abuse (IOA) Screen. The Gerontologist, 38 (4): 471-480.

Note: The risk factors listed in this tool have been drawn from the literature on elder abuse and domestic violence. All of the 27 indicators of elder abuse identified in the Reis & Namaish study (1998) are listed in the tool. The list also includes those items/problem areas that 60 experienced clinicians from various disciplines and agencies identified as being "high risk" characteristics for elder abuse and domestic violence as part of this project (Anetzberger, Bass, Ejaz & Nagpaul, 1999).

APPENDIX C

Activities of Daily Living (ADLs)

If the elder needs assistance or supervision with an activity, please assess the adequacy of the assistance or supervision the elder receives and whether or not you feel the elder recognizes he or she needs assistance by checking the appropriate response.

ACTIVITIES OF DAILY LIVING

	Circle the Appropriate Response		(If requires assistance or is dependent)	
	Needs no assistance or supervision from another person	Needs some assistance or supervision from another person	Please check below if older person does not have adequate assistance or supervision with this activity	Please check below if older person does not recognize that she/he needs help this activity
Eating	0	1		
Toileting	0	1		
Bathing (sponge, shower, or tub)	0	1		
Dressing	0	1		
Grooming (combing and shampooing hair, shaving, trimming nails)	0	1		
Transferring	0	1		
Sum of "YES" Responses: **GRAND TOTAL =**				

Scoring: If the elder is impaired in one or more areas, she/he is dependent in ADLs. Use information on the adequacy of assistance or the failure to recognize the need for assistance for clinical decision-making.

Reference: The Benjamin Rose Institute (1992). Service use by impaired elderly and informal caregivers. Grant funded by the National Institute of Mental Health, # 1RO1 MH45918-01A1.

Functional (Instrumental) Activities Questionnaire

The Functional Activities Questionnaire (FAQ) is an informant-based measure of functional abilities. Informants provide performance ratings of the target person on 10 complex, higher-order activities.

	Circle the Appropriate Response			
	Does without difficulty	Has difficulty but does by self	Requires assistance by another person	Totally dependent on others
1. writing checks, paying bills, and balancing a checkbook.	0	1	2	3
2. assembling tax records, business affairs, or papers.	0	1	2	3
3. shopping alone for clothes, household necessities, or groceries.	0	1	2	3
4. playing a game of skill, working on a hobby.	0	1	2	3
5. heating water, making a cup of coffee, turning off the stove.	0	1	2	3
6. preparing a balanced meal.	0	1	2	3
7. keeping track of current events.	0	1	2	3
8. paying attention to, understanding, discussing a TV show, book, or magazine.	0	1	2	3
9. remembering appointments, family occasions, holidays, medications.	0	1	2	3
10. traveling out of the neighborhood, driving, arranging to take buses.	0	1	2	3
Sum Responses in Each Column: **COLUMN TOTALS =**				
Sum Column Totals: **GRAND TOTAL =**				

Scoring: A total score for the FAQ is computed by simply summing the scores across the 10 items. Scores range from 0 to 30; the higher the score the poorer the function, i.e., the greater the impairment. A cut-off point of "9" (dependent in three or more activities) suggests problems with functioning.

Notes: Two other response options can also be scored: Never did [the activity], but could do now = 0; never did and would have difficulty now = 1.

Reference: Pfeiffer RI, Kurosaki, TT, Harrah CH, et al (1982). Measurement of functional activities of older adults in the community. Journal of Gerontology, 37:323-329.

Cognitive Status

Please administer the following measure directly to the elder and score as noted below. The scores from each of the items are multiplied as detailed below to yield a weighted score. Please add together the computed weighted scores and enter the total weighted score below. Possible total weighted scores range from 0 to 28.

The Blessed Orientation-Memory-Concentration Test

Items		Maximum error	Score	Weighted score
1	What year is it now?	1	X 4 =	
2	What month is it now?	1	X 3 =	
Memory phrase	Repeat this phrase after me: John Brown, 42 Market Street, Chicago			
3	About what time is it? (within 1 hour)	1	X 3 =	
4	Count backwards 20 to 1	2	X 2 =	
5	Say the months in reverse order	2	X 2 =	
6	Repeat the memory phrase	5	X 2 =	
		TOTAL WEIGHTED SCORE =		

Scoring:
Item 1: Score "1" for each incorrect response.

Item 2: Score "1" for each incorrect response.

Item 3: Score "1" for each incorrect response.

Item 4: Score "0" for no errors, score "1" for self-corrected errors, and score "2" for uncorrected errors.

Item 5: Score "0" for no errors, score "1" for self-corrected errors, and score "2" for uncorrected errors.

Memory Phrase: If the elder can recall both the name and address found in the memory phrase without any cue, score item as "0." If the elder cannot spontaneously recall the name and address, cue with "John Brown" only once. If cue is necessary, the elder automatically has 2 errors. Score 1 point each subsequent part the elder cannot recall. The three subsequent parts are: 42; Market Street; Chicago.

Note: Possible total scores can range from 0 (all items answered correctly) to 28 (all items answered incorrectly. Weighted errors scores greater than 10 could indicate possible dementia.

Reference: Katzman, R., Brown T., Fuld P., et al. (1983). Validation of a short orientation-memory-concentration test of cognitive impairment. American Journal of Psychiatry, 140:734-739.

Depression

The questions relate to how the person may have felt **during the past week**.

During the past week, how often did the person:	Circle the Appropriate Response HARDLY EVER OR NEVER (less than one day)	SOMETIMES (1- 2 days)	OFTEN (3 -7 days)
a) feel depressed?	0	1	2
b) feel everything she/he did was an effort?	0	1	2
c) experience restless sleep?	0	1	2
d) feel happy?	2	1	0
e) feel lonely	0	1	2
f) enjoy life	2	1	0
g) feel people were unfriendly?	0	1	2
h) feel sad?	0	1	2
i) feel that people disliked her/him?	0	1	2
j) feel she/he could not get "going"?	0	1	2
Sum Responses in Each Column: **COLUMN TOTALS =**			
Sum Column Totals: **GRAND TOTAL =**			

Scoring: A score of 13 or higher for men and 14 or higher for women is indicative of depression.

Reference: Kohout, Berkman, Evans, & Huntley (1993): Two Shorter Forms of the CES-D Depression Symptoms Index. Journal of Aging and Health, V(2), 179-193.

Evidence of Alcohol or Drug Abuse

The person:	Circle the Appropriate Response: YES	NO
1. feels she/he is a normal drinker.		2
2. feels that her/his husband, wife, a parent, or other near relative worries or complains about her/his drinking.	1	
3. feels guilty about her/his drinking.	1	
4. feels friends or relatives think she/he is a normal drinker.		2
5. feels she/he is able to stop drinking when she/he wants to.		2
6. has attended a meeting of Alcoholics Anonymous (AA).	5	
7. feels that drinking has created problems between her/himself and her/his husband, wife, a parent, or other near relative.	2	
8. has gotten into trouble at work because of drinking.	2	
9. has neglected obligations, family, or work for two or more days in a row because she/he was drinking.	2	
10. has gone to someone for help about her/his drinking.	5	
11. has been in a hospital because of drinking.	5	
12. has been stopped by the police for drunken driving or driving under the influence of alcohol.	2	
13. has been arrested, even for a few hours, because of drunken behavior.	2	
Sum Responses in Each Column: **COLUMN TOTALS =**		
Sum Column Totals: **GRAND TOTAL =**		

Scoring: Each item on the tool is assigned a weight of 0 to 5, with 5 considered diagnostic of alcoholism. Weights for the items are listed in the appropriate columns. Negative responses to items 1, 4, and 5 are considered alcoholic responses, and positive responses to the other items are considered alcoholic responses. An overall score of 3 points or less is considered to indicate non-alcoholism, 4 points is suggestive of alcoholism, and 5 points or more indicates alcoholism.

Reference: Selzer, M.L, Vinokur, A. and van Rooijen, L. (1975). A Self-administered Short Michigan Alcoholism Screening Test, Journal of Studies on Alcohol, 36, 117-126.