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Reaching Out for Help: Recommendations for Practice Based on an In-depth Analysis of an
Elder Abuse Intervention Program

Jennifer E. Storey

Royal Holloway University of London

and

Melanie R. Perka

Family and Community Services, Strathcona County, Canada

Author Notes

Jennifer E. Storey, School of Law, Royal Holloway University of London, Egham, Surrey, UK; Melanie R. Perka, Family and Community Services, Strathcona County, Canada.

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Correspondence concerning this article should be addresses to Jennifer Storey, School of Law, Royal Holloway University of London, Egham, Surrey, UK, TW20 0EX. Email: jennifer.storey@rhul.ac.uk

Abstract

Elder abuse is a growing public health concern with serious and sometimes fatal consequences. Intervention research is lacking despite its potential value to victim protection. This study investigates the first and longest running social work intervention program for elder abuse in Canada. The aim of this study is to provide a better understanding of the scope of the problem and needs of the population to inform program development through the recommendations made. 164 cases of elder abuse reported from January 2012 to April 2014 were examined. Case characteristics and related recommendations are reported. Third parties reported most abuse, which was typically emotional and financial; polyvictimization was present in most cases. Intake practices that may have facilitated reporting are described and recommendations to improve victim reporting and confidentiality are made. Victim health problems and dependency were common and many victims lacked support. Perpetrators often resided with victims and had mental health and social functioning problems. Case management varied in length and several barriers were identified. Multiagency work is recommended to better manage the needs of the victim, risk factors related to the perpetrator and victim-perpetrator cohabitation. Recommendations to improve the safety of the victim and that of professionals are also made.

Keywords: Elder abuse, social work intervention program, elder mistreatment, elder abuse and neglect prevention, abuse of older persons

Introduction

Like other Western countries, Canada is experiencing an increase in elderly citizens and a subsequent rise in elder abuse (also known as elder mistreatment or the abuse of older persons) (Brennan, 2012). The global past-year prevalence of elder abuse is 15.7% (Yon, Mikton, Gassoumis, & Wilber, 2017). In Canada, a national survey found that 8.2% of community dwelling older adults (aged 55+) had experienced mistreatment in the past year (McDonald, 2015). Although no single definition of elder abuse exists, most definitions include similar components, namely that elder abuse is a single or repeated act of commission or omission that causes harm or distress to an older person and that occurs within a relationship where there is trust between the perpetrator and victim (WHO, 2002; Wolf et al., 2002). Further, almost all definitions include the same five types of abuse, physical, emotional (or psychological), financial, sexual and neglect (Lachs & Pillemer, 2015; Wolf et al., 2002). The consequences of elder abuse are varied and severe, impacting victims physically, mentally and financially and in some cases causing death (Dong et al., 2009; WHO, 2016).

Elder abuse came to public attention in the 1970s and was the subject of scientific study for the first time in 1981 (Erlingsson, 2007). Research progress has been slow, lagging 30-years behind similar areas like child abuse and intimate partner violence (Dyer et al., 2003). Intervention research that could assist in developing effective responses to elder abuse is severely limited (Baker et al., 2017). Further, few intervention strategies are evidence based (Dong, 2015). It has been suggested that community based participatory research, including community-academic partnerships could assist by building on community needs and strengths (Dong, 2015).

The research that exists on elder abuse intervention programs consists primarily of three types of studies. First, authors have made suggestions about what the intervention and management of elder abuse should include, but agree that there is limited empirical literature upon which such recommendations can be made (Ploeg et al., 2009). Second are program descriptions. For instance, Reingold (2006) describes the development of programs to address elder abuse in the community and Bonnie and Wallace (2002) summarize interventions in the USA to encourage evaluation. The third type of study is program evaluations. A small number of program evaluations have been conducted, but results remain limited (Baker et al., 2017). A systematic review by Ploeg and colleagues (2009) identified only eight evaluations, none were from Canada (most were from the USA), and only one examined a social service intervention, comparing it to a criminal justice system intervention (Bronwell & Wolden, 2003). A later literature review of seven intervention studies conducted by Baker and colleagues (2017) concluded that much of the evidence reported in the studies was of low quality, making program efficacy uncertain.

A fourth type of elder abuse intervention study, rarely conducted and the focus of the present study, is an analysis of the characteristics of serviced populations to identify recommendations for practice that will assist those populations. The first such study by Neale and colleagues (1996) described a state-wide social service program in the USA. The authors provided descriptive information on the cases handled by the program, where the most common types of abuse were financial, emotional and neglect, and information on the amount of administrative time spent providing services, with most cases remaining open between 61 and 120 days. Victim and perpetrator characteristics were not reported.

Next, Anetzberger and Yamada (1999) described a new help line for elder abuse in Japan. Characteristics of the reporter, victims, perpetrators and abuse were described. Reporters were most often the victim or the victim's daughter. Victims were mostly female and did not

have dementia or require care. Perpetrators were typically adult children living with the victim. Financial abuse was most common, followed by psychological abuse, physical abuse and neglect. Recommendations were made for program enhancement; however, the recommendations did not appear to be based on the study's findings.

In their comparison of two intervention types in the USA, Bronwell and Wolden (2003) reported characteristics of the populations served by each intervention program, one criminal justice and one social service. Most victims were white females living with the perpetrator. Physical health problems were more common among victims than mental health problems. Reports of abuse were most often made by the victim's family or the victim. Adult children were the most common perpetrators. Perpetrator information was otherwise limited. Financial abuse was most common, followed by psychological and physical abuse. The characteristics identified were not used to recommend program improvement but by comparing program types offer direction for intervention.

Milne and colleagues (2013) examined adult protection data from two UK locations. Referrals were described, including information on the abuse, perpetrator and reporters. Results were typically displayed based on the mental health of the victim. Suffering from multiple forms of abuse was most common, followed by physical abuse, financial abuse and neglect alone. Perpetrators were typically care home staff or managers. Reports were most often made by family, carers or professionals. The authors note that information on characteristics was limited and its inclusion would have strengthened the study. No information was provided on victim characteristics, beyond the presence of a mental health problem. The authors concluded that victim mental health is a major factor, and suggested that adult protection programs collect data on victim and perpetrator health to develop appropriate management strategies.

Therefore, few studies of serviced populations have directly linked findings to recommendations for practice. Fewer still have investigated victim characteristics and those that have, have not connected those characteristics to service improvements. Further, no studies have examined the characteristics of serviced populations in Canada.

The management of elder abuse in Canada varies provincially. With limited reporting of elder abuse to police (Wang et al., 2015), initial steps in the assessment and management of elder abuse often fall to social service organizations. The longest running community based social service intervention program for elder abuse in Canada is the Elder Abuse Resource and Support team (EARS) in Edmonton, Alberta. In 2016, Edmonton had a population of 1,366,050 people, of those 169,650 individuals were 65 and over (Statistics Canada, 2016). The city is 15,783.77 square kilometres, which equates to 86.5 persons per square kilometre. The program started in 1989 and developed by the non-profit community based program, Catholic Social Services in Edmonton, EARS was the first of its kind and established an intake line run by professionals from the human services field, to service vulnerable and abused seniors and provide a place where professionals, friends or family members could confidentially report elder abuse concerns. Once reported, a case worker is assigned to educate the senior on the signs and impact of elder abuse, provide resources and a safe place for them to speak to a professional and explore options for change. EARS's priority is to assess and manage cases as per the senior's wishes. However, in some instances, police partners lay criminal charges despite a senior's objections. In most cases, interventions and supports are voluntary, as each senior is respectfully assumed to be competent to make decisions about their own well-being, unless EARS is provided with information suggesting otherwise. Case workers consist mainly of registered social workers; however, some have higher education backgrounds in related fields of study. By 1998, EARS had become so successful that the city added a high-risk branch, where high-risk cases reported to EARS

could be diverted. This branch, called the Senior's Protection Partnership (SPP), pairs the social work program, where needed, with partners from with Edmonton Police Services, City of Edmonton, the Victorian Order of Nurses and Covenant Health.

Despite providing services for 28 years, little is known about the operation of EARS or similar Canadian programs. Further, nothing is published about the number and type of victims assisted, the nature of the abuse reported or the needs that arise in managing cases. Thus, the general demands of preventing elder abuse and the demands placed on these programs remain largely unexamined. This dearth of information and the limited empirical literature make it difficult to quantify the demands placed on elder abuse intervention programs and the utility of adopting such programs. Research is needed to clarify the nature of the population requiring assistance (e.g., prevalence, nature of abuse), the needs of that population (e.g., mental health, physical health) and the demands of case management (e.g., case length, contact requirements).

Current Study

The present study identifies the nature and characteristics of reported elder abuse as well as the characteristics of the victim, perpetrator and case management in a representative sample of cases managed by a social work intervention program (EARS/SPP) over a 28-month period. Based on the identified characteristics, recommendations are proposed to improve practice so as to best meet the needs of victims and perpetrators and improve elder abuse intervention.

Method

Overview

All cases of elder abuse reported to EARS in Edmonton, Canada from January 2012-April 2014 were collected to obtain a representative sample. The sample is representative

because it is the product of systematic continuous sampling from a population rather than a sample of convenience. Case files contained two sets of documents: (1) an intake form with demographic information, the nature of abuse alleged and risk factors for abuse, and (2) contact notes detailing all interactions with the senior, relatives, professionals and EARS/SPP members involved with the file. A total of 164 anonymized cases handled by EARS/SPP were reviewed. Information regarding the nature of the abuse, the victim, the perpetrator and case management was analysed. For clarity, older adults subjected to abuse will be referred to as *victims* and individuals alleged to have perpetrated that abuse will be referred to as *perpetrators*.

Cases

Cases managed by EARS/SPP were those where elder abuse defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" was alleged (Action on Elder Abuse, 1995). EARS/SPP's mandate is to assist victims of elder abuse aged 65-years or older. However, in a minority of cases younger victims were assisted where it was believed the victim was especially vulnerable or living in an area without access to services. Variables that could make a victim vulnerable include severe mental or physical health issues that impede access to services, extreme violence requiring police intervention, and unique victim needs that could only be met by EARS/SPP.

A total of 371 reports were received by EARS during the study period. Cases were excluded from the study sample based on three criteria. First, 202 cases were excluded because they included minimal information (i.e., name, reason for referral) and involved no follow-up. Second, of the 169 unique cases remaining three cases were excluded because no abuse had occurred (i.e., a false report was made). Third, two cases were excluded because they involved mutual abuse between intimate partners. In these cases, both parties were

perpetrating and the victims of abusive behaviour, thereby making it impossible to identify separate ‘victim’ and ‘perpetrator’ characteristics. Mutual abuse among intimate partners is not uncommon (Archer, 2000) and is an issue in need of examination among seniors, but is not within the scope of the present study. The final sample therefore included 164 cases.

Procedure

Phone calls reporting suspected elder abuse to EARS/SPP are answered by case workers and later assigned based on case load and risk. The assigned case worker then works with the victim and other parties (e.g., family, health professionals, perpetrator) to increase the victim’s safety and end the abuse. Care is taken to respect victim autonomy, by setting and working toward goals identified by the victim. The present sample includes reported cases of elder abuse. It is important to note that unreported cases of elder abuse are likely to have important differences such as increased isolation and health or social problems that limit communication.

For research purposes, intake forms and case notes were obtained for cases of abuse reported from January 2012 to April 2014. This 28-month period was selected because during that time there was a consistent supervisor and members of staff working on cases.

Identifying information (e.g., name, address, phone number) related to individuals involved in the case was concealed prior to review by the researcher. Variables in the intake form were coded a second time by the researcher based on the case file. Consensus ratings were then developed for each variable. This was done to improve the accuracy of the coding and ensure that additional information gathered throughout case management was captured for the purposes of the study.

Ethical approval was not required because in Canada the Tri-Council Policy (Article 2.5., 2010) does not require ethical approval for studies related to program evaluation. Ethical

guidelines were however followed in the administration of the study. Data was anonymized by EARS/SPP staff members prior to review by the researcher. Original files never left EARS/SPP offices and anonymized data were stored in a secure location. Permission to undertake the study was obtained from the EARS/SPP program manager.

Materials

Information on the characteristics of the abuse, victim, perpetrator and case management were collected from case files. Each case file consisted of two types of documents. The first document was the intake form, completed during and immediately after referral. The intake form gathered information needed for follow-up (e.g., contact details), risk assessment (e.g., nature of abuse, risk factors for abuse) and risk management (e.g., risk for future violence, previous intervention attempts). The second document consisted of contact notes. Contact notes varied in length and were generated by the case worker or supervisor each time the victim or anyone involved in the case were spoken to, or when any action was taken (e.g., home visit, unanswered phone call to the victim). Contact notes recorded single actions or several actions taken over the course of a day. Contact notes included the date and time of the note, actions taken and detailed content of conversations.

Data analysis

Data was analysed using SPSS (Version 21). Analyses were primarily descriptive and comparisons were made using chi-square. Cases typically involved one victim (92%, $n=151$) and one perpetrator (79%, $n=130$). However, a minority included two victims (8%, $n=13$), and between two (15%, $n=25$), three (4%, $n=6$) or four (1%, $n=2$) perpetrators. In one case, perpetrators were specified only as staff at the victim's care home. The age and gender of each victim and perpetrator were recorded as well as the type of relationship they held; all other characteristics were recorded for the case. For example, if perpetrator substance abuse

was recorded as present in a case with two perpetrators it would mean that at least one of the perpetrators had a substance abuse problem.

Results

Abuse characteristics. Abuse was most often reported by someone with a professional relationship to the victim (e.g., physician) (35%, $n=58$), followed by the victim's family (33%, $n=54$), the victim (18%, $n=29$), a non-relative of the victim (12%, $n=19$), and the perpetrator (2%, $n=4$).

The type and prevalence of abuse across cases is presented in Table 1. Although the abuse reported most often fell within the five categories of elder abuse and mirrored the typical forms abuse described in the elder abuse literature, (e.g., stealing money, hitting) there were some uncommon forms of abuse that were more difficult to categorize. For example, one perpetrator visited the victim for Thanksgiving dinner and then refused to leave, ultimately moving in without the victim's permission. No rent was paid and thus abuse was categorized as financial, although it could be argued that denying the victim's wishes could be emotional abuse.

In 25% of cases ($n=41$) abuse was escalating, meaning that it was increasing in frequency, severity or diversity. In 50% of cases abuse was chronic ($n=96$), meaning that it had been ongoing for several months or years. Weapons were used in 5% ($n=8$) of cases and victims sustained severe or life-threatening injuries in 7% ($n=12$) of cases (information was missing in 1% of cases). Elderly victims were not always the only target of the perpetrator's abusive behaviour. In 31% ($n=51$) of cases abusive behaviour was also directed at others.

Victim characteristics. Most of the 177 victims were female (70%, $n=124$). Victims had an average age of 75 years ($SD=9.40$, range: 50-95) (5% missing information). Across cases ($n=164$), 70% of victims ($n=114$) had a health problem. For 33% ($n=54$), problems were

physical in nature, for 14% ($n=14$) problems were related to mental health, and for 23% ($n=37$) both physical and mental health problems were present. In 10% of cases ($n=17$), victims had substance abuse problems.

Due to health and other problems, just over half of victims (52%, $n=85$) were dependent. Physical dependence was most common (23%, $n=38$), followed by dependence due to mental health (9%, $n=15$), financial dependence (4%, $n=7$) and dependence on others for communication (1%, $n=1$). The remaining 24 victims (28%) were dependent on others in two or more of these ways. Dependent victims were most often dependent on the perpetrator (22%, $n=36$), followed by one or more professionals (10%, $n=17$), family members (6%, $n=10$), or their spouse (2%, $n=4$). In 18% ($n=15$) of cases, victims were dependent on two such individuals. In three cases (4%), it was unclear upon whom the victim was dependent. Despite these dependencies, 87% of victims were legally independent ($n=142$), only 8% ($n=13$) had a guardian (6% missing information). Most victims also managed their finances independently (68%, $n=111$), although 17% ($n=27$) had family support, 10% had a trustee or power of attorney ($n=16$) and 3% had support from the perpetrator ($n=5$) (3% missing information).

Victims' living situations and connection to resources were also examined. Most victims lived with others (77%, $n=126$). Of those, 45% ($n=73$) lived with the perpetrator, 15% ($n=25$) lived with the perpetrator and another person, 6% ($n=10$) lived with a spouse, 6% ($n=9$) lived in a care facility, 4% ($n=6$) lived with family and 1% ($n=2$) lived with a non-relative. Concerns about the victim's home environment were present in 31% ($n=50$) of cases. Most often, concerns were about the safety of the victim or visiting professionals (15%, $n=24$), followed by concerns about the cleanliness of the home (12%, $n=19$), the lack of a home (2%, $n=4$), both safety and cleanliness (1%, $n=2$), or insufficient food in the home (1%, $n=1$).

Approximately a third (33%, $n=54$) of seniors were isolated (1% missing information). Seniors were isolated when they had a limited ability to obtain resources and supports due to the control of the perpetrator, where they lived, their mobility or due to physical or mental health reasons. Victims were not significantly more likely to be isolated when living alone than when living with others $\chi^2(1, N=162) = .58, p = .280$. Just under half of victims had professional support (45%, $n=74$) and 51% had informal or family support ($n=84$). In 24% of cases victims had neither professional nor informal support.

Perpetrator characteristics. Of the 206 perpetrators, 113 (55%) were male. Perpetrators had a mean age of 47 years ($SD=15.84$, range: 13-89) (33% missing information). Most perpetrators were the adult children (biological or in-law) of the victim (59%, $n=121$). Other relatives, defined as blood relatives or relatives by marriage, were the next most common relationship type (18%, $n=37$), followed by spouses (14%, $n=28$) and non-relatives (10%, $n=20$).

Many perpetrators struggled with mental health and addiction issues. Across cases, 17% ($n=28$) of perpetrators had been diagnosed with a mental health problem and 23% ($n=37$) were suspected of having a mental health problem. Suicidal ideation or intent was verbalized by 7% ($n=12$) of perpetrators. Issues with addiction including licit or illicit substances and gambling were present in 43% ($n=71$) of cases. In cases where a mental health problem was suspected or diagnosed, it was also significantly more likely for addiction issues to be present, suggesting comorbidity in diagnoses, $\chi^2(1, N=164) = 10.09, p=.001, \phi=.25$.

Many perpetrators experienced problems with social functioning and few had traumatic experiences. A minority of perpetrators were experiencing caregiver stress (11%, $n=18$) (2% missing information). More common, was dependency (e.g., financial, physical, emotional) on the victim (39%, $n=64$) (1% missing information). Similarly, 40% ($n=65$) of perpetrators

had employment problems, meaning that they were unemployed, on social assistance or sporadically employed. Perpetrators who were dependent on the victim were significantly more likely to have employment problems, $\chi^2(1, N=162) = 32.26, p < .001, \phi = .45$.

Perpetrators had a prior criminal charge or conviction in 32% of cases ($n=53$) (5% missing information). Perpetrators had been the victims of abuse in 10% ($n=16$) of cases (5% missing information). A recent divorce (4%, $n=6$) or the recent death of someone close to them (3%, $n=5$) had been experienced by a minority of perpetrators (2% missing information).

Case management characteristics. Prior to reporting abuse to EARS, unsuccessful attempts at intervention were made in 34% ($n=56$) of cases. In 66% ($n=37$) of such cases the attempts were formal, meaning they involved professionals, in 21% ($n=12$) they were informal, involving family or friends, and in 13% ($n=7$) they were both formal and informal. When cases were reported, 13% of reporters ($n=21$) did not want their name revealed to the victim and/or the perpetrator, and 5% ($n=8$) were concerned that they would be subject to retaliation for reporting the abuse.

Cases remained open and were actively worked or monitored for between one and 1096 days ($M=135, SD=178.77$). The number of contact notes ranged from 1 to 118, with a mean of 15 ($SD=17.35$). In 45% of cases ($n=74$) there were barriers for case workers in communicating with or visiting the victim (1% missing information). Barriers were most often related to the perpetrator (20%, $n=32$) who would not allow contact and/or make contact unsafe. Other barriers to communication with or visiting the victim included language (10%, $n=17$), the victim's memory or mental health problems (4%, $n=7$), the safety of the victim's home (3%, $n=5$), the victim's hearing problems (2%, $n=3$), the victim's refusal of help (2%, $n=3$), the lack of a fixed address for the victim (1%, $n=1$), or the victim's substance abuse problem (1%, $n=1$). In 2% ($n=4$) of cases, a combination of two of these factors were barriers to communication.

Discussion

The results highlight the diversity of elder abuse cases and provide a clearer picture of the scope of the problem as viewed through a social work intervention program. Recognition of patterns across cases can help to illuminate relationships between victim, perpetrator and management characteristics. This information can then inform evidence based practice, helping to target factors related to abuse and ultimately improve prevention. Although findings relate to the EARS/SPP program, they have relevance to other programs as they represent a normative sample of referred cases. Further, the longstanding nature of EARS ensures that the data represent an experienced practice and stabilized referrals. Thus, the characteristics identified and recommendations made may have relevance to similar intervention programs.

With respect to the overall findings, the large amount of information gathered in case files is encouraging and went beyond that suggested by Heisler (1991), who relayed the information typically required by police. Heisler (1991) states that such information will help to prioritize reports and assign resources and can be vital should the victim recant or pass away. In addition, we would suggest that for intervention programs where contact with the perpetrator is a possibility, detailed information is critical to staff safety. The collection of information on perpetrator characteristics related to violence risk (e.g., substance abuse, criminal history, abusive behaviour toward others), as well as information on the home environment and barriers to communication can help to prevent staff from encountering situations where their safety is at risk. This is supported by the fact that in 12% of cases there were specific safety concerns for the victim or visiting professionals related to the victim's home. Because they were aware of the risk, case workers would attend the home with an SPP police partner to ensure their and the victim's safety. Police partners also provided access to the perpetrator's criminal record. For social work teams, access to police officers, or ideally

multidisciplinary teams that include police, would improve elder abuse management by enhancing access to information and safety.

The characteristics of elder abuse identified, reveal several key implications for practice and research. Abuse was most often reported by professionals followed by the victim's family. Abuse was rarely reported by victims, confirming previous studies that have identified underreporting (Wang et al., 2015). These reporting practices suggest that professionals may be better able to identify elder abuse and understand the importance and benefits of reporting it. The longstanding nature of this intervention program may also mean that more professionals were aware of its existence. Efforts need to be made to increase victim reporting. Increasing victims' knowledge of the management process may help. Programs may want to highlight the high level of control that victims have over how their case is handled. Victims should be made aware that their wishes will be respected, and that even if abuse is criminal in nature few cases proceed to court without a victim statement. In this way, returning autonomy to someone who has recently been stripped of it through abuse may increase victims' willingness to seek help.

Emotional and financial abuse were common. Most striking was that in about three quarters of cases polyvictimization was present. This is higher than that reported by Milne and colleagues (2013), who, unlike the present study, found low rates of financial and emotional abuse and high rates of perpetrators who had a professional relationship with the victim. Thus, the present results may reflect the fact that adult children commonly engage in both financial and emotional abuse. The results may also reflect the design of the intake form used by EARS/SPP, which queries each form of abuse using multiple questions. Intake practices should query the presence of all five types of elder abuse, probing should not cease after one type has been identified as more types of abuse are likely to be present.

The results also suggest that in probing for the presence of abuse, a broad definition of physical, emotional, financial, and sexual abuse and neglect should be maintained. Several unusual manifestations of abuse were present in the sample and could have been missed had case workers not broadly constructed the definition of elder abuse. We are not suggesting alterations to legal or other definitions, only that case workers maintain a broad understanding of elder abuse so that victims' needs can be fully met. We would also suggest that when taking reports, reporters be encouraged to fully describe their circumstances and concerns. Providing reporters with definitions of abuse may limit the information given, since reporters may not be able to situate their experiences clearly within one of the five categories of abuse and consequently omit something from their report. It would be better practice for the case worker to listen to the concerns presented and then try to situate those concerns within the definition. To ensure that all abuse was identified and followed-up with management, EARS/SPP also used a supervisory system where reports taken by junior members of staff were reviewed by a supervisor. In addition, it was important in some cases to clarify victims' perceptions of abuse. On several occasions case workers needed to explain to victims why certain perpetrator behaviours were abusive and therefore could be targets for change. Victims' lack of understanding about what constitutes elder abuse could partially explain low reporting rates and might be a useful focus for education and research.

Half of cases involved chronic abuse, and in a quarter abuse was escalating. This suggests that once abuse has been reported it is crucial that intervention occur as soon as possible. The consequences of elder abuse can be severe, sometimes causing death (Dong et al., 2009). Thus, the more quickly that abuse can be reduced and victim stress alleviated the more likely it will be that negative health outcomes for the victim can be reduced. EARS found that to respond in a timely manner, it was important to adequately staff the intake phone line since

seniors were not adept at leaving voicemail messages, often neglecting to include adequate information for a call-back.

In approximately a third of cases, individuals other than the victim were subject to abuse from the perpetrator. This suggests that intervention in some cases might benefit from the joint efforts of multiple services or victims. Thus, using methods such as case conferencing and joint interviewing could help to identify the extent of the perpetrator's abusive behaviour and ways that it might be jointly managed.

Cases typically involved one female victim who suffered from health problems and lived with others. The high prevalence of health problems indicates a high needs population with limitations beyond the abuse experienced. This is of concern because only around half of victims had formal or informal support and a quarter of victims had neither. This suggests that case workers needed to implement a great deal of support for victims. Organizations engaging in elder abuse intervention therefore need to be aware of and strongly align themselves with other institutional supports to both fulfil victims' needs related to abuse and their health needs since these can be risk factors for continued abuse (Dong, 2015; Lachs & Pillemer, 2015). EARS found it beneficial to work in groups with social workers, police officers, nurses and mental health nurses, where only some team members would attend home visits so as not to overwhelm victims.

Although approximately half of victims were dependent on others, most were legally independent. Victims were most often dependent on the perpetrator. This presents a considerable problem as these needs will need to be fulfilled by another person. Failure to adequately replace the perpetrator and meet the victim's needs may lead to victims recanting or refusing to cooperate with intervention. As such, interventions should query to what extent

the victim is dependent on the perpetrator and make it a priority to work with the victim to meet those needs in other ways.

The most common cohabitant for victims was the perpetrator. This raises several key issues. Contacting the victim can be challenging because it may make the perpetrator aware of the report and subsequently upset, which could place the victim at further risk. To increase victim safety, case workers should avoid leaving messages for victims that identify the service. Further, when speaking with the victim, case workers should ask whether the perpetrator is in the home and ideally arrange another time to speak when the victim is alone. It would also be good practice to have a safe word so the victim can discretely indicate distresses, although in an emergency, victims should be encouraged to call emergency services directly.

Victim and perpetrator cohabitation also presents a management barrier because cohabitation is a risk factor for continued abuse (Wolf & Pillemer, 2000). Thus, case management plans will often necessitate that the perpetrator move-out. It was the experience of EARS that this was a last resort for victims, only considered once other strategies had failed and that it was necessary not to push the victim in this regard. Because the results show victim-perpetrator cohabitation to be a common problem, intervention teams could establish a working plan to help case workers secure such moves. Plans could include how to convince the victim and perpetrator that a move is optimal and a list of resources (e.g., low income housing) to facilitate the move.

Living alone did not mean that victims were more isolated. Isolation refers to a limited ability to obtain resources and supports and is a risk factor for elder abuse (Lachs & Pillemer, 2015). It is important that case workers understand that isolation is not synonymous with living alone and can be brought on or enforced by others (e.g., a perpetrator who refuses to

allow visitors into the home). Thus, isolation should be assessed and managed separately to living situation.

Perpetrators were typically male adult-children who perpetrated abuse alone. Perpetrator mental health and substance abuse problems are risk factors for elder abuse (Lachs & Pillemer, 2015), and were relatively common among perpetrators suggesting the need for treatment. Further, the significant relationship between these risk factors suggests dual treatment needs and additional difficulties in resolving the abusive situation as neither problem is quickly or easily remedied. Since most perpetrators were related to the victim, we must consider that victims will want treatment and support options for the perpetrator. Services should consider that in many instances aiding the perpetrator will ultimately assist the victim. Although the victim is always the primary concern, adopting an attitude of understanding and support toward the perpetrator may assist in reducing the abusive behaviour and maintaining victim engagement.

Many perpetrators were unemployed and dependent on the victim. These risk factors for elder abuse (Lachs & Pillemer, 2015) were also significantly associated with one another. This association suggests that perpetrator dependency may be reduced by increasing perpetrator employment. Intervention services may therefore want to develop information packages or relationships with employment agencies. These resources may also support the perpetrator in obtaining the funds necessary to move into their own residence, thereby eliminating another risk factor. Traumatic perpetrator experiences were uncommon and therefore may not be high priority targets for intervention programs. Thus, developing interventions that meet perpetrators' mental health and self-sufficiency needs may be high return targets for intervention programs.

Case management was varied and findings reveal information that should be collected at intake as well as implications for practice. In a third of cases, failed formal and informal intervention attempts had been made prior to the abuse being reported. This suggests that prior failed attempts and the reasons for those failures should be queried to better inform future interventions. Further, those engaging in intervention should recognize that case resolution will likely require multiple attempts, necessitating persistence and patience.

Some reporters were concerned about retaliation for reporting elder abuse or about their name being revealed. This finding raises two notable issues. First, this suggests that intervention programs should advertise and assure reporters that their identities will remain confidential. Second, maintaining confidentiality within the cases examined raised some challenges, including making it difficult to dispute victim or perpetrator denial. There were also cases when victims and perpetrators became fixated on who had reported the abuse and had to be redirected several times. This made it difficult to move forward with intervention and seemed to somewhat erode the relationship that the case worker was trying to form with the victim or perpetrator. Because maintaining confidentiality is necessary and appropriate, interventions programs may wish to formalize their policies around confidentiality so that case workers can cite policy or law that prohibits information sharing.

The total number of days that cases remained open and the number of contact notes reflect considerable variation across cases and a substantial amount of intervention. In many cases, there were barriers to communicating or visiting with the victim and those barriers highlight areas of need for intervention programs. As noted above the most common barrier, the perpetrator, was managed in the present sample through police presence. Programs without this support may need to limit home visits in high risk cases or meet with the victim outside of the home and without the perpetrator's knowledge. Language barriers suggest the need for access to interpreters. This need will only increase with immigration trends, since seniors

may be slow to learn new languages and therefore more at-risk due to isolation and dependency.

This study has limitations and strengths that should be considered when interpreting the results. First, characteristics were reported based on the existence of evidence for their presence within the intake form or case notes. We must consider however, that false negatives may have occurred, resulting in an underestimate of reported characteristics. For example, it is possible that victims failed to disclose certain types of elder abuse (e.g., sexual abuse) or characteristics (e.g., substance abuse) due to embarrassment or out of fear of losing independence or their loved one. Thus, the results should be considered to represent the minimum presence of the characteristics reported. Second, the results provide descriptive characteristics and associations within the sample but, cannot be interpreted as providing direct evidence for the causes or prevention of elder abuse. That said, most of the characteristics reported were included in the intake form because they are empirically related to elder abuse risk. An important area for future research will be the examination of the efficacy of management strategies used in elder abuse cases. Follow-up with victims that queries revictimization and their experience with management could achieve this. A key strength of this study is the representative sampling method used which eliminates sampling bias. A second strength is that EARS has been operating for 28 years, thus there is likely to be an experienced program with stabilised referrals.

Conclusion

Research in the field of elder abuse trails that of other forms of interpersonal violence. Particularly limited is research examining intervention programs. The results provide important information about the nature of elder abuse, as well as victim, perpetrator and case management characteristics. To our knowledge, this study is the first to examine a Canadian

intervention program in this way. Although localized to one city, the representative sampling method mitigates against bias and the lengthy tenure of the program provides valuable insight into an elder abuse intervention program that has developed and shown its value over time.

The results reveal important characteristics that may help to improve elder abuse intervention by improving key aspects of programs such as staff safety, the identification and reporting of elder abuse, and the support of victims and perpetrators. Further research examining elder abuse intervention should be prioritized, active sharing of information about established intervention programs can hasten help for victims by increasing evidenced based practice.

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Table 1.

Prevalence of Abuse Type and Characteristics

Abuse type	Characteristics of abuse	<i>n</i>	%
Emotional		128	78%
	Threats and intimidation	75	46%
Financial		107	65%
Physical		55	34%
	Required medical treatment	8	5%
	Life threatening	8	5%
	Use of weapon	7	4%
Neglect		43	26%
	Withholding food or money	25	15%
	Medication not as prescribed	18	11%
	Inappropriate clothing or shelter	14	9%
	Lack of medical appointments	11	7%
Sexual abuse		2	1%
Polyvictimization		121	74%
	One form of abuse	39	24%
	Two forms of abuse	76	46%
	Three forms of abuse	40	24%
	Four forms of abuse	9	6%

Note. *N*=164