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Elder abuse detection and intervention: Challenges for professionals and strategies for engagement from a Canadian specialist service

Silvia Fraga Dominguez, MSc, PhD student¹,

Jennifer Valiquette, RN, BScN, SANE(A), Clinical Nursing Manager²,

Jennifer E. Storey, PhD, Lecturer in Forensic Psychology³,

Emily Glorney, PhD, Senior Lecturer in Forensic Psychology¹

¹Royal Holloway, University of London, UK

²Renfrew Victoria Hospital, ON, Canada

³University of Kent, UK

Author Note

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Correspondence concerning this article should be addressed to Jennifer E. Storey, School of Psychology, University of Kent, Canterbury CT2 7NP. Telephone number: 01227 823138. E-mail: J.storey@kent.ac.uk

Abstract

Elder abuse (EA) is of increasing relevance in the context of an aging society and this has implications for detection and intervention for several types of health care providers, including forensic nurses. Knowledge related to EA is important as victims are likely to interact with providers, either due to existing health problems or the consequences of abuse. This paper provides a brief overview of EA, followed by an outline of current detection and intervention efforts used by health care providers in community and hospital settings. In addition, knowledge about help-seeking and barriers to disclosure are discussed to inform health care provider interactions with older adults where EA is suspected or disclosed. To illustrate challenges faced by health care providers in this area, two cases of EA involving case management by a forensic nurse in a specialist service in Canada are presented.

Key words: older adult mistreatment, older adult neglect, disclosure, barriers, engagement

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Elder Abuse Detection and Intervention: Challenges for Professionals and Strategies for Engagement from a Canadian Specialist Service

Elder abuse, also known as older adult abuse or mistreatment, is of increasing relevance in the context of an aging society and constitutes a prevalent type of interpersonal violence, estimated to affect more than 140 million older adults annually worldwide (United Nations, 2017; Yon, Mikton, Gassoumis, & Wilber, 2017). Elder abuse (EA) is often defined as “a single or repeated act or lack of appropriate action, which occurs within a relationship of trust, and which causes harm or distress to an older person” (World Health Organization, 2018, para. 2). There is no universally agreed definition of EA (Bows, 2018). However, there is general agreement regarding the five main types of abuse: financial abuse or exploitation; physical abuse; psychological or emotional abuse; neglect; and sexual abuse (Lachs & Pillemer, 2015).

Professional Detection and Intervention

Despite the importance of EA prevention, initiatives worldwide have generally focused on professional detection of existing abuse, as well as intervention (Rosen et al., 2019). Health care providers, including forensic nurses, that encounter EA cases may be legally required to report suspected or identified cases (Lachs & Pillemer, 2015). The actions health care providers should take when they identify EA will vary depending on the laws and regulations of the country and jurisdiction where they work (Donnelly, 2019). Encounters with EA victims can occur in both hospital settings and in the community. In hospital settings, victims could be admitted due to existing physical or mental health problems, but also as a result of the abuse (e.g., injuries, malnutrition) (Yunus, Hairi, & Choo, 2017). In community settings, victims may be receiving health care services on a regular basis. Given that some EA victims are isolated, accessing health services in the community may be their

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only chance to disclose abuse concerns, thus stressing the importance of health care providers as detectors of abuse and disclosure recipients in these settings (Lachs & Pillemer, 2015). The interaction between health care providers and victims may differ depending on the setting, potentially creating specific challenges for detection and barriers to engagement, which will be addressed within this manuscript.

Intervention efforts vary widely by country and many countries lack dedicated EA services (Butchard & Mikton, 2014). Victims and perpetrators of EA may receive services from adult protection/safeguarding organizations (Crome et al., 2014). EA cases may also be addressed within the criminal justice system, but this is less frequent due to under-reporting and victims' low receptivity to criminal justice involvement (Jackson & Hafemeister, 2013). Despite cross-country differences, intervention has generally focused on victims. Most services targeting perpetrators are tailored only to caregivers, which ignores a large proportion of perpetrators (Labrum & Solomon, 2018; Rosen et al., 2019).

Victim Disclosure and Help-Seeking Behaviors

To date, the research literature has focused on EA detection by health care providers. While it is essential to have knowledge about possible indicators of EA to enhance detection, relatively little has been written about how health care providers can facilitate disclosure if they suspect abuse, or how to engage victims in intervention efforts (Fraga Dominguez, Storey, & Glorney, 2019). However, victims' rejection of interventions is a critical challenge in this field and research has shown that supportive formal networks, including health care providers, facilitate victim disclosure and engagement (Burnes, Lachs, Burnette, & Pillemer, 2017; Jackson & Hafemeister, 2015).

Health care providers may interact with older adults where they suspect EA but may require a disclosure and consent in order to provide comprehensive intervention to address

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the consequences of abuse. When a disclosure does occur, providers are in a privileged position to secure engagement and positively impact victims' attitudes towards help. In fact, listening to the victim's disclosure may also help other health care providers understand the victim's wishes and guide further intervention. Talking about what happened may have a positive impact on the victim's wellbeing (Storey & Perka, 2018; Truong, Burnes, Alaggia, Elman, & Rosen, 2019). The role of health care providers remains essential even after abuse has been reported by victims or others and intervention has taken place. For example, forensic nurses may support engagement with a victim who feels ambivalent about continuing to accept help (Vrantsidis, Dow, Joosten, Walmsley, & Blakey, 2016).

Victims of EA are a diverse group. Mental and physical health, as well as factors related to the abuse or perpetrator, such as culture, social support, and formal support, may impact victims' ability or willingness to disclose the abuse (Fraga Dominguez et al., 2019), all of which impact the necessary health care response. Considering some of these factors, EA victims can be classified into one of four presentation types: victims with mental capacity who *do* or *do not* disclose abuse, and victims without mental capacity who *do* or *do not* disclose abuse. The specific presentation depends on whether the victim has the capacity to understand and appreciate decisions related to their health, personal care or finances and whether they can or want to make a disclosure of abuse. The aim of this paper is to discuss existing research findings relevant to each of the four EA presentation types, and identify the unique challenges that they present and how forensic nurses and other providers should respond in these different situations. Following this, two of the four presentation types will be demonstrated in two case studies.

Victims with mental capacity who disclose. In addition to being aware of mandatory reporting laws applicable to each professional and jurisdiction, there are other considerations when a victim makes a disclosure (Donnelly, 2019; Lachs & Pillemer, 2015). It is important

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that disclosures are responded to supportively. EA victims, like all victims, are likely to be sensitive to the reactions of others (Sylaska & Edwards, 2014). Certain reactions (e.g., not believing the victim) may negatively impact future help-seeking behavior by making the victim feel hopeless (Truong et al., 2019). A complete disclosure of abuse may also occur over several conversations and the nature of a health care provider's reaction could impact whether victims choose to fully report their experience (Truong et al., 2019). Following disclosure, there is still a need to encourage engagement to facilitate intervention and ensure victim safety. This can be accomplished by respecting victims' wishes and autonomy when planning and implementing interventions (MacKay, 2017).

Victims with mental capacity who do not disclose. There are several reasons why EA victims with the mental capacity to disclose choose not to do so (Fraga Dominguez et al., 2019). For example, a fear of consequences for themselves or the perpetrator, feelings of shame or embarrassment, and barriers related to a lack of effective access to or support from formal services or their informal network (Fraga Dominguez et al., 2019). Other factors such as cultural norms and societal expectations may also influence help-seeking behaviors (Dong, 2012; Fraga Dominguez et al., 2019). The likelihood of engaging in help-seeking can vary based on the relationship between the victim and the perpetrator and the type(s) of abuse experienced (Jackson & Hafemeister, 2015). For example, abuse perpetrated by family members or other close -rather than superficial- relationships may be more difficult to report (Jackson & Hafemeister, 2015; Vrantsidis et al., 2016). In addition, psychological abuse and neglect may be harder to report compared to financial abuse because the latter is perceived as more common and less shameful to discuss (Fraga Dominguez et al., 2019). In these cases, providers can identify abuse by utilizing indicator-based screening tools during each future encounter with the suspected victim, and facilitate disclosure by providing privacy, support, and information about EA. The health care provider will need to consider mandatory

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reporting laws that require only reasonable suspicion of abuse to report (Donnelly, 2019; Lachs & Pillemer, 2015).

Victims without mental capacity who disclose. Specific challenges may arise for health care providers when an older adult suffers from cognitive impairments, such as those associated with dementia or other degenerative brain conditions. Such impairments are not uncommon among victims of EA; in fact, cognitive impairments place older adults at increased risk of abuse (Storey, 2020). Unfortunately, when a victim suffering from cognitive impairments makes a disclosure, health care providers may be unsure of its veracity, and perpetrators may use the victim's cognitive limitations to cast doubt on the victim's credibility (Bows, 2018; Walsh, Olson, Ploeg, Lohfeld, & MacMillan, 2010). For this reason, it is important that these disclosures are fully investigated. Forensic nurses can play a key role in the assessment of EA victims without mental capacity who make disclosures, by identifying indicators of abuse and documenting findings including forensic photography of injuries. Forensic nurses may also be required to report EA as governed by relevant legislation, professional standards, and organizational policies.

Victims without mental capacity who do not disclose. In cases where victims suffer from cognitive impairments and do not disclose abuse, health care providers must rely on their ability to detect abuse. There is a large volume of research identifying the signs of EA from a health care perspective (Lachs & Pillemer, 2015). For example, researchers such as Burgess and Phillips (2006) have highlighted the importance of behavioral cues of distress displayed by older adults with dementia who have experienced sexual abuse. Many of those signs have been consolidated into tools that use different methods to identify cases of suspected EA (Gallione et al., 2017; Spencer, 2009). Once indicators of abuse have been identified through the use of such tools, a multidisciplinary approach to intervention and prevention of future harm which systematically considers case specific risk factors (Storey,

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2020) will be most effective in managing the case and may include mandatory reporting based on relevant legislation.

Case Examples

There is a lack of research about what works for health care providers, like forensic nurses, when attempting to engage or facilitate EA disclosures from victims. To assist providers, two examples of good practice from an older adult protection unit in Canada will be presented. Additional points to consider when working with rural communities will also be included. A summary of the research and case information can be found in Table 1.

Older Adult Protection Services

The Renfrew Victoria Hospital Regional Assault Care Program is one of 36 government funded Sexual Assault/Domestic Violence Treatment Centres in Ontario, Canada. Staffed by forensic nurses, its mandates include the care of sexual assault, domestic violence, and child maltreatment cases. In 2010, this rural-based service implemented an EA program. Forensic nurses are trained users of the Elder Abuse Risk Level Index (EARLI) (Storey, 2020), and participate in EA trainings offered by the International Association of Forensic Nurses, the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, the Registered Nurses' Association of Ontario, and Elder Abuse Prevention Ontario. The forensic nurses provide case management for older adults at high risk for maltreatment or who are experiencing abuse. Referrals come from the community as well as emergency departments (EDs) or hospital units, and funding also covers costs for short-term crisis respite. Interventions are patient centered with the goal of providing care to prevent harm and increase safety. To facilitate engagement by victims, caregivers and abusers, the program was named the Older Adult Protection Services (OAPS). In Ontario, there is no mandatory reporting for community-dwelling EA victims. The following two case examples highlight unique challenges for care providers associated with two of the four presentation types. To

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preserve anonymity, the cases presented are not actual cases but an amalgamation of different cases representing typical presentations to the service.

Victim with Mental Capacity Who Discloses

A 75-year-old woman, Mary, presented with her son, John, to the ED by ambulance with a fractured hip. Her injuries were consistent with the history provided and the reported accidental fall. However, later on during the course of treatment, Mary would disclose that the fall was a result of a physical assault by John. Mary faced multiple barriers to spontaneous disclosure. Generally there are challenges for detection and screening in ED environments, including brief encounters with staff that limit rapport and trust building opportunities. In this case, the level of pain, lack of privacy, and presence of the abuser during history taking and assessments likely contributed to Mary initially reporting the fall as accidental.

Mary was admitted for surgery and then to the rehab department where she formed a trusting rapport with the social worker (SW) responsible for discharge planning. During her admission, the SW witnessed an aggressive verbal interaction between Mary and John. When the SW directly expressed her concerns to Mary, she admitted to a history of emotional abuse and communicated that John suffered from schizophrenia. The SW had previously established a good working relationship with a particular OAPS forensic nurse, and this relationship supported how the SW was able to respond to Mary in that moment. The SW was able to vouch for the expertise and trustworthiness of the forensic nurse, and prior positive outcomes for her clients. The SW was able to leverage trust such that Mary consented to a referral to OAPS. Within a rural community, the development of relationships between the forensic nurse and referral service providers is essential to successful access. The

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SW facilitated the first meeting between Mary and the forensic nurse and left when Mary indicated she was comfortable.

The forensic nurse met with Mary several times during the course of the disclosure of the physical and emotional abuse. Mary eventually disclosed that John had developed paranoid ideas that she had been withholding his mail which escalated to an incident involving being slapped across the face and pushed, leading to her fall. Through the process of engaging with Mary, barriers to disclosure were identified and addressed, beginning with confidentiality. Meetings occurred in locations that John could not access, and unit staff were prompted on how to manage John's enquiries if he presented to the unit. Confidentiality was discussed with emphasis on the fact that no disclosure of information could be made without consent. Confidentiality concerns can be amplified in a rural setting given the interconnectedness of residents in small communities (Warren & Blundell, 2019). Through direct exploration, Mary identified that her niece worked at the hospital registration and she feared that she would have access to her case file. A thorough review of privacy policies and processes reassured Mary of confidentiality.

Other identified barriers to Mary's full disclosure included shame, fear of consequences for John, and hopelessness. Direct exploration and validation of feelings was central to understanding Mary's perspective. Her shame was lessened by reducing the isolation she felt through helping her to recognize how common EA is, especially for women, and that she was not alone. A key strategy for gaining Mary's engagement and trust was a non-judgmental approach to her experience of the situation and how this impacted her decisions for management. Focusing on Mary's feelings of fear and the impact of John's behaviours on her wellbeing was more effective than labelling her son an abuser. Expressions of disgust or anger towards the abuser when a close familial relationship exists will often silence the victim reinforcing feelings of shame (Fraga Dominguez et al., 2019; Ramsey-

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Klawnsnik & Miller, 2017). Mary was adamant that she would never agree to police intervention because of John's illness and her role as his caregiver. Helping her to understand that her choices would be respected was instrumental in gaining her trust. The forensic nurse facilitated her access to services and reconnection with supportive family members, enabling her feelings of hope to develop and increasing her receptivity to intervention.

Prior to discussing options for intervention, the forensic nurse utilized the Stages of Change Model adapted from Prochaska and DiClemente's theory (Prochaska & DiClemente, 1986). Mary was identified to be at the Preparation Stage, accepting of the fact that she needed to make changes to enhance her safety but needing assistance to overcome obstacles, connect with supports, and build confidence. She was motivated by her fear of further injuries and negative consequences for John related to future violent behaviour, knowing she may not always be able to protect him from legal consequences. Post-assault, her level of functioning declined substantially: she had to use a walker, could not manage shopping, housework, or climbing stairs, and required assistance with bathing. The forensic nurse assisted Mary in identifying areas of need, risks related to John's behaviours, and his inability to cope with services entering the home due to his paranoid ideation. Information was provided on options that could assist in preventing future harm by decreasing Mary's dependence on John; the implications of each option were reviewed. Mary's engagement was sustained by also addressing John's needs, related to decreasing his emotional and financial dependence on his mother and addressing underlying motivations for aggression.

Over a six-month period, an intervention plan was implemented. Services engaged with John to develop rapport and trust, mediate conversations with his mother, facilitate connection with supportive family, and engage community mental health services and his family physician to address escalation in his symptoms. Mary chose to move to a retirement home but selected one she could afford while continuing to fund expenses for John. With

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Mary's consent, a summary of the abuse history was provided to her doctor, retirement home administrators, and community care coordinator as part of her safety plan. Future planning involved assigning a trusted family member as Power of Attorney (POA) for Personal Care and Property in the event that she lost mental capacity to make legal decisions in the future. Monitoring coordinated by the forensic nurse enabled evaluation of outcomes and ongoing risk management. Mary was unwilling to end contact with John but due to ongoing verbal abuse she conceded to supervised visits involving family or his mental health workers. Outcomes included no further incidents of physical aggression, growth of her informal support system through reconnecting with family/friends, and significant improvements in her quality of life.

Victim Without Mental Capacity Who Discloses

Community referral was made by a health care provider for a 71-year-old woman, Rose, with moderate dementia. Rose lived with her spouse, Bill, and was functionally dependent for all activities of daily living (ADL) and Instrumental ADL. She ambulated without use of mobility aids and had no other comorbidities. She had an activated Continuing POA for Property assigned to Bill, who also acted as her substitute decision maker for health. No other family members were actively involved in her care. Rose attended a day program three days per week and had a personal support worker for respite, who took her on outings twice per week. There were no personal care services in the home as Bill reported she was resistant to care. The provider expressed concerns about caregiver burnout, with Bill presenting as anxious and disorganized, and there was an observed incident of Bill yelling at Rose. Medical assessments were initiated in response to Bill's reports of Rose's frequent falls with injuries, resistance to care, and long term, self-injurious behaviours. Unable to identify any medical reasons for history of falls, the provider recommended a home environment evaluation for safety hazards. Risk factors identified included Rose's isolation, dependency

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on Bill, inability to access help independently, and Bill's poor coping. The goal of referral to OAPS was preventative interventions to improve Rose's wellbeing and Bill's coping through caregiver support and education.

One of the challenges faced by the OAPS in supporting Rose was Bill's control over her access to health care and support systems. Bill refused home visits by involved services, but consented to an OAPS referral. Building rapport and trust with Bill involved using a non-judgemental approach, validation of his feelings, listening, and providing encouragement. The forensic nurse had difficulty engaging Bill (e.g., unavailable due to stress), leading to delays between contacts. After six weeks of telephone support, he verbally consented to the forensic nurse meeting with Rose and staff at the Day Program. He followed through with instructions to notify the administrator of his consent for the visit and sharing of information.

Prior to the first appointment, the Day Program administrator contacted OAPS to state Rose had made a disclosure of physical abuse. She disclosed "Bill hit my head on the wall, he's mad at me". Bill reported that Rose fell and when asked if he had her assessed he stated he brought her to the ED. No visible injury to Rose's head was noted. The forensic nurse met with Rose at the Day Program. Barriers to disclosure included an inability to provide a coherent history, significant short-term memory impairments and word finding issues.

In this example, challenges identified included vague disclosures, no witnesses, a history provided by the suspected abuser, lack of communication or consent to share information between care providers, and staff lack of awareness of indicators of abuse and risk factors. To address this, collateral history was obtained from various Day Program staff and a timeline of events, injuries, and disclosures made by Bill was created. There was no history of falls over a three-year period while attending the Day Program. Rose followed direction and accepted assistance readily. Rose frequently presented to the Day Program in

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soiled clothing with poor hygiene and grooming. On two occasions Rose presented with untreated infections, and staff facilitated medical assessment when Bill did not act on advice that she needed treatment. There were documented incidents of verbal abuse and rough handling by Bill, including screaming and pulling Rose to a standing position by her head and arms. There was a three-year history of Rose presenting with multiple scratches reported by Bill as self-inflicted, but this behaviour was not observed by staff. Rose frequently presented with bruising to her arms, hands, face, and ears. In a recent incident, bruising to her eye was covered in make-up and there was no disclosure by Bill. There were also multiple incidents documented where the cause of injury provided by Bill was questionable.

In response to the investigation of Rose's disclosure of abuse, Rose was taken to the ED for assessment, documentation of injuries, and forensic photography; Bill provided consent. Examination revealed bruising to palms of hands, swelling to hands with multiple deep cuts and scratches, and there was grimacing observed when Rose used her hands. Rose's ears were covered in superficial scratches, and there was bruising to her back, chest, and arms. The forensic nurse met individually with Bill and used a direct but supportive, non-judgemental approach to engage disclosure related to Rose's injuries. Bill disclosed rough handling of Rose in response to her "resistance to care", and attributed injuries to her hands to unsafe behaviours such as using sharp knives unsupervised, or sustaining falls. Bill was highly anxious and admitted to caregiver strain but denied any substance abuse issues. Consents were signed to share information between services and health care providers. Bill was agreeable to a respite stay for Rose. The aim of the respite was to ensure Rose's safety, enable further observation and assessment, time for connection with collateral informal sources, supervised observations with Bill, and care planning meetings. The respite stay was funded by the OAPS.

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During respite stay, Rose was cooperative, with no need for physical interventions to ensure safety. No observed self-injurious behaviour or falls were noted, and all swelling, bruising, and scratches healed. Supervised visitation indicated that Rose became anxious and fearful with Bill. Further collateral information was sought from the community personal support worker, who had observed Bill with slurred speech, unsteady gait, anger, and had seen many empty alcohol bottles outside the house. Furthermore, the forensic nurse confirmed that Rose had not been seen by the ED or her primary care provider after reported falls, even though Bill had reportedly pursued medical assessment at these times. Legal information indicated a POA for Personal Care assigned to Rose's sister, and connection was made to obtain history. The sister reported that Bill isolated Rose from her family when she developed symptoms of dementia, and she could no longer self-initiate contact. The sister was interested in acting as Rose's decision maker for personal care.

When EA victims lack the capacity to direct their own care, the OAPS looks to advanced care planning documents that may outline their prior known wishes. The OAPS works with substitute decision makers guided by what is in their best interests and likely to improve wellbeing and quality of life. In Rose's case, police referral was made related to concerns of imminent risk of harm, but no charges were initiated due to the challenges of providing clear evidence in support of prosecution. The forensic nurse facilitated reconnection between Rose and her family to rebuild her network of support. A care planning meeting was held with involved health care providers, Bill, and Rose's sister. During the meeting, concerns were expressed regarding Bill's ability to safely care for Rose at home, and the authority of her sister as POA for personal care. A recommendation was made for permanent nursing home placement. Bill was offered resources to support his alcohol use and coping. Contact between Rose and Bill was ended due to consistent evidence of her distress in his company. A safety plan was implemented at the nursing home to ensure Rose's safety.

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The documentation related to history of abuse was provided to health care providers involved in Rose's care as part of her ongoing safety plan.

Discussion and Conclusion

This paper aimed to provide an overview of EA, research on EA victims' help-seeking behavior, and guidance for detection and intervention efforts by health care providers. This guidance is based on research literature and the practical experience of a forensic nurse. Four potential presentation types were identified based on the victim's mental capacity and disclosure of EA. Each presentation has its unique challenges, which have been described in the literature review and case studies.

The first case study, involving disclosure by an older adult with mental capacity, illustrates the importance of considering the victim's needs and wishes, as well as offering information to support informed choices, consistent with a victim-centered approach (Spangler & Brandl, 2007). Case two highlighted the unique challenges for health care providers when an older adult lacks the ability to express what is happening to them (Burgess & Phillips, 2006). In such cases, the need to obtain corroborating evidence and collaborate with other professionals is essential; forensic nurses can play a pivotal role here in the assessment and documentation of indicators of abuse. Both cases have also highlighted specific challenges associated to rural communities, stressing the importance of local context (e.g., degree of interconnectedness or geographical isolation) when considering the older adult's ability to disclose abuse and when implementing interventions (Warren & Blundell, 2019).

This paper was able to identify relevant research to support many of the recommendations provided and utilized practitioner experience to expand on those points. However, there are still many gaps in the empirical literature around best practices in EA case

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management and victims' experiences of elder abuse and help-seeking, especially when victims suffer from cognitive impairments. To facilitate disclosure and successful case management, research needs to focus on how EA victims experience intervention by health care providers and explore the approaches that they find helpful and unhelpful. Much of the research to date has focused on the providers' perspective. By integrating victims' voices into studies, intervention will be able to best meet victims' wishes.

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Table 1

Considerations for Providers in Working with Potential Elder Abuse (EA) Victim Presentations

Victim capacity for decisions related to health, personal care, or finances	Disclosure	
	Yes	No
Yes	<p>Victim with mental capacity who discloses:**</p> <ul style="list-style-type: none"> • Respond to disclosure in a supportive manner • Ensure privacy, inform of limits to confidentiality early • Build trust and rapport • Identify and address barriers to engagement/intervention • Engage in victim-directed interventions and respect victims' wishes • With consent, involve multidisciplinary team in plan of care • Possess knowledge of risk factors (i.e. victim vulnerabilities, perpetrator risk factors) for case management • Consider mandatory reporting requirements 	<p>Victim with mental capacity who does not disclose</p> <ul style="list-style-type: none"> • Identify indicators of abuse • Possess knowledge of risk factors • Possess knowledge about common barriers and sensitive situations (i.e., close family perpetrators) • Identify and address barriers to engagement/intervention • Speak in private, develop a relationship of trust • Identify unmet needs and opportunities to engage client in services • Provide information on EA, safety planning and resources available • Educate service providers involved in care on EA and resources • Consider mandatory reporting requirements
No	<p>Victim without mental capacity who discloses:**</p> <ul style="list-style-type: none"> • Document injuries, condition, disclosures, explanations for injuries, history provided • Possess knowledge of risk factors • Provide support to suspected abuser to gain trust and facilitate disclosures/cooperation • Get consent to share information with other care providers • Validate history with collateral sources • Provide hospital or respite stay to ensure safety and time for corroboration • Consider mandatory reporting requirements 	<p>Victim without mental capacity who does not disclose:</p> <ul style="list-style-type: none"> • Possess knowledge of EA indicators to facilitate detection • Document indicators of abuse • Understand relevance of behavioral indicators where verbal disclosure is not possible • Possess knowledge of risk factors • Validate history with collateral sources • Multidisciplinary collaboration to address identified EA concerns • Consider mandatory reporting requirements

**These two presentation types are addressed in case examples