15446l

# Determining Effective Interventions in a Community-Based Elder Abuse System

## Final Report

U.S. Department of Health & Human Services
Administration on Aging
Grant # 90AM0447/02

May 29, 1993

NCJRS

MAY 24 1995

Kathleen M. Quinn
Project Director

ACQUISITIONS

Melanie Hwalek, Ph.D.
Research Director

Carolyn Stahl Goodrich
Project Consultant

154461

**U.S. Department of Justice**
**National Institute of Justice**

# Project Abstract

This project aimed to understand interventions and outcomes of reports of elder abuse, neglect and exploitation. The research focused on answering ten questions related to understanding successful interventions: (1) Are certain types of elder abuse, neglect or exploitation more likely to have successful interventions than others? (2) Is the immediacy or severity of elder abuse, neglect or exploitation related to future success? (3) Are there characteristics of the abuser and/or family that predict the likelihood of success in intervening? (4) Are initial risk factors of the victim related to future success in intervening? (5) What risk factors are likely to change in successful interventions? (6) Is there a pattern of services related to successful and unsuccessful interventions, or is success more related to characteristics of the victim or abuser? (7) Can successful case closure be predicted by the status of the case only 90 days after intake? (8) Does the amount of case work time spent on a case predict successful interventions? (9) Are cases of self-reported elder abuse, neglect or exploitation more often resolved than cases reported by someone else? (10) Is the length of time a case stays open within an agency related to a reduction in risk? To answer these questions, data from the Illinois Department on Aging's management information system were analyzed. Additional data collected directly from the elder abuse workers' files were also analyzed. Three major themes emerged from the data analyses:

(1) Intervention in cases of elder abuse is complex and time consuming. On the average, the elder abuse worker made 17 contacts with the victim and/or others involved in the situation between the time of the report and case closure. In 50% of the cases, investigation and intervention took more than 14 hours to implement.

(2) Although the elder abuse program was in its infancy during the time of the study, 52% of the victims at substantial risk at intake saw a reduction in risk by case closure. Those victims likely to improve over time appear to be cases of neglect involving a victim who is disoriented or who has Alzheimer's disease. Cases that remain at high risk for future abuse tend to be those involving a chronic history of abuse, and an abuser who is financially and/or chemically dependent on the victim. Many reasons can be posed to explain these results. Neglect cases may involve more cooperative abusers whose major motive for neglect is stress or lack of resources. Abuse and exploitation cases, on the other hand, may be more likely to involve families which have been dysfunctional for a long time or involve intentional maltreatment.

(3) The role of substance abuse in elder abuse must be highlighted. Substance abuse of the abuser is a major predictor of high risk situations at intake. Chemical dependency of the abuser predicts continued high risk for victims. Substance abuse of the abuser, among other risk factors, it also the least likely to change over time. These findings indicate that unless interventions take serious aim at resolving problems of abusers, victims' situations are not likely to improve. This means that case workers should know about substance abuse in the family. They must look beyond the aging network for services likely to help the abuser. Case workers must know how to identify chemical dependency and what to do after the problem emerges.

This study is the first known outcome-based research on a statewide elder abuse intervention program. These results, however, may not reflect the population of elder abuse victims in Illinois because the study involved cases in the first two years of funded operations of the statewide program. At the time of analysis, 85% of the cases had not yet been closed. Before program or policy changes are made from these results, replication of this analysis using later years of data, as well as replication using data from other states, is recommended.

A training program was developed, based on the findings from this study. The program focuses on working with abusers, particularly those with chemical dependency. The training materials can be obtained from the Illinois Department on Aging.

# DETERMINING EFFECTIVE INTERVENTIONS IN A COMMUNITY-BASED ELDER ABUSE SYSTEM

# EXECUTIVE SUMMARY

**May 29, 1993**

## Executive Summary

The goal of this project was to better understand interventions that are successful in reducing the risk of future abuse, neglect or exploitation among elder abuse victims. Specifically, this research was designed to answer the following questions:

1. Are certain types of elder abuse, neglect or exploitation more likely to have successful interventions than others?

2. Is the immediacy or severity of elder abuse, neglect or exploitation related to future success?

3. Are there characteristics of the abuser and/or family that predict the likelihood of success in intervening?

4. Are initial risk factors of the victim related to future success in intervening?

5. What risk factors are likely to change in successful interventions?

6. Is there a pattern of services related to successful and unsuccessful interventions, or is success more related to characteristics of the victim or abuser?

7. Can successful case closure be predicted by the status of the case only 90 days after intake?

8. Does the amount of case work time spent on a case predict successful interventions?

9. Are cases of self-reported elder abuse, neglect or exploitation more often resolved than cases reported by someone else?

10. Is the length of time a case stays open within an agency related to a reduction in risk?

The objectives of this project were to:

(1) Enhance the Illinois Department on Aging's existing elder abuse data base and analytical system to be able to provide detailed longitudinal data analyses on client services and status.

(2) Abstract detailed information from a minimum 400 closed case files within the Illinois elder abuse program to obtain information about risk factors, intensity of case work and services provided during every three-month interval from intake to case closure.

(3)    Use relevant bivariate, multi-variate and longitudinal statistical techniques to determine demographic, environmental, functional, psycho-social and service-related variables that discriminate among "reduced," "increased," and "no change" in risk for victims in the Illinois elder abuse program.

(4)    Use the results from this research to develop a training module to further enhance the training provided to the state's elder abuse case workers and other professionals so that the quality of assessment and intervention services to older victims of abuse, neglect and exploitation can be improved.

There were two sources of data for this study:

(1)    Illinois Department on Aging's Abuse, Neglect and Exploitation Tracking System (ANETS), and

(2)    Data abstracted from 537 client files from 39 different elder abuse agencies. These cases represent 97% of the 552 cases which were either closed or had been opened 15 months or more at the time of data collection.

Subjects

Analysis of the total population of reported cases shows the following characteristics of victims:

o    The most frequently reported abuse was financial exploitation (49%), followed by emotional abuse (36%) and neglect (33%). Physical abuse was reported in 22% of the cases.

o    Victims were most often reported to the elder abuse program by social workers.

o    Victims' ages ranged from 60 to 99 years, with an average age of 77 years.

o    Almost three-quarters (72%) of the victims were Caucasian.

o    About three-quarters (73%) of the victims were female.

o    About one-half (52%) of the victims were widowed.

o    About three-quarters (74%) of the victims lived in their own homes,

o    Only about one-quarter (27%) of the victims lived alone.

o    The predominant barrier to self-sufficiency of victims was functional impairment, present in approximately one-third of the cases. Substance abuse was a barrier for 3% of the victims.

Analysis of data from the total population of reported cases showed the following characteristics of abusers:

- ○ · Most frequently (39%), the abuser was the child of the victim.

- ○ Abusers were almost equally split between males (54%) and females (46%).

- ○ The average age of abusers was 47 years.

- ○ As with the victims, the abusers were most likely to be Caucasian (68%).

- ○ Almost all (93%) of the abusers had no formal legal relationship to the victims at the time of the report.

- ○ Sixty percent of the abusers lived with their victims.

- ○ Fifty-three percent of the abusers were also caregivers to the victims.

- ○ Chemical dependency was the most frequently reported barrier to self-sufficiency of abusers, present in 13% of the cases.

## Data Analysis

The data analysis plan for this study involved both descriptive and inductive statistics. Initially, the ANETS data were analyzed to describe the population of alleged victims, abusers, services and outcomes. Then, data were analyzed to answer the aforementioned research questions. Bivariate and multivariate statistics were used, as appropriate, depending upon the research question being addressed.

Successful outcomes were defined in two ways:

- ○ Decreasing risk scores over time. Successful cases were those in which the elder abuse worker assessed that risk for future abuse, neglect or exploitation had been reduced from intake to case closure.

- ○ Reason for case closure being "no longer at risk." This second measure of success was included in some analyses to validate the results obtained using the first measure of success.

## Findings: Outcomes of Elder Abuse Interventions

Excluding those cases which were at low risk at the time of the report,[1] 53% of the cases had a reduction in risk by the time of case closure. Only 1% of the cases "got worse." The most common reasons for case closure were "no more risk" (25% of closed cases) and that the victim entered long term care (29% of closed cases).

## Findings: Research Questions

1.    **Are certain types of abuse more likely to have successful interventions than others?**

The results indicate that the type of abuse, neglect and/or exploitation substantiated is not related to whether the victim's risk level improves by the time of case closure. Neither the change in risk score from intake to case closure nor whether the case was closed because of "no more risk" was significantly related to the type of abuse, neglect and/or exploitation substantiated. However, the results also suggest that neglect cases may see initial improvement within the first three months more frequently than victims of other types of abuse. Further, neglect victims are significantly more likely to be placed into long term care than victims of physical abuse, emotional abuse or exploitation. Cases of neglect are also more likely to be closed because of the death of the victim. On the other hand, cases of exploitation are more likely to close because the victim moved. Cases of emotional abuse tend to be closed either because the victim moved or for administrative reasons.[2] Except for cases of sexual abuse (which tend to be closed for administrative reasons), there is no pattern in the reason for closure for cases of physical abuse.

2.    **Is the immediacy or severity of ANE related to future success?**

Immediacy or priority of the case at intake is related to change in risk over time. However, part of the relationship may be an artifact of the data. That is, cases that enter the program at low risk cannot lower their risk scores, while cases that enter the system at high risk have greater opportunity for change. While the results are statistically significant, the strength of the relationship between immediacy and risk reduction is not strong.

3.    **Are there characteristics of the abuser and/or family that predict the likelihood of success in intervening?**

Cases in which the abuser was married to the victim, and the abuser was the informal caregiver tended to improve over time. Substance abuse of the abuser is related to the victim remaining at high risk.

---

[1]    These 36% of cases were excluded from this estimate because they were already at the lowest risk score possible and, therefore, had no possibility of having their risk scores reduced.

[2]    Administrative closure results when an open case has had no subsequent reports of abuse, neglect or exploitation within a consecutive 12 month period.

## 4. Are initial risk factors of the victim related to future success in intervening?

An unanticipated finding from these analyses was that a significant amount of information about perpetrators was not obtained during the assessments. This may mean that case workers find it difficult to obtain information about abusers. It may also mean that case workers are uncomfortable dealing with abusers, and therefore learn less about perpetrators than they do about victims. A third explanation is that abusers are more frequently absent or refuse to provide information about themselves. Yet another interpretation is that the client may not have consented to the worker contacting the alleged abuser. More research is needed on the reasons for limited information obtained about perpetrators.

When examining those factors that are significant predictors of risk at two or more points in time, results show that substance abuse of the perpetrator, the abuser's inability to handle stress, financial dependence of the perpetrator and past history of abuse, neglect and/or exploitation consistently predict the victim remaining at high risk.

These results suggest that the cases of elder abuse most difficult to change are those in which there is a history of abuse, neglect and/or exploitation and cases in which the perpetrator demonstrates behavioral problems -- substance abuse, poor coping with stress and financial dependence. Financial dependence of the abuser has been demonstrated to exist in previous studies. This is the first objective documentation, however, of the role of substance abuse in relation to lack of risk reduction in victims' situations over time.

## 5. What risk factors are likely to change in successful interventions?

Quality of care, severity of neglect, abuser access to the victim and adequacy of formal/informal supports are more likely to change in successful interventions than other risk factors. These results correspond to the previous finding that victims of neglect are more likely to see improvement within the initial three months, as quality of care and adequacy of supports are likely to be more of a problem with neglect than with abuse or exploitation.

Successful interventions differ by type of abuse. When risk for physical abuse is reduced, changes tend to occur in the severity of the abuse, the perpetrator's response to stress, and substance abuse of the abuser. Reduction in risk for emotional abuse centers around decreasing the severity of the abuse. Reduced risk for neglect victims involves mostly environmental improvements, enhanced transportation/support systems and improved quality of care. Reduction in risk for exploitation is primarily in the severity of exploitation.

These results relate to the previous finding of placement of neglect victims into long term care as a successful risk reduction strategy. Since cases of neglect reported to the elder abuse program involve only domestic settings and exclude self-neglect,[3] indeed long term care placement may provide a mechanism for improving the environment, support system and quality of care for victims. For other types of abuse and exploitation, it appears that workers

---

[3] Abuse and neglect in institutions is reported to the Department of Public Health and/or the State Long Term Care Ombudsman. Self-neglect is handled by Illinois' statewide case management program.

are successful in decreasing the severity or frequency of the occurrences of abusive or exploitive acts, themselves. The risk assessment measure does not identify specific interventions used to reduce these occurrences.

**6.    Is there a pattern of services related to successful and unsuccessful interventions, or is success more related to characteristics of the victim or abuser?**

Results indicate that services are more predictive of changes in risk than characteristics of the victim or abuser. Specifically, placing a cognitively impaired neglect victim into long term care was a strong predictor of reduction in risk. Victims of physical abuse, emotional abuse or exploitation tend to remain in the community and to remain at higher risk for future abuse.

An unanticipated finding is the importance of providing medical/psychiatric services to the abuser as a means of reducing risk to the victim. This result underscores the importance of providing interventions to abusers if risk to victims is to be reduced.

**7.    Can successful case closure be predicted by the status of the case only 90 days after intake?**

For most victims in this sample, their 3 month risk score _is_ the closure risk score. The most likely reason for this relationship is that most of the cases in this sample were closed within four months. A negative correlation was found between 3 month risk score and change in risk. This indicates that those victims still at high risk after 3 months show little chance of improving by the time the case is closed.

**8.    Does the amount of case work time spent on a case predict successful interventions?**

There is great variation in the amount of intervention provided to cases of elder abuse. In this sample of cases, caseworkers spent between 2 and 95 hours investigating and intervening with victims. On the average, the elder abuse worker made 17 contacts with the victim and/or others involved in the situation before the case was closed. In over one-half of the cases, investigation and intervention took 14 or more hours to complete.

The amount of time spent on a case is related to success in contradictory ways. There appears to be a subset of cases in which interventions are simple with the case closed because the victim is "no longer at risk." Those cases which close because of "no more risk" receive significantly less time and significantly fewer post-substantiation encounters than cases which close for some other reason.

On the other hand, there appears to be a subset of cases in which greater time spent on intervention is less likely to be related to change after three months, but more likely to be related to improvement in risk score at case closure. These may be more difficult cases which enter the program at high risk, and receive many hours of intervention. Perhaps the

longer these difficult cases are open, the more trust the victim will have in the worker and program, and therefore more likely to make changes.

**9.   Are cases of self-reported ANE more often resolved than cases reported by someone else?**

Using the second measure of success -- reason for case closure -- there is a small but significant relationship between the report being self-generated and successful intervention. That is, self-reported cases are more likely to close because of "no more risk." However, self-reported cases are also more likely to enter the program at a low level of risk. Thus, it is concluded that there appears to be no relationship between self-reported abuse and improvement over time.

**10.   Is the length of time a case stays open within an agency related to a reduction in risk?**

Results from a correlational analysis indicate that there is no significant relationship between the number of days a case stays open and either change in risk score or whether a case closes because of "no more risk." These results underscore the great variation in the needs of victims. It appears that some victims can be served in a short amount of time, while for others reducing risk of abuse takes a long time.

Interpretations and Recommendations

This study represents the first known objective investigation of interventions and outcomes for elder abuse victims. Several important findings resulted from this research which led to the preparation of a case worker training curriculum. The results can also be used to make recommendations for future efforts aimed at successful intervention with victims of abuse, neglect or exploitation.

It is significant to note that even in its infancy, the Illinois statewide elder abuse program was successful in reducing the risk level of more than one-half of the cases which were not already at low risk at the time of the report. Of those cases in which the victim was at high risk at intake, the elder abuse worker was able to reduce 44% to low risk, and an additional 13% were reduced to moderate risk.

Cases most difficult to change were those involving chronic and/or severe abuse, substance abuse of the abuser, abuser inability to respond appropriately to stress, and financial dependence of the abuser on the victim. This finding emphasizes the role of abusers' behavioral and emotional problems in maintaining high risk situations for victims. Coupled with the finding that information about the abuser is frequently lacking, the need to focus training and intervention efforts on dealing with abusers is apparent. In fact, the training program developed from this research focuses on case workers' attitudes, knowledge and skills in dealing with abusers, particularly abusers who are chemically dependent.

Another important finding from this research is that placement into long term care is a significant intervention used to reduce risk, especially for neglect victims who are mentally ill or who have Alzheimer's disease. This points to a need to link information between the elder abuse program and the State Long Term Care Ombudsman.

The role of institutions in ameliorating neglect leads to a series of questions that could be addressed in future research. For example, why is long term care placement the intervention most often used for neglect cases? Were other, less restrictive, interventions deemed inappropriate or were they unavailable? By the time neglect cases were reported, was the victims' situations so advanced that long term care placement was the only appropriate solution? Do victims of domestic neglect continue to be victimized by family members after institutionalization? Are nursing homes more vigilant about visitors or potential financial exploitation of these clients?

The role of substance abuse must also be highlighted. Substance abuse of the abuser is a major predictor of high risk situations at the time of the report. Chemical dependency of the abuser predicts continued high risk for victims. Substance abuse of the abuser, among other risk factors, it also the least likely to change over time. These findings indicate that unless interventions take serious aim at resolving problems of abusers, victims' situations are not likely to improve. This means that case workers must know about substance abuse in the family. They must look beyond the aging network for services likely to help the abuser. Case workers must know how to identify chemical dependency and what to do after the problem emerges.

This research documented the level of effort needed to intervene in cases of elder abuse. On the average, 17 encounters are made with an elder abuse case from the time of intake to the time of case closure. In one case, 225 encounters were made by the time the case was closed. This finding highlights the importance of limiting the case loads of elder abuse workers. The results also make understandable the burnout and frustration often voiced by elder abuse workers. Findings from this research suggest that elder abuse cases are highly complex and are likely to require several visits, phone calls and other activities. To be successful, case workers must be allowed the time to intervene appropriately and spend as much time as is needed to reduce the victim's risk of future abuse, neglect or exploitation. To be successful, case workers must also have the skills and resources to attack life-long problems in family dynamics.

One reason for the outcomes from this study is that the Department places a strong emphasis on client self-determination. Many clients may choose not to make changes, or to coerce their families into making changes, which would reduce their risk of abuse but might result in other unwanted changes in their lives such as separation from family members and/or moving. While unfortunately not eliminating the risk of abuse, this emphasis on self-determination preserves victims' independence and control to the maximum extent and prevents the Department from paternalistically forcing changes older persons do not want and would probably not support. This also affects how much influence the program can have with abusers. If the abuser is unwilling to accept services, and the victim will not agree to forcing

the abuser to do so, such as through a court order, the case worker may have limited control over the outcome.

The results from this research were used to develop a training program to assist case workers in learning what interventions to use and what degree of "success" to expect when intervening with cases of elder abuse, neglect and exploitation. The Department's policies require elder abuse case workers to obtain continuing education related to elder abuse. Training materials were developed and pilot tested with two groups of elder abuse workers. Both training programs received very favorable responses from the participants. Training materials, the trainers' manual and training consultants are available to others wishing to replicate the training program in other locations.

The results from this research are biased by the fact that subjects in the study were from the first two years of Illinois' elder abuse program. Some rural areas of the state are not fully represented among the victims. Many long-time, "unofficial" cases were grandfathered into the program once funding became available. Further, early problems identified with the definition of "initial risk score" resulted in some questions as to the validity of this measure.[4] These threats to external validity indicate that these analyses should be repeated on a second data set of cases entering the program in later years, as well as with data from other states.

Replication of these analyses on other data sets can address many questions left unanswered by this research. For example, do some victims remain at high risk because the program does not have sufficient resources to handle problems involving chronic abuse or chemical dependency? Or, because a number of seriously ill, complex and chronic cases were grandfathered into the program once funding became available to serve these clients? Do other states have similar outcomes? Do states with mandatory reporting yield different outcomes? Are outcomes different when state agencies deliver services rather than subcontracted providers? These and many other questions raised by this research should be answered before drawing conclusions about successful interventions. Caution is advised in making program or policy decisions based on these findings until the study is replicated on a second sample of victims to determine the generalizability of the results.

In conclusion, it should be noted that outcome research in aging services is rare. This research represents the first and only known outcome data published on the effects of statewide elder abuse program interventions. Results from this study provided important information to the State of Illinois about ways its statewide elder abuse program can be improved. It is recommended that other states examine their own outcome data to monitor the effectiveness of interventions in community-based elder abuse systems.

---

[4] It was found that many elder abuse workers were recording the risk level at the time of substantiation rather than reflecting the risk level at the time of the report. This was later corrected via follow-up training.

Determining Effective Interventions in a Community-Based Elder Abuse System

U.S. Department of Health & Human Services -- Administration on Aging
(Grant # 90AM0447/02)

## Highlights of Project Outcomes

This study address ten questions related to interventions and outcomes in cases of elder abuse, neglect and exploitation. The major findings from this research were:

o   Even in its infancy, the elder abuse workers were able to reduce the risk for future harm in the majority of cases where substantial risk was present.

o   Intervention in cases of elder abuse is complex and time consuming.

o   Substance abuse of the abuser was a major barrier to improvement of the victim.

A research report and a training manual were produced through this project. The training program focuses on working with abusers, particularly those with chemical dependency. The report and training materials can be obtained from the Illinois Department on Aging.

The products from this study will be valuable to two major audiences. Researchers in aging and adult protective services should be interested in this study because it is the first known outcome-based research on a statewide elder abuse intervention program. State adult protective services administrators and elder abuse case workers should have an interest in the training program as it addresses an area of training not readily available within the aging and/or adult protective services networks.

Determining Effective Interventions in a Community-Based Elder Abuse System

U.S. Department of Health & Human Services -- Administration on Aging
(Grant # 90AM0447/02)

## Dissemination Paper

Results from this research have been shared with a variety of audiences, and will continue to be shared after the termination of grant activities. The following dissemination activities have been completed during the active period of the project:

o    Presentation to the National Association of APS Administrators Conference in San Antonio in November, 1992.

o    Presentation to service providers at the Illinois Elder Rights Conference presentation in August, 1992.

o    Results from this study were used to solicit a grant from the National Institute on Aging on October 1, 1992, to develop a multivariate causal model to predict the substantiation decision and outcomes of interventions. This grant was not approved by the review committee.

o    Presentation to service providers, policy makers and agency representatives at the National Eldercare Dissemination Forum in Washington, D.C. on December 15, 1992.

o    A training program focused on working with abusers was developed. Two pilot training sessions were held, each with 40 elder abuse case workers in Illinois. One session was held in Springfield, Illinois, in January, 1993. The second was in Chicago, in February, 1993.

o    Training was provided to elder abuse workers in Pennsylvania using the training materials developed through this grant.

The following dissemination activities are in the planning stages and are expected to be completed in 1993:

o    Grant application to the Retirement Research Foundation requesting funding to replicate the research results with more recent data.

o    Grant application to the Administration on Aging to replicate the research with more recent data in Illinois as well as with data from four other diverse states.

o    Articles to be submitted to The Gerontologist, and the Journal of Elder Abuse and Neglect.

o    Presentation of findings to the American Evaluation Association meetings in Dallas, Texas in November, 1993.

o    Training will be offered to statewide Adult Protective Service units throughout the U.S. using the training materials developed through this grant.

# Table of Contents

## List of Tables

## List of Figures

## Introduction

The goal of this project was to better understand what interventions are successful in reducing the risk of future abuse, neglect or exploitation among elder abuse victims. Specifically, this research was designed to answer the following questions:

1. Are certain types of elder abuse, neglect or exploitation more likely to have successful interventions than others?

2. Is the immediacy or severity of elder abuse, neglect or exploitation related to future success?

3. Are there characteristics of the abuser and/or family that predict the likelihood of success in intervening?

4. Are initial risk factors of the victim related to future success in intervening?

5. What risk factors are likely to change in successful interventions?

6. Is there a pattern of services related to successful and unsuccessful interventions, or is success more related to characteristics of the victim or abuser?

7. Can successful case closure be predicted by the status of the case only 90 days after intake?

8. Does the amount of case work time spent on a case predict successful interventions?

9. Are cases of self-reported elder abuse, neglect or exploitation more often resolved than cases reported by someone else?

10. Is the length of time a case stays open within an agency related to a reduction in risk?

The objectives of this project were to:

(1)   Enhance the Illinois Department on Aging's existing elder abuse data base and analytical system to be able to provide detailed longitudinal data analyses on client services and status.

(2)   Abstract detailed information from a minimum 400 closed case files within the Illinois elder abuse program to obtain information about risk factors, intensity of case work and services provided during every three-month interval from intake to case closure.

(3)   Use relevant bivariate, multi-variate and longitudinal statistical techniques to determine demographic, environmental, functional, psycho-social and service-related variables that discriminate among "reduced," "increased," and "no change" in risk for victims in the Illinois elder abuse program.

(4)   Use the results from this research to develop a training module to further enhance the training provided to the state's elder abuse case workers and other professionals so that the quality of assessment and intervention services to older victims of abuse, neglect and exploitation can be improved.

## Need for this Research

The professional literature has reported on elder abuse research since the late 1970's and early 1980's.[1] It has now been accepted by the professional community that elder abuse exists in our society[2] and that it can take many forms, including abuse, neglect and financial exploitation.[3] It is now widely accepted that elder abuse victims reported to statewide programs are likely to be frail elderly with limited incomes, and that elder abuse, neglect and exploitation is present in all ethnic groups.[4]

Despite the increasing number of research studies on the topic, little is known about effective intervention strategies for substantiated cases of elder abuse, neglect and exploitation. Most research focuses on describing the prevalence,[5] the definition,[6] or dynamics of abusive families.[7] While types of intervention have been described in the research literature[8] and in clinical literature,[9] no empirical research has ever related specific intervention strategies to specific client outcomes. Little is known about the types of interventions that can be expected to result in reduced risk for various types of victims.

## Data Collection

The state's Elder Abuse Standards & Procedures Manual and related legislation requires that client files be made available for state-sponsored research purposes. Because the Illinois Department on Aging was the grantee, all data in client files were made available for this research.

There were two sources of data for this study:

### (1) Illinois Department on Aging's Abuse, Neglect and Exploitation Tracking System (ANETS)

Illinois Department on Aging's statewide elder abuse program collects data on client characteristics and outcomes that allowed for an objective analysis to address the aforementioned questions. Through the Department's system of assessment, follow-up, and statewide certification training program, comprehensive and standardized data are collected about elderly victims and abusers during the investigation/assessment, and every three months until case closure. In addition, at the termination of the investigation and every three months until case closure, the case worker completes the elder abuse, neglect and exploitation Risk Assessment Form developed and validated as a client risk assessment by the State of Florida.

A subset of these data are reported to the Department and entered into the statewide data base. The data base allowed for preliminary analysis of the status of the client, at intake, at the termination of the investigation, three months later and at case closure. The statewide data base also contains summary information about the location of the

-case, demographic data on the victim and abuser(s), and services provided 90 days after intake.

## (2). Client Files

The existence of ANETS greatly streamlined the data collection process. Through the use of ANETS, cases from which data were to be abstracted could be identified. Those cases which were closed or in the program at least 15 months were selected for inclusion in the research.

An attempt was made to abstract data from all of the 552 cases which were closed or in the program at least 15 months at the time of data collection. Data were abstracted from a total of 537 of the 552 cases, representing a 97% response rate. There were 39 different elder abuse agencies from which case-level data were abstracted.

The research team traveled to those agencies which had 10 or more cases from which data were to be abstracted. For those agencies with fewer than 10 cases, agency representatives mailed copies of all of the information in the case files to the research team, and the data were abstracted from these photocopies.

The following information was abstracted by the research team:

o **risk status:** For every three-month interval from the end of the investigation to case closure (or 15 months from intake), risk scores (ranging from 0 to 3 on each of the 23 risk factors) were obtained. In addition, the overall risk score assigned by the case worker was recorded.

o **types of services offered and dates:** Services types and status (provided, refused, unavailable) were obtained from each Care Plan in the case file. Since the status of each service could change over time, the abstracted data indicated if the service had ever been needed, provided, refused or unavailable for the client.

o **intensity of case work services:** Each encounter the case worker had with the case was recorded, along with the date and type of the encounter. Encounters included face-to-face visits, phone calls, meetings, preparation, and "other" encounters with the case.

o **danger:** The type of danger present in the victim's situation was abstracted from the intake report. This included weapons, animals, drugs/mental illness, and dangerous neighborhood.

Prior to abstracting data on all cases, a sample of eligible cases were identified and used for pilot testing the data abstraction system. Data abstraction instructions were developed and two members of the data collection team abstracted the aforementioned data from the same 10 cases. The inter-rater agreement on the cases was determined to be over 90%. Further, for every case, data abstraction was validated by a second

rater. When differences were found, the original case file was reviewed and necessary corrections were made.

## Data Collection Instruments

The implementation of Illinois' elder abuse system has resulted in the mandatory use of several data collection forms. Between the data contained in ANETS and the data abstracted directly from the case files, the following instruments were the sources of data for this study:

(1)   **Intake Report**: completed by the agency receiving a call of suspected elder abuse, neglect or exploitation (Senior Help Line, Area Agency on Aging or certified Elder Abuse Provider Agency). This instrument collects information about:

- o   alleged victim (social security number, intake date/time, intake agency and agency type);

- o   alleged victim (name, age, phone number, address, directions to the home, best time/place to contact victim);

- o   immediacy and potential danger (priority code (24-hour response, 72-hour response, 7-day response), reason for report, if immediate danger is present, if client is in need of immediate assistance, if environment is dangerous (neighborhood, animals, mental illness/drugs, weapons));

- o   alleged abuser (number, name(s), address(es), phone number(s), relationship(s) to alleged victim);

- o   report (statement of reporter, abuse(s) suspected, if client and/or abuser are aware of the report);

- o   reporter information (name, phone number, willingness to provide further information, address, type, others known with information);

- o   agency to whom report was referred (agency name, date of referral, phone, worker receiving referral, report taker name & phone); and

- o   report type (initial, subsequent report on an existing case or related information to prior report).

(2)  **Investigation Report:** This form is completed on all reports of elder abuse, neglect or exploitation. It collects information about the:

   o ·  date investigation was initiated and completed;

   o  victim (name, phone number, social security number, date of birth, sex, income, marital status, ethnicity, ability to speak/understand English, legal status, living arrangements, living status, mental competency and barriers to self-sufficiency (Alzheimer's, hearing, vision, speech, disoriented, non-ambulatory, functionally impaired, functionally illiterate, financially dependent on abuser, substance abuse));

   o  abuser(s) (name, address, sex, age, relationship to victim, marital status, ethnicity, barriers (same as victim except financial dependence on <u>victim</u>), legal status to victim and whether abuser is caregiver (paid or unpaid) to victim);

   o  type(s) of abuse substantiated (physical, emotional, confinement, sexual, passive neglect, willful deprivation, financial exploitation);

   o  abuser(s) responsible for each type of abuse substantiated;

   o  specific indicators identified during the investigation for each type of elder abuse, neglect or exploitation substantiated;

   o  status of case at close of investigation (substantiated (and client: consents to services, deceased, refuses assistance, entered long term care facility, moved), not substantiated, no jurisdiction or unable to substantiate (and reason));

   o  date substantiation decision was made; and

   o  case worker and supervisor responsible for making substantiation decision.

(3)  **Risk Assessment Form:** This form is a reformatted version of the risk assessment protocol developed in Florida. According to the Florida APS (personal communications), this risk assessment instrument has been validated using elder abuse case workers and found to have content validity for describing the current risk of the victim for future harm or injury due to elder abuse, neglect or exploitation. The instrument obtains the case worker's assessment of risk on 23 factors. For each factor, the meaning of no/low risk, intermediate risk and high risk are defined within the context of the factor.

The 23 factors assessed on this instrument are combined into five major categories. As a whole, the instrument provides a measure of risk including most elements of the victim's situation described in the literature:

o    **client factors**: age/sex, physical health/functional abilities, mental/emotional health, substance abuse or other special problems, income/financial resources;

o    **environmental factors**: structural soundness of the home, appropriateness to the client, cleanliness of residence;

o    **transportation/support services**: availability/access and reliability of services, adequacy of formal or informal support network;

o    **current and historical factors**: severity of physical or psychological abuse, frequency/severity of financial exploitation, severity of neglect, quality/consistency of care, previous history of violence, abuse, neglect or exploitation; and

o    **perpetrator factors**: access to the client, situational stress/response to home crises, physical health, mental/emotional health/control, perpetrator/victim dynamics contributing to risk, cooperation with the investigation, financial resources/dependency on the client, substance abuse and other special problems.

In addition to the scores on each of the 23 factors, an overall rating, based on clinical judgement, is provided, ranging from 1 (no/low risk) to 3 (high risk). After reviewing the risk scores on each of the individual factors, the worker is asked to make a clinical judgement as to the overall assessment of risk, with:

1 =    Overall, the situaion is not likely to recur or to escalate in severity,

2 =    In general, there is some possibility that the situation will continue and possibly escalate, and

3 =    It is very likely the situation will continue and probably escalate in the future.

(4)    **Care Plan**: This form logs the types of services needed and either provided, unavailable or refused by the victim. A new form is completed each time services are added or deleted. The types of service categories included on the Care Plan are:

| | | | |
|---|---|---|---|
| o | income support/material aid, | o | housing, |
| o | institutional placement, | o | medical, |
| o | mental health, | o | legal, |
| o | in-home health, | o | supervision, |
| o | socialization, | o | education, |
| o | nutrition, | o | transportation, |
| o | case work, and | o | other. |

(5)     **Case Recording Form:** This form is used for a chronological, narrative documentation of events related to the investigation, assessment and intervention with the case. Of particular interest to this research is the component of the form that logs the amount of time the case worker spent on each event related to the case. Summing all of the minutes spent on each encounter with the case provides a surrogate measure of the intensity of case work services provided to each victim.

This documentation is completed and filed by the elder abuse agency for each case of elder abuse, neglect or exploitation reported to the statewide program, with the exception of the risk assessment and care plan which are completed only on substantiated cases.

## Subjects

The subjects of this research were the population of 3,727 reports of elder abuse, neglect or exploitation in non-institutional settings received by the Illinois Department on Aging between October, 1989 and December, 1991. The Illinois Elder Abuse Program is a voluntary reporting system. Types of abuse that the program responds to are:

o    *Physical Abuse:* causing the infliction of physical pain or injury to an older person.

o    *Sexual Abuse:* touching, fondling or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual behavior.

o    *Emotional Abuse:* verbal assaults, threats of abuse, harassment or intimidation so as to compel the older person to engage in conduct from which s/he has a right to abstain or to refrain from conduct which the older person has a right to engage.

o    *Confinement:* restraining or isolating an older person for other than medical reasons.

o    *Passive Neglect:* the failure by a caregiver to provide an older person with the necessities of life including, but not limited to food, clothing, shelter, or medical care, because of failure to understand the older person's needs, lack of awareness of services to help meet needs, or a lack of capacity to care for the older person.

o    *Willful Deprivation:* wilfully denying an older person who requires medication, medical care, shelter, food, therapeutic device, or other physical assistance, and thereby exposing that person to the risk of physical, mental or emotional harm; except with regard to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment.

o       *Financial Exploitation:* the misuse or withholding of an older person's
        resources by another to the disadvantage of the elderly person and/or the profit
        or advantage of a person other than the older person.

The program excludes self-neglect because these cases are already served through the
Department's statewide case management program. The program does not respond to reports
of institutional abuse because these are investigated by the State Long Term Care
Ombudsman program.

Of the 3,727 reports, a total of 552 cases (15%) had been substantiated and closed by March
of 1992. Cases can be closed for the following reasons:

o       Victim refuses services,
o       Victim deceased,
o       Victim entered long term care,
o       Victim moved from area,
o       Victim no longer at risk, and
o       Administrative closure (after 12 months not interrupted by further reports).

Analysis of the total population of reported cases shows the following *characteristics of
victims:*

o       **Victims were most often reported to the elder abuse program by social
        workers.** Social workers made 24% of the reports. The next most frequent
        reporter (13%) was described as "other," including friends, ministers, bankers,
        etc. Other referral sources were the victims themselves (11%), spouses (1%),
        children (7%), other relatives (9%), neighbors (5%), nurses (8%), physicians
        (1%), other medical personnel (2%), hospitals (4%), non-relative caretakers
        (1%), law enforcement (3%), in-home workers (4%), other paraprofessionals
        (2%), anonymous reporters (5%), and attorneys (2%).[1]

o       Victims' ages ranged from 60 to 99 years, with and *average age of 77 years.*

o       Almost *three-quarters (72%) of the victims were Caucasian,* 24% were
        African-American, and 3% were Native American, Latino, Asian/Pacific
        Islanders, or from another ethnic group. The ethnic backgrounds of 1% were
        unknown. The relatively high percent of minorities may be because, at the
        time of data collection, some predominantly Caucasian parts of the state had
        only recently be phased into the program, yielding a disproportionately small
        number of closed cases.

o       About *three-quarters (73%) of the victims were female.*

---

[1]     Numbers do not add to 100% due to rounding error.

o   About *one-half (52%) of the victims were widowed,* 27% were married, 5% were divorced, 8% were single from birth, 1% were separated from their spouse, and the marital status of 8% was unknown.

o   *About three-quarters (74%) of the victims lived in their own homes,* while 16% lived in the home of a relative, 7% lived in a home for the aged, 2% were in a short-term care facility and the living arrangement of 1% was unknown.

o   *Only about one-quarter (27%) of the victims lived alone.* The remainder lived with children (26%), spouses (17%), spouse and children (6%), other relatives (13%), non-relatives (8%) or in some other living arrangement (3%).

o   *The predominant barrier to self-sufficienty of victims was functional impairment (32%).* Twenty-three percent of victims were reported to have no barriers. Other barriers of victims were disorientation (17%), nonambulatory (16%), hearing problems (16%), vision problems (15%), speech impairment (7%), Alzheimer's Disease (6%), other mental illness (4%), functional illiteracy (3%), financial dependency (3%) and substance abuse (3%).

Table 1 shows the types of abuse reported and substantiated among the subjects in this study:

## Table 1
## Types of Abuse Reported & Substantiated
### (N=3,727)

| TYPE: | # Reports | % of Reports | % Substantiated[2] |
|-------|-----------|--------------|--------------------|
| Physical | 825 | 22% | 61% |
| Sexual | 81 | 2% | 21% |
| Emotional | 1,350 | 36% | 77% |
| Confinement | 256 | 7% | 36% |
| Neglect | 1,241 | 33% | 66% |
| Deprivation | 447 | 12% | 44% |
| Exploitation | 1,817 | 49% | 66% |

---

[2]   Substantiation includes cases assessed by the caseworkers as "verified" as well as "some indication." Totals add to more than 100% due to multiple types of abuse present within cases.

Preliminary analysis of the total population of reported cases shows the following *characteristics of abusers:*

○   *Most frequently (39%), the abuser was the child of the victim.* For 14%, the abuser was the spouse of the victim. For about one-quarter of the victims (24%), the abuser was another relative. The remaining 23% of abusers were unrelated caretakers (7%), housemates (2%), former housemates (1%), or some other relationship to the victim (13%).

○   *Abusers were almost equally split between males (54%) and females (46%).*

○   Abusers' ages ranged from 7 years to 96 years, with a *mean age of 47.*

○   As with the victims, *the abusers were most likely to be Caucasian (68%),* with 28% African-American, 2% Latino, 1% Native American or Asian Pacific/Islander. The ethnic background of the remaining 1% was unknown.

○   *Almost all (93%) of the abusers had no formal legal relationship to the victims at the time of the report.* Four percent reported having power of attorney, 2% were representative payees, and 1% were legal guardians of the victims at the time of the report.

○   *Sixty percent of the abusers lived with their victims.*

○   *Fifty-three percent of the abusers were also caregivers to the victims.* Forty-five percent were informal caregivers, and 9% were paid caregivers.[3]

○   *The most common barrier to self-sufficiency of abusers was chemical dependency* (13%). This was followed closely by abusers' financial dependence upon the victims (12%). Mental illness was present in 5% of the abusers.

---

[3]   Numbers do not add to 53% due to rounding error. The smaller than expected percent of paid caregivers may reflect the fact that the elder abuse program in Illinois excludes abuse in mental health or long term care institutions.

## Data Analyses

The data analysis plan for this study involved both descriptive and inductive statistics. Initially, the ANETS data were analyzed to describe the population of alleged victims, abusers, services and outcomes. Then, data were analyzed to answer the aforementioned research questions. Bivariate and multivariate statistics were used, as appropriate, depending upon the research question being addressed. The results section of the report defines the analyses that were used to address each question.

Successful outcomes were defined in two ways:

o   Decreasing risk scores over time. Successful cases were those in which the elder abuse, neglect or exploitation risk score had been reduced from intake to case closure.

o   Reason for case closure being "no longer at risk." This second measure of success was included in some analyses to validate the results obtained using the first measure of success.

## Training Curriculum

The results from this research were used to develop a training program to assist case workers in learning what interventions to use and what degree of "success" to expect when intervening with cases of elder abuse, neglect and exploitation. The Department's policies require elder abuse case workers to obtain continuing education related to elder abuse.

The quantitative analyses focused on describing those situations in which reduction in risk was possible or nearly impossible. In addition to the statistical analyses, exemplary cases were identified through this research which provided insights to elder abuse case workers about successful methods of intervening with difficult cases.

Training materials were developed and pilot tested with two groups of elder abuse workers. The first session was held in Springfield, Illinois on January 28, 1993. Approximately 35 trainees attended this session. Feedback from this session was used to modify the training program.

The final version of the program was conducted on February 4, 1993 in Chicago. Approximately 40 participants attended. A copy of the training materials and trainers' manual is included in the appendix of this report.

## Findings and Outcomes

This section presents the findings from the research. The results are presented according to the original research questions listed in the "Introduction" section. Before presenting the results from each question, the analysis of the risk change data is presented, as these results apply to all of the research questions.

**Change in Risk Level**

Risk change was defined as the difference between the initial risk score and the risk score:

- o  3-months after intake, and
- o  at case closure.

A positive change score of "2" means that a victim's initial risk score was "3" but was reduced to a "1." A positive change score of "1" means either that the victim's initial risk score was "2" and was reduced to a "1," or that the victim's initial risk score was a "3," and was reduced to a "2." A negative change score of "-1" means that the victim's overall level of risk increased from a "1" to a "2," or from a "2" to a "3."

The number of cases with each risk change score are presented in Table 2.[4]

### Table 2
### Risk Change Scores of Clients

| Change Score | At 3 months (N=817) | At case closure (N=327) |
|---|---|---|
| -2 | 0 (0%) | 0 (0%) |
| -1 | 23 (3%) | 4 (1%) |
| 0 | 391 (48%) | 150 (46%) |
| 1 | 349 (43%) | 131 (40%) |
| 2 | 54 (7%) | 42 (13%) |

As the table illustrates, after three months, 50% of the cases saw some improvement in risk. By the time of case closure, 40% saw a reduction in risk of "1," meaning that the case entered the program either as high risk and was rated as moderate risk at closure, or that the case entered the program at moderate risk, and was rated as low risk at closure. An

---

[4]  Only those cases which had an initial risk score of "2" or "3" were included in this analysis. For 36% of the cases, the initial risk score was "1." For these cases, reduction in risk score was not possible. Inclusion of these cases would artificially deflate the results.

additional 13% were cases that were rated as high risk at intake, and left the program at low risk. Figure 1 graphically presents these results.

## CHANGE IN RISK: INITIAL TO CLOSURE
### (N = 327)
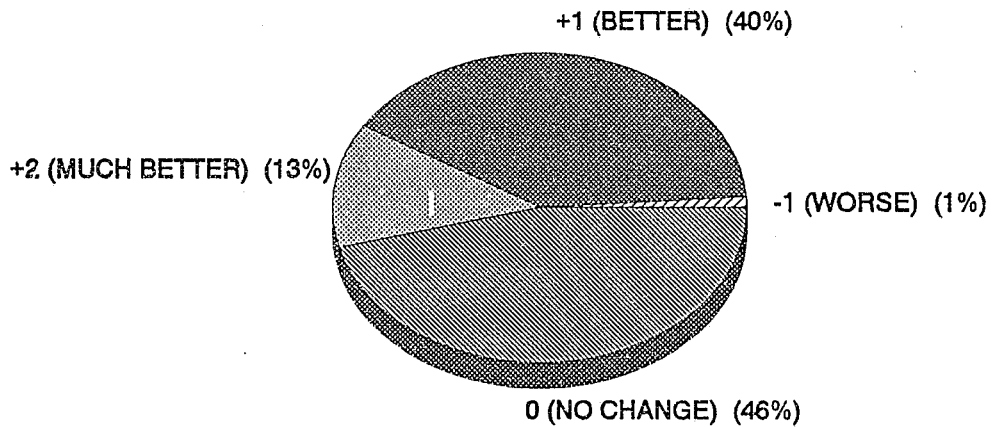


**Figure 1**

Table 3 shows the percent of cases that are closed for each reason.

**Table 3**
**Reason for Case Closure**
(N=552)

| REASON | NUMBER | PERCENT |
| --- | --- | --- |
| Victim refused services | 112 | 20% |
| Victim deceased | 86 | 16% |
| Victim entered long term care | 159 | 29% |
| Victim moved | 39 | 7% |
| Victim no longer at risk | 133 | 24% |
| Administrative closure | 23 | 4% |

As Table 3 indicates, *the most common reason for case closure is that the victim entered long term care (29%)*. The next most common reason for case closure is that the victim was assessed to be no longer at risk (24%). Victim refusal of services accounted for 20% of case closures. The relatively high refusal rate may, in part, reflect the Department's policy to protect the victim's right to self-determination. Clients may refuse services or refuse to coerce their families into making changes that would reduce their risk of abuse because the changes might result in unwanted results, such as separation from family members and/or moving. While unfortunately the reason for refusal may be coercion or fear, the Department's emphasis on self-determination preserves victims' independence and control to the maximum extent and prevents the Department from paternalistically forcing services that older persons do not want or would probably not accept.

Another reason for the relatively high refusal rate may be an artifact of the data. These data came from the first two years of the state's funded elder abuse program. At the time of data analysis, only 15% of all of the cases reported to the system were closed, and therefore eligible for inclusion in the study. These may disproportionately represent more difficult cases that were "unofficially" served by agencies and grandfathered into the program when funding became available. This interpretation is supported by the fact that the 1992 data on case closures shows only an 13% refusal rate. Year-to-date figures for fiscal year 1993 show an even smaller number percent (8%) of cases closed because the victim refuses services.

## 1. Are certain types of abuse more likely to have successful interventions than others?

Type of abuse was measured from the substantiation documentation in the ANETS. Each type of abuse listed as "verified" or "some indication" was considered to be present in that case.

In order to determine if the type of abuse was related to positive risk change, a multiple regression analysis was computed using the seven types of abuse as predictor variables and risk change from intake to closure as the dependant variable. The seven types of abuse included in the analysis were:

- Physical,
- Emotional,
- Neglect,
- Exploitation.

- Sexual,
- Confinement,
- Deprivation, and

Results from the regression indicate that none of the abuse types successfully predicted risk change. No type of abuse has a beta coefficient that was significantly related to change in risk. Thus, *the type of abuse substantiated appears to have no direct relationship to whether or not risk is reduced at the time of case closure*. This finding supports the hypothesis that there is no relationship between victim's improvement over time and the type of abuse, neglect or exploitation. Rather, other characteristics about the victim, abuser and/or intervention are more important in predicting change than the type(s) of abuse substantiated.

Slightly different results occur when examining change in risk in the first three months of intervention. Table 4 lists the regression coefficients and significance level for the seven types of abuse in predicting change in risk scores after three months. As the table indicates, *victims of neglect are more likely to have improved risk scores after three months*. This suggests that initially, it may be easier to intervene with neglect cases than with situations involving other types of abuse. An alternative explanation is that the initial risk scores of neglect case are higher than risk scores for other types of abuse (therefore have greater opportunity to change).

## Table 4
## Regression Coefficients
## Predicting Change in Risk
## by Type of Substantiated Abuse
## (N=1,213)

| TYPE OF ABUSE | BETA | SIGNIFICANCE P $\leq$ |
|---|---|---|
| Physical | .06 | NS[5] |
| Sexual | NA[6] | NA |
| Neglect | .58 | .04 |
| Emotional | .27 | NS |
| Confinement | -.42 | NS |
| Deprivation | -.14 | NS |
| Exploitation | .39 | NS |

Figure 2, on the following page, shows the percent of cases with an initial risk score of "3" by the type of abuse reported. As the figure demonstrates, the percent of neglect reports rated as high risk is not higher than other types of abuse. This finding supports the interpretation that *initially, it is easier to intervene with neglect cases.*

To validate this finding of no relation between type of abuse and change in risk at case closure, a regression analysis was computed investigating whether the type of abuse or neglect predicted the second measure of intervention success -- the "no longer at risk" reason for case closure. The results indicate that *type of abuse is not predictive of whether a case closed because it is "no longer at risk."*

---

[5] NS = Not statistically significant.

[6] There were insufficient number of cases for this analysis.

## HIGH RISK BY TYPE OF ABUSE
### (VERIFIED & SOME INDICATION COMBINED)
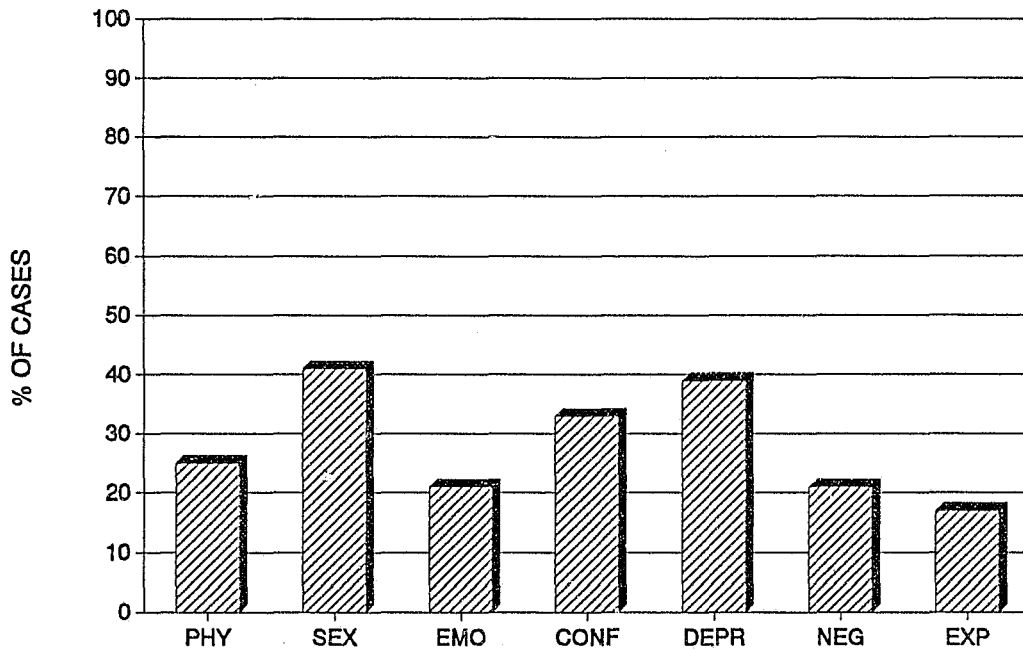


**Figure 2**

*Summary:* In summary, the results indicate that the type of abuse, neglect and/or exploitation substantiated is not related to whether the victim's risk level improves by the time of case closure. Neither the change in risk score from intake to case closure nor whether the case was closed because of "no more risk" was significantly related to the type of abuse, neglect and/or exploitation substantiated. However, the results also suggest that neglect cases may see initial improvement within the first three months more frequently than victims of other types of abuse.

## 2.    Is the immediacy or severity of ANE related to future success?

Abuse severity was defined as the priority score given to the case at the time the report was made. This score is an indication of the extent to which immediate action was assessed to be needed, based upon the perception of the report taker at the time the abuse was reported. Priority scores ranged from 1 to 3, with:

    o     1 indicating immediate intervention was required within 24 hours,
    o     2 indicating intervention was required within 72 hours, and
    o     3 indicating that intervention was required within 7 days.

Figure 3 shows the priority score at intake for each type of abuse. As would be expected, the type of abuse with the highest percent of Priority 1 designation is sexual abuse. Twenty percent or more of deprivation, physical abuse and confinement cases are also likely to receive a Priority 1 designation. The relatively low percent of Priority 1 designation for exploitation is due to the fact that the Department, by definition, assigns Priority 3 to almost all cases of exploitation, unless there are other types of abuse or neglect involved.

## PRIORITY AT INTAKE BY TYPE OF ABUSE
### (VERIFIED & SOME INDICATION COMBINED)
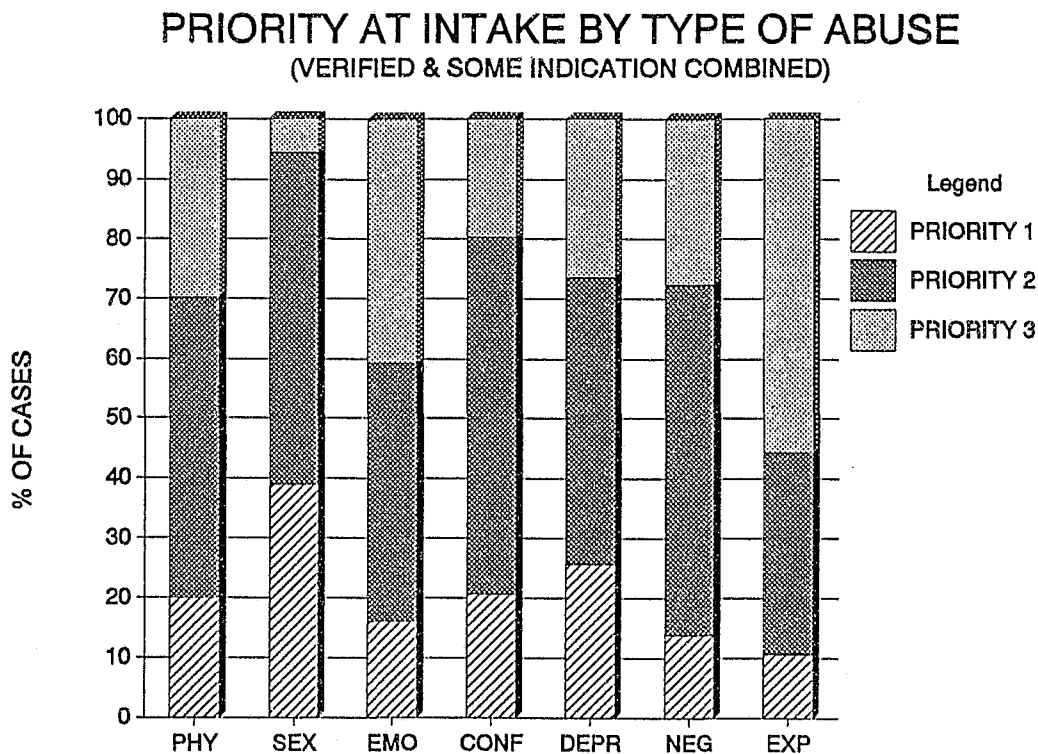


Figure 3

To examine the relationship between severity and successful intervention, correlations were calculated between priority score and overall risk at intake, at 3 months, and at closure; and change in risk from intake to 3 months, and change from intake to closure. Results are shown in Table 5.

### Table 5
### Relationship between Priority
### and Risk Scores at 3 Months and Closing

| CORRELATION BETWEEN PRIORITY AND... | NUMBER OF CASES | CORRELATION | SIGNIFICANCE ($p \le$) |
|---|---|---|---|
| Initial Risk Score | 2,713 | -.24 | .000* |
| 3 Month Risk Score | 1,242 | -.09 | .001* |
| Closing Risk Score | 521 | -.15 | .000* |
| Risk Change at 3 Months | 1,232 | -.14 | .000* |
| Risk Change at Closure | 516 | -.13 | .001* |

\* This relationship is statistically significant.

These results indicate a significant negative relationship between priority score assigned by the report taker and both risk score and change in risk. *The more immediate the priority* (ie. lower priority score), *the higher the risk score of the victim initially, after three months, and at case closure.*

*On the other hand, the more immediate the priority at the initial report, the more likely the victim is to improve over time.* Part of the explanation for this relationship may be the fact that victims entering the program with low risk scores and with less immediate needs have less "room to change" since a risk score of "1" cannot be improved over time.

An alternative explanation is that victims entering the system with a high priority may be more likely to be affected by interventions that can improve their overall level of risk compared with those entering with less severe situations. Perhaps for the "initially low risk" individuals, maintaining low risk levels may be the goal of the interventions.

It is important to note that *although these relationships are statistically significant, they are not strong.* Correlations can be as high as 1.00 and as low as -1.00. In these relationships, the strongest correlation is -.24. This suggests that other factors besides initial level of risk account for improvement over time.

Table 6 further explains the relationship between severity of abuse and change over time.

## Table 6
## Initial vs. Closure Risk Score

| CLOSURE SCORE | INITIAL RISK SCORE | | |
|---|---|---|---|
| | 1 (N=191) | 2 (N=231) | 3 (N=96) |
| 1 (N=347) | 97% | 52% | 44% |
| 2 (N=124) | 2% | 47% | 13% |
| 3 (N=47) | 1% | 2% | 44% |

As Table 6 indicates:

o    97% of cases with initial scores of 1 closed with scores of 1,

o    3% of cases with initial scores of 1 got worse over time (2% scored "2" and 1% scored "1"),

o    52% of cases with initial scores of 2 improved to a risk score of 1 by case closure, and

o    57% of cases with initial scores of 3 "got better" (44% went from a score of "3" to a score of "1"; 13% went from a score of "3" to a score of "2").

It is interesting to note that 44% of cases with initial scores of 3 remained at high risk at case closure. One question this raises is "what was the outcome of intervention for these cases?" The reason for case closure among these 42 cases was examined. The reasons are:

o    Victim entered long term care facility (41%),
o    Victim deceased (26%),
o    Victim refused assistance (21%), and
o    Victim moved (12%).

Thus, most of the cases which leave the program still at high risk are terminated for reasons beyond the control of the elder abuse worker. For most of the cases that are terminated still at high risk, victims refused assistance, died, or moved. For the remaining cases, placement into long term care is the reason for case closure.[7]

---

[7]  The reader is reminded that the Department's elder abuse program only covers domestic settings. Once admitted into long term care, the State Long Term Care Ombudsman's Office receives reports of abuse.

*Summary:* Immediacy or priority of the case at intake is related to change in risk over time. However, part of the relationship may be an artifact of the data. That is, cases that enter the program at low risk cannot lower their risk scores, while cases that enter the system at high risk have greater opportunity for change. While the results are statistically significant, the strength of the relationship between immediacy and risk reduction is not strong. This suggests that other factors besides the initial risk score are also related to risk reduction.

### 3. Are there characteristics of the abuser and/or family that predict the likelihood of success in intervening?

To answer this question, the analyses were divided into 4 parts: the relationship between characteristics of the victim, barriers of the victim, characteristics of the abuser, and barriers of the abuser with change in risk from intake to closure. Multiple regressions were used to test these relationships.

Victim Characteristics: Age, sex, race, income, whether living alone, and whether the victim owns his/her own home were used as predictor variables. Results indicate that none of these variables was a significant predictor of risk change. *Neither race, sex, income, living status or living arrangement are related to improvement over time.*

Victim Barriers to Self-Sufficiency: Having Alzheimer's Disease, hearing impairment, vision impairment, speech impairment, disorientation, being nonambulatory, functionally impaired, illiterate, financially dependent, abusing substances, being mentally ill, or having no barriers related to self-sufficiency were used as predictors of risk change. Results indicate that *none of the victim barriers successfully predict risk change.*

Abuser Characteristics: The abuser being married to the victim, being the child of the victim, being an informal care provider, or being a paid care provider were used to predict risk change. *Being married to the victim and providing informal care are related to improvement in the victim's risk score over time.* Table 7 illustrates these results.

Although these characteristics are significant predictors of change, the overall amount of variance accounted for by these predictors is small (2%). This suggests, again, that *other factors besides the abuser being married to the victim and being the informal caretaker predict intervention success.*

### Table 7
### Abuser Characteristics Related to Risk Change
### from Intake to Closure

| Abuser Characteristic | Beta Coefficient | Significance |
|---|---|---|
| Married | .12 | .01* |
| Informal Care | .09 | .04* |
| Child of Victim | -.06 | .24 |
| Paid Care Provider | .05 | .24 |

\* This relationship is statistically significant.

<u>Abuser Barriers to Self-Sufficiency</u>: Information about the same barriers to self-sufficiency listed above for victims were also available for alleged abusers. The multiple regression analysis indicates that only the conditions of the abuser having substance abuse problems and the abuser having Alzheimer's predicts change over time.

Interestingly, the abuser having Alzheimer's and the abuser having substance abuse problems are both related to the victim getting better. Further analysis of these data indicate that, in fact, this counter-intuitive relationship is an artifact of the data. Both of these significant predictors drop out of the equation when initial risk score is controlled. Further, *substance abuse among the abuser is significantly related to high initial risk score.* In other words, substance abuse among the abuser is, in actuality, a surrogate measure of high initial risk when used alone in the regression.

### Table 8
### Abuser Barriers Predicting Change in Risk
### (when initial risk score not in equation)

| Abuser Barrier | Beta Coefficient | Significance Level* |
|---|---|---|
| No Barrier | -.04 | NS |
| Alzheimer's | .11 | .02 |
| Hearing Impaired | .02 | NS |
| Vision Impaired | -.00 | NS |
| Disorientation | .04 | NS |
| Non-ambulatory | .05 | NS |
| Functionally Impaired | .00 | NS |
| Illiterate | .03 | NS |
| Financial Dependence | .05 | NS |
| Substance Abuse | .12 | .005 |
| Mentally Ill | .02 | NS |

\*     NS = not statistically significant. Number equals the probability that the relationship could be due to chance (ie. these are statistically significant).

*Summary:* The only victim or abuser factors which predict change in risk score are the abuser being married to the victim, and the abuser being the informal caregiver. Abuser characteristics do not appear to be related to change in risk when initial risk score is controlled. However, substance abuse of the abuser is related to the victim having a "high" initial risk score.

## 4. Are initial risk factors of the victim related to future success in intervening?

Scores on the 23 risk factors were taken from the risk assessment form completed by the elder abuse workers. Scores were abstracted from the files for each 3 month period that the case was open. In each case, ratings ranged from 1 to 3 (low to high risk). A score of "0" was coded if the worker did not have sufficient information to assign a level of risk for a particular factor. Scores of "0" were considered missing data and excluded from the statistical analyses.

The 23 specific risk factors include five categories: client factors, environmental factors, support services, current and historical factors, and perpetrator factors. The factors and definitions of each risk score were taken from the risk assessment form developed by the Florida APS System. A copy of this scoring system is included in the appendix. In summary, the 5 categories and the 23 risk factors are:

Client Factors:

Risk due to patient's age and sex          Physical health and/or functional abilities
Mental/emotional health                    Substance abuse and other special problems
Income and other financial resources

Environmental Factors:

Structural soundness of the home           Appropriateness to the client
Cleanliness of the residence

Transportation/Support Services:

Availability/access and reliability of services
Adequacy of formal/informal support network

Current/Historical Factors:

Severity of physical/psychological abuse   Frequency/severity of financial exploitation
Severity of neglect                        Quality/Consistency of care
History of abuse, neglect, or exploitation

Perpetrator Factors:

Access to the client                       Situational stress/response to home crises
Physical health                            Mental/emotional health/control
Perpetrator-victim dynamics                Cooperation with the investigation
Financial dependency on the client         Substance abuse and other special problems

The preliminary analysis of the risk indicators provides an interesting unanticipated finding from the study. Figure 4 shows the percent of cases for which caseworkers assigned "0" to the risk indicator. As the figure illustrates, *risk-related information most likely to be missing is information about the abuser.* For three risk factors (mental health of abuser, physical health of abuser and response to stress), this high rate of missing data reflects the Department's policy not to record information on these risk indicators if the abuser is not the caregiver. However, even if these three risk factors are excluded from the analyses, perpetrator factors still remain the highest in terms of missing information. The limited information obtained about the abuser may reflect the Department's policy to respect the victim's right to consent, or not to consent, to the worker contacting the abuser. It may also reflect difficulties case workers may have in accessing the abuser or discomfort with approaching an abuser.
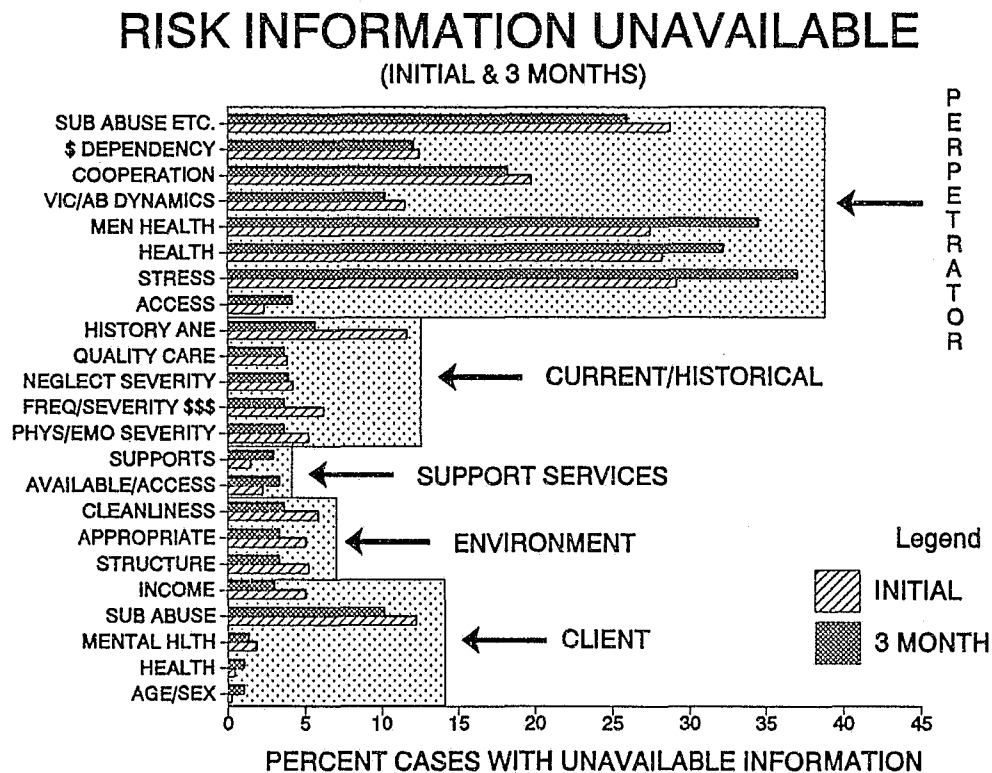


**Figure 4**

Multiple regression analyses were computed to determine if the specific risk factors could predict the overall level of risk for the same time period, or the overall risk score three months later. First, the relationship between the 23 risk factors and overall risk at the same time interval was examined, using a non-lagged regression analysis. The results are summarized in Table 9.

As the table shows that there are a variety of factors predicting high risk at intake. In this study, clients had high initial risk scores for one or more of the following reasons:

- o · lack of consistency of care,
- o severe abuse present,
- o poor mental or physical health,
- o unclean home,
- o abuser's poor response to stress,
- o lack of cooperation of the abuser, and/or
- o substance abuse of the abuser.

## Table 9
### Specific Risk Indicators at Intake
### Predicting High Overall Risk at Intake
### (N=276)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Quality/consistency of care | .18 | .00 |
| perpetrator response to stress | .23 | .00 |
| Residence cleanliness | .10 | .04 |
| Physical/psychological abuse severity | .13 | .00 |
| Perpetrator cooperation | .16 | .00 |
| Availability of public services | .15 | .00 |
| Client mental health | .11 | .02 |
| Perpetrator substance abuse | .19 | .00 |
| Client health/functioning | .11 | .02 |

Table 10 shows the significant predictors of high risk three months after the substantiation decision. As the table shows, *those clients still at risk after three months of intervention tend to be those who have historical factors and problematic abusers.* Clients with poor or inconsistent care, frequent or severe exploitation and/or frequent or severe abuse are still at high risk after three months. Similarly, those clients with caregivers that inappropriately respond to stress and/or have substance abuse problems remain at high risk after three months.

## Table 10
### Specific Risk Indicators at 3 Months
### Predicting Overall Risk at 3 Months
#### (N=159)

| RISK INDICATORS | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Quality/consistency of care | .30 | .00 |
| Financial dependence on client | .26 | .00 |
| Financial exploitation severity/frequency | .16 | .02 |
| Perpetrator response to stress | .17 | .01 |
| Client substance abuse | .14 | .01 |
| Physical/psychological abuser severity | .15 | .02 |

*After 6 months, clients still at high risk are those where there is severe neglect or abuse, or where the perpetrator is financially dependent on the victim.* Table 11 illustrates these results.

## Table 11
### Specific Risk Indicators at 6 Months
### Predicting Overall Risk at 6 Months
#### (N=54)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Neglect severity | .44 | .00 |
| Financial dependence on client | .43 | .00 |
| Physical/psychological abuser severity | .24 | .01 |

*After nine months* (Table 12) *and after twelve months* (Table 13), *again, perpetrator factors and historical factors predict high risk situations.*

## Table 12
### Specific Risk Indicators at 9 Months
### Predicting Overall Risk at 9 Months
### (N=37)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Financial dependence on client | .41 | .00 |
| Physical\psychological abuse severity | .26 | .02 |
| Support network | .30 | .01 |
| History of abuse | .38 | .00 |
| Perpetrator-victim dynamics | -.30 | .01 |

## Table 13
### Specific Risk Indicators at 12 Months
### Predicting Overall Risk at 12 Months
### (N=28)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Perpetrator response to stress | .48 | .01 |

The next series of regressions were intended to examine the relationship between the 23 risk factors and the overall risk score given in subsequent 3-month intervals. Results for those factors found to be statistically significant in predicting risk are summarized in tables 14-17.

It is interesting to note the strong relationship of historical and perpetrator factors in predicting future risk. In each of tables 14 through 17, *perpetrator financial dependence and/or substance abuse and/or history or frequent abuse tends to predict continued risk over time.*

## Table 14
### Specific Risk Indicators at Intake
### Predicting High Overall Risk 3 Months Later
### (N=199)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Perpetrator financially dependent on client | .24 | .00 |
| History of abuse, neglect or exploitation | .22 | .00 |
| Perpetrator substance abuse | .14 | .04 |

## Table 15
### Specific Risk Indicators at 3 Months
### Predicting High Overall Risk at 6 Months
### (N=60)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| Financial dependence upon client | .23 | .02 |
| Environmental appropriateness for client | .33 | .00 |
| Perpetrator substance abuse | .25 | .01 |
| Client financially dependent on others | .27 | .00 |
| Physical/psychological abuse severity | .19 | .03 |
| Perpetrator response to stress | .19 | .04 |

## Table 16
### Specific Risk Indicators at 6 Months
### Predicting High Overall Risk at 9 Months
### (N=38)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| History of abuse, neglect or exploitation | .53 | .00 |
| Financial dependency on client | .51 | .00 |
| Perpetrator-victim dynamics | -.35 | .02 |

## Table 17
### Specific Risk Indicators at 9 Months
### Predicting High Overall Risk at 12 Months
### (N=31)

| RISK INDICATOR | BETA COEFFICIENT | SIGNIFICANCE LEVEL |
|---|---|---|
| History of abuse, neglect or exploitation | .31 | .02 |
| Client substance abuse | .40 | .00 |
| Perpetrator substance abuse | .40 | .00 |
| Client health/functioning | .34 | .01 |

Tables 18 and 19 summarize the significant risk factors related to risk at the same time as the factors were assessed (Table 18) and predicting continued high risk 3 months later (Table 19). There appears to be a pattern of factors that consistently predict high risk of victims--perpetrator characteristics and historical factors. *In both types of analyses, abuser financial dependence predicts high risk situations. Perpetrator response to stress continually predicts current risk. Perpetrator substance abuse predicts continued risk of abuse over time.*

## Table 18
### Summary of Factors
### Predicting Current High Risk

| MONTH: | INITIAL | THREE | SIX | NINE | TWELVE |
|---|---|---|---|---|---|
| SAMPLE SIZE: | N=276 | N=159 | N=54 | N=37 | N=28 |
| Quality of care | X | X | . | | |
| Perpetrator response to stress | X | X | | | X |
| Cleanliness of residence | X | | | | |
| Severity of physical/psych abuse | X | X | X | X | |
| Perpetrator cooperativeness | X | | | | |
| Availability of services | X | | | | |
| Victim mental health | X | | | | |
| Perpetrator substance abuse | X | | | | |
| Victim physical health | X | | | | |
| Perpetrator financial dependence | | X | X | X | |
| Severity of exploitation | | X | | | |
| Victim substance abuse | | X | | | |

## Table 18
## Summary of Factors
## Predicting Current High Risk

| MONTH: | INITIAL | THREE | SIX | NINE | TWELVE |
|---|---|---|---|---|---|
| SAMPLE SIZE: | N=276 | N=159 | N=54 | N=37 | N=28 |
| Severity of neglect | | | X | | |
| Available social support | | | | X | |
| History of abuse, neglect or exploitation | | | | X | |
| Perpetrator victim dynamics | | | | X | |

## Table 19
## Summary of Factors
## Predicting High Risk after 3 Months

| MONTH: | THREE | SIX | NINE | TWELVE |
|---|---|---|---|---|
| SAMPLE SIZE: | N=199 | N=60 | N=38 | N=31 |
| Abuser financial dependence | X | X | X | |
| History of abuse, neglect or exploitation | X | | X | X |

*Summary:* The 23 individual items from the risk assessment scale were analyzed to understand what changes occurred within the victims' situations that predict overall improvement over time. An unanticipated finding from these analyses was that a disproportionate amount of information about perpetrators was missing from the assessments. This can mean that case workers find it difficult to obtain information about abusers. It may also mean that case workers are uncomfortable dealing with abusers, and therefore learn less about perpetrators than they do about victims. A third explanation is that abusers are more frequently absent or refuse to provide information about themselves. Yet a fourth explanation is that the victim does not consent to the worker talking to the abuser. More research is needed on reasons why limited information is obtained about abusers.

When examining those factors that are significant predictors of risk at two or more points in time, results show that the quality and consistency of care, perpetrator's ability to manage stress, the severity of physical abuse, and financial dependence of the abuser on the victim consistently predict present continued high risk. Substance abuse of the perpetrator, financial dependence of the perpetrator and past history of abuse, neglect and/or exploitation consistently predict high risk 3 months later.

These results suggest that the cases of elder abuse most difficult to change are those in which there is a history of abuse, neglect and/or exploitation and cases in which the perpetrator demonstrates behavioral problems -- substance abuse, poor stress management, and financial dependence. Financial dependence of the abuser has been demonstrated to exist in previous studies. This is the first objective documentation, however, of the role of substance abuse in relation to lack of risk reduction in victims' situations over time.

## 5. What risk factors are likely to change in successful interventions?

To further examine the effects of successful interventions, more detailed analyses were conducted on the 23 risk factors. First, individual risk factors were identified that were associated with high overall risk scores. Then, the change in risk scores for the first three months was computed by subtracting the three-month risk score from the initial risk score on each factor.

Figure 5 shows the percent of cases which received a score of 3 (high risk) on each risk factor. As shown in Figure 5, the risk factors likely to be high at intake are:

    o      Abuser access to victim (63%),
    o      Victim age/gender (59%),
    o      Abuser cooperativeness (26%),
    o      Victim's health (24%), and
    o      Quality of care (20%).
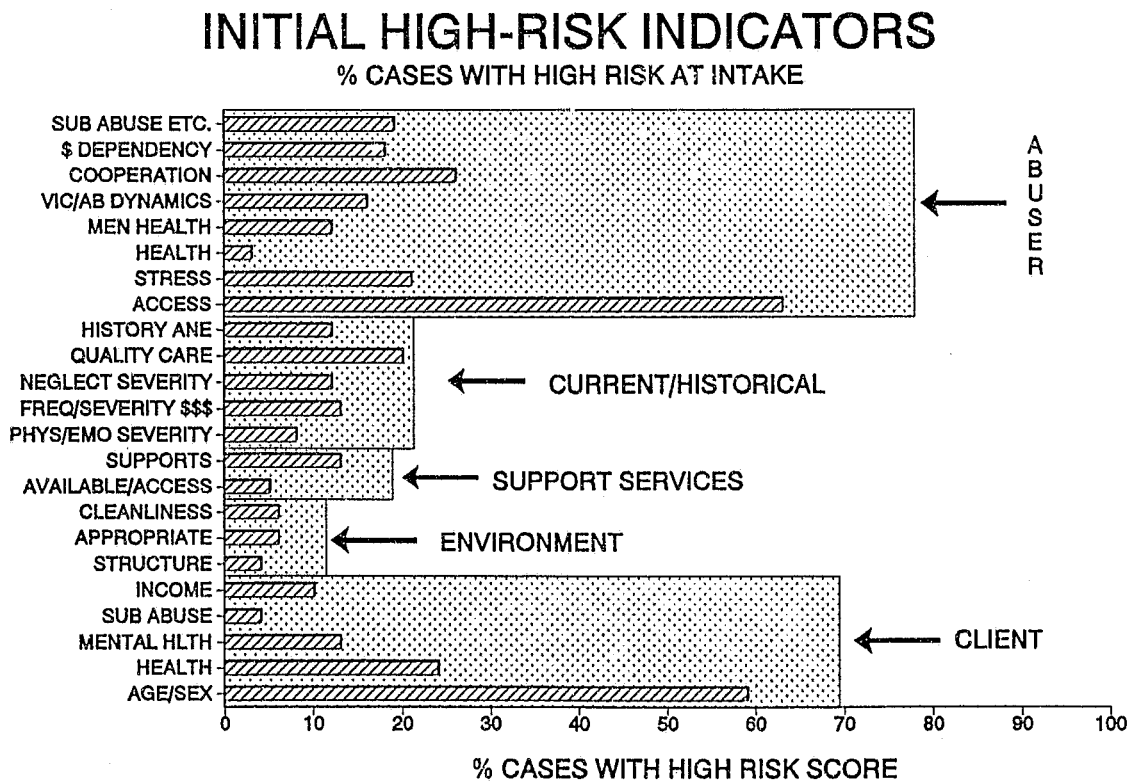


**Figure 5**

When correlations were computed between the initial scores on individual risk factors and initial overall risk score, results indicated that all risk factors were significantly correlated with overall initial risk. This indicates that *the presence of high risk on any one of the risk factors was sufficient reason for the case to be assigned a high overall risk score.*

## CHANGE ON INDIVIDUAL RISK INDICATORS
### INITIAL TO 3 MONTHS
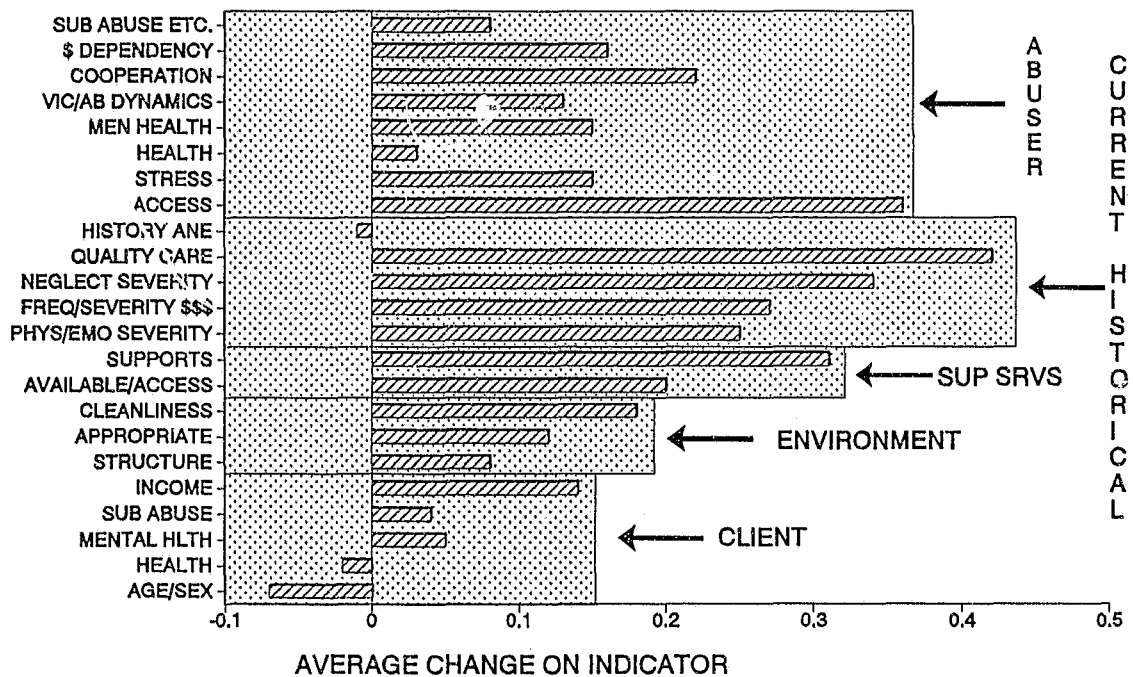


**Figure 6**

Figure 6 shows the average change for victims on each of the 23 risk factors. As the figure shows, those risk factors with the greatest change during the first three months are:

- o  Quality and consistency of care to victims (0.42),
- o  Abuser's access to the client (0.36),
- o  Severity of neglect (0.34), and
- o  Adequacy of formal/informal support network (0.31).

On these four risk factors, clients' situations changed an average of 0.30 or higher out of a possible maximum change of 2.0 points. Two of these factors, abuser access to the victim and quality/consistency of care, are among the five factors for which victims are likely to initially be at high risk.

These results suggest that *interventions related to reducing the severity of neglect, improving the quality or consistency of care, improving the victim's support network and*

*decreasing the abuser's access to the victim are easier to implement. An alternative explanation is that these interventions are most often needed by victims.* On the other hand, *interventions focusing on changing the client, the abuser or the environment were either not implemented very often, or were not effective in changing the risk status of the victim.* It would be expected, for example, that there would be few or no interventions that could change the victim's physical or mental status. As Figure 5 shows, there was virtually no change in the physical or mental health of the client. Similarly, there was virtually no change in the physical health status of the abuser. On the other hand, *there was also less change in the abuser's substance abuse, abuser's reactions to stress, the abuser's financial dependency on the victim, or the victim-abuser dynamics.* On each of these factors, close to 20% of cases were at high risk at the initial assessment. Interventions related to reducing risk on these factors may either be less available or more difficult to implement. Thus, it appears that case workers focus on interventions that both address high risk characteristics and are more likely to meet with the victim's consent. Interventions that focus on abuser characteristics are likely to be more difficult to implement.

Table 20 describes which risk factors are likely to improve when changes occur within each type of abuse. Only the four major types of abuse were included in this analysis, as the other three types (sexual, confinement and deprivation) had too few cases to make interpretations valid. Those correlations **bolded** are those that are statistically significant.

As the table indicates, *those factors most likely to change when risk level improves[8] within the first three months tend to be different for different types of elder abuse.* For physical abuse, the risk factors likely to change when victims improve are:

- o the severity of abuse,
- o the perpetrator's response to stress, and
- o substance abuse of the perpetrator.

For emotional abuse, the risk factor most likely to improve is the severity of the abuse.

For neglect, the risk factors most likely to improve are:

- o Physical health/functional ability of the victim,
- o Structural soundness of the home,
- o Appropriateness of the environment to the client,
- o Cleanliness of the residence,
- o Availability, accessibility and reliability of services,
- o Adequacy of formal/informal social supports,
- o Severity of neglect,
- o Quality/consistency of care, and
- o Perpetrator's access to the client.

For exploitation, only the frequency and/or severity of the exploitation is likely to improve.

---

[8] That is, those with positive and statistically significant correlations.

## Correlation between Type of Abuse and Change on Risk Factor

|  | PHYSICAL | EMOTIONAL | NEGLECT | EXPLOITATION |
|---|---|---|---|---|
| **CLIENT FACTORS** | | | | |
| Patient's age/sex | 0.09 | -0.04 | 0.08 | -0.03 |
| Physical health/functional abilities | 0.02 | -0.06 | **0.14** | -0.08 |
| Mental/emotional health | -0.02 | 0.07 | 0.08 | -0.02 |
| Substance abuse/other problems | 0.09 | 0.02 | 0.09 | -0.01 |
| Income/financial resources | 0.04 | -0.04 | 0.09 | 0.04 |
| **ENVIRONMENTAL FACTORS** | | | | |
| Structural soundness of home | **-0.11** | 0.01 | **0.24** | **-0.14** |
| Appropriateness to the client | -0.04 | **-0.11** | **0.26** | -0.02 |
| Cleanliness of residence | -0.00 | **-0.14** | **0.26** | -0.07 |
| **TRANSPORTATION/SUPPORT SYSTEM** | | | | |
| Srvs available accessible reliable | -0.00 | -0.05 | **0.16** | **-0.12** |
| Adequacy of supports | -0.02 | -0.09 | **0.22** | -0.03 |
| **CURRENT/HISTORICAL FACTORS** | | | | |
| Severity physical/psych abuse | **0.28** | **0.22** | -0.00 | **-0.10** |
| Frequency/severity exploitation | -0.05 | -0.00 | 0.08 | **0.18** |
| Severity of neglect | -0.02 | -0.18 | **0.45** | **-0.18** |
| Quality/consistency of care | 0.01 | -0.09 | **0.43** | -0.13 |
| Previous history violence/exploit | -0.01 | -0.02 | 0.04 | -0.07 |
| **PERPETRATOR FACTORS** | | | | |
| Access to client | -0.00 | -0.05 | **0.14** | -0.10 |
| Response to stress | **0.14** | 0.11 | 0.04 | -0.20 |
| Physical health | -0.00 | 0.03 | 0.05 | -0.04 |
| Mental/emotional health | 0.07 | 0.04 | -0.09 | -0.14 |
| Perpetrator victim dynamics | 0.07 | 0.05 | -0.05 | -0.13 |
| Cooperation with investigation | 0.03 | -0.03 | 0.11 | -0.17 |
| Financial dependency on victim | -0.09 | -0.05 | 0.08 | -0.03 |
| Substance abuse/other problems | **0.18** | 0.03 | -0.07 | -0.05 |

*These results suggest that caseworkers are using different interventions, depending upon the type of abuse encountered.* For example, one would expect that interventions for victims of neglect would focus on the environment, access to available services, and quality of care. On the other hand, interventions for victims of physical abuse would tend to focus on perpetrator factors such as response to stress and substance abuse since these factors would more likely be present in physically abusive situations.

The results also suggest that *interventions may be easier to implement in cases of neglect --* more risk factors changed for victims of neglect than for victims of abuse or exploitation. This finding echoes a previous finding that being the victim of neglect is a significant predictor of overall improvement in the victim in the first three months of intervention.

*Summary:* Quality of care, severity of neglect, abuser access to the victim and adequacy of formal/informal supports are more likely to change in successful interventions than other risk factors. Changes in risk factors appear to be related to the type of abuse, neglect or exploitation encountered in the situation. When victims of physical abuse "get better," changes occured in the severity of the abuse, the perpetrator's response to stress, and substance abuse of the abuser. When risk of emotional abuse is reduced, change centers around decreasing the severity of the abuse. Reduced risk for neglect victims involves several risk factors, mostly involving environmental improvements, enhanced transportation/support system and quality of care. When the risk of exploitation is reduced, changes occur in the severity of the exploitation.

## 6. Is there a pattern of services related to successful and unsuccessful interventions, or is success more related to characteristics of the victim or abuser?

Successful intervention is assumed to occur when the victim's risk is reduced. Overall risk was measured by the risk assessment score on the ANETS. Risk change was measured by subtracting the three-month risk score from the initial risk score so that a positive change in risk means improvement over time.

Interventions were measured using two methods:

**Method (1):** Service data were abstracted from the service plans in each case file. For each case, all services needed, provided and/or refused were logged. It should be noted that for any given client, during the time the case was open, a service could be listed as needed, provided and refused since the status of the service could change over time. Although this is a gross measure of services, it provides the first detailed look at the relationship between outcome (risk reduction) and specific types of services.

Abstracted data were categorized into the following groups of services:

| | |
|---|---|
| Income support/material aid, | Housing, |
| Institutional placement, | Medical Services, |
| Mental health services, | Legal services, |
| In-home health service, | In-home assistance, |
| Supervision, | Socialization, |
| Education, | Nutrition, |
| Transportation, and | Case Work. |

**Method (2):** Services provided to the abusers and victims within the first three months of intake are also logged on the ANETS. For any client, the worker can list a maximum of 7 different services provided to the victim, and 6 different services provided to the abuser. The availability of this second data base allows for a validation of the findings using the abstracted data described in (1).

There are 74 specific services that could be recorded in ANETS. These were categorized into the same groups as in Method (1), with three exceptions. First, case work was not a service category in ANETS. Second, early intervention was a service category available in ANETS that was not categorized in the abstracted data. Third, this data set allowed for a separation of services provided to victims from services provided to abusers, which was not possible with Method (1).

Thus, this method included the following groups of services for both victims and abusers:

Income support/material aid,                     Housing,
Institutional placement,                         Medical Services,
Mental health services,                          Legal services,
In-home health services,                         In-home assistance,
Supervision,                                     Socialization,
Education,                                       Nutrition,
Transportation, and                              Early Intervention.

Scale scores were generated for each group of services, summing the number of services provided within each group. It should be noted that the range of possible scale scores differed for each group, as there were different numbers of services listed within each category.

First, the correlation between services needed and services provided was examined to determine if those who needed services actually received them. The results are summarized in Table 21.

### Table 21
### Correlations between Services Needed & Services Provided
### (N=537)

| SERVICE LISTED IN CASE FILE | CORRELATION |
|---|---|
| Material assistance | .84 |
| Housing | .57 |
| Institutional placement | .84 |
| Medical | .90 |
| Mental health services[9] | .69 |
| Legal services | .81 |
| In-home health | .84 |
| In-home assistance | .67 |
| Supervision | .83 |
| Socialization | .71 |
| Education | 1.00 |
| Nutrition | .78 |
| Transportation | .91 |

---

[9]  Mental health services include counseling, outpatient psychiatric, inpatient psychiatric, *substance abuse* and crisis intervention services.

## Table 21
## Correlations between Services Needed & Services Provided
### (N=537)

| SERVICE LISTED IN CASE FILE | CORRELATION |
|---|---|
| Other | .92 |
| Case work | .98 |

As the table indicates, there is a strong relationship between services determined to be needed and services actually provided. Although all relationships are quite strong, the weakest relationships are for housing (r=0.57), in-home assistance (r=0.67) and mental health services (r=0.69), including substance abuse. These results can be interpreted in two alternative ways. Either these types of services are not readily available to all victims, or victims are more likely to refuse services in these areas.

To examine these interpretations, frequency distributions were computed on services found to be needed, provided to and/or refused by victims. Table 22 shows these results.

## Table 22
## Number and Percent of Clients Refusing Services

| SERVICE | # NEEDED | # PROVIDED | # REFUSED | % REFUSED |
|---|---|---|---|---|
| Material assistance | 44 | 37 | 3 | 7% |
| Housing | 64 | 27 | 34 | 53% |
| LTC placement | 96 | 72 | 23 | 24% |
| Medical | 100 | 84 | 18 | 18% |
| Mental health services | 52 | 26 | 28 | 54% |
| Legal services | 97 | 74 | 22 | 23% |
| In-hone health | 92 | 69 | 20 | 22% |
| In-home assistance | 131 | 74 | 60 | 46% |
| Supervision | 37 | 26 | 7 | 19% |
| Socialization | 40 | 21 | 13 | 33% |
| Education | 4 | 4 | 0 | 0% |
| Nutrition | 52 | 33 | 15 | 29% |
| Transportation | 42 | 35 | 7 | 17% |
| Other | 71 | 61 | 8 | 11% |
| Case work | 186 | 180 | 11 | 6% |

SOURCE: Care Plan in case files

As this table reveals, the second alternative explanation of the lower correlation between services needed and services provided for housing, mental health and in-home assistance is supported. That is, *the areas in which clients are considered to need a service but are not receiving it are those very services that clients are refusing most often. Clients are most likely to refuse housing assistance, in-home care and mental health services, including substance abuse.*

Analysis of the meaning of mental health services indicates that most often provided to victims was counseling (10%). Substance abuse services were only provided to 0.1% of victims and 0.4% of abusers.

Services provided to clients were used in a series of regression analyses to predict change in risk from intake to three months later. Table 23 shows the services that are significant predictors of change in risk score from intake to three months after substantiation.

## Table 23
### Relationship between Services Provided and Change in Risk Score at Intake and 3 Months after Substantiation
#### (N = 293)

| SERVICE PROVIDED | BETA | SIGNIFICANCE |
|---|---|---|
| Institutional placement | .23 | .00 |
| Medical services | .16 | .00 |
| In-home health | -.12 | .00 |
| Variance accounted for ($R^2$) | | 9% |

SOURCE: Care Plan in case notes.

As Table 23 indicates, three services are related to change in risk score. Both institutionalization and medical services are significant predictors of improvement over time. Victims who are institutionalized, and those who receive medical services are more likely to have reductions in risk score after three months. On the other hand, those receiving in-home health care are *less* likely to have a reduction in their risk level after three months.

Thus, table 23 suggests that *placing an elderly victim into long term care is one method of reducing risk.* Medical services may have reduced risk because it may have been for the care of an immediate problem. On the other hand, *those who remain at home, and receive health care services there, appear to remain at higher risk for continued abuse.*

Although these results are logical explanations of the relationship between services and risk reduction, they are in conflict with current trends to keep elderly in their homes. *The results imply that while it may be most desirable to provide in-home services to support the victim's desire to remain at home, these cases also bear close monitoring to prevent future abuse, neglect or exploitation.*

Table 24 shows a replication of the regression analysis using the service data available from ANETS. This analysis uses the second method of measuring services provided.

## Table 24
## Relationship between Services Provided and Change in Risk Score
### (N = 1,206)

| SERVICE PROVIDED | BETA | SIGNIFICANCE |
| --- | --- | --- |
| Institutional placement of victim | .19 | .00 |
| Medical services to abuser | .09 | .00 |
| Early intervention to victim | .07 | .00 |
| VARIANCE ACCOUNTED FOR ($R^2$) | | 5% |

SOURCE: ANETS

While these results replicate the previous regression analysis with respect to the impact of institutional placement on reductions in risk, they differ in the role of services to the abuser and the role of early intervention services in risk reduction. In this analysis, two service categories not available in the first data base proved to be significant predictors of risk reduction. *The provision of medical services to the abuser and the provision of early intervention services to the victim were both related to reductions in risk over time. This is the first objective evidence of the impact of services to the abuser on reducing the risk of future abuse, neglect or exploitation.*

To understand the meaning of these results, the specific types of abuser medical services and early intervention services were investigated. Table 25 shows the services provided under the category of "medical services to the abuser." Table 26 shows the services provided under the category of "early intervention services."

## Table 25
## Meaning of Medical Services to Abuser
### (N=1,260)

| SPECIFIC MEDICAL SERVICE | FREQ | % |
| --- | --- | --- |
| In-patient/acute care | 3 | 0.2 |
| Psychiatric | 7 | 0.6 |
| Physician MD/DO | 10 | 0.8 |
| Other | 1 | 0.1 |

## Table 26
## Meaning of Early Intervention Services
## (N=1,260)

| SPECIFIC MEDICAL SERVICE | FREQ | % |
|---|---|---|
| Material aid | 8 | 0.6 |
| Medical expenses | 8 | 0.6 |
| Psychiatric evaluation | 4 | 0.3 |
| Transportation | 6 | 0.5 |
| Environmental aid | 7 | 0.6 |
| Respite care | 2 | 0.2 |
| Court costs | 4 | 0.3 |
| Guardianship proceedings | 2 | 0.2 |
| Order of Protection | 7 | 0.6 |
| Attorney fees | 5 | 0.4 |
| Recovery of damages | 1 | 0.1 |
| Emergency housing | 6 | 0.5 |
| Relocation | 4 | 0.3 |

As Table 25 indicates, medical services to the abuser means primarily physician services and psychiatric services. As shown in Table 26, early intervention includes a wide variety of services. Most frequently early interventions are material aid, medical expenses, environmental aid, transportation, orders of protection and emergency housing.

Taken together, *these results suggest that those victims likely to see reductions in risk over time are those who are institutionalized, whose abusers receive either medical or psychiatric services, and/or who receive one or more of a variety of early interventions.*

Finally, to completely answer question #6, the role of victim and abuser characteristics was examined in a regression analysis along with services provided. The demographic characteristics predictive of change -- victim being spouse of the victim and informal caregiver -- were entered into the regression along with the services which significantly predicted change in risk. Table 27 shows the results of comparing services provided with those abuser and victim characteristics likely to be related to change in risk score.

## Table 27
## Relative Importance of
## Services and Characteristics of Victims and/or Abusers
## in Predicting Change in Risk from Intake to Case Closure
## (N = 1,206)

| VARIABLE | BETA | SIGNIFICANCE |
|---|---|---|
| Institutional placement of victim | .21 | .00 |
| Abuser medical services | .14 | .00 |
| VARIANCE ACCOUNTED FOR | | 6% |

As Table 27 indicates, the two demographic variables were not significant predictors of change in risk at case closure. Only institutional placement of the victim and the abuser receiving medical services predicted change in risk.

It is logical to expect a reduction in risk for victims placed in institutions. *An unanticipated finding is that medical services to the abuser is the other service that is significantly related to reducing the risk of abuse, neglect or exploitation.*

Because of the importance of long term care placement in predicting risk reduction, further analyses were conducted to understand which victims were placed into long term care. First, correlations were computed between long term care placement and type of abuse substantiated. Results indicate that the only type of abuse significantly correlated with long term care placement is neglect[10] and deprivation[11]

A regression analysis was computed to determine if any victim barriers predicted long term care placement. Results indicate that the victim being disoriented[12] and the victim having Alzheimer's Disease[13] are the only two significant predictors of long term care placement, while the victim having no barriers significantly predicted non-placement of the victim into long term care.

---

[10]   $r = 0.21$; $p \leq .000$)

[11]   $r = 0.11$; $p \leq .004$

[12]   $Beta = 0.24$; $p \leq .000$

[13]   $Beta = 0.13$; $p \leq .000$

*Summary:* Results indicate that services are more predictive of change in risk than characteristics of the victim or abuser. Specifically, placing a cognitively impaired victim of neglect into long term care appears to be related to risk reduction. This finding indicates that although community-based interventions are preferred by the elderly, remaining in the community is less of an option for those victims of neglect, especially those who are disoriented.

An unanticipated finding is the importance of providing medical/psychiatric services to the abuser as a means of reducing risk to the victim. This result underscores the importance of providing interventions to abusers if risk to victims is to be reduced.

## 7. Can successful case closure be predicted by the status of the case only 90 days after intake?

Case status at 90 days is taken from the overall risk score on the ANETS. A correlation analysis was computed to determine the relationship between this 3-month risk score and initial risk score, risk score at closure, change in risk score at three months and change from intake to closure. Table 28 illustrates the results.

### Table 28
### Relationship between 3-Month Risk, Risk at Other Times and Change in Risk Over Time

| Risk Score | N | Correlation with Risk Score at 3 Months | Significance (p $\leq$) |
|---|---|---|---|
| Initial Risk Score | 1,233 | .51 | .000* |
| Overall Risk at Closure | 239 | .98 | .000* |
| Change in Risk at 3 Months | 1,233 | -.44 | .000* |
| Change in Risk at Closure | 239 | -.30 | .000* |

* These relationships are statistically significant.

These results indicate that the risk score of the victim at three months is strongly related to the risk score at case closure. The correlation of 0.98 between risk score at closure and 3 month risk is probably due to the fact that 72% of the closed cases in this study were found to be closed within 4 months. This result, however, is likely to be biased as most (85%) of the cases in the program at the time of data analysis were still open. Further, of all the cases in the program at the time of data analyses, 67% had been open more than 4 months.

These results also indicate that a higher risk score at 3 months is associated with lack of improvement for the victim at case closure. This suggests that *if a case has not improved within three months, it is not likely to improve any more beyond three months.* These results may also be biased by the non-representativeness of the sample.

The correlation between initial risk score and risk change after three months was calculated to be 0.54 (not shown in table; p $\leq$ .000). Similarly, the correlation between initial risk score and risk change at closure is 0.56 (p $\leq$ .000). These findings replicate the results shown in Table 5, that the more severe the case at intake, the more it will improve after three months.

*Summary:* For most victims in this study, their 3 month risk score is the closure risk score. The most likely reason for this relationship is that among these subjects, most of the cases were closed within four months. These results are likely to be biased since only 15% of all of the cases in the program at the time of the study were closed at the time of data analyses.

## 8. Does the amount of case work time spent on a case predict successful interventions?

The amount of time caseworkers spend on elder abuse cases was calculated by adding the total number of minutes spent in face-to-face visits, making phone calls and doing preparatory activities such as meetings and documentation. Table 29 shows the amount of time, in minutes, that the case workers spent on these activities prior to making the substantiation decision, and after the decision had been made.

### Table 29
### Time (in minutes) Spent on Elder Abuse Cases
### (N=529)

|  | MIN | MAX | MEAN | MEDIAN | SD |
|---|---|---|---|---|---|
| **PRE-SUBSTANTIATION ACTIVITIES** | | | | | |
| Face-to-face visits | 15 | 2,060 | 173 | 135 | 159 |
| Phone calls | 1 | 715 | 105 | 65 | 108 |
| Preparatory | 5 | 575 | 71 | 45 | 73 |
| Total pre-substantiation time | 80 | 2,465 | 388 | 315 | 282 |
| **POST-SUBSTANTIATION ACTIVITIES** | | | | | |
| Face-to-face visits | 5 | 2,545 | 271 | 150 | 320 |
| Phone calls | 5 | 3,267 | 145 | 82 | 235 |
| Preparatory | 1 | 1,395 | 112 | 60 | 150 |
| Total post-substantiation time | 35 | 5,697 | 668 | 440 | 689 |

The table illustrates the complexity of elder abuse cases. The range of time spent in investigating a report ranges from 80 minutes to 41 hours (2,465 minutes). The range of time spent intervening after substantiation ranges from 35 minutes to 95 hours (5,697 minutes). Clearly, these data indicate that *enormous effort must sometimes be expended in handling cases of elder abuse.*

On the average, 6.5 hours of time are spent investigating cases of elder abuse, and about 11 hours per case are spent intervening. For 50% of the cases, more than 5 hours are spent investigating abuse, and more than 7 hours are spent intervening after substantiation. On the average, 7 encounters (face-to-face, phone calls, meetings, etc.) with the case are made prior to substantiation, and 12 encounters are made after the decision is made. These numbers may be underestimates, as 8% or more of the cases had missing data in the recording of time involved in each encounter.

To determine whether the amount of time spent on the case was related to successful intervention, correlations were computed between time spent on the case and both the change in risk score and reason for case closure. The results are displayed in Table 30.

## Table 30
## Correlation between Time Spent on Case
## and Success in Intervening[14]

| | 3-Month Change in Risk Score | Closure Change in Risk Score | Case Closed Due To "No more risk" |
|---|---|---|---|
| Pre-substantiation time | .01 | .07 | -.10 |
| Post-substantiation time | **-.24** | **.17** | **-.23** |
| Total time | **-.22** | **.20** | **-.20** |
| Pre-substantiation number of encounters | .02 | .08 | .03 |
| Post-substantiation number of encounters | -.16 | **.12** | **-.11** |
| Total number of encounters | -.11 | **.14** | -.07 |

**bold** = correlation is significant $p \leq .05$.

As indicated in Table 30, the amount of time spent on the case is *negatively* correlated with improvement after three months and with the case closing because of "no more risk." These results probably refer to those cases of elder abuse that are easier to "fix." *There appears to be a subset of cases that require little time of the case worker but result in successful outcomes.*

On the other hand, there is a significant and positive relationship between the time spent on a case and change in risk score by the time of closure. These results indicate that *those cases in which much time is spent in intervention are likely to result in improvement in risk by the time of case closure.*

Similarly, the total number of encounters the case worker has with a case is positively related to change in risk score at case closure. But, the number of encounters with the case after substantiation is *inversely* related to closing a case due to "no more risk." That is, *cases that close because of "no more risk" tend to be cases in which less time and fewer encounters are made.*

*Summary:* There is great variation in the amount of intervention provided to cases of elder abuse. In this sample of cases, caseworkers spent between 2 and 95 hours investigating and intervening with victims.

The amount of time spent on a case is related to success in contradictory ways. There appears to be a subset of cases in which interventions are simple with the case closed because the victim is "no longer at risk." Those cases which close because of "no more risk" receive significantly less time and significantly fewer post-substantiation encounters than cases which close for some other reason.

---

[14] Ns for each correlation varied, ranging from 66 to 286.

On the other hand, there appears to be a subset of cases in which greater time spent on intervention is less likely to be related to change after three months, but more likely to be related to improvement in risk score at case closure. These may be more difficult cases which enter the program at high risk, and receive many hours of intervention. For these cases, risk is reduced at the time of closure, even though they are not closed because of "no more risk." Perhaps the longer these cases are open, the more trust the victim comes to have in the worker and program, and therefore the more likely s/he is to make changes.

## 9. Are cases of self-reported ANE more often resolved than cases reported by someone else?

The correlation was computed between reporter type on the ANETS and risk change. Reporter type was coded so that a score of 1 indicated self-reported abuse and a score of 0 indicated a report made by someone else. Results are shown in Table 31.

### Table 31
### Relation between Self-Report and Change in Risk

| Type of Risk Change | N | Correlation with Self Report | Significance |
|---|---|---|---|
| Risk Change: Intake to 3 Months | 1,233 | -.06 | $p \leq .02$ |
| Risk Change: Intake to Closure | 518 | -.03 | NS |

These results indicate that other-reported abuse is significantly associated with an improvement in risk after 3 months. However, victims who report themselves are no more likely to improve at the end of intervention than those reported by others.

This analysis was replicated by computing the correlation between self-reports and "no more risk" as the reason for case closure. The correlation between self-reported abuse and the case being closed for "no more risk" was 0.14.[15] While this correlation was statistically significant, it is not strong. However, this result does contradict the finding above, using change in risk as the measure of intervention success.

To understand this contradiction, Chi-Square analyses was computed between initial risk score and self versus other-reported abuse. The results indicate that self-reported cases are more likely to be assigned an initial risk score of "1." Forty-four percent of self-reported cases had initial risk scores of "1" compared with 35% of other-reported cases.[16] This finding supports the lack of relationship between self-reported abuse and change in risk score.

*Summary:* Using the second measure of success -- reason for case closure, there is a small but significant relationship between the report being self-generated and successful intervention. The measure of risk change is not a valid measure for intervention success in this analysis, since significantly more self-reported cases of abuse, neglect or exploitation receive a low risk score an intake and, therefore, cannot receive a positive change score at case closure.

---

[15]  N=552; $p \leq .001$

[16]  Chi-Square=12.21; $p \leq .002$; N=2,717 df=2.

## 10. Is the length of time a case stays open within an agency related to a reduction in risk?

Case-open time was defined as the number of days between intake and case closure. The distribution of time that cases stay open is illustrated in Table 32.

**Table 32**
**Range of Time Cases Stay Open**

| Time Range in Days | # of Cases | % of Cases |
|---|---|---|
| <7 days | 2 | .4% |
| 7-14 days | 3 | .5% |
| 15-30 days | 13 | 2% |
| 31-60 days | 46 | 8% |
| 61-90 days | 132 | 24% |
| 91-120 days | 257 | 47% |
| 121-150 days | 26 | 5% |
| >150 days | 69 | 13% |

To answer this question, a correlation analysis was computed between the number of days the case is open and risk change. The results are shown in Table 33.

**Table 33**
**Relation between Case Work Time and Risk Change**

| Type of Risk Change | Correlation With Time Case Open | Significance |
|---|---|---|
| From Intake to 3 Months | -.008 | NS |
| From Intake to Closure | -.050 | NS |

These results indicate that the relationship between the amount of time the case is open and change in risk is not significant. *This suggests that the length of time the case stays open does not relate to success in intervention.*

To validate this result, the second measure of intervention success -- no more risk -- was used in a correlational analysis with the number of days the case stays open. The results indicate that the number of days a case stays open is not significantly associated with a case closing because of "no more risk."

*Summary:* Results from a correlational analysis indicate that there is no significant relationship between the number of days a case stays open and either change in risk score or whether a case closes because of "no more risk."

# Interpretations and Recommendations

This study represents the first known objective investigation of interventions and outcomes for elder abuse victims. Several important findings resulted from this research which led to the preparation of a case worker training curriculum. The results can also be used to make recommendations for future efforts aimed at successful intervention with victims of abuse, neglect or exploitation.

It is significant to note that even in its infancy, the Illinois statewide elder abuse program was successful in reducing the risk level of more than one-half of the cases which were not already at low risk at the time of the report. Of those cases in which the victim was at high risk at intake, the elder abuse worker was able to reduce 44% to low risk, and an additional 13% were reduced to moderate risk.

Cases most difficult to change were those involving chronic and/or severe abuse, substance abuse of the abuser, abuser inability to respond appropriately to stress, and financial dependence of the abuser on the victim. This finding emphasizes the role of abusers' behavioral and emotional problems on maintaining high risk situations for victims. Coupled with the finding that information about the abuser is frequently lacking, the need to focus training and intervention efforts on dealing with abusers is apparent. In fact, the training program developed from this research focuses on case workers' attitudes, knowledge and skills in dealing with abusers, particularly abusers who are chemically dependent.

Another important finding from this research is that placement into long term care is a significant intervention used to reduce risk, especially for neglect victims who are mentally ill or who have Alzheimer's disease. This points to a need to link information between the elder abuse program and the State Long Term Care Ombudsman.

The role of institutions in ameliorating neglect leads to a series of questions that could be addressed in future research. For example, why is long term care placement the intervention most often used for neglect cases? Were other, less restrictive, interventions deemed inappropriate or were they unavailable? By the time neglect cases were reported, was the victims' situations so advanced that long term care placement was the only appropriate solution? Do victims of domestic neglect continue to be victimized by family members after institutionalization? Are nursing homes more vigilant about visitors or potential financial exploitation of these clients?

The role of substance abuse must also be highlighted. Substance abuse of the abuser is a major predictor of high risk situations at the time of the report. Chemical dependency of the abuser predicts continued high risk for victims. Substance abuse of the abuser, among other risk factors, it also the least likely to change over time. These findings indicate that unless interventions take serious aim at resolving problems of abusers, victims' situations are not likely to improve. This means that case workers must learn more about substance abuse in the family. They must look beyond the aging network for services likely to help the abuser. Case workers must learn how to identify chemical dependency and what to do after the problem emerges.

Further, systemic changes may be needed to support the case workers efforts. For example, substance abuse treatment must be available and accessible for any headway to be made in

these areas. Funding sources for serving victims must allow for services aimed at reducing chemical dependency among abusers if these cases are to be resolved. This need is particularly acute when the abuser is not eligible for aging network services. Attacking substance abuse of the abuser means accessing services not within the aging network. This may involve creative methods of serving victims and abusers in the home. Services should include helping the victim learn about and control codependency and enabling behaviors. It could involve changes in licensing policies that license provider sites instead of individual therapists, and is likely to involve collaborating with service providers not well-versed in the problems of aging or the dynamics of elder abuse.

An unanticipated finding from this research is that for almost one in ten victims, the abuser is a paid caregiver. This supports the need for quality assurance and monitoring of in-home services for the elderly.

This research documented the level of effort needed to intervene in cases of elder abuse. On the average, 17 encounters are made with an elder abuse case from the time of intake to the time of case closure. In one case, 225 encounters were made by the time the case was closed. This finding highlights the importance of limiting the case loads of elder abuse workers. The results also make understandable the burnout and frustration often voiced by elder abuse workers. Findings from this research suggest that elder abuse cases are highly complex and are likely to require several visits, phone calls and other activities. To be successful, case workers must be allowed the time to intervene appropriately and spend as much time as is needed to reduce the victim's risk of future abuse, neglect or exploitation. To be successful, case workers must also have the skills and resources to attack life-long problems in family dynamics.

On the other hand, an unwelcomed conclusion from this research is that for some cases of elder abuse -- those chronic cases with long histories of abuse and chemical dependency -- successful intervention may not be totally within the case worker's control.

One reason for the outcomes from this study is that the Department places a strong emphasis on client self-determination. Many clients may choose not to make changes, or to coerce their families into making changes, which would reduce their risk of abuse but might result in other unwanted changes in their lives such as separation from family members and/or moving. While unfortunately not eliminating the risk of abuse, this emphasis on self-determination preserves victims' independence and control to the maximum extent and prevents the Department from paternalistically forcing changes older persons do not want and would probably not support. This also affects how much influence the program can have with abusers. If the abuser is unwilling to accept services, and the victim will not agree to forcing the abuser to do so, such as through a court order, the case worker may have limited little control over the outcome.

The results from this research were used to develop a training program to assist case workers in learning what interventions to use and what degree of "success" to expect when intervening with cases of elder abuse, neglect and exploitation. The Department's policies require elder abuse case workers to obtain continuing education related to elder abuse. Training materials were developed and pilot tested with two groups of elder abuse workers. Both training programs received very favorable responses from the participants. Training

materials, the trainers' manual and training consultants are available to others wishing to replicate the training program in other locations.

The results from this research are biased by the fact that subjects in the study were from the first two years of Illinois' elder abuse program. Some rural areas of the state are not fully represented among the victims. Many long-time, "unofficial" cases were grandfathered into the program once funding became available. Further, early problems identified with the definition of "initial risk score" resulted in some questions as to the validity of this measure.[17] These threats to external validity indicate that these analyses should be repeated on a second data set of cases entering the program in later years, as well as with data from other states.

Replication of these analyses on other data sets can address many questions left unanswered by this research. For example, do some victims remain at high risk because the program does not have sufficient resources to handle problems involving chronic abuse or chemical dependency? Or, because a number of seriously ill, complex and chronic cases were grandfathered into the program once funding became available to serve these clients? Do other states have similar outcomes? Do states with mandatory reporting yield different outcomes? Are outcomes different when state agencies deliver services rather than subcontracted providers? These and many other questions raised by this research should be answered before drawing conclusions about successful interventions. Caution is advised in making program or policy decisions based on these findings until the study is replicated on a second sample of victims to determine the generalizability of the results.

In conclusion, it should be noted that outcome research in aging services is rare. This research represents the first and only known outcome data published on the effects of statewide elder abuse program interventions. Results from this study provided important information to the State of Illinois about ways its statewide elder abuse program can be improved. It is recommended that other states examine their own outcome data to monitor the effectiveness of interventions in community-based elder abuse systems.

---

[17] It was found that many elder abuse workers were recording the risk level at the time of substantiation rather than reflecting the risk level at the time of the report. This was later corrected via follow-up training.

# Bibliography

1. Block, M. and Sinnott, J. (1979) The battered elder syndrome: An exploratory study. College Park: University of Maryland, Center on Aging. Lau, E. and Kosberg, J. (1979) Abuse of the elderly by informal care providers. Aging, September/October, 10-15. Steinmetz, S.K. (1981) Elder abuse. Aging, 315-316, 6-10. Hickey, T. and Douglass, R.L. (1981) Mistreatment of the elderly in the domestic setting: An exploratory study. American Journal of Public Health, 72, 500-507.

2. Tatara, T. (1989) Toward the development of estimates of the national incidence of reports of elder abuse based on currently available state data: An exploratory study. In Filinson, R. and Ingman, S.R. (Eds.) Elder abuse: Practice and policy. New York: Human Sciences Press. Pillemer, K. and Finkelhor, D. (1988) The prevalence of elder abuse: A random sample survey. Gerontologist, 28 (1), 51-57.

3. Sengstock, M.C. and Hwalek, M.A. (1986) Critical Analyses of Measures for the Identification of Elder Abuse, Journal of Gerontological Social Work. Hudson, M.F. (1989) Analyses of the concepts of elder mistreatment: Abuse and neglect. Journal of Elder Abuse and Neglect, 1 (1), 5-25. Fulmer, T.T. and Cahill, V.M. (1984) Assessing elder abuse: A study. Journal of Gerontological Nursing, 10 (12), 16-20.

4. Wolf, R.S. (1986) Major findings from three model projects on elder abuse. In K.A. Pillemer and R.S. Wolf (eds.), Elder abuse: Conflict in the family (pp. 218-238). Dover, MA: Auburn House Publishing Company. SPEC Associates (1986) Final report from an evaluation of four elder abuse demonstration projects. Detroit: SPEC Associates.

5. Ibid.

6. Ibid. Sengstock, M.C. and Liang, J. (1982) Identifying and characterizing elder abuse. Detroit: Wayne State University, Institute of Gerontology.

7. Phillips, L.R. (1983) Abuse and neglect of the frail elderly at home: An exploration of theoretical relationships. Journal of Advanced Nursing, 8, 379-392.

8. Ibid. Sengstock, M.C., Hwalek, M.A. and Petrone, S. (1989) Services for aged abuse victims: Service types and related factors. Journal of Elder Abuse and Neglect, 1 (4), 37-56.

9. Breckman, R.S. and Adelman, R.D. (1988) Strategies for helping victims of elder mistreatment. Beverly Hills: Sage Publications. Quinn, M.J. and Tomita, S. (1986) Elder abuse and neglect: Causes, diagnoses and intervention strategies. New York: Springer.

# Illinois Department on Aging

# Risk Assessment Form[1]

---

[1] This instrument was modified from the risk assessment form developed and validated by the Florida Protective Services System of the Florida Department of Health and Rehabilitative Services, Aging and Adult Services

Illinois Department on Aging

# ANE RISK ASSESSMENT

## SECTION A: CASE CONTROL INFORMATION

| CLIENT # | CLIENT NAME | ASSESSMENT DATE |
|---|---|---|
| | | |

INITIAL ABUSE SUBSTANTIATED

☐ PHYSICAL   ☐ SEXUAL   ☐ EMOTICHAL   ☐ CONFINEMENT   ☐ P. NEGLECT   ☐ DEPRV   ☐ EXPLOIT.

| ASSESSMENT TYPE (Check one) | | | |
|---|---|---|---|
| INITIAL | | 9-MONTH | |
| 3-MONTH | | 12-MONTH | |
| 6-MONTH | | 15-MONTH | |

| RISK ASSESSMENT CODES |
|---|
| 0 = INSUFFICIENT INFORMATION |
| 1 = NO/LOW RISK |
| 2 = INTERMEDIATE RISK |
| 3 = HIGH RISK |

## SECTION B: RISK FACTORS

| CLIENT FACTORS | RISK CODE | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | |
| CLIENT'S AGE/SEX | | | | | |
| PHYSICAL HEALTH AND/OR FUNCTIONAL ABILITIES | | | | | |
| MENTAL/EMOTIONAL HEALTH | | | | | |
| SUBSTANCE ABUSE AND OTHER SPECIAL PROBLEMS | | | | | |
| INCOME/FINANCIAL RESOURCES | | | | | |

| ENVIRONMENTAL FACTORS | RISK CODE | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | |
| STRUCTURAL SOUNDNESS OF THE HOME | | | | | |
| APPROPRIATENESS TO THE CLIENT | | | | | |
| CLEANLINESS OF RESIDENCE | | | | | |

| TRANSPORTATION AND SUPPORT SERVICES | RISK CODE | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | |
| AVAILABILITY/ACCESS AND RELIABILITY OF SERVICES | | | | | |
| ADEQUACY OF FORMAL OR INFORMAL SUPPORT NETWORK | | | | | |

IL-402-0711 (Rev. 10-16-89)

| CURRENT AND HISTORICAL FACTORS | RISK CODE | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| SEVERITY OF PHYSICAL OR PSYCHOLOGICAL ABUSE | | | | |
| FREQUENCY/SEVERITY OF FINANCIAL EXPLOITATION | | | | |
| SEVERITY OF NEGLECT | | | | |
| QUALITY/CONSISTENCY OF CARE | | | | |
| PREVIOUS HISTORY OF VIOLENCE, ABUSE, NEGLECT OR EXPLOITATION | | | | |

| PERPETRATOR FACTORS | RISK CODE | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| ACCESS TO THE CLIENT | | | | |
| SITUATIONAL STRESS/RESPONSE TO HOME CRISES | | | | |
| PHYSICAL HEALTH | | | | |
| MENTAL/EMOTIONAL HEALTH/CONTROL | | | | |
| PERPETRATOR/VICTIM DYNAMICS CONTRIBUTING TO RISK | | | | |
| COOPERATION WITH THE INVESTIGATION | | | | |
| FINANCIAL RESOURCES/DEPENDENCY ON THE CLIENT | | | | |
| SUBSTANCE ABUSE AND OTHER SPECIAL PROBLEMS | | | | |

## SECTION C: OVERALL ASSESSMENT OF RISK

| # INSUFFICIENT INFORMATION | # NO/LOW RISK | # INTERMEDIATE RISK | # HIGH RISK | TOTALS | WORKER'S SIGNATURE | SUPERVISOR'S INITIALS |
|---|---|---|---|---|---|---|
| | | | | | | |

OVERALL LEVEL OF ASSESSED RISK [ ]

## COMMENTS

_____

_____

_____

_____

_____

_____

# INSTRUCTIONS FOR ANE RISK ASSESSMENT

## USES OF FORM

a. Risk assessment is an ongoing evaluation process in which each factual observation and each piece of evidence is analyzed in order to determine the extent to which the aged person or disabled adult is in danger of harm, injury, or loss.

b. The risk assessment form is not designed to diagnose or confirm if abuse, neglect, or exploitation occurred.

c. The risk assessment is to be used:

   (1) to provide a comprehensive listing of factors and variables on which the assessment of risk could be based;

   (2) to ensure a uniform and systematic method for assessing risk;

   (3) to provide an assessment tool to evaluate the aged person and his/her present environment;

   (4) to increase the accuracy of all decisions revolving around the assessment of risk;

   (5) to strengthen the accountability of the decisions made by the elder abuse case worker by providing a means to document decisions;

   (6) to make decisions based on facts rather than "feelings";

   (7) to compare the most recent risk assessment to previous assessments to determine patterns or trends, case plan or need for revisions;

   (8) to provide elder abuse case workers and supervisors a means for pertinent case information to share with other staff who will assist in evaluation of the victim's needs for services.

A risk assessment must be completed for all reports of abuse, neglect or exploitation found to be substantiated. Risk assessments are to be completed at the close of the assessment, at the termination of case work (ie. 90 days after intake) and after each 3-

---

month face-to-face follow-up. A completed risk assessment from each of these time periods must be kept in the case file.

## SECTION A: CASE CONTROL INFORMATION

CLIENT #

Write the nine-digit number assigned to this case. This should be the same number as that of the CLIENT # on the ANE INVESTIGATION REPORT and the ANE INTAKE FORM.

CLIENT NAME

Enter the name of the client.

ASSESSMENT DATE

Enter the date that this risk assessment is being completed.

INITIAL ABUSE SUBSTANTIATED

Enter the codes from the ANE INVESTIGATION FORM (Section D) that was the final determination at the end of the assessment (ie. V, S, N or U).

ASSESSMENT TYPE

Check the type of assessment that is being recorded on this copy of the form.

INITIAL: The assessment is being completed for the first time on this client. (NOTE: This assessment should reflect the risk status of the client BEFORE any interventions were put into place by the case worker.)

3-MONTH: The assessment is being completed at the close of case-work, 90 days after the intake date (+ or - 10 working days).

6-MONTH: The assessment is being completed after the fist 3-month follow-up face-to-face visit.

9-MONTH: The assessment is being completed after the second 3-month follow-up face-to-face visit.

12-MONTH: The assessment is being completed after the third 3-month follow-up face-to-face visit.

---

15-MONTH: The assessment is being completed after the fourth 3-month follow-up face-to-face visit.

## SECTION B: RISK FACTORS

Each risk factor must be scored, either 0, 1, 2 or 3. The meaning of a 1, 2 and 3 varies, depending upon the exact risk factor being assessed. The meaning of these scores for each factor are described, beginning on page 3.

Relevant details, examples, etc., that help illustrate or clarify the scores on the factors should be written in the space provided to the right of the factors (eg. client diagnosed as Alzheimer's, broken windows in house, etc.) Professional judgement and experience must be used, along with the information reflected in the case recording form to assign a level of risk to each factor. The degree of risk assigned to a given factor must be checked in the appropriate space.

Factors that are not applicable to the specific case are to be scored "0", and an explanation as to why the factor is not relevant should be written in the space at the right of the factor. For instance, under the Perpetrator Factors section, there are factors applicable only when the abuser is a caregiver to the victim.

Factors for which there is insufficient information to assess risk are to be scored "0."

If there is more than one abuser, a Perpetrator Factors Section shall be completed on each abuser.

Following the completion of the risk assessment, the elder abuse worker should tally the total number of items checked 0, 1, 2, and 3. These numbers should be entered in the spaces provided on the back page of the ANE RISK ASSESSMENT.

All items should be checked to ensure that they have been assessed. Numbers on the last page should be added and MUST total 23. If different, the assessment must be re-checked. A higher total indicates that a factor has been counted twice; a lower number indicates that a factor has not been counted. In order to ensure that the tallied scores equal 23 on risk assessments completed where there is more than one abuser (i.e. the Perpetrator Factors Section has been completed for more than one abuser), use the highest score assigned to each individual factor as the risk factor score.

Use professional judgement and experience, as well as the information gathered during the investigation, to assign an overall level of risk to the client. Enter assessment (either "1", "2", or "3") in the space provided for OVERALL LEVEL OF ASSESSED RISK.

---

In the COMMENTS section, write a brief summary indicating the factors that were decisive in determining the client's overall level of risk. In preparing comments, consider that it will likely be read by others who lack the benefit of direct contact with the client. An effective summary should communicate to the reader how the protective elder abuse case worker interpreted and weighed the relative strengths and weaknesses reflected in individual risk factors to reach the client's overall level of risk.


## SECTION C: OVERALL ASSESSMENT OF RISK

This section of the form is for tallying scores on the 23 risk factors. Count the number of times each category (insufficient information, no/low risk, intermediate risk, high risk) was checked. Enter this subtotal in the appropriate space. Use the "TOTALS" box to add the subtotals to assure that all 23 factors have been examined and tallied. THE TOTAL SHOULD ALWAYS EQUAL 23. If the total is greater than 23, either two risk scores were checked for a particular factor, or there was an error made in addition. If the total is less than 23, it is likely that a score is missing on one or more risk factors.

After reviewing the subtotals in each subcategory, make a clinical judgement as to the overall assessment of risk. Assign a number of 1, 2, or 3 as the overall risk score, using the following guide:

  1 =   Overall, the situation is not likely to recur or to escalate in severity.

  2 =   In general, there is some possibility that the situation will continue and possibly escalate.

  3 =   It is very likely that the situation will continue and probably escalate in the future.

Use the comments section to explain the rationale for the overall level of assessed risk.

CASEWORKER SIGNATURE:

The worker who has completed the assessment should place his/her signature here.


SUPERVISOR'S INITIALS/DATE:

The supervisor of the case worker who completes the assessment must initial this report in the space provided. The initials indicate that the supervisor discussed with and approved the level of assessed risk made by the elder abuse case worker. Enter the date the supervisor approved the assessment.

---

| CLIENT FACTORS | | |
|---|---|---|
| 1 = NO RISK/LOW RISK | 2 = INTERMEDIATE RISK | 3 = HIGH RISK |
| **CLIENT'S AGE/SEX**<br>60 year old female<br>60 - 74 year old male | 60 - 74 year old female | 75+ male or female |
| **PHYSICAL HEALTH AND/OR FUNCTIONAL ABILITIES**<br>Ambulatory, minimal physical disability. Capable of meeting ADLs. | Diminished capacity. Moderate physical disability. Difficulty ambulating; requires prosthesis (cane, walker, etc.) or hands-on assistance to be ambulatory. Occasioually non-ambulatory. | Severe and functionally limiting disability. Bedridden, completely dependent on others, chronic disease, rapid deterioration of functional abilities. |
| **MENTAL/EMOTIONAL HEALTH**<br>None, or minimal/controlled mental or emotional disability. Willingness to accept needed assistance. | Moderate mental retardation. Periodic confusion. Impaired reasoning abilities. Decompensated mental illness. Resists accepting needed services. | Profound mental retardation. Severe functionally-limiting mental illness. Confusion. Recent, rapid deterioration of mental/emotional health. Refuses needed services. |
| **SUBSTANCE ABUSE AND OTHER SPECIAL PROBLEMS (e.g., wandering, misuse of medication, non-compliance with physician's instructions)**<br>No indication of substance abuse. None, or minor special problems (specify). | Periodic episodes of alcohol or substance abuse. | Active alcoholic or substance abuser. Any change that places the client at high risk (specify). |
| **INCOME/FINANCIAL RESOURCES**<br>Adequate. Able to provide for the necessities of life. Financially independent of others. | Partially dependent on others financially. Marginal financial resources; barely able to provide for the necessities of life. Must sometimes choose between necessities, e.g., medicine versus food. | Totally dependent on others financially or, regardless of income unable/unwilling to provide for the necessities of life. |

| ENVIRONMENTAL FACTORS | | |
|---|---|---|
| 1 = NO RISK/LOW RISK | 2 = INTERMEDIATE RISK | 3 = HIGH RISK |
| **STRUCTURAL SOUNDNESS OF THE HOME**<br>Sound structure with no apparent safety problems. | Deteriorating structure, or safety problems that pose some degree of risk. | Client living in a structurally unsound or condemned structure. Gross safety problems. |
| **APPROPRIATENESS TO THE CLIENT**<br>Operating utilities (heat, power, water, ventilation, etc.) appropriate to climate and client's health. Residence does not contribute to client's risk. | Service temporarily terminated or periodic interruption of heat, power, water, ventilation (unvented heaters). Residence poses special problems that place the client at risk (specify), e.g., client wanders and lives near major highway. | Services terminated or utilities inoperative. Residence poses special problems that place the client at immediate high risk (specify), e.g., non-ambulatory client residing on third floor; client repeatedly victimized by violent crime, residence cannot be made safe. |
| **CLEANLINESS OF RESIDENCE**<br>Residence meets minimum standard of cleanliness. Trash not exposed. No odors present. | Trash and garbage not disposed of; animal droppings and some evidence of pest/insect infestation. | Gross health violations, e.g., severe pest/rodent infestation. Human waste present. |

| | TRANSPORTATION & SUPPORT SYSTEMS | | |
|---|---|---|---|
| | 1 = NO RISK/LOW RISK | 2 = INTERMEDIATE RISK | 3 = HIGH RISK |
| AVAILABLILITY/ACCESS AND RELIABILITY OF SERVICES, i.e., transportation, homehealth, medical, etc. | Adequate and reliable community resources available. Client able to leave residence on a regular basis. Transportation available. | Limited community services available, or short-term waiting list. Service reliability is problemmatic. Public transportation is unavailable; private transportation is problemmatic. | Geographically isolated from community services. Long waiting lists. Services unreliable or not available at frequency required. |
| ADEQUACY OF FORMAL OR INFORMAL SUPPORT NETWORK. | Family, friends and neighbors available, willing, and able to provide or arrange needed services. Has a well-informed, effective advocate; known to service system; already receiving services. | Family somewhat supportive, but not in geographic area. Limited support from family, friends, and/or neighbors. Support is irregular in quality and/or frequency. Limited or incomplete knowledge of available public or private resources. | Client is socially isolated, no one available, willing, or able to provide assistance. No knowledge of formal support system. Unable to access available services. Lacks a willing/effective advocate. |

| | CURRENT & HISTORICAL ANE | | |
|---|---|---|---|
| | 1 = NO RISK/LOW RISK | 2 = INTERMEDIATE RISK | 3 = HIGH RISK |
| SEVERITY OF PHYSICAL OR PSYCHOLOGICAL ABUSE. | None or minor injury limited to bony body parts, i.e.,knees, elbows. No apparent adverse psychological effect on client. | Minor or unexplained injury (limited to bony body parts, buttocks or torso) requiring medical treatment/diagnosis. Pattern of increasing severity of abuse. Client evidencing some adverse psychological effects of abuse (fear, anger, withdrawal, depression, etc.). | Client requires immediate medical treatment/ hospitalization. Any sex abuse or injury to head, face, genitals. Escalating pattern of severe abuse. Client evidences serious adverse psychological effects of abuse. |
| FREQUENCY/SEVERITY OF EXPLOITATION OF PERSON OR PROPERTY. | None, or exploitation with little, if any, impact on the client's health, safety, or well-being. | A pattern of on-going exploitation which, if unchecked, could threaten the health, safety, or well-being of the client. | Any exploitation which threatens the health, safety, or well-being of the client, or deprives the victim of the necessities of life. Any systematic misuse of client's resources, e.g., fraud/forgery. |
| SEVERITY OF NEGLECT | None. Isolated, explainable incident, or neglect with little risk to the client. | Deprivation of adequate supervision of basic needs, e.g., medical care, food, shelter, etc., which if unchecked, will endanger the health and well-being of the client. | Client requires immediate intervention (medical treatment, placement, emergency services, etc.). Client at risk of death or serious harm for lack of adequate supervision or care. |
| QUALITY/CONSISTENCY OF CARE | Client/caregiver is well informed, responsible and provides the degree of care required. | Client/caregiver provides care, but knowledge, skills and abilities, or degree of responsibility are problemmatic and may contribute to risk. | Client is at risk due to self/ caregiver irresponsibility or lack of knowledge, skills and abilities of caregiving. Client lives alone and has diminished mental and/or physical capacity. |
| PREVIOUS HISTORY OF VIOLENCE ABUSE, NEGLECT, OR EXPLOITATION. | No known history of violence, abuse, neglect, or exploitation. | Any previous informal or formal report (HRS, law enforcement, medical, etc.) of violence, abuse, neglect, or exploitation. | On-going history or pattern of increasing frequency of violence, abuse, neglect, or exploitation. Any previous report that led to the prosecution or was classified as confirmed or indicated. |

| | PERPETRATOR | | |
|---|---|---|---|
| | 1 = NO RISK/LOW RISK | 2 = INTERMEDIATE RISK | 3 = HIGH RISK |
| ACCESS TO THE CLIENT | Never or rarely alone with client. Client has frequent, regular contact with others in or out of household. | Unpredictable presence of others in the home. Limited opportunity to be alone with the client. Despite allegation(s), uncertainty if others will deny access to the client. | Complete, unrestricted access to the client. |
| SITUATIONAL STRESS/RESPONSE TO HOME CRISES, e.g., the investigation, recent birth, death, marital difficulties, hospitalization, caregiving responsibilities, unemployment, financial problems (CAREGIVER ONLY) | Realistically adapts and adjusts to situational stress/life crises. | Difficult, prolonged, inappropriate or unrealistic adjustment to situational stresses/life crises, e.g., frustration, fatigue, depression, anger. | Gross overreaction or highly inappropriate reaction to stress/life crises, e.g., severe depression, hopelessness, violation of societal norms. Caregiver suffering chronic fatigue. |
| PHYSICAL HEALTH (CAREGIVER ONLY) | Good health or minimal, but controlled or compensated physical difficulties. | Physical handicap and/or episodic physical difficulties. May be in poor health or have a poorly compensated or controlled chronic illness. | Severe and functionally limiting physical disability; chronic or uncontrolled disease Recent, rapid deterioration of physical health. |
| MENTAL/EMOTIONAL HEALTH/CONTROL (CAREGIVER ONLY) | None, or minimal, but controlled mental or emotional difficulties. Responsive to client. Realistic expectations of the client; can plan to correct problem. | Periodic mental/emotional difficulties or problems of control. Poor reasoning abilities. Immature, dependent, or has unrealistic expectations. Somewhat unresponsive to the client. Periodic episodes of alcohol/substance abuse. Parasitic/oportunistic behavior. | Severe and functionally limiting mental disability; history of chronic or uncontrolled mental disease. Desire to harm the client; over-concern with client's "bad" behavior. Bizarre or violent behavior; suicidal. Unresponsive to the client. Asks to be relieved; threatens client with hospitalization or institutionalization. Recent, rapid deterioration of mental/ emotional health/control. |
| PERPETRATOR/VICTIM DYNAMICS CONTRIBUTING TO RISK | Normal relationship. No apparent fear or reluctance to discuss allegation. No apparent special problems. | Client makes excuses for, or desires to protect the perpetrator because of blood relationship, concern over consequences, guilt, shame, or low self-esteem. Victim guarded or reluctant to discuss allegations. | Client fears or has irrational desire to protect the perpetrator. Any bond that causes victim or caregiver (if not perpetrator) to tolerate ANE, e.g., victim or caregiver emotionally dependent or obsessed with perpetrator. |
| COOPERATION WITH INVESTIGATION | Aware of the problem; cooperates to resolve problems and protect client. | Minimal cooperation, with constant encouragement/support. | Despite evidence, doesn't believe there is a problem; refuses to cooperate. |
| FINANCIAL RESOURCES/DEPENDENCY ON THE CLIENT | Financially independent of, or not wholly dependent on the client for income. | Feels obligated to care for the client by financial necessity or blood relationship. Victim or caregiver provides partial or supplementary support. Some indication of parasitic/ opportunistic behavior. | Perpetrator is financially dependent on victim. History of parasitic/opportunistic behavior. |
| SUBSTANCE ABUSE AND OTHER SPECIAL PROBLEMS | No apparent special problems. | Episodic substance/alcohol abuse (specify any other special problems). | Chronic substance abuse/ alcoholism (specify any other special problems). |