SUMMARY TECHNICAL REPORT

Elder Abuse Prevention Demonstration: Planning Phase

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Abstract

From January 2017 to December 2018, the Urban Institute and its Maricopa County, Arizona, partner—the Area Agency on Aging, Region One—completed an initial, planning phase of the National Institute of Justice (NIJ)-funded, multiphase Elder Abuse Prevention Demonstration. During this planning phase, the project team co-developed a 12-week in-home intervention, EMPOWER©, based on a theoretical framework of elder abuse prevention and with input from an advisory panel of violence prevention and elder abuse experts.

The program is designed to empower older adults with the resiliency and resources to lead safe and healthy lives throughout the aging process. Its modules focus on home safety, physical health, emotional well-being, social connectedness, and financial well-being. A pretest of EMPOWER's implementation and survey data collection methods was conducted during the planning phase, with findings informing revisions to program and research design materials, as well as expectations about challenges related to program participation and completion.

The next phase of this NIJ-funded Elder Abuse Prevention Demonstration is a pilot study of EMPOWER, which is scheduled to begin in January 2019 with the goal of testing the program's efficacy in a randomized controlled trial of 500 older adults in Maricopa County. If the pilot study indicates short-term efficacy of the program on improving resiliency and protective factors related to elder mistreatment, the next phase would entail full-scale implementation in Maricopa County with approximately 2,500 older adults and, ultimately, dissemination of an intervention and evaluation toolkit for replication across the U.S.

Introduction

Over the past decade, and as the proportion of older individuals residing in communities throughout the United States has increased, so too have reports of elder abuse, including emotional, physical, sexual and financial abuse.[1] Current estimates indicate that between three and four percent of older adults report being victims of financial exploitation, while approximately nine percent report instances of verbal and emotional abuse.[2]

Although awareness and attention to elder abuse and the need for intervention programs has increased over the past decade, along with federal funding to support the development and implementation of programs, programs focused specifically on elder abuse prevention are almost nonexistent.[3] In response, and in collaboration with the Area Agency on Agency (Agency), Region One, in Maricopa County, Arizona, and an advisory group of experts, this study sought to develop a theory-driven elder abuse prevention program entitled EMPOWER, to pretest the program and research design with older adults in Maricopa County, and to finalize a research design to guide a larger pilot study of EMPOWER.

This report summarizes findings from the initial, planning phase of this multiphase Elder Abuse Prevention Demonstration—including discussion of the need for elder abuse prevention programs, development of the theory-informed EMPOWER program, and pretest implementation, survey data collection, and findings. The development of EMPOWER and findings from the pretest provide the foundation for a randomized controlled pilot study to assess the efficacy of EMPOWER at improving socio-emotional outcomes associated with elder mistreatment and reports of elder abuse.

[1] Cecil, K., Lawrence, S., & Teaster, P. 2007. Elder abuse and neglect. *Aging Health*, 3, 115.; Hawes, C., & Kimbell, A. M. (2010). *Detecting, addressing, and preventing elder abuse in residential care facilities*. School of Rural Public Health, Texas A & M Health Science Center.

[2] Acierno, R., Hernandez-Tejada, M., Muzzy, W., & Steve, K. (2009). *National Elder Mistreatment Study*. Washington, DC: U.S. Department of Justice. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/226456.pdf; Lifespan of Greater Rochester, Inc., (2011) *Under the Radar: New York State Elder Abuse Prevalence Study*. New York: Weill Cornell Medical Center of Cornell University & New York City Department for the Aging; Lachs, Mark. S. and Karl A. Pillemer. 2015. *Elder Abuse*. The New England Journal of Medicine, 373: 1947-1956; Acierno, R., Hernandez-Tejada, M., Muzzy, W., & Steve, K. (2009). *National Elder Mistreatment Study*. Washington, DC: U.S. Department of Justice.

[3] MDTs emerged on a national scale in the early 1980s in recognition that elder abuse cases frequently present clinical and systemic issues that are outside the boundaries of any single agency or disciplinary approach. MDT's typically include APS, criminal justice, health care, and social service representatives, as well as community members and past victims of elder abuse, to respond and assist in elder mistreatment cases and investigations (Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A national look at elder abuse multidisciplinary teams. *Journal of Elder Abuse & Neglect*, 15(3-4), 91-107; Teaster, P. B., Wangmo, T., & Anetzberger, G. J. (2010). A glass half full: the dubious history of elder abuse policy. *Journal of Elder Abuse & Neglect*, 22(1-2), 6-15).

Background

Meeting the needs of aging adults is an issue of increasing national concern, garnering both executive and legislative action.[4] This concern is well-founded: in 2010, over 40 million individuals, or 13% of the U.S. population, were 65 years of age or older—the greatest number and proportion of older individuals recorded in the history of the U.S. Projections suggest that by the year 2050, this number will exceed 100 million and represent over 25% of the US population.[5]

Over the past decade and as the proportion of older individuals residing in communities throughout the U.S has increased, so too have reports of elder abuse, including emotional, physical, sexual and financial abuse. Research indicates that the number of elder abuse cases reported annually has increased by more than 30 percent over the past decade to an estimated 5 million cases annually.[6] In particular, between 3 to 4 percent of adults between the ages of 57 to 85 report being victim to financial exploitation,[7] and approximately 9 percent report being victim to instances of verbal and emotional abuse.[8]

The consequences of elder abuse are significant. The National Center on Elder Abuse reports that older adults who experience abuse have up to a 300% higher risk of death compared to their peers who have not been abused.[9] Abuse also increases the likelihood of mental health issues, such as depression and anxiety, as well as physical health issues, such as bone or joint problems, high blood pressure, and heart problems.[10] Furthermore, abuse can have significant financial consequences; costs associated with elder abuse are estimated at over $5.3 billion in national annual health expenditures, while victims of elder abuse incur estimated annual losses of approximately $2.9 billion.[11]

Yet, the actual prevalence of elder abuse is likely much greater given the significant number of cases which go unreported each year. In many cases, older adults may not report abuse because they feel threatened by their abuser or socially pressured to protect

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[4] i.e., Elder Justice Act and the Older Americans Act

[5] U.S. Census Bureau, Department of Commerce. 2010. *The next four decades: The older population in the united states: 2010 to 2050* (Publication P25-1138). Washington, D.C.

[6] Cecil, K., Lawrence, S., &Teaster, P. 2007. *Elder abuse and neglect. Aging Health*, 3, 115; Hawes, C., & Kimbell, A. M. (2010). *Detecting, addressing, and preventing elder abuse in residential care facilities*. School of Rural Public Health, Texas A & M Health Science Center.

[7] Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), 292-297; Lifespan of Greater Rochester, Inc., (2011) *Under the Radar: New York State Elder Abuse Prevalence Study*. New York: Weill Cornell Medical Center of Cornell University & New York City Department for the Aging.

[8] Lachs, Mark. S. and Karl A. Pillemer. 2015. Elder Abuse. The New England Journal of Medicine, 373: 1947-1956; Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), 292-297.

[9] Dong, XinQi, Melissa Simon, Carlos Mendes de Leon, Terry Fulmer, Todd Beck, Liesi Hebert, Carmel Dyer, Gregory Paveza, and Denis Evans. "Elder self-neglect and abuse and mortality risk in a community-dwelling population." JAMA 302, no. 5 (2009): 517-526

[10] Gibbs, L. (2014). Medical implications of elder abuse and neglect, Clinics in Geriatric Medicine, 30(4). Elsevier Health Sciences.

[11] National Committee for the Prevention of Elder Abuse, Virginia Tech, MetLife Mature Market Institute (2011). The MetLife study of elder financial abuse: Crimes of occasion, desperation and predation against America's elders. Westport, CT: National Committee for the Prevention of Elder Abuse.

the abuser, particularly when the abuser is a relative. Further, physical and psychological factors may deter victims of elder abuse from reporting incidences of maltreatment.[12]

For example, cognitive impairments such as Alzheimer's and dementia can alter quality of life perceptions, including the recognition of abusive behaviors; meanwhile, depression can increase feelings of loneliness and apathy to reporting abuse. Sexual abuse and exploitation, in particular, can lead to helplessness and isolation which may decrease reporting rates.[13] Underreporting may also occur when older individuals are uncertain of the ramifications of reporting abuse to authorities. For example, undocumented or noncitizen Latina elders who lack citizenship may fear reporting abuse due to fears of deportation.[14]

Just as physical, cognitive and social circumstances can impede an older adult from reporting instances of abuse, they also increase the likelihood that abuse may occur in the first place. While living with family members confers certain benefits like companionship, social support, and practical assistance, living at home with one or more caregivers or family members also increases the risk of elder abuse, particularly for physical abuse and financial exploitation.[15] Experts on elder abuse commonly report that family members are the most common perpetrators of abuse—according to APS, 90% of perpetrators are family members—including adult children, spouses, and partners.[16] The likelihood that family members will perpetrate abuse is heightened for caregivers who have experienced trauma or very stressful events, as well as those who engage in substance use.

Elder abuse is concentrated most heavily in certain groups: women, physically frail and disabled adults are more likely to report verbal mistreatment and emotional abuse, while African Americans and older individuals in poor health are more likely to report financial exploitation. Research also demonstrates that older adults identified as being in need of services but for whom insufficient funds exists to deliver those services are at elevated risk for abuse, neglect, and financial exploitation.[17] Despite this, funding for in-home service provision to older individuals has decreased over the past five years due to federal sequestration and state budget cuts, while reports of abuse to APS have increased over the same period of time.[18]

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[12] Lifespan of Greater Rochester, Inc., (2011) *Under the Radar: New York State Elder Abuse Prevalence Study*. New York: Weill Cornell Medical Center of Cornell University & New York City Department for the Aging; National Research Council. (2003) *Elder mistreatment: Abuse, neglect and exploitation in an aging America*. Washington, D.C.: The National Academies Press.

[13] Gibbs, L. (2014). Medical Implications of Elder Abuse and Neglect, An Issue of Clinics in Geriatric Medicine (Vol. 30, No. 4). Elsevier Health Sciences; Cooney C, Howard R, & Lawlor B. (2006) Abuse of vulnerable people with dementia by their carers: Can we identify those most at risk? *International Journal of Geriatric Psychiatry*, 21(6), 564-571; Vande Weerd C, Paveza G. (2006) Verbal mistreatment in older adults: A look at persons with Alzheimer's disease and their caregivers in the state of Florida. *Journal of Elder Abuse & Neglect*, 17(4), 11-30.

[14] DeLiema, M., Gassoumis, Z. D., Homeier, D. C., & Wilber, K. H. (2012). Determining prevalence and correlates of elder abuse using promotores: Low-income immigrant Latinos report high rates of abuse and neglect. *Journal of the American Geriatrics Society*, 60(7), 1333-1339.

[15] Acierno, R., Hernandez-Tejada, M., Muzzy, W., & Steve, K. (2009). *National Elder Mistreatment Study*. Washington, DC: U.S. Department of Justice. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/226456.pdf; Lachs, Mark. S. and Karl A. PIllemier. 2015. Elder Abuse. *The New England Journal of Medicine*, 373: 1947-1956; Amstadter, A., Cisler, J., McCauley, J., Hernandez, M., Muzzy, W., & Acierno, R. (2011). Do Incident and Perpetrator characteristics of Elder Mistreatment Differ by Gender of the Victim? Results from the National Elder Mistreatment Study. *Journal of Elder Abuse & Neglect*, 23: 43-57.

[16] Adult Protective Services. (2015). *Arizona Adult Protective Services Annual Report SFY 2015*.

[17] Adult Protective Services. (2015). *Arizona Adult Protective Services Annual Report SFY 2015*.

[18] National Association of States United for Aging and Disabilities (NASUAD). (2014). State of the States in Aging and Disability: 2014 Survey of State Agencies. Washington, DC.

Rationale for Research

Recently, attention to—and most notably—federal funding for elder abuse intervention programs has increased. These programs have largely focused on the implementation of multidisciplinary teams (MDTs), which are now considered the hallmark of elder abuse intervention, despite the fact that to date, little to no rigorous research has determined the effectiveness of elder abuse interventions such as MDTs.

Yet, programs focused specifically on elder abuse prevention are almost nonexistent. The lack of emphasis on prevention to some extent may reflect a dearth in theoretical conceptualizations of elder abuse. In 2014, NIJ released a report arguing for the application of broader theories of violence and victimization, including domestic violence and polyvictimization, to elder abuse in an effort to build bridges across disciplines and expand knowledge across experiences. Echoing the findings of this report, researchers like Dr. Sherry Hamby argued that elder abuse does not exist independently and is often connected with experiences of child abuse and neglect and intimate partner violence. Additionally, sociocultural frameworks such as those developed by the National Academy of Sciences, as well as ecological models that focus on social factors (e.g. race, socioeconomic status, and physical and mental health) and relationships (e.g. ties to family and friends, embeddedness in social networks) can make important contributions to our understanding of elder abuse and prevention responses.[19]

This study aimed to contribute to the understanding of the types of services and components of programming that are critical to decreasing the likelihood that an older person will experience abuse. Specific goals included:

1. Developing an elder abuse prevention program, guided by a theory-driven logic model;
2. Pretesting the program and research design with older adults in Maricopa County, and
3. Finalizing a research design, short- and long-term outcome measures, and fidelity measures to guide a randomized control trial pilot study.

The following sections outline the development of the EMPOWER program, pretest methods and findings, and design for the pilot test.

[19] National Academy of Sciences. (2003). A theoretical model of elder mistreatment. In Bonnie, R.J., & Wallace, R.B. (Eds.), *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*. Washington, DC: The National Academies Press. Available at: http://www.nap.edu/read/10406/chapter/5

Theory-Informed Program Development

EMPOWER was developed by the Urban Institute (Urban) in collaboration with the Area Agency on Aging and under the guidance of NIJ and elder abuse/violence prevention experts. Program development began by specifying a theoretical framework of elder mistreatment. This theory was derived from literature emphasizing the importance of self-regulation and resilience,[20] general strain,[21] and sociocultural context[22] in describing the interconnected and often bidirectional relationships among factors contributing to elder mistreatment. The model accounts for both victimization of older adults and perpetration by persons of trust (e.g., family, friends, caregivers).

According to this theory, protective factors associated with the individual older adult (potential victim), as well as those associated with the older adult's relationships to others and overall environment (e.g., home/community situation) affect their exposure to situational strains and potential abuse opportunities. Regardless of this protectiveness, strainful situations will emerge, and it is then that internal and external coping mechanisms the older adult possesses—which can (hypothetically) be developed or clarified for clients during EMPOWER's 12 weeks of in-home visits —affect the likelihood of that abuse occurring.

Importantly, the EMPOWER pathway to abuse (or abuse avoidance) is embedded in a larger framework of causation that involves persons of trust and their protective/risk factors as well as sociocultural influences—which EMPOWER does not purport to address. For example, when potential abuse situations occur, their likelihood of evolving into actual abuse is affected by coping mechanisms of both the person of trust and the older adult. Yet, the only mechanisms that EMPOWER facilitators can impact are those of their direct clients—the older adults. All of these processes can happen instantaneously or over long periods of time.

Although the envisioned theory of elder mistreatment is intended as comprehensive, the primary focus of EMPOWER is on one of the theory's many pathways to abuse—that related to older adults' internal assets and connections to external resources. More specifically, this elder mistreatment framework envisions older adults' limitations in external resources (e.g., low-income, unstable home/community) and disrupted internal assets (e.g., negative personality, cognitive impairment, perceived lack of purpose in life) as having direct and indirect effects on the likelihood of elder mistreatment.

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[20] Hamby, S., Banyard, V., Hagler, M., Kaczkowski, W., Taylor, E., Roberts, L, & Grych, J. (2015). Virtues, narrative, & resilience: Key findings of the Life Paths Project on the Laws of Life Essay and pathways to resilience. Sewanee, TN: Life Paths Research Program. Available at: http://www.lifepathsresearch.org/wp-content/uploads/Virtues-Narrative-Resilience-Report-Hamby-et-al-2015-2.pdf

[21] Agnew, R. (2008). General strain theory: Current status and directions for further research. In Cullen, F.T., Wright, J.P., & Blevins, K.R. (Eds.), *Taking Stock: The Status of Criminological Theory. Advances in Criminological Theory*, Volume 15. New Brunswick: Transaction Publishers.

[22] National Academy of Sciences. (2003). A theoretical model of elder mistreatment. In Bonnie, R.J., & Wallace, R.B. (Eds.), *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America.* Washington, DC: The National Academies Press. Available at: http://www.nap.edu/read/10406/chapter/5

Directly, these limitations and disruptions contribute to mistreatment by placing individuals physically or mentally into environments conducive to neglect and violence. Indirectly, they contribute to poor social, emotional, and psychological well-being (negative affect[23]) and associated mechanisms for coping with, or self-regulating in response to, potentially abusive situations (resilience portfolios[24]). Thus, EMPOWER focuses on strengthening older adults' internal assets and connections to external resources.

Accordingly, the EMPOWER elder abuse prevention program is a 90-day intervention of 12 weekly one-on-one, in-home visits by a trained social worker or case manager (see Appendix K). The program is designed to empower community-residing older adults with the resiliency and resources to lead safe and healthy lives throughout the aging process. EMPOWER provides one-on-one assessment, client-centered prevention education, and needs-responsive life skills training, embedded in a series of cognitively reframing conversations with an experienced facilitator.

The curriculum includes seven modules, focused on the following topics: initial assessment, home safety, physical health, emotional well-being, social connectedness, financial well-being, and overall empowerment plan. During delivery of the module curricula, EMPOWER providers use cognitive reframing techniques to improve clients' communication, coping, conflict resolution, and self-regulation skills (i.e., their resilience portfolios), and correspondingly, improve their social, emotional, and psychological well-being.

[23] According to Agnew (2008), id.
[24] According to Hamby et al. (2015), id.

Pretest Implementation and Program Completion

A pretest of the EMPOWER program and data collection methods was implemented between August and November 2018. Older adults were recruited from the Agency's list of individuals who resided in Maricopa County at the time, were 60 years of age or older, and were waitlisted to receive services from the Agency upon funding availability. Individuals' waitlist status was not affected by pretest participation.

Out of 62 individuals recruited for the pretest, 30 were not interested or not qualified to receive the program because they were living with a family member, 20 were unreachable by phone or did not return a phone call, and one did not speak sufficient English to participate in the pretest.[25] A total of 11 individuals (eight women, three men) consented to participate in the pretest (see Table 1).[26] Of these, six individuals (five women, one man) were considered to have completed the EMPOWER program, because they met with the Agency facilitator for at least seven of the 12 weekly sessions and engaged in conversations covering at least six of the seven program modules.[27] Reasons for non-completion for the five non-completers included failing to appear for home visits or return phone calls, moving away from the area to live with family, discontinuing the program because conversations were "too personal," and revealing a substance abuse problem.

Urban administered in-person surveys to gather baseline and follow-up data from pretest participants. Baseline surveys were completed with eight female participants and follow-up surveys were completed with four women and one male participant. Debriefing interviews were also conducted with program completers to learn about participants' experiences and perspectives on EMPOWER.

Table 1. EMPOWER Pretest Participation

	Gender		*Race*		*Completed Program*		*Completed Survey*	
	Male	Female	Black	White	Yes	No	Baseline	Follow-Up
R1		X	X		X		X	X
R2		X		X	X		X	
R3		X		X		X	X	
R4		X		X	X		X	X
R5		X		X	X		X	X
R6		X		X		X	X	
R7		X		X	X		X	X
R8		X				X	X	
R9	X		X			X		
R10	X			X	X			X
R11	X			X		X		

[25] Although resources to deliver the EMPOWER pretest in Spanish were unavailable, Spanish versions of the program and survey data instruments will be available for the larger pilot study.
[26] The men were identified as eligible for EMPOWER after program implementation had begun with the women. Consequently, baseline surveys could not be administered to the men, and the program could only be implemented over 8 rather than 12 weeks.
[27] Of the six program completers: two completed all 12 sessions; one completed all eight sessions possible in the study period at the time he was recruited; one completed 10 sessions then had a health-related interruption; one completed eight sessions despite medical- and housing-related interruptions; and one completed seven sessions but was thereafter unreachable.

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Overall, the EMPOWER pretest completers participated in an average of 10 in-person sessions over the course of 11 weeks. For each session, the EMPOWER facilitator recorded how much time (in 15-minute intervals) was spent discussing each module topic. Table 2 shows a summary of the average amount of time spent on each module.

Virtually all EMPOWER weekly sessions began with an approximately 15 minute discussion of the previous session(s) topics, in accordance with the EMPOWER program manual. Given this continued review of previously set goals and activities, the seventh module topic became less critical to defining program completion. It was something the EMPOWER facilitator covered only in the 12th week for two of the program completers.

Based on qualitative discussions with program completers, participants felt comfortable discussing all of the EMPOWER modules with the facilitator and felt that the facilitator treated them with respect and compassion and was trustworthy. None of the participants believed the gender of the facilitator was of consequence to their participation, given the level of professionalism that he showed to them.

Program completers felt that EMPOWER had made them feel stronger and better able to stand-up for themselves. Several were connected to outside resources of which they had previously been unaware, including a local senior center, church group, and prescription delivery service. None of the participants felt the program's 12 sessions were too long, although only half of the program completers participated in all 12 weeks (the other half participated in seven to 10 weeks). Although program completers felt the resources accompanying the program were useful, two expressed a desire to be introduced to the specific module and resource content early on—for example, so that she could complete a living will before learning about how to do so in the seventh week of EMPOWER. The program manual was adjusted accordingly in response.

Table 2. EMPOWER Pretest: Average Time Spent on Module per Session

	M1. Assess-ment	M2. Home Safety	M3. Physical Health	M4. Emotional Well-being	M5. Social Connected-ness	M6. Financial Well-being	M7. Empower-ment Plan
Session 1	60 min						
Session 2	18 min	42 min					
Session 3	15 min	10 min	35 min				
Session 4	15 min	0 min	22 min	22 min			
Session 5	10 min	0 min	2 min	48 min	0 min		
Session 6	10 min	0 min	2 min	32 min	12 min	0 min	
Session 7	10 min	0 min	5 min	10 min	28 min	2 min	0 min
Session 8	9 min	0 min	3 min	12 min	21 min	12 min	0 min
Session 9	10 min	0 min	5 min	0 min	20 min	25 min	0 min
Session 10	10 min	0 min	0 min	5 min	15 min	30 min	5 min
Session 11	15 min	8 min	8 min	8 min	8 min	8 min	0 min
Session 12	15 min	0 min	0 min	0 min	0 min	0 min	45 min

Pretest Survey Data Collection

Survey data collection for the pretest was conducted to test the cognitive relevance and logistical considerations regarding interviewing older adults. Baseline and follow-up surveys were designed as a method to collect short- and long-term outcome information about the impact of EMPOWER on social connectedness, emotional well-being, physical well-being, financial well-being and mistreatment and neglect.

An in-person, baseline survey was administered to eight participants by Urban prior to the program beginning. An in-person, follow-up survey was administered by Urban to the 5 participants who completed the program and for whom we were able to contact at approximately week 12.

Table 3. EMPOWER Short-Term Outcomes (Survey Domains)

Outcomes (Survey Domains)	*Description (Survey Measures)*
Social-connectedness	Social activities and hobbies, social networks and interactions, including frequency of interaction and instrumental and emotional support provided by family and friends
Emotional well-being	Resiliency, perceptions of self, perceptions of the future, social competence, coping mechanisms, and depression
Physical well-being	Physical health, interactions with doctors, medications prescribed, medication use, physical activity/exercise, and alcohol use
Financial well-being	Employment, financial strain, power of attorney, and financial decision-making
Mistreatment and neglect	Mistreatment and abuse, including emotional, financial, physical, and sexual; also, neglect by others or by self (latter is not a crime)
Housing	Housing situation, neighborhood, and accessibility
Background	Participant demographics, socioeconomic status, residency in U.S. and in Maricopa County, and languages spoken

Baseline and follow-up surveys were designed to be administered in person via a tablet, to allow respondents confidentiality in their reporting. Most respondents, however, preferred to have survey questions read to them by the Urban researcher, who entered responses into the tablet. After administration of the baseline survey, participants were asked to provide qualitative feedback regarding their ease in taking the survey, any language challenges, and questions that should be added to or removed from the survey.

Based on this feedback and the experience of administering the survey, the survey was modified prior to administration as a follow-up with individuals who completed the program. For example, the baseline survey included questions about victimization and abuse and neglect experienced in the past year, but did not include questions pertaining to victimization experiences prior to the past year—so these questions were added to the

survey instrument. Also, it was noted that the survey was too long and might be difficult to complete in one sitting—so researchers closely edited to remove substantively similar questions. The final survey took approximately 45 minutes for respondents to complete.

Measures included in the survey were identified through a scan of previous research on abuse and mistreatment, research with older adults, and in consultation with the project's advisory group and NIJ project monitor. Validated measures were included whenever available. Responses to questions derived from select scales are reported in Tables 4-6.

Notably, Urban relied on six questions from the University of Southern California Older Adult Conflict Scale (USC-OACS) to measure neglect, and the Geriatric Mistreatment Scale (GMS) to measure abuse and mistreatment.[28] Five people reported experiencing some form of neglect[29] or mistreatment at baseline, and three respondents reported experiencing neglect or mistreatment during the follow-up, which was also reported during the baseline.[30]

Table 4. Baseline and Follow-up Survey Responses, Neglect and Mistreatment

	Baseline (n = 8)			*Follow-Up (n = 5)*		
	Yes	*No*	*Refuse/ Missing*	*Yes*	*No*	*Refuse/ Missing*
Neglect[31]						
Been left alone by the person you rely on when you felt you should not be left alone	2	5	1	2	3	0
Been unable to get to a medical appointment because the person you rely on didn't take you	2	5	1	1	4	0
The person you rely on has not taken care of you because they took drugs or had too much to drink	0	6	2	0	5	0
The person you rely on not get you to the hospital when you had an emergency	0	7	1	0	5	0
The person you rely on refused to give you items that you need, such as a walker, eyeglasses, hearing aids, or dentures	0	7	1	0	5	0

[28] DeLiema, M., Gassoumis, Z. D., Homeier, D. C., & Wilber, K. H. (2012). Determining prevalence and correlates of elder abuse using promotores: Low-income immigrant Latinos report high rates of abuse and neglect. *Journal of the American Geriatrics Society*, *60*(7), 1333-1339; Giraldo-Rodríguez, L., & Rosas-Carrasco, O. (2013). Development and psychometric properties of the Geriatric Mistreatment Scale. *Geriatrics & Gerontology International*, *13*(2), 466-474.

[29] Neglect questions were asked of all respondents during the pretest; in the pilot study, neglect questions will only be asked of those who indicate reliance on someone, paid or unpaid, for daily activities or personal selfcare.

[30] Human subjects' protocols approved for this study in June 2018 by the Urban Institute's Institutional Review Board (IRB) were part of the study consent form each respondent signed. Study researchers, who were not mandated reporters of elder abuse, followed these IRB protocols which stated that information provided by respondents would be held in the strictest confidence and not disclosed to others in identifiable ways. Researchers could only break confidentiality if told of respondents' future criminality or immediate harm to self and others. By contrast, the EMPOWER program facilitator was a trained social worker required to operate in accordance with Arizona's laws, which mandated their reporting of suspected elder abuse or neglect to Adult Protective Services.

[31] DeLiema, M., Gassoumis, Z. D., Homeier, D. C., & Wilber, K. H. (2012). Determining prevalence and correlates of elder abuse using promotores: Low-income immigrant Latinos report high rates of abuse and neglect. *Journal of the American Geriatrics Society*, *60*(7), 1333-1339

The person you rely on not provided you with enough food or water	0	7	1	0	5	0
Mistreatment[32]						
Been hit	0	8	0	0	5	0
Been punched or hit	0	8	0	0	5	0
Been shoved or had your hair pulled	0	8	0	0	5	0
Had an object thrown at you	0	8	0	0	5	0
Been assaulted with a knife or blade	0	8	0	0	5	0
Been humiliated or made fun of	1	7	0	1	3	1
Been treated with indifference or ignored	3	3	2	3	2	0
Been isolated or kicked out of the house	1	6	1	0	5	0
Someone made you feel afraid	0	8	0	0	5	0
Your decisions have not been respected	2	5	1	1	4	0
Been forbidden to go out or be visited	0	7	1	0	5	0
Kept from getting clothes, footwear, etc.	0	7	1	0	5	0
Kept from receiving the medications you need	1	6	1	0	5	0
Been denied protection when you need it	0	7	1	0	5	0
Been denied access to the house where you live	0	7	1	0	5	0
Managed your money without consent	0	8	0	0	4	1
Your money has been taken from you?	1	7	0	0	5	0
Someone has taken your belongings without your permission	1	6	1	0	5	0
Your property has been sold without your consent	0		1	0	5	0
Been pressured so that you no longer own your house or any other property	0	6	2	0	5	0
Been forced to have sex even if you did not want to	0	8	0	0	5	0
Your genitals have been touched without your consent	0	6	2	0	5	0

Table 5. Baseline and Follow-up Survey Responses, Social Connectedness

	Baseline (n = 8)		*Follow-Up (n = 5)*	
	$\bar{x}$	*Refuse/ Missing*	$\bar{x}$	*Refuse/ Missing*
Social Support[33] *(1 = Never; 2 = Some of the time; 3 = Most of the time; 4 = Always)*				

[32] Giraldo-Rodríguez, L., & Rosas-Carrasco, O. (2013). Development and psychometric properties of the Geriatric Mistreatment Scale. *Geriatrics & Gerontology International*, *13*(2), 466-474.

[33] Hamby, S., Grych, J., & Banyard, V. L. (2015). *Life Paths measurement packet: Finalized scales*. Sewanee, TN: Life Paths Research Program. http://www.lifepathsresearch.org/strengths-measures; Adapted from: Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). Poly-victimization in a national sample of children and youth. *American Journal of Preventive Medicine*, 38(3), 323-330. Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52, 30-41.

Help you if you were confined to bed	2.1	2	3.5	2
Give you good advice about a crisis.	3.0	2	3.0	1
Talk with you about your problems	3.0	1	3.0	1
Love you and make you feel wanted	3.0	1	3.6	2
Social Participation[34] *(Over the past 3 months; 1 = Never, 2 = at least once a month; 3 = at least once a week; 4 = at least once a day)*				
Visiting with family/friends outside of your house.	1.8	2	2.5	1
Attending sports or physical activities with others.	1.0	2	1.4	0
Attending music, theatre or other arts activities.	1.3	2	1.4	0
Volunteering or charity work	1.3	2	1.4	0
Attending neighborhood, community or professional association activities	1.0	2	1.6	0
Other recreational activities with others, such as playing games, visiting museums, or attending educational activities.	1.0	2	2.25	1

Table 6. Baseline and Follow-up Survey Responses, Emotional Well-being

	Baseline (n = 8)			*Follow-Up (n = 5)*		
	Yes	*No*	*Refuse/ Missing*	*Yes*	*No*	*Refuse/ Missing*
Emotional Well-being[35] *(0 = No; 1 = Yes)*						
Are you basically satisfied with your life?	2	3	3	3	2	0
Have you dropped many of your activities and interests?	4	2	2	2	3	0
Do you feel that your life is empty?	2	2	4	0	5	0
Do you often get bored?	3	3	2	5	0	0
Are you in good spirits most of the time?	4	1	3	5	0	0
Are you afraid that something bad is going to happen to you?	0	6	2	1	4	0
Do you feel happy most of the time?	3	1	4	5	0	0
Do you often feel helpless?	2	1	5	2	3	0
Do you prefer to stay at home, rather than going out and doing new things?	3	0	5	2	2	1
Do you feel you have more problems with memory than most?	0	4	4	2	3	0
Do you think it is wonderful to be alive now?	3	0	5	5	0	0

[34] Gilmour, H. (2012). Social participation and the health and well-being of Canadian seniors. *Health reports*, 23(4), 23-32.
[35] Geriatric Depression Scale – Short Form: http://web.stanford.edu/~yesavage/GDS.html; Brink TL, Yesavage JA, Lum O, Heersema P, Adey MB, Rose TL: Screening tests for geriatric depression. Clinical Gerontologist 1: 37-44, 1982.Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO: Development and validation of a geriatric depression screening scale: A preliminary report. Journal of Psychiatric Research 17: 37-49, 1983.Sheikh JI, Yesavage JA: Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. Clinical Gerontology: A Guide to Assessment and Intervention 165-173, NY: The Haworth Press, 1986.Sheikh JI, Yesavage JA, Brooks JO, III, Friedman LF, Gratzinger P, Hill RD, Zadeik A, Crook T: Proposed factor structure of the Geriatric Depression Scale. International Psychogeriatrics 3: 23-28, 1991

Do you feel full of energy?	0	4	4	1	4	0
Do you feel that your situation is helpless?	0	3	5	1	4	0
Do you think that most people are better off than you?	0	3	5	2	3	0

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Pretest Challenges and Program Revisions

Two key challenges emerged during the pretest implementation that provided insight into preparations needed before launching of the larger pilot study.

First, staff experienced challenges recruiting study participants—particularly older men—and retaining contact with those who expressed interest in the study—particularly due to health-related reasons. Although these challenges were similar to those experienced by other service providers working with older adults, including the Agency, the project team made several adjustments in response. These adjustments included the decision to vary the gender of study recruiters, attempt to retain contact with participants at different times of the day and at least three times over the course of two weeks (before considering someone a non-respondent), and by working to verify immediately beforehand and reschedule as needed in-person appointments to respect participants' changing health needs and medical obligations.

Second, the EMPOWER facilitator noted that conversations regarding participants' emotional well-being—which were intended to cover only one program module—needed to be expanded into two modules, as follows: cognitive reframing and gratitude. When implementing the emotional well-being module, it was apparent to the facilitator that very few older adults were familiar with key concepts related to cognitive behavior techniques, and that an in-depth introduction to these concepts was needed before clients could make important connections to their own attitudes, thoughts, and behaviors, and plan goals accordingly for the future. Similarly, the facilitator felt the discussion of gratitude, its importance to clients' emotional well-being, and the numerous possible reasons for feeling gratitude, necessitated its own EMPOWER module focus. Accordingly, the program module was revised so that it now reflects the separation of these two module topics.

Pilot Study Design

An RCT of EMPOWER will be conducted in partnership with the Area Agency on Aging in Maricopa County, AZ, and the Arizona State University's Southwest Interdisciplinary Research Center (SIRC) between January 1, 2019 and December 31, 2020. Designing this pilot study was one focus of the current project. The population for the pilot study will include 500 adults, aged 60 and older who reside in the community in Maricopa County, AZ and who are referred, authorized, and waitlisted due to insufficient funding to receive home and community-based services (HCBS) services through the Agency. Half of the sample (n = 250) will comprise the treatment group, and the other half (n = 250) will comprise the control group. Individuals with severe cognitive impairments, such as Alzheimer's or dementia, will not be included in this study. Also, only those individuals who live alone will be included in this study.

The overarching goal of the pilot study is to determine if there are significant improvements in the short-term outcomes associated with elder mistreatment, including social connectedness, emotional wellbeing, physical wellbeing, and financial wellbeing, as well as reports of mistreatment and abuse, as result of participating in EMPOWER. Impact will be assessed through self-reported survey data, assessments conducted by Agency staff, and reports of abuse made to Adult Protective Services (APS).

Specifically, three in-person, tablet-based surveys will be administered to all individuals who consent to participate in the pilot study, regardless of whether they are assigned to the treatment or control group. A first (baseline) survey will be administered after the person consents to the study, and prior to randomization to the treatment; a second (follow-up) survey will be administered approximately 4 months after the baseline survey (e.g., after the program is over for those who receive the treatment); a final survey will be administered approximately 8 months after the baseline (or approximately 4 months after the second follow-up survey).

As outlined above, surveys will ask questions related to participant's family, friends, emotional, physical, and financial health, experiences of mistreatment, and daily activities. To assess differences in official reports of abuse, APS will share information on whether a case of abuse was reported during the project period, whether the case was substantiated, the type(s) of abuse that were reported, and the dates of reports for the treatment and control samples.

Conclusion

In partnership with the Area Agency on Aging and experts in the field of elder mistreatment, this planning phase of the Elder Abuse Prevention Demonstration sought to develop and pretest an elder abuse prevention program for older adults residing in the community of Maricopa County. In consultation with an advisory board of experts and NIJ, the EMPOWER program was developed with the goal of strengthening resiliency factors related to older adults' ability to lead safe and healthy lives throughout the aging process, including protecting themselves from physical, emotional, and financial mistreatment. The intervention was designed as a 90-day program that consisted of 12 weekly one-on-one in-home visits to the program participant by a trained social worker or case manager, employed by the Agency. The program incorporated modules focused on the physical, emotional, and financial health of participants, and their connections with family, friends, and the community.

A pretest of EMPOWER and survey data collection methods was conducted during this project period. Findings from the pretest will guide the implementation of an RCT pilot study with 500 older adults residing in Maricopa County, AZ, 250 of whom will receive the treatment, beginning in January 2019. The goal of the pilot study is to understand whether there are significant improvements in the short-term outcomes associated with elder mistreatment, including social connectedness, emotional wellbeing, physical wellbeing, and financial wellbeing, as well as reports of mistreatment and abuse, as a result of participating in EMPOWER; and, to develop an EMPOWER intervention and evaluation toolkit to allow for replication across the U.S. if the program demonstrates efficacy.[36]

[36] Prior to the end of the multiphase Elder Abuse Prevention Demonstration period, the final EMPOWER program manual, logic model, and research measures will be submitted to NIJ.