The Use of Evidence-Based Practices for Elder Abuse Programs

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The problem and issue of elder abuse is gaining public attention and reflects the inescapable fact that greater numbers of individuals are living to advanced ages, with more older adults facing the possibility of abuse now than at any other time in our history. The number of older adults is increasing dramatically: in 2000, there were approximately 35 million Americans over the age of 65, who constituted 12.4% of the total population (Census Bureau, 2005). Today, this number has increased to 40 million, representing 13% of the total population. It is estimated that by 2030, there will be 71.5 million older Americans comprising 19.7% of the total population (Administration on Aging, 2011).

An instructive example of elder abuse and reflecting the population increase is the national study of Adult Protective Services (APS), conducted periodically by the National Center on Elder Abuse (NCEA) through its partner organizations. In 1997, Tatara and Kuzmeskas reported that, in one year, APS received 293,000 reports of elder abuse. Nearly a decade later, Teaster and colleagues' 2006 nationwide study of elder abuse estimated that in one year APS received a total of 381,430 reports of elder abuse, suggesting that reports of elder abuse have increased by approximately 30% in ten years (Teaster, Otto, Dugar, Mendiondo, Abner, & Cecil, 2006; Teaster, Lawrence, & Cecil, 2007). Similarly, in a recent study in Kentucky, APS reports of elder abuse rose 49.9% from fiscal years 2004 to 2008 (Teaster, Wong, Grace, Wangmo, Mendiondo, & Blandford, 2010).

In addition to the studies above, which are based solely on administrative data from APS, a number of incidence and prevalence studies have suggested that the problem of elder abuse as reported to APS is far more pervasive than the number of reports indicates. For about 20 years, The gold standard study was that of Pillemer and Finkelhor (1988), who found a prevalence rate of 32/1,000 of all persons 65 years of age and older in Boston and that only one in 14 cases of elder abuse came to public attention; the study did not include exploitation.

Four recent studies provide additional information. The first, conducted by Cooper, Selwood, and Livingston (2008) reviewed 49 studies that examined the prevalence of elder abuse and neglect and concluded that 6% of older adults reported significant abuse in the last monthand that 5.6% of couples reported spousal abuse. The second study sampled 3,005 participants recruited using a multistage area probability design for the National Social Life, Health, and Aging Project (Laumann, Leitsch, & Waite, 2008). An examination of three types of abuse revealed that 9% of the population reported verbal abuse, 3.5% financial exploitation, and 0.2% reported physical abuse by a family member. A third study by Acierno, Hernandez, Arnstadter, Resnick, Steve, Muzzy, and Kilpatrick (2009) using 5,777 respondents found a one year prevalence for the following: emotional abuse (4.6%), physical abuse (1.6%), sexual abuse (0.6%), neglect (5.1%), and financial abuse by a family member (5.2%). A fourth study (as yet unreleased) from a sample of 4,156 older New Yorkers, revealed that 76/1,000 New York elders were victims of abuse in a one year period, and that overall, the elder abuse incidence rate in that state was nearly 24 times greater than the number

of cases referred to social service, law enforcement, or legal authorities (Lifespan, 2011).

Despite the information above, the growing number of elder abuse reports does not necessarily auger that the incidence of abuse is increasing, although the problem remains a potentially life-threatening one. Easily attributable are other factors, including the rising aging population, a better understanding of elder abuse through social marketing and other educational efforts, refined research methods and measurement instruments, more generous funding by federal agencies and other entities, and, across the country, the proliferation of multidisciplinary teams dedicated to addressing elder abuse (Brandl, Dyer, Heisler, Otto, Stiegel, & Thomas, 2007; Teaster, Nerenberg, & Stansbury, 2003). Regardless, the issue of elder abuse remains a real and troubling one and deserves amelioration and intervention.

The purpose of this paper is to discuss the potential of evidence-based practice for elder abuse programming. First, we provide information on the foundations of evidence-based medicine, the discipline where evidence-based practice emanated. Second, we discuss evidence-based programs. Third, we consider implementation of evidence-based practice through the use of multidisciplinary teams and other evidence-based programs related to elder abuse. Finally, we identify challenges and suggest directions for implementation of an evidence-base to elder abuse intervention efforts.

Foundations of Evidence-Based Medicine

Evidence-based medicine is “the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions”

(Rosenberg & Donald, 1995, p.1122). Evidence-based medicine arose within social and psychological contexts in order to respond to problems in the provision of health services and to a fundamental problem and pervasive lack of knowledge (Elstein, 2004). Problems that existed in the provision of health care services included unexplained variations in clinical practice, an increase in diagnostic and therapeutic options, patient empowerment, and decision psychology (Eddy, 2005; Elstein, 2004). The purpose of evidence-based medicine is to move a situation on which there is ignorance to one on which there is knowledge based on something more trustworthy than opinion. The solution is to consult the research literature to assist in making a treatment decision. Proponents of evidence-based medicine acknowledge that a one-size fits all mentality is not the most advantageous application of this method, and so they increasingly espouse overlapping implementation strategies that target a specific group or problem (Timmermans & Mauk, 2005).

According to Eddy (2005), features of evidence-based medicine include analyzing the evidence; using an explicit, rigorous process; creating a generic product intended for application to a group of patients or issue; and intending effects to move physicians and other health care providers to deliver certain types of care and away from directing care to an individual patient. Evidence-based medicine can influence evidence-based guidelines. Guidelines establish parameters for good practice and have saliency for other issues confronted by practitioners addressing other health issues. Similar to concerns in medicine about aspects of clinical diagnosis, prognosis, or management (Rosenbery & Donald, 1995), there have arisen concerns about the identification of elder abuse, its prognosis, and management. The use of evidence-

based practice holds great promise for other areas, including that of elder abuse. We turn now to a discussion of what constitutes evidence-based programs.

The Promise of Evidence-Based Programs

Evidence-based programs are those whose intervention results in positive behavioral changes (e.g., improving dietary habits, increasing exercise, decreasing drug use, stopping elder abuse) (Administration on Aging, 2010; SAMHSA, 2006). These programs are scientifically proven to be effective and beneficial in preventing or changing a targeted outcome.

According to the National Council on Aging and the Substance Abuse and Mental Health Services Administration, a successful evidence-based program should incorporate at least three important requirements:

(1) Evidence-based programs should be grounded in the systematic identification and review of the current body of literature regarding a well-defined question,

(2) Methods and procedures for evaluating the program should be scientifically sound, and

(3) Outcome measures must describe and detail how the intervention has changed the characteristics and environment of the targeted population (NCOA, 2006; SAMHSA, 2006).

Evidence-based programs are usually multi-faceted and can be modified for a targeted outcome (Moreland, Richardson, Chan, O'Neill, Bellissimo, Grum & Shanks, 2003). In a perfect world, evidence-based programs also contain information on a

program's fidelity as well as information on costs and cost effectiveness (Prohaska & Etkin, 2010).

The Potential of Evidence-Based Programs for Addressing Elder Abuse

Positive outcomes produced by similar evidence-based programs carry the potential to address the problem of elder abuse. If demonstrably effective, they could guide the allocation of resources to replicate, expand, and support a program or series of programs, those geared towards efforts made in a particular direction and following an established line of evidence. In addition and importantly, appropriate and rigorous evaluation using quantitative and qualitative methods to analyze measurable outcomes would ensure that a program is accountable and useful to its clients, its program participants, and its funder(s). Furthermore, the use of demonstrated, evidence-based effectiveness can sustain funding and attract supporters, including new funders.

The importance of evidence-based programs for the mission of addressing elder abuse lies in the ability to highlight the importance and utility of the work and outcomes of a particular program (Stein, 2007). Despite growing interest in evidence-based programming, very little is known about existing evidence-based programs or practices. The lack of interest exists because most evidence-based literature is derived from biomedical arenas, where evidence-based research is used to develop concrete blueprints for health care. The limited knowledge related to existing programs presents a clear challenge when dealing with issues outside the disease paradigm, particularly in the case of applying evidence-based practices to elder abuse.

Related Arenas and the Application of an Evidence Base

When considering an evidence base for elder abuse programming, it is arguably appropriate to search for and analogize to a related arena, the Substance Abuse and Mental Health Services Administration (SAMHSA), which operates a National Registry of Evidence-Based Programs and Practices (NREPP) (SAMHSA, 2006). The NREPP presents information related to mental health programs that demonstrably proven effectiveness in reducing the time between the creation of scientific knowledge and implementation within communities. SAMHSA instituted the Center for Substance Abuse Prevention Programs for professionals to inform consumers regarding these programs.

A second and related example instructive for elder abuse programming is that of the Evidence-Based Disease and Disability Prevention Program, a program funded by the Administration on Aging, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, and private foundations (AoA, 2010). The state-based program began in 2006-2007, *vis a vis* public and private partnerships. Nearly 30 states have implemented evidence-based programs in their communities. The programs are required to implement the Stanford University Chronic Disease Self-Management Program, but participating states also have the latitude to select another program to help in reducing chronic diseases in its population of elders. The Stanford program capitalizes on patients' roles in managing their illnesses so that they are in a position to be as successful as possible to adopt healthy behaviors in order to take control of their health. Included are weekly workshops held in community-based settings and

facilitated by trained and certified leaders, persons who also have a chronic illness. Beyond these two programs, other literature in this domain describes how evidence-based programs could be created and provides directions and suggestions as to how such programs should be evaluated and applied with the goal of expanding their use in community programming (NCOA, 2006; Stein, 2007).

The Promise of Multidisciplinary Teams to Address Elder Abuse

In the field of elder abuse, a promising approach that of the multidisciplinary team (MDT), is proliferating in local, state, and national efforts to prevent and address elder abuse. MDTs typically include rich, diverse, and collaborative efforts incorporating professionals from a variety of disciplines (Brandl et al., 2007; Mosqueda, Burnight, Liao, & Kemp, 2004; Teaster, Nerenberg, & Stansbury, 2003; Twomey, Jacson, Marino, Melchior, Randolph, Restelli-Deits, & Wysong, 2010). These disciplines typically include APS, aging services professionals, attorneys, mental health and medical professionals, law enforcement, money managers, guardians, social scientists, policy makers, and long-term care ombudsmen (Nerenberg, 2003; 2006).

Although little actual evidence exists indicating the effectiveness of MDTs (Erlingsson, 2007; Ploeg, Hutchinson, MacMillan, & Bolen, 2009), available literature continues to suggest its positive role in addressing elder abuse and its benefits for older adults (Anetzberger et al., 2005; Teaster, Nerenberg, & Stansbury, 2003; Teaster & Wangmo, 2010; Twomey et al., 2010; Wiglesworth et al., 2006). A study of Vulnerable Adult Specialist Teams providing medical experts to APS and criminal justice agencies proved helpful in confirming elder abuse in 97% of the cases and also provided other

services, thereby benefiting the older victim (Mosqueda et al., 2004). Similarly, Anetzberger et al. (2005) reported that MDTs were useful in addressing clinical aspects of elder abuse. Recent published literature of MDTs examined Local Coordinating Councils Elder Abuse (LCCEAs) in the Commonwealth of Kentucky (Teaster & Wangmo, 2010). Findings revealed that the councils provided various services across the state, including expert consultation and keeping members up to date about services, programs, and legislation.

As suggested by the National Research Council (NRC), MDTs address elder abuse in many states (Bonnie & Wallace, 2003). From the NCEA Promising Practices Database on the website of the National Center on Elder Abuse (NCEA, 2010), at least 89 such multidisciplinary programs are in operation around the country. They focus on many aspects of intervention and prevention. Several employ some aspects of evidence-based practices, although no one program fully incorporates or embraces evidence-based practice.

Prevention Examples and Application of Evidence-Based Practices to Elder Abuse

In an institutional setting, Hsieh, Wang, Yen and Liu (2009) examined the prevention of elder abuse by institutional caregivers through educational support groups. They found that such support groups provided mutual support, information on elder abuse, and stress management for caregivers. These positive outcomes hold promise for replication and expansion, thus making this intervention a good candidate for an evidence-based practice designed for formal and informal caregivers of older adults.

Another promising direction is that of social support, which appears to be central to the health and well being of older adults as well as an important factor in curbing their risk for abuse. According to Acierno and colleagues (2010), low social support is both a predictor of elder abuse, neglect, and maltreatment as well as an indicator that it will not be reported. Programs that attempt to increase social support for elders could well reduce the potential for caregiver abuse.

Issues of dementia and cognitive impairment are also critical when addressing elder abuse. These two conditions are found more often in older adult populations than in their younger counterparts and can significantly limit an elder's ability to guard against abuse, report abuse, or to be a candidate for intervention (e.g., an institutionalized Alzheimer's patient who fondles another resident) (Vierthaler, 2008). According to Cooper, Selwood, Blanchard, Walker, Blizard, and Livingston (2010), those who care for older adults with dementia and who were more depressed and anxious had poorer coping strategies and were more likely to become abusers than those who did not have these conditions. Caring for someone who is an abuser themselves, either in the past or who is currently abusive, may also be a predictor of caregiver abuse. Programs that target those caregivers with these issues hold promise for prevention or reduction of elder abuse by a caregiver.

In another arena, exploitation of elders appears to be another growing and undercounted problem (Broken Trust, 2009). Older persons at risk for financial exploitation are those with low social support and who exhibit problems of dementia and/or failing health. Evidence-based programming could be developed to target individuals at risk for exploitation such as older adults living isolated and alone, and

those living in high crime environments. Such programs must take into account and instruct the caregivers about when the fine line of the exchange model of care crosses into the darker and more problematic realm of abuse.

Sexual Abuse Examples and Application of Evidence-Based Practices to Elder Abuse

Finally, the neglected problem of the sexual abuse of older adults presents a potential arena for the development of evidence-based programming. Myths regarding sexual abuse have often left out older adults and there are therefore inadequate resources to help them when they are victimized in this way (Bergeron, 2004; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008; Vierthaler, 2008). Because myths include that older adults are atypical victims of sexual abuse, older adults who are sexually abused are often unaware of where to turn for help. When it is identified, sexual violence volunteers and personnel who are ill equipped to meet the special needs of elders may provide assistance. This situation is particularly problematic because victims of elder sexual abuse tend to need more aid than their younger counterparts (Ramsey-Klawsnik et al., 2008). Unfortunately, they often receive fewer services (Vierthaler, 2008).

To respond to these findings, rape crisis centers, sexual violence coalitions and aging services must collaborate in multidisciplinary ways and use an evidence base in order to properly train staff members and volunteers, provide advocacy, and increase the awareness of elder victims. In employing the team approach, targeting an at-risk

population of older adults as well as their caregivers could easily be an effective way to address the problem and could help to prevent and reduce elder abuse.

Challenges for an Evidence-Based Program Applied to the Phenomenon of Elder Abuse

Demonstrated above, the use of evidence-based practice is touted as a way to increase both the quality of and access to many community-based services, such as those in the health, mental health, and social service arenas (Scheinholtz, 2010). The promise and potential of drawing from the above sources to guide evidence-based practices in programs for elder abuse requires incorporating programs, practices, and services undergirded by an applicable theoretical foundation or understanding. Such programs would effectively intervene in or prevent elder abuse and, consequently, produce positive behavioral changes, with demonstrable prevention or reduction of elder abuse.

As evidence-based research on elder abuse continues to emerge, it will be crucial to address a number of specific limitations that plague efforts in this arena. The litany of challenges includes underreporting, lack of a universal definition of abuse, limitations in samples and generalizability, and a lack of consensus on the goals of intervention into the problem. Although the number of physical, mental, and social conditions can be underreported in the general population and among other targeted age groups, studies on elder abuse specifically indicate that it is grossly underreported (Acierno et al., 2010; Bergeron, 2004; Cooper et al., 2010). There are several reasons for this, ranging from a failure to recognize signs and symptoms of abuse, denial of abuse, to the most pervasive reason, unclear definitions of what constitutes abuse,

neglect and maltreatment (Bergeron, 2004; Cooper et al., 2010; Killick & Taylor, 2009; Lachs, 2004; Nelson, Nygren & McInerney & Klein, 2004; Ploeg, Fear, MacMillan, Bolan & Hutchison, 2009; Sandmoe, 2007).

Definitions of what constitutes abuse vary from state to state as well as from study to study. This lack of uniformity results in inadequate training, insufficient evidence to support emerging best practices and efficacy rates, and creates wide fluctuations in prevalence rates.

Research on elder abuse is often reliant on accumulated data from various entities such as APS records. An important proxy measure, the use of data from APS, the ombudsman, medical records, or law enforcement increases the risk of underestimating elder abuse, as large numbers of cases are unnoticed and unreported to authorities (Acierno et al., 2010). Small sample sizes and cultural taboos regarding reporting abuse can further limit generalizability. When individuals are unable or unwilling to talk about elder neglect, exploitation, and abuse, studying it rigorously becomes challenging, as it is difficult to increase both numbers of and the diversity of sample populations and environments, which contribute significantly to establishing program efficacy.

Relatedly, the nascent field of elder abuse has yet to come to consensus on the appropriate goals of intervention (e.g., justice, safety, autonomy). In many instances, interventions are not examined because of fears on the part of those involved that research will reveal that the intervention is ineffective. If so, the determination would

affect the continuation of those interventions as well as the positions of those responsible for them.

Further Challenges for Evidence-Based Programs: Translation and Methodology

The primary challenge for the application of evidence-based practices for elder abuse programming lies in translating research with demonstrated efficacy to real-world successful programs. Prohaska and Etkin (2010) outlined four barriers to this translation: concerns with external and internal validity; criteria for a relevant outcome; treatment fidelity; and program reach. Pointedly, if the guidelines are followed, will the program under scrutiny work outside the research setting with the target population? It is simply not enough to have evidence supporting an intervention.

Additional challenges lie in a lack of training for those implementing the programs, a lack of multidisciplinary coordination, staffing shortages, and a paucity of financial resources (Ell, 2006). Also imperative is an understanding of the evidence base and selection of a facilitator for its implementation (Kitson, Harvey & McCormack, 1998; Rycroft-Malone et al., 2003). The research methodology, not just the evidence, must be efficacious outside the research setting. The evidence must be replicable in the real world and must also have similar effects. Evidence also needs to be well-informed (i.e., the methodology is sound, results are reliable, and design and findings take into consideration resource availability). By taking into account the levels of implementation from community awareness, professional training, and elder involvement, evidence-based practices have a better chance of translation into real world settings (Ell, 2006).

If the intended goal of using evidence-based practices for elder abuse is to create behavior change and reduce instances of it, this intention may pose a challenge. One of the ways evidence-based practices establish efficacy is through demonstrating causal relationships for behaviors. The practice in question should have similar or the same results in the real world. This is a challenge because researchers and practitioners alike are discovering that elder abuse represents a phenomenon far more heterogeneous than homogeneous. As yet, a good understanding of what causes some people to become abusers and not others in similar situations does not exist. As a result, no evidence-based interventions exist yet to reduce the abuse of older adults by family caregivers (Cooper et al., 2010). However, some important findings and efforts point the way.

Toward the Application of an Evidence-Based Program to the Issue of Elder Abuse

We propose that the use of evidence-based programming for elder abuse holds promise for addressing the problem of elder abuse. Evidence-based programs in similar arenas such as mental health, chronic disease, and exercise are already in place and are being successfully implemented with measurable and positive outcomes. A theoretically driven, evidence-based program on elder abuse is a hopeful measure and direction for the field. In the past 20 years, increasingly rigorous scientific methods are addressing the problem of elder abuse, engendering creative and interdisciplinary approaches to the problem.

These efforts, tested in the most rigorous ways possible and applied to the real world, hold much potential for the victims and perpetrators of elder abuse. Available

evidence-based programs on the prevention of elder abuse are the right and appropriate way to channel the efforts of many dedicated, talented, and visionary individuals and entities towards the definition, identification, prevention, intervention and reduction of elder abuse.

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