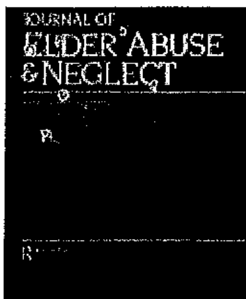

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Eliciting Change in At-Risk Elders (ECARE): Evaluation of an Elder Abuse Intervention Program

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The current study evaluated the effectiveness of a community-based elder abuse intervention program that assists suspected victims of elder abuse and self-neglect through a partnership with local law enforcement. This program, Eliciting Change in At-Risk Elders, involves building alliances with the elder and family members, connecting the elder to supportive services that reduce risk of further abuse, and utilizing motivational interviewing-type skills to help elders overcome ambivalence regarding making difficult life changes. Risk factors of elder abuse decreased over the course of the intervention and nearly three-quarters of participants made progress on their treatment goal, advancing at least one of Prochaska and DiClemente's (1983) stages of change (precontemplation, contemplation, preparation, action, and maintenance). Forty-three percent of elders moved into the stages of action and maintenance regarding their goal. The usefulness of eliciting change via longer-term relationships with vulnerable elders in entrenched elder abuse situations is discussed.

KEYWORDS elder abuse intervention, risk factors for abuse, self-neglect

Elder abuse and neglect continue to be prevalent in families and care facilities across the nation. Most recently, Acierno et al. (2010) found that approximately 10% of elder respondents from a nationally representative phone survey reported some form of abuse within the past year. The

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percentage increased to 13.5% when respondents were asked about abuse occurring since the age of 60. Data such as these coupled with a dramatically growing older adult population tell of a continued increase of elder abuse and neglect in the United States. Despite this trend, there remains a dearth of intervention and outcomes research (Bonnie & Wallace, 2003; Daly, Merchant, & Jogerst, 2011). A recent review of published studies on elder abuse interventions found only eight studies meeting its methodological standards, none showing intervention to be more beneficial than nonintervention and some showing worsened outcomes for the intervention group (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2012). Ploeg and colleagues called for more innovative approaches to elder abuse intervention alongside more rigorous research on the effectiveness of these interventions.

The first substantive component of most elder abuse interventions is the development of a relationship or alliance between a vulnerable elder and a service provider, or between family members and caregivers of significantly impaired elders and a service provider. This alliance is crucial for gaining an understanding of the often complex situation in which abuse has occurred, for identifying the elder's needs and wishes, and for facilitating the elder's openness to receiving assistance. As elder abuse victims have traditionally underutilized available services (Ploeg et al., 2012; Wolf & Pillemer, 1994), a strong alliance between elder and service provider can help the elder become engaged in services they might otherwise have refused. This alliance can also pave the way for the elder to permit the introduction of still other sources of support. The importance of the therapeutic alliance in predicting mental health treatment outcomes has been well documented (e.g., Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Hyer, Kramer, & Sohnle, 2004). Similarly, the development of adequate trust to forge a working alliance is an elemental precursor to assisting vulnerable adults who have recently been exploited, often by a friend, family member, or other person they trusted. Allotting an adequate amount of time to building trust allows elders to discuss and increasingly overcome reluctance to receiving assistance.

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Second, effective elder abuse interventions aim to decrease risk factors of further abuse. In a panel review published by the National Research Council, Bonnie and Wallace (2003) presented risk factors that have been supported by research. The editors listed risk factors validated by substantial evidence, including environmental risk factors (e.g., living arrangements), elder-related risk factors (e.g., social isolation and dementia), and abuser-related risk factors (e.g., mental illness, hostility, alcohol abuse, and dependency). As with most forms of abuse, access to the potential victim is a significant risk factor for the emergence of or continuation of elder abuse. Also in regard to living arrangements, social isolation has been shown to contribute to and result from ongoing abusive situations. Caregivers, family members, and potential victims who lack substantial social

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networks experience increased demand on a limited number of caregivers and decreased social sanctions as a result of abusive behavior, and they may avoid further social interactions out of shame or fear of discovery. It is notable that the risk factors identified by Bonnie and Wallace involve not only elder vulnerabilities, but characteristics of the abuser, caregivers, family members, and living environment. Intervention that reduces these diverse risk factors can involve intervening with family members, caregivers, and others who have a direct effect on the elder's living environment, in addition to working directly with the elder.

Finally, in addition to addressing environmental and abuser-related risk factors, effective elder abuse interventions involve tools for empowering elders with adequate decision-making capacity toward enhanced safety and autonomy. This can include helping elders utilize available resources to end an abusive relationship or act to enhance their own health and well-being. Effective tools to evoke change and nuanced measures to assess change are particularly important for jeopardized elders, as interventions often show small effects over an extended period of time (Yang, Garis, & McClure, 2005). With an approach based on relationship building and practical intervention, the current program utilized a pragmatic and nonjudgmental approach to reducing risk factors by matching interventions with elders' preferences and needs. In a recent meta-analysis by Norcross, Krebs, and Prochaska (2011), the authors consistently found clinically significant effects between a psychotherapy client's stage of change and his or her outcome. Norcross et al. also argued that interventions not tailored to a client's stage of change were more likely to prompt refusal of services or early dropout. More specifically, Fried et al. (2010) examined stages of change related to advance care planning in older adults. Participants reported varying levels of readiness to engage in each of the measured behaviors (e.g., creation of an advance directive), and the authors suggested, "Individualized assessment and interventions targeted to the stage of behavior change for each component of [advance care planning] may be an effective strategy to increase older persons' participation" (Fried et al., 2010, p. 2335). In light of these and previous findings, the current program chose to conduct assessments of an elder's readiness to change as well as draw on motivational interviewing in working with elders' intense ambivalence about accepting abuse-related assistance.

Eliciting Change in At-Risk Elders (ECARE), generously funded by the Archstone Foundation as a continuation of their 5-year Elder Abuse and Neglect Initiative in California, is an elder abuse intervention and prevention program developed by Regina McClure, Janet Yang, and others at Heritage Clinic and the Community Assistance Program for Seniors over 20 years of community-based elder mental health and dementia care intervention, in Pasadena, California. Through a community partnership with local law enforcement, program staff followed up with referrals of individuals on

whose behalf a Report of Suspected Elder Abuse had been made and who had elder abuse prevention or intervention needs.

Trained outreach specialists followed up with these jeopardized elders through phone and/or face-to-face contact, spending time establishing a working alliance with the elder and with key family members to facilitate the identification of the elder's needs post-abuse and forge a collaborative context in which the elder's needs could be met. To abate elder ambivalence regarding receiving services, outreach specialists met with elders in their own homes. When elders' reluctance to receive assistance impeded the development of a working alliance, project staff actively engaged related perceptions, whether verbally (e.g., identifying elders' life experience as a resource) and/or nonverbally (e.g., initially addressing a less evocative, practical need). The alliance-building phase of service delivery occurred on a time continuum from very brief to approximately 3 months, depending on the elder's cognitive abilities, symptoms of mental illness, and levels of interpersonal conflict, dependency, and ambivalence. Where elders had significant cognitive impairment and were unable to develop a relationship or advocate on their own behalf, the alliance was built primarily with a family member or caregiver.

After an adequate alliance had been established and the elder's preferences and needs identified, outreach specialists directly connected elders to sustainable community resources that enhanced elder safety and independence. Community resources included geriatric assessment, financial and medical insurance benefits establishment, medical care, mental health services, transportation, in-home meals, in-home caregiving, safer housing options, assistance with loss of vision, friendly visitors, and interpersonal reconnection (e.g., faith community, family member, friend). To facilitate the elder fully utilizing available resources for enhancing safety and promoting autonomy, outreach specialists utilized motivational interviewing-type skills to help elders identify needs, think through options, and make steps towards change. Change was understood as movement along Prochaska and DiClemente's (1983) stages of change, which included precontemplation (no desire for change), contemplation (ambivalence about change), preparation (plans for change within next month), action (making change), and maintenance (following through with change). Understanding and targeting this process of change was crucial to the current project, as chronic, change-resistant situations (e.g., self-neglect, family conflict) were common among the elders served by the ECARE program. The emphasis on elder change in the midst of an abusive situation did not implicate the elder as the cause of his/her abuse, but rather prioritized the elder's capacity to choose his/her response to an abusive situation. For some program participants this choice involved maintaining a relationship with the suspected abuser or underutilizing available legal options (e.g., restraining or eviction orders), often out of a desire to preserve that relationship. Outreach specialists informally assessed

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elder readiness to change and intervened in a manner consistent with the elder's stage of change to promote elder safety and autonomy.

For example, intervention for elders at the precontemplation stage often involved encouraging the elder to discuss the issues that brought the elder's situation to the attention of law enforcement, with focus on acknowledging any harmful effects experienced by the elder. For elders at the contemplation stage, intervention involved discussing costs and benefits of making change and when appropriate creating a plan for safety. Intervention for elders in the preparation stage focused on educating the elder about available resources and helping remove barriers to action, such as lack of transportation. For elders in the action stage the intervention involved assisting the elder to connect to supportive resources or make constructive changes, while helping the elder overcome obstacles and frustration encountered as he or she began making changes. Finally, for elders in the maintenance stage, intervention focused on consolidating gains and making relapse prevention plans. Attention to project participants' stage of change was expected to reduce participant dropout and facilitate intervention targeted at the needs of each individual.

The current study was designed as an evaluation of the ECARE program, which ran from July 2011 through December 2012. Three components of the ECARE program were evaluated: (a) the development of a working alliance between the elder and outreach specialist, (b) the decrease in risk factors for abuse from beginning to end of the intervention, and (c) the elder's movement along Prochaska and DiClemete's (1983) stages of change regarding the primary focus of intervention. We hypothesized that (a) the strength of the working relationship would increase over the course of the intervention; (b) risk factors related to impaired physical/mental health and social/community functioning would decrease over the course of the intervention, while economic/housing and independent living functioning would remain stable; (c) risk factors related to dependency and isolation would decrease; and (d) participants would on average progress to the next of Prochaska and DiClemente's (1983) stages of change.

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METHOD

Participants

Among referrals of suspected elder and dependent adult abuse from local law enforcement, 175 were identified for follow-up based on the criteria of age over 55 and the elder speaking a language known to outreach staff. Referrals were largely female (67.40%), with an average age of 79.59 years and ethnicity consistent with that of the surrounding community: African American (18.86%), Asian (8.57%), Caucasian (34.29%), Hispanic (16.00%), and Middle Eastern/North African (2.86%). Ethnicity was unknown for

TABLE 1 Demographic Information by Intervention Group

	Outreach Only ($n = 94$)	Limited ($n = 26$)	Full Intervention ($n = 55$)	Total ($N = 175$)
Gender				
Male	30 (32%)	13 (50%)	13 (24%)	56 (32%)
Female	63 (67%)	13 (50%)	42 (76%)	118 (67%)
Ethnicity				
African American	11 (12%)	6 (23%)	16 (29%)	33 (19%)
Hispanic	13 (14%)	4 (15%)	11 (20%)	28 (16%)
Asian American	7 (7%)	—	8 (15%)	15 (9%)
Caucasian	29 (31%)	14 (54%)	17 (31%)	60 (34%)
Mid-Eastern/North African	2 (2%)	—	3 (6%)	5 (3%)
Unknown	32 (34%)	2 (8%)	—	34 (19%)
Age				
Mean	81.46	79.11	77.11	79.59
Standard Deviation	9.33	11.25	10.56	10.19

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19.43% of elders. Services were available in English, Cantonese, Mandarin, and Spanish.

Among these elders, 46.29% were responsive to outreach efforts and interested in receiving assistance. Elders who were engaged in services were similar in demographics to those who were not engaged in services (see Table 1). The extent of services provided to engaged elders was based on the number, type, complexity, and chronicity of problems faced by the elder, the elder's openness to receiving assistance, and the elder's capacity to follow through with plans or referrals (see Table 2). Twenty-six elders received a brief, targeted intervention (e.g., connection to support group) of an average duration of 3 hours and 10 minutes over 1 to 6 meetings spanning 1 to 3 months (mode = 1). Forty-seven elders and seven family caregivers of jeopardized elders received more extensive assistance in either multiple areas of need, or one major area of need (e.g., assistance leaving an abusive relationship) of an average duration of 15 hours and 5 minutes over 3 to 36 meetings across 3 to 18 months (mode = 5). For those who received

TABLE 2 Outreach and Intervention Services Provided by Intervention Group

	Limited Intervention ($n = 26$)	Full Intervention ($n = 55$)
Outreach		
Minutes spent[a]	—	99.76 (43.20)
Intervention		
Minutes of service provided	190.62 (100.04)	905.51 (958.85)
Number of face-to-face contacts	1.69 (1.19)	9.40 (8.58)
Months	1.31 (0.55)	6.76 (3.95)

[a]Minutes of outreach not listed for limited intervention group, as outreach and intervention times were collapsed together to indicate total minutes of service.

extensive assistance, on average 1 hour and 40 minutes were spent engaging in outreach to the elder or caregiver (i.e., phone calls or home visits, rapport building). Only those who received extensive assistance were included in this program evaluation.

Procedure

Outreach specialists, those who provided direct services, assessed elder functioning at the beginning and end of the intervention. Outreach specialists included two psychology graduate students and one experienced geriatric mental health case manager who worked at a publicly funded mental health agency. Outreach specialists were supervised by an elder abuse specialist with a strong mental health background, who provided supervision to improve service provision to program participants and provided feedback on outreach specialist ratings of participant functioning. Measures of pre- and post-intervention functioning included a problem checklist, Likert-type measures of Working Alliance and Dependency and Isolation developed by the second and first authors, and identification of elder readiness for change per Prochaska and DiClemente's transtheoretical model of change (1983). The problem checklist was made up of 42 observable risk factors for abuse or poor health in key domains of elder functioning, including Physical and Mental Health, Economic and Housing, Social and Community, and Independent Living (see Figure 1; Jones, Holstege, & Holstege, 1997; Quinn & Tomita, 1997). Outreach specialists used the problem checklist to rate the presence or absence of risk factors such as "diminished cognitive capacity," "at risk of eviction," "conflict in living environment," or "difficulty with activities of daily living." In addition to this checklist of risk factors, strength of the working alliance between elder and outreach specialist was assessed by a 3-item Likert-type scale, and elder dependency on inconsistent or harmful others and elder isolation from community resources and social support was assessed with an 11-item scale (see Figure 2). Internal consistencies were high for the Working Alliance scale ($\alpha = .87$ at intake and .90 at discharge) and adequate for the Dependency and Isolation scale ($\alpha = .73$ at intake and .75 at discharge). Stage of change, per Prochaska and DiClemente (1983), was rated by each outreach specialist pre- and post-intervention and then was discussed and jointly agreed upon by a treatment team including outreach specialists and the program coordinator. Since ECARE interventions utilized a treatment team approach, input from all team members informed determinations of treatment outcome.

RESULTS

The effectiveness of the ECARE program was evaluated by examining pre- to post- intervention change in the strength of the working alliance

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Physical and Mental Health Functioning
- Chronic medical illness
- Mental illness (formally diagnosed)
- Depressed or anxious symptoms
- Psychotic symptoms
- Substance abuse
- Delays seeking medical attention
- Diminished mental capacity
- Lack of compliance with medical treatment
- Gross inattention to nutrition or hygiene
- Frequent hospitalizations

Economic and Housing Functioning
- Gives away money in a way that is harmful to the elder
- Inadequate housing or unsafe conditions in home
- At risk of eviction
- Experiencing eviction
- At risk of utility shutoff
- Experiencing utility shutoff
- Complaints *from* apartment manager regarding elder
- Complaints *to* apartment manager regarding elder
- Suspected financial exploitation
- Late payment or failure to pay rent/mortgage

Social and Community Functioning
- Legal proceedings are ongoing *against* the elder
- Elder is involved in legal proceedings *against* another
- Living with potentially abusive/exploitive caregivers
- Utilizes Emergency Room rather than Primary Care Physician for medical services
- Utilizes personal or financial resources to keep loved one closely attached to the elder
- Compromises own safety to keep loved one closely attached to the elder
- Elder seeks eviction of an individual from the premises
- Frequent calls to civic/emergency services
- Absence of family or friend relationships
- Lack of community connection
- Conflict in living environment
- Lack of access to resources
- Does not leave home

Independent Living Functioning
- Difficulty with Instrumental Activities of Daily Living
- Difficulty with Activities of Daily Living
- Greater dependency on caregiver than need suggests
- Declines needed supportive services
- At risk of premature move to a higher level of care
- Prematurely moved to higher level of care
- At risk of premature conservatorship
- Prematurely conserved
- Others are seeking conservatorship of the elder

FIGURE 1 Problem checklist.

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Please rate the following statements on a scale from 1 (Not at all True) to 5 (Very True).

Dependency and Isolation

Elder receives needed help from social services.
Elder is dependent on family and friends in a way that is harmful to the elder.
Elder is often hospitalized.
Elder often presents to the emergency room for treatment.
Elder reports conflict in his or her living environment.
Others report conflict in the elder's living environment.
Elder utilizes personal or financial resources to keep a loved one closely attached to the elder.
Elder compromises his or her own safety to keep a loved one closely attached to the elder.
Elder refuses needed help from others.
Elder has social support from community members.
Elder leaves his or her home.

Working Alliance

The alliance between the clinician and the elder is strong.
The elder regularly attends or is available for meetings with the outreach specialist.
The elder openly shares with the outreach specialist.

FIGURE 2 Dependency and isolation and working alliance scales.

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between outreach specialist and participant, risk factors for further abuse, and movement along Prochaska and DiClemente's (1983) stages of change regarding the key focus of intervention. As interventions were directed toward 48 vulnerable elders and 7 caregivers, the sample sizes for analyses varied. Analyses that included ratings of services provided directly to the elder (i.e., Working Alliance and movement along stages of change) had a sample size of 47. Analyses that included measures of elder functioning (i.e., problem checklists and Dependency and Isolation), which were expected to be affected by interventions targeting caregivers as well as those targeting elders, included a sample size of 54, as one elder died during the course of the intervention.

A paired-group t-test supported the hypothesis that outreach specialists' estimates of working alliance increased from pre- to post-intervention, $t(47) = -4.58, p < .001$ (Table 2). Next, a Repeated Measures ANOVA indicated a drop in overall number of risk factors observed by the outreach specialist over the course of the intervention, $F(1, 53) = 17.01, p < .001, \eta p^2 = .24$, as well as differences in change in risk factors observed among the four areas of functioning, $F(3, 51) = 9.21, p < .001, \eta p^2 = .35$. Specifically, a drop in risk factors was observed for Economic and Housing, and Social and Community functioning. No change was observed in Physical and Mental Health and Independent Living risk factors. Change in another risk factor for abuse, dependency, and isolation was evaluated by a paired-group t-test and showed a significant drop in outreach specialists' report of dependency and isolation, $t(52) = 3.11, p < .003$. Results showed significant change from pre- to post-intervention in scores on Prochaska and DiClemente's stages of

TABLE 3 Change in Elder Functioning Over the Course of the Intervention

	Pre-Intervention	Post-Intervention
Working Alliance*	3.20 (0.93)	3.83 (0.84)
Number of Risk Factors		
Physical and Mental Health	2.59 (1.93)	2.52 (1.81)
Economic and Housing*	1.52 (1.38)	0.70 (0.98)
Social and Community*	2.56 (1.98)	1.52 (1.55)
Independent Living	1.35 (1.39)	1.24 (1.10)
Dependency and Isolation*	2.48 (0.73)	2.21 (0.66)
Stage of Change*	1.94 (0.84)	3.19 (1.10)

Note. For Stage of Change, 1 = Precontemplation, 2 = Contemplation, 3 = Preparation, 4 = Action, and 5 = Maintenance.
*Change is statistically significant, $p < .01$.

change, $t(47) = -8.48$, $p < .001$. By the end of the intervention 12.50% of participants moved three stages, 29.20% moved two stages, 29.20% moved one stage, and 29.20% did not demonstrate any change. By the end of the intervention 7.30% of participants were in the Precontemplation stage, 18.20% were in the Contemplation stage, 18.20% were in the Preparation stage, 38.20% were in the Action stage, and 5.50% were in the Maintenance stage. Results of the analyses are presented in Table 3.

DISCUSSION

The current project's outcomes contribute to decreasing the gap in knowledge of effective interventions in the elder abuse field. The findings suggest that working alliances can be forged with intensely ambivalent elders, that risk factors of elder abuse can be reduced, and that nuanced, less easily observable changes can occur during intervention.

Conclusions

Working Alliance

Given the well-documented importance of the therapeutic alliance in predicting mental health treatment outcomes, and the reluctance of many older adults to receive services, the project's finding that the strength of the working relationship between the at-risk elder and the service provider increased over the course of intervention is promising. Further exploration may clarify the potential utility of working alliances in effective elder abuse intervention, including when elders are reluctant to receive almost all services. Furthermore, since the project utilized a variety of service providers (e.g., volunteer and paid, varying levels of education), the finding that the working alliance between the at-risk elder and the service provider increased

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may promote diversification of service providers to better match the needs of individual communities.

RISK FACTORS

An additional notable feature of the current project was its attempt to capture subtle change in participants during intervention, in contrast to more readily observable outcomes such as percentage of successful cases or incidence of further abuse. The result of an overall drop in risk factors suggests that the use of sensitive measures may more accurately detect incremental change in older adults as well as shed light on the pace at which elders change. Another distinction between more common elder abuse intervention models and the current project was an increased length of intervention as compared with the short-term or crisis services that are the standard in most states for first responders such as Adult Protective Services (National Center on Elder Abuse, 2013). The project's overall reduction in risk factors may warrant continued exploration, especially regarding complex impediments to safety and self-determination. Investigation of longer-term outcomes, recidivism rates, and strategic applications of lengthier interventions may be informative, as well.

The change found in each of the four observed areas of functioning may also offer direction to optimize intervention outcomes. Since a majority of older adults have significant housing costs and rely on fixed incomes (National Council on Aging, 2012), the project aimed only to stabilize participants' baseline risk factors regarding their economic/housing functioning. Yet, the project observed a drop in risk factors related to this area. The items endorsed in this larger-than-expected finding (i.e., economic/housing functioning did improve) suggest that meeting the basic needs of at-risk elders includes serving as an advocate between endangered elders and their apartment managers, utility companies, and sometimes financial institutions, as well as helping elders access additional resources. The predicted drop in risk factors associated with social/community functioning was the project's strongest outcome, consistent with the usefulness of social connection documented in the existing literature, and points to the utility of actively linking elders to safer, sustainable services in their community. Regarding elders' economic/housing functioning and social/community functioning, the interventions of building relationship with elders and their caregiving networks, and direct connection to needed services delivered in the context of a working alliance, were associated with lowered risk factors.

The project anticipated a reduction in risk factors around physical/mental health functioning, but found none. Since this area of functioning may reflect risk factors that are more severe (e.g., "psychotic symptoms," "frequent hospitalizations") and chronic (e.g., "substance abuse," "chronic medical condition"), the observed absence of change (i.e., neither

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improvement nor worsening) may reasonably represent a desirable outcome in that no additional risk accrued. Such a gain could include not-overtly-observable changes (e.g., decreased denial, increased consideration of medical care) or increased protective factors (e.g., relationship with service provider) that represent steps forward but do not constitute a definitive drop in risk factors. In the future, protective factors may be shown to be central to reducing the incidence of elder abuse, especially in regard to elders with more serious cognitive and/or physical impairment. Related to physical changes, older adults need more assistance with everyday activities as they age (e.g., 9% between ages 65 and 69; up to 50% over age 85; American Psychological Association, 2013); therefore, the project proposed only to preserve participants' starting level of independent functioning. Consistent with this reasoning, the project observed no reduction in risk factors related to independent living. Beyond age-related changes, the same reluctance to receive services common during the outreach phase of intervention may also hinder elders' acceptance of assistance necessary to maximize independent-living functioning. Thus, strong working alliances and sensitive measures to better detect subtle change in elders may be particularly applicable to the emotional complexities related to the areas of physical/mental-health and independent-living functioning.

Since the risk factors of dependency and isolation are well established in the elder abuse literature, we anticipated helping in this area. Given that older adults need more assistance as they age, the project did not expect dependency per se to decrease; rather, the project focused on shifting elders' reliance to safer, steadier resources. The study found a small but significant decrease in dependency and isolation. Similar to risk factors related to physical/mental health and independent-living functioning, dependency may be associated with emotional complexity and chronicity. Thus, the slight reduction may include more subtle changes (e.g., verbalization of desire for increased socialization, consideration of limit-setting behavior with abusive family members) that represent progress but do not comprise clearly observable, reduced risk factors. The small drop in isolation is consistent with the project being most effective at increasing elders' community connection. Since each of these two risk factors can exacerbate the other, it could be illuminating to separate the risk factors of dependency and isolation in future research.

Less Readily Observable Change

A critical issue in elder-abuse intervention involves the tension between safety and autonomy. As Wiglesworth, Mosqueda, Burnight, Younglove, and Jeske (2006) noted, "elders may remain vulnerable and resist help that protects them . . . because this is their right as autonomous adults," and "the safest solution may still fail to satisfy the victim's wishes." For these

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reasons, the project's time-intensive approach to addressing at-risk elders' reluctance to receive services and make changes is apt. Regarding its effectiveness, we posited that on average participants would progress one stage on Prochaska and DiClemente's Stages of Change model (1983), although not necessarily to the Action stage, during intervention. Results of pre- and post-intervention measures of participants' readiness to change were significant, suggesting that the approach is useful. The majority (70.9%) of participants moved forward and enhanced the likelihood of reducing their abuse-related risk factors. By the end of intervention, 5.5% of participants were in the Maintenance stage, 38.20% were in the Action stage, 18.20% were in the Preparation stage, and only 7.30% remained in the Precontemplation stage, where they were least likely to progress toward reducing abuse-related risk factors. It appears that the inclusion of the Stages of Change model helped detect more nuanced, less easily observable changes not captured previously. This new information about at-risk elders' readiness to change, coupled with more behavioral checklist items, provides direction for intervention decisions when progress toward change is slow related to intense ambivalence or entrenched interpersonal dynamics. Similarly, a fuller picture of elders' often gradual movement toward reduced risk of abuse assists in weighing the costs and benefits of time-intensive interventions with reluctant, at-risk elders.

It is important to note that although the project focused on decreasing risk factors for elder abuse related to the environment (e.g., establishing in-home assistance) and the abuser (e.g., connecting to mental health treatment and benefits), its primary focus was on empowering the elder toward enhanced safety and autonomy. This provision of services to the at-risk elder could be construed as a form of blaming the victim, in that the suspected victim, not the perpetrator, is the target of change. However, given that elder abuse occurs in the context of relationship, the abusive situation can be changed by the elder as well as the abuser. To ignore a vulnerable elder's potential power in abusive relationships, in an attempt to avoid a perception of blaming the victim, would foster an older adult's silence and helplessness, thereby missing strategic opportunities for conflict resolution, reduction of risk, and empowerment of elders.

Limitations of the Study

Limitations of the study include the limited number of participants, the subjective nature of the raters' responses to the checklist items, and the possible halo effect of positive relationships developed over the course of the intervention. Additionally, the lack of a control group made it difficult to measure whether the observed change in participants' function was the result of the intervention or whether participants not receiving assistance might have shown similar improvement over a comparable period of time.

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Field and Research Applications

For other agencies serving at-risk elders, the project's findings suggest that a longer-term, relationship-based intervention for entrenched elders who are reluctant to receive services may be effective and therefore worth considering. More specifically, effective intervention may not only reduce risk factors of abuse in pertinent areas of functioning, but also facilitate perceivable progress toward elders' readiness to change. These findings surfaced after employing sensitive evaluative tools such as the checklist items and Stages of Change model.

Other aspects of the project may be informative for those who serve older adults. Since interventions can be provided by a variety of staff with strong people skills and adequate project-related training, and since services are delivered primarily in elders' homes, the project's setting is flexible (e.g., community center, faith-based organization, District Attorney's office, graduate school, medical clinic). It is recommended that service providers have regular access to consultation with a mental health professional with geriatric experience. The project's partnership with local law enforcement encourages a fresh look at creative collaborations, including between public and private service providers.

As investigators continue to shape elder abuse research regarding theory and intervention, the project's findings indicate that it may be useful to further study the strength of the relationship between at-risk elders and their service providers, as well as subtle, incremental progress in elders' readiness to change. When progress in establishing a working alliance or in moving toward change is slowed by elders' reluctance to receive services, focus on elders' perceived need may be helpful in light of its consistent strength as a predictor of service use (Wacker & Roberto, 2007). Finally, the project's introduction of sensitive tools to better capture both behavioral and less observable changes (e.g., checklist items, Stages of Change model) related to decreased risk factors resulted in previously missed information that more accurately depicted the impact of intervention.

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