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## After Older Adult Maltreatment: Service Needs and Barriers

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### ABSTRACT

Little research is available specific to the service needs or related barriers of maltreated older adults. Further, no studies have asked at-risk older adults directly for their perspectives on service needs and barriers. As part of a larger study, a sample of 40 diverse older adults (*M* age = 76 years) were recruited from the population of older adults who were involved in an abuse, neglect, and/or financial exploitation case where the offender was in a position of trust to the victim. Responses to open-ended questions about participants' service needs and reasons for not seeking services were thematically coded. The majority of older adults expressed needing more help than currently received, with needs including transportation, housing, food, household assistance, and medical and mental health care. Participants also described reasons their service needs were not being met. The study elaborates on the specifics and descriptive statistics of the themes that emerged. Implications for older-adult victim services, as well as broader older-adult services, are discussed.

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### KEYWORDS

Elder abuse; service use; exploitation; older adults

## Introduction

Meeting older adults' services needs is critical to their health and well-being. Relative to their peers, older adults with unmet service needs have poorer health, diminished access to healthy foods, inferior housing quality, greater perception of neighborhood danger, and higher likelihood of requiring assistance with activities of daily living (Chen & Thompson, 2010; Desai, Lentzner, & Weeks, 2001; Ferris, Glicksman, & Kleban, 2016; Komisar, Feder, & Kasper, 2005). Relative to their peers, older adults who have experienced maltreatment are at even greater risk of experiencing the negative effects associated with unmet service needs (Benton, 1999), pointing to the importance of studying this group's service needs and barriers in order to improve access and outcomes. For instance, maltreated older adults are at risk of being isolated and may not be able to access services, advocate for their service needs and/or rely on social supports to do so on their behalf (Jackson & Hafemeister, 2011). Though approximately 1 in 10 older adults experience abuse, neglect and/or exploitation (Lachs & Pillemer, 2015; Laumann, Leitsch, & Waite, 2008), little research has

focused on service needs of and barriers facing older adults in the aftermath of maltreatment. In the following section, we build on the service use literature with older adults broadly to examine older adults' service needs and barriers following maltreatment.

### ***Older adult services broadly***

In the United States, services for older adults are many and varied and range from medical, mental health, financial, and long-term services and supports (Jackson, 2017; Reder, Hedrick, Guihan, & Miller, 2009). Research on older adults' service needs, use, and barriers has been relatively limited and findings unequivocal. For example, older adults presented with a list of service needs indicated that their needs were generally well met with few exceptions, such as medical needs (e.g. not having access to a doctor, suffering from unaddressed physical ailments, Calsyn & Winter, 2001). Other research, however, has found that caregivers perceive wide-ranging service gaps that range from support groups, community-based programs, and respite care to home-based programs, and transportation (Casado, van Vulpen, & Davis, 2011). Comparing older adults' reported needs (e.g., identified physical health impairment) to services received (e.g., medical or nursing services), Cohen-Mansfield and Frank (2008) found that more than 60% of older adults had their needs met in terms of assistance with mobility, physical health, social activities, and activities of daily living. However, more than 75% of older adults had unmet needs in the other assessed areas, including managing finances, mental health services, vision impairment services, or exercise services. Community-dwelling older adults asked to describe the services they thought were needed to maintain healthy independent living expressed the greatest need for communication, education, or advertisement about available services as well as supportive home care (e.g., shopping, house cleaning); service providers largely mirrored older adults' responses (Nolin, Wilburn, Wilburn, & Weaver, 2006).

Research into barriers to service use among older adults broadly has generally converged on issues related to awareness and accessibility of services. For example, in a representative sample of community-dwelling older adults, roughly two-thirds of respondents indicated that services they needed were unavailable or inaccessible, or that they were unsure about the availability of services (Nolin et al., 2006). This was consistent with studies spanning the last two decades that have documented that older adults are often unaware of or unable to access available services or perceive themselves as not having service needs (Denton et al., 2008; Hightower, Smith, & Hightower, 2006; Moon, Lubben, & Villa, 1998; Newton, 1980; Nolin et al., 2006; Starrett, Wright, Mindel, & Van Tran, 1989). Further, many older adults do not believe they need services, as illustrated when Casado et al. (2011) asked caregivers to report on older adults' service use and needs. The vast majority (83–96%) of caregivers reported that older adults had never used most types of

assessed services in the study, largely because the older adults did not need the services. Caregivers continued to report unmet needs, though, which suggests that services currently offered might not be tailored to meet older adult needs.

### ***Service needs of maltreated older adults***

Older adults at risk of maltreatment (e.g., following a maltreatment allegation) face a unique set of challenges that affects their service needs compared to their non-maltreated peers, ranging from low social support, psychopathology, or criminal and civil justice involvement (Acierno et al., 2010). Thus, at-risk older adults might need services ranging from case management, civil and criminal legal services (e.g., protective/restraining orders, restitution, law enforcement referral, court accompaniment, eviction notices) to guardianship services in the aftermath of maltreatment (Jackson, 2017). Despite the importance of understanding service needs and barriers of older adults following maltreatment, only scant research is available. For Pritchard (2000, 2001), identified older adults' service needs following abuse, which included medical and psychological assessment or care, social company, financial management, safety, criminal justice involvement, and housing. This work suggests that even though older adults have come to the attention of the authorities and service providers because of their maltreatment, they continue to face a series of unmet needs; however, this research does not speak to the barriers that older adults faced in accessing services. Newmark (2004) found that older adults who are able to access victim services tended to express satisfaction. However, there is no work available on older adults' perceptions of barriers to service use following maltreatment.

### ***Current study***

The current study examined older adults' perceptions of service needs, use, and barriers following formal allegations of abuse, neglect, and/or exploitation. The focus on needs and barriers draws from Anderson and Newsom (2005) theory of health-care service utilization which describes how while ideally service needs should influence service use, other predisposing factors at the individual level (i.e., sociodemographics, residential mobility, attitudes) and enabling factors at the system level (access and availability of services) may often facilitate or bar use, even when it is needed. This study was part of a larger randomized control trial examining the impact of a multidisciplinary team response to cases in which older adults were reported to be victims of abuse, neglect, and/or financial exploitation with an offender in a position of trust to the victim, and potential danger to the older adult. The current analyses focus on audio-recorded interviews with older adults about service needs and barriers to service access.

## Methods

From cases identified for the randomized control trial, which were primarily through police incident reports, older adults who spoke English and had a safe location for the interview were invited to participate in structured interviews. Participants were sent a recruitment letter describing a study on older adult health, stress, and service needs ahead of a phone invitation. Interviews were scheduled at locations preferred by participants (e.g., homes, libraries). After an explanation of informed consent, a consent quiz was used to assess understanding, a consent protocol carried out regularly by this research team (hidden citation). The larger project was longitudinal with interviews occurring at 1, 6, and 9 months after the initial baseline interview. Interviews were audio-recorded and participants' responses were transcribed verbatim. Participants were asked about service needs at each interview as part of the larger longitudinal project. Because participants were invited to share feedback at each time point about any experience they had since the beginning of the study, and given the assumption that the abuse that was reported to the authorities was not the first and only occurrence (Benton, 1999), responses were collapsed across time.

## Participants

Of the 272 older adults referred to the multidisciplinary team, 201 older adults were sent a recruitment letter and 71 older adults had incorrect or missing contact information. Upon receiving a letter, 57 older adults agreed to an interview; the others could not be reached, declined or were not eligible. Ultimately, 40 older adults participated in the first interview and 17 older adults did not participate because they declined or failed the consent quiz. Retention was 75% at the second interview, 70% at the third interview, and 58% at the fourth interview. Results reported below reflect percentages of valid cases.

Participants ( $N = 40$ ) ranged in age from 58 to 94 years (average = 76;  $SD = 8.63$ ) and were primarily female (75%). Almost a quarter (21%) had high school education or less, and 20% were retired. Thirty-eight percent were of ethnic minority. Nearly half of participants were widowed (48%); the remaining half were divorced (28%), married (18%), or single/never married (8%). Half (50%) of participants reported at least one other person living in their home, with up to four cohabitants. Participants reported their perceptions of the research at each interview using the Response to Research Participation questionnaire (procedure described in Newman & Kaloupek, 2001); paired t-tests indicated greater positive (Personal Benefits; Global Evaluation-Participation) than negative (Drawbacks; Emotional Reactions) perceptions.

## **Measures**

### ***Victim characteristics and trauma experiences***

Participants reported on demographic variables, including age, race/ethnicity, number of children, relationship status, sexual orientation, socio-economic status. The Trauma History Questionnaire (THQ; Hooper, Stockton, Krupnick, & Green, 2011) uses 24-items to measure the frequency and age at which traumatic experiences occur per three categories: general disaster (e.g., car accidents, earthquakes), crime-related events (e.g., robberies), and interpersonal events (e.g., physical or sexual abuse).

### ***Service use***

Service use and satisfaction were assessed with the Service Use Checklist (Morrow-Howell et al., 2008), which assesses frequency and satisfaction of use of services in the past 3 months. Services assessed included: medical health (e.g. hospital stay, doctor appointment), mental health (e.g. mental health specialist, self-help or support groups, etc.), legal (e.g. professional legal assistance, contacted police, professional financial planning), emergency crises (e.g. safe shelter, 24-h crisis phone line, etc.) and aging services (e.g. senior center, activity program, etc.). Participants were also given the opportunity to list any other services and asked to rate if they needed more help than they were getting, ranging from 0: 'not at all' to 3: 'a lot more help'.

### ***Qualitative questions about service needs and barriers***

Participants were asked two open-ended questions about service needs and barriers: "*What other services or responses would you like to be available for older adults at risk for maltreatment, neglect, and financial exploitation?*" and "*What do you think are the reasons you are not getting more help.*" The full transcripts were reviewed for additional utterances specific to service needs, use, or barriers.

### ***Qualitative coding procedure***

A coding system was developed for the content analysis (Bernard & Ryan, 2000). Initial coding categories were identified from the available literature and through research team discussion about the interview content. Using the initial coding system, the authors coded a randomly selected subset of transcripts and determined that additional codes were needed to reflect themes not adequately reflected in the initial coding system. Two broad thematic categories were specified: (1) Service, response, or help needs; (2) Reasons for not getting help. The service needs theme included 24 codes. Reasons for not getting help included 19 codes.

With the final coding system, all transcripts were double-coded by two separate coders. Within each time point, transcripts were coded in random sequence. After coding was complete, 14 codes were eliminated because they were used less than 3

times across all participants. The two raters displayed good agreement (kappas ranged from 0.6 to 1), with all kappas classified within the range of substantial agreement or greater (Landis & Koch, 1977). Finally, the two coders discussed all coding discrepancies to arrive at a consensus code. Organization and coding of the qualitative data utilized QRS NVivo qualitative analysis software, Version 10. SPSS software, Version 24, was used to calculate inter-rater reliability and frequency of codes.

## Results

### *Older adult experiences of maltreatment and service use (Table 1)*

Half of the participants reported lifetime physical maltreatment by family members (e.g., being hit with an object), with 15% describing one or more incidents in the previous year. Over a third reported neglect; and one in five faced unmet basic needs in the last month ranging from lacking assistance for transportation to the grocery store to assistance in obtaining and taking medication. More than half of these incidents reported financial exploitation in the previous year, such as a close friend or family member taking money or property without permission. For services used in the last 3 months, a majority of participants reported having used medical health services and less than half having used mental health services. Almost half used senior center services. Over two-thirds reported the use of legal services while less than one in five reported the use of emergency services. Less than one in five of participants reported receiving the assistance of a case manager.

### *Older adult service needs (Table 2)*

A majority of participants reported needing “some” to “a lot” more help than they were currently receiving. Moreover, during open-ended interviews, every participant in the sample reported having at least one unmet service need and/or experiencing a barrier to accessing services at one or more time points. Among

**Table 1.** Older adult experiences of maltreatment and service use.

Older Adults Experiences of Maltreatment	%
Physical maltreatment	50%
Neglect	38%
Unmet basic needs (e.g. transportation to the grocery store)	20%
Financial exploitation	52%
<b>Service Use</b>	
Medical health services	76%
Mental health services	42%
Senior center services	47%
Legal services	73%
Emergency services	16%
Case manager	15%

**Table 2.** Older adult service needs.

Unmet service needs	%
Transportation	45%
Medical	38%
Mental Health	38%
Household Services	38%
Obtaining housing	23%
Obtaining food	28%
<b>Reasons for unmet service need</b>	
Insufficient knowledge	33%
Needing help navigating services	25%
Cost of services	40%
Other financial burdens	40%
Limited eligibility criteria for services	18%
Insufficient governmental assistance	13%
Lack of legal system based response	13%
Inadequacy of services	38%
Poor provider communication	15%
Lack of communication <i>across</i> providers	10%
Lack of case coordination	10%
Lack of overall care and compassion	10%
Lack of provider understanding of older adults needs	23%
Not having asked for services	33%
Not trusting providers	18%
Felt too guilty/ashamed to ask for help	18%

the specific service needs identified during interviews, almost half cited transportation due to inability to drive, scarcity of/distance to public transportation, and/or physical limitations. More than a third of participants described unmet medical health service needs and unmet mental health service needs. In addition, more than a third needs related to household services (e.g. help with yard work, cleaning, etc.). Participants also faced challenges obtaining housing and food. Participants described problems finding affordable or accessible housing, including long waitlists; and indicated that food was often too expensive (e.g. food stamps did not cover needs) or inadequate (e.g. charity meal services not meeting nutritional needs).

Participants described several reasons service needs were not met in the open-ended, qualitative questions. Approximately one third reported that they had insufficient knowledge of or needed assistance finding and navigating available services. One quarter expressed needing help navigating services they knew existed. For instance, participants cited impediments to accessing services they knew existed, such as physically being unable to reach the service (e.g. due to mobility challenges from medical conditions) or unfamiliarity with technology necessary to use the service. Others stated someone, such as a family member, had actively prevented them from accessing services. Participants also reported finances as a primary obstacle to obtaining services, whether the actual cost of needed services or the presence of other financial barriers that took precedence (e.g., rent took priority over paying for a service). One in four participants



reported needing financial assistance to help manage personal finances. Almost one in five wished for broader eligibility criteria for services (e.g. financial eligibility) and 1 in 10 identified governmental programs (e.g. supplemental security income, disability, etc.) as a need, deeming programs to be inadequate (e.g. not enough to financially support a household) or nonexistent. Finally, participants also expressed a need for criminal-justice-system-based services to be more responsive, such as providing adequate victim compensation or responding appropriately to crimes reported.

Needs also went unmet due to inadequacy of available services. Over a third reported having used or attempting to use services, but found them lacking or inadequate (e.g. able to access the doctor but not being treated with dignity and respect). For instance, participants described poor provider communication with the older adult as a barrier to effective services, such as the provider not updating them (e.g. on a legal case or medical findings) or following up (e.g. provider not returning calls). Further, communication *across* providers was often an impediment, such as medical personnel not communicating amongst themselves about the participant's medical treatment needs. Indeed, participants reported case coordination as a specific service need and wished for greater overall care and compassion from providers, and needing better provider understanding of participants' needs. Of note, some participants reported not having asked or initiated services. Almost one in five reported not trusting providers even if they were aware of services or indicated that they felt too guilty or ashamed to ask for help.

## Discussion

The current study captured older adults' service needs and barriers to receiving services following a police-reported maltreatment incident. Thus, this population had already come to the attention of service providers and the authorities, which in turn suggests that they be more likely to receive services. However, and despite common service use (e.g., 76% using medical services, 73% legal services, 42% mental health services) in the past month, older adult participants identified significant service needs and difficulty meeting those needs. While nearly 70% of the sample indicated unmet needs when asked in a close-ended question, all participants reported unmet needs when asked in an open-ended format. This discrepancy highlights the importance of framing and format of interview and assessment questions (Bowling, 2005). Needs identified indicate that older adults who have experienced maltreatment have both similar and unique service needs compared to their non-maltreated peers. As such, older adults who have experienced maltreatment are at risk for having several unmet service needs. This is striking given that their abuse came to the attention of service providers and they are using services at higher rates than peers (e.g., Casado et al., 2011; Cohen-Mansfield & Frank, 2008). Some service needs may be unique to older adults who have experienced maltreatment, such as criminal and civil legal services as well as

emergency responses. Likewise, some barriers might be unique, such as family members preventing older adults from accessing services.

Participants described situations in which service needs and barriers were often intertwined with maltreatment experiences. Maltreatment may be the reason services are needed (e.g., legal assistance, medical care), and inability to access needed services may further increase risk of additional abuse. For example, as a result of service barriers, many of the older adults in this sample described not being able to meet fundamental basic needs, such as housing, food, and physical and mental health. In turn, unmet basic needs can increase older adults' risk for exploitation and abuse. Homelessness is a prime example: O'Connell et al. (2004) found older adults living on the streets of an urban city experienced an average of 153 emergency room visits per person, per year, frequently for traumatic injury. The maltreatment-service need interconnection can be further exacerbated when a perpetrator of maltreatment actively prevents an older adult from accessing services, as occurred for 1 in 10 participants in this study.

Aside from the interconnection between maltreatment and unmet need, the types of services participants needed largely aligned with previous studies of community older adult samples' service needs (Reder et al., 2009). Sheer unavailability of services appeared to play a role in whether needs were met. The lack of services may be a financial issue, as protective services funding for older adults is nearly 12 times smaller than funding for child protective services (U.S. House of Representatives, 1990). Beyond accessibility, Casado et al. (2011) noted a possible fundamental mismatch between older adult needs and the services options for older adults. Instead, needs go unmet due to barriers to access and quality of care.

Participants in the present study felt they lacked knowledge of and access to services, which was the primary barrier to receiving services. A similar pattern has been found in general samples of community-dwelling older adults (Nolin et al., 2006). While general service information may be available online, this medium might not be easy for older adults to access (Chang, McAllister, & McCaslin, 2015). One suggestion is to target information to older adults in frequented locations, such as primary care settings (McMurdo et al., 2011). Considerations should also be made for how best to reach Black and Latino older adults (and other cultural minorities), who are more likely to experience barriers to accessing services (Jimenez, Cook, Bartels, & Alegría, 2013). The current study's findings that at-risk older adults tended not to attend activity groups, libraries, or simply leave their home, suggests they may be socially isolated. Thus, traditional methods of information sharing, such as paper advertising or phone calls may be needed. Future research should explore strategies to reach at-risk older adults, too.

Communication challenges emerged as the second primary barrier to receiving adequate services. Almost one in five older adults indicated that they felt too ashamed to ask for help. Those participants who successfully accessed a service often described the service as inadequate or unsatisfactory because they felt

providers had communicated poorly with the older adult and with other providers. They perceived provider communication to be essential to decisions about physical health, finances, and safety. Here, providers are likely to under-communicate because of perceptions that older adults are incapable of managing complex information (Higashi, Steinman, & Johnston, 2012). In attending to potential cognitive impairments, providers may inappropriately over-simplify explanations or omit information, as an accommodation for older adults (Williams, Haskard, & DiMatteo, 2007). Such well-meaning provider strategies may, in fact, diminish older adults' belief in their self-efficacy, which is often associated with reduced well-being (Harris et al., 2003; McAuley et al., 2006). Communication strategies may need to incorporate developmentally appropriate scaffolding. For example, older adults might benefit from repetition, follow-up contacts to repeat and review information, or navigators who can assist with logistical matters. Frustration at the lack of communication *between* providers is not a problem specific to older adults (Gagnon, Wright, Srinivas, & DePrince, 2018). However, inter-provider communication difficulties may be more likely with older adults whose complex needs require multiple providers (Wydra, 1993). The emergence of multidisciplinary teams collaborating to address older adult maltreatment is one promising strategy to increasing inter-provider communication and client satisfaction (Schneider, Mosqueda, Falk, & Huba, 2010).

The current study also points to the complexity of responding to violence and other forms of abuse in older adults' homes might not be effective or sufficient. For instance, the perpetrator may also be the older adult's sole provider of material and social support. In such situations, removal of the perpetrator must be accompanied by other interventions to support the older adult. Providers may be broadly aware of these dynamics, but traditional justice systems may not provide a response that addresses the needs of the older adult (Davey, 2016) and agencies may not be adequately resourced to meet the range of older adults' needs.

This study sought to examine service needs of maltreated older adults. However, those same risk factors that put these older adults at risk also impeded recruitment and retention. Difficulties included loss of contact (e.g., phone bill not paid; moved), hospitalization, perpetrator-driven isolation, and significant mental and physical health symptoms (e.g. depression, PTSD). Thus, our sample size was smaller than initially planned and limited some of our analyses. In addition, traditional methods of empirical data collection, such as close-ended or Likert-scale questions, can be less accessible to at-risk older adults. Indeed, study participants had difficulty responding on Likert scales, though they were eager and capable of recounting experiences in detail when given the chance. In addition, there are potential challenges not explored here that may also contribute to unmet service needs, such as cognitive performance, or physical distance to services. These limitations, may in turn, have repercussions on the validity of current findings and demonstrate the need for additional research.

## Conclusions

Older adults who are at risk of or who have experienced maltreatment face serious health and safety risks, yet appear to fall through the cracks in terms of unmet service needs. Indeed, the majority of unmet service needs described by older adults in this study had to do with basic, fundamental needs such as housing, food, and transportation. Additional research is urgently necessary to identify interventions to meet the service and basic needs of vulnerable older adults. The current study suggests that future research should use mixed methods to best capture the breadth and scope of needs and strategies for addressing those service needs.

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