# Assessing risk for older adult abuse: Case presentation and analysis using the Harm to Older Persons Evaluation (HOPE)

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## Abstract

Older adult abuse (OAA) is gaining research attention with a well-developed understanding of risk factors for abuse. However, research examining the use of violence risk assessment in cases of OAA is almost non-existent. The present paper illustrates the use of the Harm to Older Persons Evaluation or HOPE (Storey et al., 2021) to assess violence risk and recommend management strategies in a case of OAA. The HOPE is a violence risk assessment instrument for OAA. Designed in the structured professional judgment framework, the HOPE includes six steps. The HOPE was completed by two trained evaluators. The results present the analysis of each of the six steps, identifying key risk factors for OAA and recommending management strategies to prevent further abuse. Through the case analysis we also highlight the identification of the OAA as well as the involvement of external agencies in the case. The case examined concerns an adult son who engaged in multiple forms of OAA toward his mother. Although OAA was not identified by the professionals involved in the case at the time, professionals were involved with both the victim and perpetrator, attempting to support their needs, most of which were risk factors for OAA. The discussion highlights considerations for the identification and assessment of risk in the case study and for OAA in general. We highlight the need for professional training on the nature, identification and assessment of OAA and for validation and comparative research on violence risk assessment tools for OAA.



*Keywords:* Elder abuse, older person mistreatment, safeguarding older adults, threat assessment and management, domestic abuse


Public significance statement: This paper describes the need for violence risk assessment for older adult abuse, and demonstrates for the reader how such an assessment can be conducted in practice. The Harm to Older Persons Evaluation or HOPE is used to assess risk in a case of older adult abuse demonstrating how risk assessment can impact our understanding of risk and development of management strategies.

# Assessing risk for older adult abuse: Case presentation and analysis using the Harm to Older Persons Evaluation (HOPE)

Older adult abuse (OAA, also known as elder abuse or mistreatment) is beginning to receive increased attention. For instance, the World Health Organization (WHO) as part of the United Nations' Decade of Healthy Aging (2021-2030) has designed initiatives around OAA to increase resources and attention to this issue (Mikton et al., 2022). Further, the research literature identifying risk factors for OAA has reached a critical mass where the assessment of risk can now be empirically supported (Storey et al., 2021). Nevertheless, there is a lack of research on management and intervention (Fearing et al., 2017; Shen et al., 2021) and a substantial need to transfer research knowledge and development into practice. For instance, research examining the use of violence risk assessment tools in cases of OAA is almost non-existent, whereas such studies have existed for decades in the field of intimate partner violence. This gap in the literature likely reflects an actual gap in practice. Thus, there is a need to demonstrate and facilitate the use of empirically based OAA violence risk assessment tools in practice, which is the aim of the present paper.

OAA is "a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (WHO, 2024). Approximately one-in-six older adults in the community is the victim of OAA; rates of abuse are higher for those in institutional settings (WHO, 2024). The consequences of OAA can be serious and wide ranging. Individually, older adults suffer physical, mental health and social consequences as well as financial loss which can also have wider implications for family and health and social care (Mikton et al., 2022).

OAA shares similarities with other forms of domestic violence such as intimate partner violence and child abuse (e.g., spousal perpetration and issues around dependency, respectively). Nevertheless, decades of research have shown it to be a distinct form of

interpersonal violence with discrete risk factors for abuse outlined in over 198 studies and 52 systematic literature reviews (Mikton et al., forthcoming; Storey, 2020). Thus, its distinction as a form of interpersonal violence is clear, and there is a substantial literature base upon which to develop violence risk assessment tools for OAA and engage in empirically supported violence risk assessment.

Violence risk (or threat) assessment and management, when conducted with the use of an empirically based violence risk assessment instrument, is a valuable process which has been shown to predict recidivism and reduce future offending (Belfrage et al., 2012). In cases violence, like OAA, where we know who the victim is likely to be, the identification of risk can help to safeguard victims. For professionals, accurate risk identification can assist in prioritising cases and identifying those at risk of being the victims and perpetrators of severe or imminent harm. Further, through the consideration and management of the identified risk factors future harm can be prevented.

Despite their importance, OAA violence risk assessment tools are rarely used in practice, instead screening for OAA has proliferated. Screening for OAA is an important practice, particularly given low rates of reporting by victims (15% of cases are reported to police or other formal authorities; Burnes et al., 2019). As such a large number of screening tools have been developed (e.g., see a comparison of 15 such tools by Van Royen et al., 2020). Screening tools help practitioners to identify *if* abuse is taking place, thus serving an investigative function. Screening tools do not identify the risk for ongoing abuse or support risk management. Thus, they are an important starting point in cases where abuse is not being disclosed, but they cannot assist the evaluator in assessing the level of risk that is present or in identifying appropriate management strategies.

For many years only screening tools were available to practitioners working on OAA cases, which may account for the use of unstructured professional judgement (i.e., risk

assessment without the use of a tool, instead using a professional's intuition or experience) or adoption of violence risk assessment tools for domestic abuse in general (e.g., Home Office, 2022; Tuner et al., 2019). This is problematic for several reasons. First, unstructured professional judgement has been shown to be no better than chance at predicting future violence (Grove, & Meehl, 1996; Monahan, 1981). Second, tools for domestic abuse are not developed based on the OAA risk literature specifically and have not been validated in older adult populations. As a result, these tools can contain irrelevant or inappropriate risk factors/items. For instance, the Domestic Abuse, Stalking and Honour Based Violence Risk Identification tool or DASH is the only tool highlighted by the UK's Government body, the Home Office, in their statutory guidance on domestic abuse (Home Office, 2022) and is used by most British police forces (Turner et al., 2019) for all cases involving domestic abuse, stalking or honour-based violence. The DASH is therefore proposed to apply to many forms of interpersonal violence. However, it is seemingly optimised for cases of intimate partner violence. For instance, it has a "focus on keeping victims and their children safe" (Richards, 2024) and includes items like "Are you currently pregnant or have you recently had a baby in the past 18 months?", and "Is there conflict over child contact?". Such items have obvious limitations when victims are older adults. Of further concern is recent literature showing low predictive validity of the DASH when used by police (AUC = .544), showing that the prediction of risk using the DASH was not much greater than chance (i.e., AUC = .50) (Turner et al., 2019). Thus, violence risk assessment tools for domestic abuse generally should not be used in OAA cases due to concerns about applicability, and, in the case of the DASH, concerns regarding validity and the possibility of misidentifying violence risk.

Fortunately, practitioners no longer need to rely on such tools as three violence risk assessment tools for OAA now exist. First, is the Harm to Older Persons Evaluation or HOPE (Storey et al., 2021, formerly known as the Elder Abuse Risk Level Index or EARLI) which

is developed based on the empirical literature and utilising the structure professional judgement (SPJ) method. The SPJ method refers to the process through which information is gathered and analyzed; this method underlies the most commonly used risk assessment tools globally (e.g., HCR-20$^{V3}$, Douglas et al., 2013). Second, the Older Persons DASH or OP DASH (Cambridgeshire & Peterborough Domestic Abuse & Sexual Violence Partnership, 2021) was adapted from the DASH for use with older victims, perhaps due to the issues with item applicability raised above. Further development information for the tool could not be located. Third, the Assessment Guideline for Elder Domestic Violence or AGED (Almeida et al., 2017) was developed to support the assessment of risk in Portugal by victim support and criminal justice professionals. The only information that the authors could find was a published abstract from a conference proceeding about the tool (see Almeida et al., 2017).

More broadly, two other tools with risk assessment as well as other aims are available. First, the Tool for Risk, Interventions, and Outcomes (TRIO; Sommerfeld et al., 2014) is a tool designed for Adult Protective Services (APS) to "facilitate consistent APS practice and collect data related to multiple dimensions of typical interactions with APS clients, including the investigation and assessment of risks, the provision of APS interventions, and associated health and safety outcomes" (Sommerfeld et al., 2014, p.1). The TRIO is designed to be used in cases of OAA or self-neglect for either older adults (age 65+) or dependent adults (ages 18-64). Limitations for the wider use of this tool for OAA include that that it is optimised for APS, that it is not specific to older adults (i.e., it is designed for 18+ years), and that it is designed to assess risk for self-neglect, a distinct form of harm perpetrated against oneself, as well as OAA (Dauenhauer et al., 2017). Second, the Elder Abuse Risk Assessment and Evaluation tool (EARAE) is designed to assess risk, track abuse indicators, risk factors, interventions and outcomes during service delivery. The tool was designed for use outside of APS with a focus on New York State where development data was collected (Dauenhauer et

al., 2017). Development comprised a review of existing forms from the Elder Abuse Prevention Program, a review of existing instruments designed to capture elements of OAA, and consultation with academic research partners to develop a new assessment process. Thus, while risk assessment forms part of the aims of the EARAE, it includes other aims which may account for why development did not follow the typical and optimal process of reviewing the empirical literature on risk factors.

### Current Study

Although available, the use of OAA violence risk assessment tools remains limited. This could be due to several factors including in some cases their recent development, their design for specific services or regions, or limited information about their content, development or validity. Thus, to increase the information available on OAA violence risk assessment the current study will demonstrate the use of the HOPE, in assessing risk and recommending management strategies in a case of OAA.

The aims of this article are to:

1) Demonstrate how to use a violence risk assessment instrument to assess and manage the risk of OAA.
2) Demonstrate how a violence risk assessment instrument might have added value to the assessment and management of risk in a case of OAA.

To accomplish these aims a case study involving a mother and adult son will be assessed and management recommendations made using the HOPE. In achieving these aims the article will also demonstrate some of the research that has been conducted in the OAA field in terms of the identification of risk factors.

## Method

A violence risk assessment was conducted, using the HOPE. The analysis of the case demonstrates the use of the HOPE in assessing violence risk and identifying risk management strategies aimed at preventing future harm.

**Case Summary**

The case study assessed herein was the subject of a major case review in the UK. Major case reviews occur in different contexts (e.g., safeguarding adult reviews, child safeguarding reviews, domestic homicide reviews) but generally consist of multi-agency reviews of cases where there was harm to an individual and a concern that partner agencies could have worked more effectively to protect that individual. The purpose of these reviews is to provide learning to avoid similar outcomes in the future. The aims of the present study are therefore in line with this learning by first demonstrating violence risk assessment for OAA so as to inform future practice and second, by demonstrating how violence risk assessment might have been beneficial in this specific case.

Many types of anonymized major case review reports are available online. The authors chose to use one such report given its public nature. A de-identified summary of the report is provided in the Appendix; this summary was used to conduct the assessment. Although the report is publicly available, ethical approval was obtained to complete this study from the first author's institution (Ethics ID: 202417147271589181) and ethical guidelines were followed in completing the study and reporting the case details. In compliance with the recommendations of the American Psychological Association (2010) and to protect the anonymity of those involved, names, dates, and locations have been changed.

For the sake of continuity and brevity, those who engage in OAA will be referred to as perpetrators and those who are the recipients of the OAA will be referred to as victims.

The assessment and management plan will be presented in the results section and findings of note related to both will be outlined in the Discussion section.

## Case Analysis

**The Harm to Older Persons Evaluation (HOPE).** The HOPE (Storey et al., 2021) is a SPJ tool designed to assist evaluators in the assessment and management of OAA. The SPJ approach refers to the process by which information is gathered and weighted to reach a decision. In this approach, and for the HOPE, guidelines are developed based on a systematic review of the scientific literature (e.g., see Storey, 2020) as well as a consideration of existing standards of practice, ethical codes, and relevant law. Guidelines are then utilized by evaluators to guide their assessments. SPJ tools outline the minimum criteria that should be considered as part of a comprehensive assessment, but also allow evaluators to consider additional case specific risk and protective factors. Additionally, SPJ tools provide recommendations regarding the type of information that should be considered, how to develop management plans, and how to communicate the results of an assessment.

Information on how to administer the HOPE can be found in the user guide. Briefly, the HOPE uses the SPJ risk assessment process which consists of six steps. The first step is to gather and summarize all relevant case information. This was completed herein as part of the major case review process. For the purposes of this risk assessment, we consider this to be a good source of information because extensive investigations were undertaken and multiple contacts were made with those involved in the case to provide a deep analysis of the case for the review and report which exceeded 40 pages in length. In practice, the evaluator would gather as much information as possible about the perpetrator, victim, and the resources surrounding them. This could include interviews, collateral informants or records and reports.

Step 2 is to consider the presence of the 29 HOPE risk factors both recently (during the four-week period prior to the evaluation) and in the past (prior to the past four weeks).

The presence of the HOPE risk factors is coded on a three-point scale as with other SPJ tools; *Present, Possibly or partially present,* or *Absent*. The risk factors in the HOPE are divided into four domains.

The *Nature of Abuse* domain includes eight factors related to the OAA being perpetrated, helping to identify the type, pattern and seriousness of the abuse. The *Perpetrator Risk Factors* domain includes eight risk factors reflecting the psychosocial adjustment and background of the perpetrator that may be relevant to decisions to engage in OAA. The *Victim Vulnerability Factors* domain is comprised of eight risk factors related to the victim's background and psychosocial adjustment. These factors are the relevant characteristics of the victim that may be associated with their decisions not to, or inability to, engage in self-protective behaviors or that may place them at heightened risk of harm. The consideration of risk related to the victim in no way means that victims are responsible for the abuse. Their consideration reflects the association identified in the research literature between these factors and OAA and evidence that managing such vulnerability factors can safeguard the victim. The *Community and Institutional Responsivity Factors* domain includes five risk factors reflecting the resources and support for the perpetrator and the victim in the institution or community in which they reside that could influence risk and management. In each domain evaluators can also consider rare, unusual, or case-specific risk or protective factors. The HOPE domains and items are displayed in Table 1.

In step 3, evaluators assess whether the risk factor may be relevant to future violence perpetration and consequently if it should be managed. Relevance is coded using the same scale used to code the presence of the risk factors. In step 4, evaluators identify the most plausible scenarios of future OAA for the case under evaluation. Step 5 involves the development of management strategies that are designed to mitigate the identified risk factors

and scenarios. Finally, in step 6, the evaluator makes conclusory opinions regarding overall risk based on the risk factors identified as present in the case.

**Completion of the HOPE.** The evaluation was completed by authors JES and SELF as part of a larger study examining older adult homicide. The HOPE was completed separately by the evaluators and then disagreements were resolved via discussion and a review of case information. JES is an author of the HOPE and SELF is trained in the use of the HOPE.

As part of the wider study on major case reviews involving older adults, 10 reports were assessed using the HOPE (including the present case) by JES and SELF. Reliability was indexed using intraclass correlation coefficients ($ICC_1$; two-way mixed effects model, absolute agreement method) measured between 0 and 1. Domains showed good to excellent agreement where $ICC_1$ was .98 for *Nature of Abuse Factors,* .82 for *Perpetrator Risk Factors,* .85 for *Victim Vulnerability Factors,* and .99 for *Community and Institutional Responsivity Factors.* The $ICC_1$ for the combined HOPE total score was .98 which is considered excellent[1].

## Results

Here we present a violence risk assessment for OAA, using the HOPE, based on the case information in the Appendix which ends in late December 2020. The purpose of the assessment is to identify the risk that Chris poses to his mother Alice and make recommendations regarding case management, with the aim of stopping Chris' abusive behavior. The violence risk assessment described herein is representative of what professionals of different backgrounds could or would complete were they to be trained in violence risk assessment. Violence risk assessment of OAA and the HOPE are not restricted

[1] Values less than .5 indicate poor agreement, vales between .5 and .75 indicate moderate agreement, values from .75 to .9 indicate good agreement and values greater than .9 are considered excellent agreement (Koo & Li, 2016)

for use by any professional type. The assessment is an in-depth case analysis and has a multi-agency focus given the frequent requirement for OAA cases to be managed by multiple agencies in a community setting, often with ongoing contact between the perpetrator and victim. Evaluators with different professional backgrounds may focus their recommendations on different forms of management (e.g., victim safety planning, perpetrator treatment).

**Step 1: Case Information**

The perpetrator in this case is Chris (age 49), and the victim is his mother Alice (age 78). The HOPE was completed based on the information in the case summary (Appendix A). This included information contributed by agencies that were involved in the case including Adult social care, the general practitioner (GP) of both Chris and Alice, the district council, and statements from Alice's other children. Although limited in some areas (e.g., Chris' childhood and personal relationships) it represents what was available to evaluators and is similar to that typically available in practice. In addition, the information was sufficient to reach the findings and opinions expressed herein with a reasonable degree of confidence and certainty.

In essence, this case involved OAA occurring over the course of several years, during which Chris was attempting to provide care for his mother but was, by his own admission, struggling to do this adequately. This neglect was furthered by Chris blocking medical care for Alice and taking her medication for his own personal use. In addition to the misuse of his mother's prescriptions, Chris was engaging in alcohol abuse, using his mother's money to pay for alcohol. There was evidence that Chris was engaging in coercive control of his mother including controlling and listening in on her phone calls with others. Professionals and family perceived that her decisions were made with his influence. Chris also made threats to take his life should his mother pass away, he be institutionalized, or they be separated.

**Steps 2 and 3: Presence and Relevance of Factors**

The presence and relevance of the risk factors in each domain are presented in Table 1. Where appropriate, the ratings of item presence are made with respect to the past and recently. Each item in the table is rated as present, meaning that there was evidence that the risk factor was *present* (denoted as Y), *possibly or partially present* (P), meaning that there was partial or conflicting information for this risk factor, or *absent* (N), meaning that there was no evidence that this risk factor was present. Ratings of relevance are made where appropriate using the same scale but with respect to the development of future risk management plans. Thus, a "Y" denotes that the factor is relevant to the development of risk management strategies, a "P" indicates that the factor is possibly or partially relevant to management strategy development and an "N" denotes that no information indicates that this factor is relevant to the development of management strategies. Multiple risk factors were identified as present and relevant across the four HOPE domains, with no items rated as possibly or partially present.

**Nature of Abuse.** In the nature of abuse domain, the eight items are coded for their presence in the past (prior to the last four weeks) and recently (within the last four weeks). Five risk factors were identified as present in the past and six were present recently. Chris was engaging in neglect of his mother, who was dependent on him for care, both recently and in the past. Chris admitted to struggling to care for Alice and to taking her medication. He also failed to take her to some of her medical appointments and blocked service providers from entering the home to provide care to Alice. Concerns were also raised around the safety of the home due to hoarding and Chris restricting the access of professionals and family members to most of the home.

Emotional abuse was present and evidenced by Chris influencing Alice's decisions, despite her having mental capacity, limiting who Alice could have contact with and dominating her contact with agencies which included monitoring her calls. Family also

mentioned witnessing verbal domination by Chris, where Alice could not express herself. Financial abuse was present and evidenced by reports from family that Chis was taking money from the victim to sustain his alcohol use. For both emotional and financial abuse, an exact timeline for the perpetration of these behaviours was not available. However, it was suggested that they were ongoing and as such they were coded as present for the past and recently. For example, Chris' substance abuse and lack of employment was ongoing and as such it is reasonable to conclude that the financial abuse was present recently.

Intimidation and threats were present through Chris' threats of self-harm which resulted in Alice fearing for his safety, and which if acted upon would have resulted in severe psychological harm to Alice. Threats of self-harm by Chris were noted on several occasions in relation to demanding medication, being separated from Alice or hospitalised. Family reported that Alice was afraid to push back against Chris' control for fear that he would be sectioned under the mental health act[2] and kill himself. There was no evidence of physical abuse in the case.

Abuse was identified as persistent given that it was ongoing for years and was continuous given that the neglect and emotional abuse were happening frequently. Within the last six weeks the OAA had been escalating; it included Chris not taking Alice to an x-ray appointment, refusing to allow a nurse into the house to check on his mother, refusing a decluttering service, and threatening to end his life (communicated to his GP) if sent to hospital. In the HOPE, 'recent' is defined as the most recent four weeks, meaning that we could code this item as present in the past but not recently. However, in discussion we determined that given the longstanding nature of the abuse (i.e., over the course of years), it was most reflective of the circumstances of the case to consider the escalation over the last

[2] The Mental Health Act (1983) in the UK allows for individuals suffering from a mental health disorder who pose a risk of harm to themselves or others to be detained and treated involuntarily (NHS, 2022).

six weeks as recent, rather than past. The escalation represented a step change in the abuse, in particular as it related to blocking health care which could lead to severe harm to Alice. The HOPE allows for this alteration stating, “The specific 4-week timeframe can be altered as necessary or desired to better capture and assess the case at hand. If altered, evaluators should make clear what timeframe they are using” (Storey et al., 2021, p. 27).

Since there were no conditions or warnings received by Chris there were no opportunities for supervision violations. No other considerations were identified related to the nature of the OAA.

**Perpetrator Risk Factors.** With respect to the perpetrator risk factors domain the eight items are coded for their presence in the past, recently and for their relevance to future violence. Case information identified that six out of eight risk factors were present in the past and five were recently present and relevant to future risk.

There was no evidence that Chris had any physical health problems. However, there was evidence that Chris suffered from mental health problems that were longstanding and diagnosed. Diagnoses included depression, compulsive behaviour, paranoid schizophrenia and psychotic depression. Chris also reported severe anxiety and paranoia leading to him not leaving the house, and his GP noted that he had double bolted the front door and sealed the mailbox at his home. Chris engaged in self-harm, attempted suicide, and threatened to commit suicide on multiple occasions. His problems with mental health were noted from the age of 18 and up to the present day and seem to underly some of the abusive behaviour, such as not providing adequate care and refusing support for himself and Alice. Management of his mental health concerns is critical to reducing risk in this case.

There is evidence of problems with substance use from the age of 18 to the present, which Chris admitted to. This includes the use of illegal drugs as well as more recently the misuse of legal drugs and alcohol. The presence of this risk factor directly relates to the

abusive behaviour including neglect via taking his mother's medication and financial abuse when he has used her money to support his alcohol use.

Chris displays both financial and emotional dependence on his mother. Chris has lived with his mother for 19 years and is not employed; he relies on Alice for housing as well as financial support for purchasing items including alcohol. Chris' emotional dependence on his mother is demonstrated by his threats and her statement that, he indicated that if they were to be separated, he would take his life. Professionals also identified Chris and Alice to be co-dependent and Chris appears to be emotionally attached to and place significant importance on holding a caregiving role for his mother, despite his admission of struggling to fulfil the role. Both dependencies need to be resolved so that Chris can live independently without risk of self-harm.

Chris has displayed longstanding problems with stress and coping. He reported to his GP on multiple occasions that he was struggling to cope with his mother's care and had not had a "break" in three years. He described not sleeping and stress around his mother's recent illness. Nevertheless, when services were offered to Chris, they were declined. Thus, he demonstrates high stress and poor coping. His refusal of services directly relates to his engagement in neglect and this risk factor needs to be managed to reduce future OAA.

Chris does not demonstrate any problems with attitudes that have been empirically identified as risk factors for OAA. Chris places great value on his caregiving role, he does not demonstrate any antisocial attitudes, and admits much of his abusive behaviour such as not providing adequate care and using his mother's medication. He has no history of criminal behaviour that would suggest any underlying antisocial attitudes. Chris was subject to emotional and physical abuse in his younger years by his father. No recent abuse is noted, and his historical victimization does not seem to be an underlying cause of the OAA. Thus, victimization is present in the past, but not recently and is not imminently relevant to risk

management. In the future, should his more acute mental health issues be stabilised the impact of the historical victimization could be explored, but at present it is not key to his management plan.

Chris has pervasive problems with relationships, and these are relevant to his future risk. Chris reports that he has not left the house in almost two years. Other than his mother, there is no mention of positive prosocial intimate or non-intimate relationships in his life. The quality of his relationship with his siblings is unclear. Thus, Chris is and feels socially isolated which is increasing his risk of OAA. These relationship problems are likely caused by and now contributing to his issues with mental health and are contributing to the abuse in the form of turning away support and making the home an unsafe environment.

In investigating other risk or protective factors related to Chris, we considered that he made a request for support for Alice (i.e., a befriending service) and the importance he places on caring for his mother. However, we recognised that in actuality he has been refusing support and not engaging in proper care. Thus, we could not conclude that these were protective factors.

**Victim Vulnerability Factors.** Victim vulnerability factors are scored in the same way as perpetrator risk factors. The case information yielded evidence that five of the eight victim vulnerability factors were present in the past, recently and were relevant to future risk. Alice has problems with her physical health related to hip replacement surgery and additional revision surgery. As a result, she has mobility issues, which at first included her not being able to climb stairs or walk without assistance, and more recently being bedbound. These problems led to her dependence on Chris. Alice also suffers from diabetes and was experiencing complications. When Chris blocked medical care, this increased her vulnerability and risk of harm. Thus, her physical health problems were present and relevant to ongoing OAA. Alice does not display problems related to mental health; assessments show

her to be cognitively intact and have capacity. She also displays no problems related to substance use.

Alice is functionally dependent on Chris due to her mobility issues. Chris assists her with personal care, toileting, and hygiene. These needs could be met by professionals if permitted; since this has not been allowed her dependence on Chris is relevant to future risk. There is evidence of problems with stress and coping. According to family, Alice has "almost given up" and is engaging in self-neglect and hoarding. She has declined some offers of assistance and the pursuit of an adult safeguarding concern. She has not reported the OAA and seems to have been engaging in passive avoidant coping. These issues with coping seem directly related to problems with attitudes that she holds. Alice shows evidence of minimising Chris' behaviour, for instance by suggesting that he turned away a nurse because the visit was unexpected. She also shows evidence of excessive loyalty to Chris, whereby she puts her own health and safety at risk to benefit Chris. Alice appears to feel responsible for staying in the abusive situation in order to keep Chris from engaging in self-harm. For instance, family reports that when challenged about not disclosing the reality of Chris' condition to a social worker, Alice said that she had no choice as she could not be responsible for Chris going to hospital. Alice's problems with coping and attitudes will need to be addressed; otherwise, they will increase the risk that she will not report future OAA and decline support. There was no noted history of victimization toward Alice other than the OAA.

Finally, there is evidence of problems with relationships. Specifically, Alice is socially isolated due to her physical limitations (which have resulted in her not leaving the house in years) and Chris' refusal to let others into the home. Family referred to Alice as a "prisoner in her own home". Contact with the GP was often made by Chris on Alice's behalf. Risk is also exemplified by the overcrowding of the house and lack of privacy, since Chris and Alice live together in one room of the house. Their living situation will need to be addressed to decrease

the risk to Alice and her isolation needs to be reduced to improve her wellbeing and increase the likelihood that others will identify further OAA. There were no other risk or protective considerations identified for Alice.

**Community and Institutional Responsivity Factors.** For this final HOPE domain each risk factor is coded separately for the perpetrator and the victim, and only ratings of future relevance are made. There were no problems identified related to the availability of resources. Both the perpetrator and victim have a high level of GP contact and the family is available and advocating for help. However, there are problems related to the accessibility of resources for both. Chris reports being too anxious to leave the home for appointments and Alice has mobility issues and is bedbound, thus these issues are relevant to future management. There are no noted problems with affordability; necessary services are free of charge.

Both Chris and Alice display problems related to acceptability. Chris has in the past stopped taking his prescribed medication and repeatedly cancelled or failed to attend appointments as well as failed to reply to requests for appointments. He has also turned down caregiver support. Although Alice has accepted help from carers, she has failed to attend a doctor's appointment and declined assistance to declutter her home or proceed with an adult safeguarding concern. These issues related to the acceptance of help will need to be resolved to reduce the risk in this case.

Finally, there were several issues related to the appropriateness of the services involved in the case. This was a focus of the major case review which is summarized but not repeated in full in the appendix. Briefly, those issues included that no professional identified or considered the OAA or challenged Chris' practice of speaking for Alice and they spoke with Chris about Alice despite her having capacity. In addition, no one considered that if Chris was using Alice's medication this meant that she was unable to access her

prescriptions. There were delays and missed opportunities to put support in place. Services were slow to identify that Chris would not attend in-person appointments. Chris was discharged from services or not followed up on several occasions and his mental health was not adequately assessed. Further, the response to concerns about his mental health were not dealt with appropriately. The state of the home was also not considered as a risk to safety. No other risk or protective factors were identified related to community and institutional support.

**Step 4: Risk Scenarios**

Three scenarios were identified as being plausible scenarios of future OAA. The scenario identified as most plausible is for the abuse to continue in a similar manner. This would involve a continuation of the neglect, emotional abuse, financial abuse, and intimidation/threats by Chris toward Alice. The abuse would occur due to his inability to adequately care for Alice, ongoing mental health problems, and emotional and financial dependence on his mother. The harm to Alice would be continued neglect of her physical and medical needs along with psychological harm. There is a chance that the situation could escalate to serious or life-threatening OAA if she missed medical appointments or medication which resulted in worsening health or increased pain. The risk is immediate since the abuse is ongoing and continuous. The abuse would occur frequently and the risk is chronic. The likelihood of this scenario is high given the lengthy history of abuse, lack of improvement, and recent escalation.

The next most likely scenario is an escalation scenario wherein Alice's condition worsens and care is forced through the enactment of safeguarding procedures. In this scenario, Alice and Chris would be separated and Chris would engage in self-harm. The scenario would result in psychological harm to both parties as well as physical and possibly life-threatening harm to the victim (e.g., due to missed diabetic care) and the perpetrator (e.g., suicide). This scenario could occur in the coming weeks or months and warning signs would

be increased mental health problems or substance use displayed by Chris which could lead to worsening care of Alice that would trigger a safeguarding intervention. The abuse would be frequent and the risk for this scenario is chronic. The likelihood of this scenario is high given the recent escalating trajectory of abuse and deterioration in Chris' mental health.

The third scenario that we considered is an improvement scenario. Although considered the least likely scenario to occur, we thought that if Chris were sectioned under the mental act and treated successfully for his mental health and substance use problems he could eventually live separately to Alice and continue to provide some care for her, bolstered by professional support. With Chris out of the home, Alice might improve through proper care and increased contact with others, such as through a befriending service. The harm to Alice in this scenario would be psychological resulting from feelings of guilt and concern about Chris being hospitalized. The risk of self-harm for Chris is elevated and he would require extremely close assessment and monitoring while hospitalized to reduce this risk. The improvement would take many months to unfold. The risk of harm to Alice would be greatly reduced while Chris was in hospital. The likelihood of this scenario is low at present due to Chris' unwillingness to accept support and the longstanding nature of his problems with mental health and substance use.

**Step 5: Management Strategies**

The management strategies outlined include those that could be imposed by the professionals currently involved in the case and are based on the risk factors and risk scenarios identified for the case. The HOPE outlines five activities to consider when identifying management strategies: monitoring, treatment, supervision, victim safety planning, and community and institutional supports.

To most substantially reduce the risk of continued harm Alice and Chris should live separately while they are both assessed and appropriate support is put in place. Neither Chris

nor Alice appear ready to choose this outcome, thus sectioning Chris under the mental health act (if appropriate) would be one path to separation. Sectioning Chris will be dependent on the upcoming medical assessment requested by his GP. The second option for separation would be for the abuse to be reported to the police, and Chris to be charged. This would require someone to identify the abuse, which outside of this assessment has not occurred. If arrested and charged, Chris would likely be given bail conditions not to reside with Alice. We believe that it is highly unlikely that Alice would report or confirm that abuse was taking place and given that she has capacity the case would be unlikely to proceed to charge. Thus, the most likely circumstance at this moment is community management of the pair while they share a residence. Thus, we will first present a community management plan, followed by additional management considerations should Chris and Alice be separated.

If managed in their home, there will need to be frequent monitoring by the GP, family and a care and support person for Alice who will need to be placed in the home. A caregiver's assessment for Chris and a care needs assessment for Alice should be completed immediately to determine what level of support is required and any aids that are needed. All parties supporting Chris and Alice should be in regular communication. The GP should monitor the situation via discussion with Alice while Chris is not present. The family should relay to professionals any changes that to they note in Chris' behaviour or Alice's physical health and professionals should liaise with the family and follow up on their concerns. The care and support person placed in the home should monitor Alice's medication use.

If separated, Alice will require a full-time caregiver and monitoring as above. Chris, while institutionalized, will require close monitoring by a mental health professional for suicide risk, mental health and substance use. He should be tested for medication compliance.

In relation to treatment in the community, Chris requires a mental health assessment and medication review. He then needs treatment and support for mental health, substance use,

social skills, emotional dependency on his mother, and coping skills. Once he has made substantial improvement in these areas he would also benefit from help around hoarding, his past victimization and vocational skills. If institutionalized, Chris will require the same support and regular assessment and monitoring for suicide risk.

Supervision describes restrictions of the perpetrator's rights and freedoms that should be put in place. Although unlikely, if Chris were charged with domestic abuse, he would likely receive bail and then probation if found guilty. In this instance, his conditions should include mental health assessment and treatment, checks on medication compliance, substance use treatment, prohibition of substance use with monitoring, a condition not to live with Alice, and supervised contact with Alice. Chris would require frequent assessment for suicide.

Victim safety planning for Alice would ideally include full time professional support so that she does not rely on Chris for her care. She should be provided with a panic alarm, a medication lock box accessed by a professional, and, where full support is not available, frequent check-ins by professionals and family. Alice should be provided with counselling to help with her attitudes related to Chris and her safety, stress and coping including asking for help, and hoarding. She would also benefit from a befriending service and education around medication and medical appointment compliance. If Chris is removed from the home, safety planning should also include changing the door locks and supervised visits with Chris.

Improved management by community and institutional supports is necessary to properly manage the case. There should be a reduction in the delays in visits and assessments as well as immediate follow-up on missed appointments. Home visits by care professionals are necessary. Ideally professional support would be placed in the home. All professionals should have training around the identification of domestic abuse, including OAA. Professionals should always speak to Alice alone. There should be a clear escalation plan in

place where professionals can escalate concerns either within their service or to other agencies. A plan to maintain communication between all professionals should be in place. Any caregiver placed in the home should be provided with safety training. In the event that our improvement scenario comes to pass, caregivers should remain involved and develop a rapport with Chris so that he has trust in support services and is likely to access their help in the future.

**Step 6: Conclusory Opinions**

Based on completion of the HOPE, Chris poses a high risk for continued OAA (case prioritization) and a moderate-to-high risk for serious physical harm. Case prioritization is high as a substantial amount of effort will be required to prevent future OAA. The risk of serious physical harm is moderate-to-high for Alice due to the blocking of medical services and her medication being taken by Chris, since either could result in serious or life-threatening physical harm to her. Imminence is high meaning that abuse is likely to occur in the near future, since it is at present daily and continuous. Alice's level of fear is considered to be too low since she is minimising the risk, turning down support, and has stated that she feels she must continue in the current situation to protect her son. Other risks indicated are those described above in relation to self-harm and suicide by the perpetrator should he be hospitalised or removed from the home. This assessment should be updated once the urgent medical assessment of Chris, requested by his GP, has been completed and further review should take place if there is a deterioration in Chris' mental health or substance use or when he reports struggling to cope.

## Discussion

### Summary of Findings

This paper aimed to demonstrate the use of violence risk assessment in a case of OAA, specifically showing how an SPJ tool, the HOPE, can be used to assess and manage OAA

risk. We also aimed to demonstrate how a violence risk assessment might have added value to the assessment and management of risk in the case study presented.

Violence risk assessment, and in this case the HOPE, provided a method of organizing and understanding the case. The assessment demonstrated how with knowledge and use of the Nature of abuse factors the many forms of OAA in this case were evident. Further, the identification of risk factors and their relevance helped to clarify how risk could be managed, and the risk level indicated the level of need and urgency in the case. Thus, risk assessment facilitated both the identification of abuse as well as its assessment and management.

**OAA Identification**. In terms of identifying abuse, at the conclusion of this case, the professionals involved had not identified the presence of OAA. With the use of the Nature of abuse items, some of which mirror the types of abuse identified by the WHO, it was clear that multiple forms of OAA were occurring. This suggests that risk assessment tools may also be able to perform abuse identification functions by helping evaluators to consider the presence of multiple forms of abuse. Had abuse been identified this could have triggered the completion of a violence risk assessment, but it would have also had other important implications. For instance, because no one identified the abuse, Chris remained the main point of contact between Alice and professionals. Further, although it was acknowledged that Chris had issues with substance misuse and took Alice's medication, the impact of this on Alice in terms of neglect of her medical needs and pain management do not appear to have been considered or addressed. Had abuse been identified these issues with communication and medication might have been addressed.

The multiple forms of abuse that were present also highlight the complexity of OAA cases. Identifying all forms of OAA in this case required gathering information from the perpetrator, victim, family, and professionals. It also required an understanding of the dependencies between and capabilities of Alice and Chris. For instance, neglect was present

because Alice was functionally dependent on Chris and he was limiting her care. Similarly, there was emotional abuse and control present due in part to Chris' contact with and monitoring of professional contact on Alice's behalf only because Alice had capacity to do this herself. We argue that education and the use of tools could help professionals to navigate these complexities in identifying OAA, and will discuss this further below.

Also of note with respect to abuse identification is that this case demonstrates why OAA specific tools are needed rather than general domestic abuse or intimate partner violence tools. Had non-OAA tools been used all forms abuse in this case would not have been identified. For instance, neglect is not considered in the DASH and is not generally considered in cases of intimate partner violence. Further, while financial abuse is sometimes considered in cases of intimate partner violence it is usually in the context of financial control. In cases of OAA, financial abuse can take other forms; more often it occurs, as in this case, when the perpetrator is financially dependent on the victim and uses the victim's funds to support their needs (e.g., Chris took money from Alice to support his alcohol use) (Storey, 2020). Thus, OAA specific tools are needed to properly and completely identify the nature of OAA.

**OAA Assessment and Management.** With regard to assessing and managing risk, since no OAA was identified, no assessment was completed. Although professionals and family did identify some of the needs or risk factors for Chris and Alice (e.g., Chris' mental health and substance abuse problems and Alice's physical health problems), many of the risk factors were not identified. Thus a full assessment of risk herein added to our knowledge of the risks posed and targets for case management.

Of note was the large number of risk factors present, including multiple forms of abuse, most of the perpetrator risk and victim vulnerability factors and over half of the community and institutional responsivity factors. The presence of these risk factors corresponded to the

rest of the violence risk assessment in terms of concerning scenarios of future harm, lengthy and complex management needs and high ratings of overall risk.

The results show that risk factors for OAA can be identified and evidenced in a case of OAA and through multiple forms of information including family reports, perpetrator and victim reports and professional reports from both medical and social care practitioners. Police were not involved in the current case but certainly could have been if the abuse had been identified and reported. They could then have been another source of information or could have conducted a risk assessment.

The large number of risk factors present also demonstrate the complexity of the case, which a comprehensive risk assessment can help to delineate. In addition, this analysis of risk highlights the interplay between the victim and perpetrator and how this contributed to risk in this case. Although the victim's dependency on the perpetrator was an influential factor in this case and its risk, the perpetrator's dependency on the victim (and her attitudes regarding this dependency) were just as influential and may be more likely to be overlooked without an OA specific assessment tool. These dynamics are critical in cases of OAA and need to be considered. In the present case, they likely contributed to the lack of reporting of abuse, and the failure of professionals to identify the OAA. For instance, as the family noted, and the victim agreed, she felt she could not report the full extent of the perpetrator's behaviour for fear that he would be hospitalized and take his life. Her attitudes and coping strategies related to the perpetrator and his behaviour were critical vulnerability factors. These factors required identification and support so that she felt able to report her concerns but also felt that she was protecting her dependent son, which was fundamental to her identity. Thus, understanding the risks of each party and how they are connected was fundamental in this case, as it is in many OAA cases, and can be supported through violence risk assessment.

Similar to the identification of risk, it is important to note that had general domestic abuse or intimate partner violence tools been used in this case key risk factors would have been missed. For instance, risk and vulnerability factors such as dependency, problems with stress and coping, victim attitudes of excessive loyalty, victim physical health, and victim engagement in self-neglect and hoarding were key in this case, are empirically related to OAA risk (Storey, 2020) and are not typically considered in general domestic abuse or intimate partner violence tools. Further, problems related to the community and institutions around and supporting the victim and perpetrator would not have been considered at all had a tool for OAA not been used. Given the high levels of need and vulnerability in these cases as well as the plethora of services that can be involved (e.g., criminal justice, health, social care, housing, long term care, legal services) the consideration of issues related to these services is necessary for a comprehensive assessment of risk and the development of a management plan. Thus, again the use of OAA specific tools is necessary in OAA cases.

The consideration of risk in this case helped to bring into focus the high level of management needed to reduce the risk of ongoing harm. Further, it highlighted the need to remove Chris as Alice's primary caregiver which had not yet been considered in the case. Chris' removal may not have been fully considered because no one person in this case had oversight of all of the forms of abuse being perpetrated or all of the risk factors that were present. Violence risk assessment can help to bring together a wholistic picture of risk in a case. And where shared appropriately these assessments can help professionals to information share and view risk in the same way, which can facilitate coordinated action.

We wish to note that, similar to major case reviews, the intention of the present paper was not to criticize or find fault in the behavior of any group or individual. We believe strongly that victims are never to blame for crimes committed against them. Our intent was to continue to use this case for a positive purpose, namely, to highlight OAA and describe its

assessment and management in the hopes of helping to move research and practice forward in this area thereby helping to prevent future OAA.

### Limitations

Some limitations of this case analysis should be taken into consideration. First, a violence risk assessment is only as good or accurate as the information upon which it is based. The information that was available to us in the major case review report included some level of vetting and de-identification to protect the identity of those involved. Nevertheless, for two reasons, we do not think that this greatly detracts from the paper. First, the aim of the major case review is to promote learning to avoid future harm through a deep analysis of the case, thus the level of detail of the review is extensive and the aims align with ours which suggests that relevant information was likely included in the report. Second, the aim of this paper was to demonstrate a method of violence risk assessment rather than accurately predict or prevent future violence, thus the lack of some information will not detract from this, particularly given how much information on risk was available. The second limitation is that because a case study was used herein the results are limited in their generalizability.

### Implications for Practice and Research

Although we acknowledge the limited generalizability of case studies, the results raise wider issues and have some implications for future practice and research. The lack of identification of OAA suggests the need for more professional education including what OAA is and how to recognize it. To assist in the identification of abuse, training should also highlight the importance of speaking with the older adult while they are alone and developing a relationship of trust, given that disclosures may not be made in front of the abuser and may not be made immediately (Fraga Dominguez et al., 2020). Further, where an older adult has capacity, they should be the primary point of contact for professionals. Following identification, abuse should be assessed using a structured and empirically based instrument

and professionals should be trained to engage in this assessment as is currently the case for other forms of interpersonal violence.

To support the use of violence risk assessment tools by practitioners there should be more research validating and comparing the available tools. Concurrent validity studies comparing the various tools would be beneficial as would research individually on their reliability, and predictive validity. Further to this, cross cultural research on the use of the tools, particularly for those developed in specific countries or regions, would be beneficial given what we know about differences in OAA and violence risk assessment cross culturally (Cook & Hart, 2017; Hart, 2016; Li et al., 2020).

**Conclusion**

OAA is a growing concern, with increased recognition but limited development in research and practice in the area of violence risk assessment. With the ubiquitous use of violence risk assessment for other forms of interpersonal violence and its demonstrated benefits to the prediction and prevention of harm it is time that equivalent progress be made in the area of OAA.

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# Appendix

## Case Summary

The victim in this case is Alice, age 78, and the perpetrator is her son Chris, age 49; both are of white European heritage. Alice and Chris currently live together in a medium sized town in the UK. They live in a home provided by the local authority that they have lived in since Chris was born. Chris and Alice provide care for one another. Alice requires physical care and Chris requires financial and emotional support.

### Alice

Alice was married and has three children. Her husband, the children's father, passed away in 2015. Chris is the only adult child who lives with Alice. Her other children live in the same area. Alice is described as kind and as wanting her children to be happy and cared for.

Alice underwent a double hip replacement in 2000 and revision surgery nine years later. This meant that she was unable to climb stairs and so lived on the bottom floor of her home. She could walk for short distances with the help of a cane or walking frame. More recently Alice has become bedbound. Alice has no known cognitive issues and was assessed as being cognitively intact and able to understand and retain information and make decisions. There is however evidence that she defers to Chris when dealing with professionals.

### Chris

Chris has two siblings and grew up with them and his father. Chris was emotionally and physically abused by his father in his younger years. At the age of 18 Chris left home to live and work in another city. At this time, Chris began to use alcohol and illicit drugs including cannabis, ketamine and amphetamines. He suffered from depression and compulsive behaviour. The family was very concerned about his drug use and in 2002 at the age of 30 Chris moved back home. Chris engaged in self-harm and subsequently spent five months in hospital where he was diagnosed with paranoid schizophrenia. While in hospital he attempted to take his life.

Chris was subsequently admitted to hospital on three other occasions between 2005 and 2008 due to deteriorating mental health. On one occasion this followed drug and alcohol use, persecutory ideas and the cessation of taking his medication. He was diagnosed with psychotic depression and paranoid schizophrenia. On the final occasion he was discharged with a treatment plan but upon failing to attend an appointment was discharged.

Chris has no known history of violent behaviour toward others except on one occasion when he assaulted his father; this was thought to be in defence of his mother. There was however no reported history of domestic abuse between his parents. Chris has been unemployed since returning home. The family reports that Chris sustains his alcohol use by using his mother's money. In 2017, Alice stated that she was keeping Chris alive and that he often said if she died he would kill himself.

**History of Older Adult Abuse (OAA)**

Chris has lived with Alice for 19 years. In recent years, Alice rarely left the house. Starting in 2018 and 2019 there is evidence that Chris began speaking to their GP on Alice's behalf. On several occasions in 2019 he raised concerns with the GP about caring for his mother, stating that he was struggling to cope. He noted that he had not had a break from caring for this mother for over three years. The GP made a mental health referral for Chris at this time. Services attempted to contact Chris on several occasions in October of 2019 and offered an appointment without success.

Around this time, Alice was admitted to hospital for knee pain. Chris told professionals that Alice was isolated and could benefit from a befriending service which would also help him to get out of the house. This was not followed up on by professionals.

In November of 2019 there was the first indication that Chris was using Alice's medication. Chris said that he would use his mother's codeine if he ran out. A month later he reported having trouble reducing his codeine use and requested lorazepam. Chris made contact with the mental health service that had contacted him in October of 2019. He told them that he needed home visits and could not attend appointments. He said that he was suffering from severe anxiety and required diazepam. He was given an appointment in January of 2020 but did not attend and cancelled his appointment in March of 2020 stating that he was feeling much better. At the GP's request the service did not discharge Chris and offered another appointment for May which would be a home visit by a psychiatrist. Chris cancelled the appointment.

The GP conducted a home visit in April of 2020 and found Chris to be in a stable mood. However, days later Chris called the GP stating that his mental health was deteriorating and requested an increase in lorazepam. The GP was concerned that Chris was abusing his medication.

In May of 2020, Chris' brother contacted the GP and expressed concern about Chris' wellbeing. He reported that Chris was drinking more alcohol and neglecting his medication. He felt that Chris was unlikely to be truthful. He also stated that his mother was effectively a prisoner in her own home. In June, Alice missed her retinopathy appointment (retinopathy is a complication of diabetes that can cause vision loss and blindness). Also in June, Chris' sister contacted the GP to say that Chris had cancelled Alice's diabetic review; she felt that he was undergoing a mental health crisis. The GP referred the sister to social care and followed up the concern in July by making a home visit. During the visit Chris said that he was drinking 6-10 alcohol units a day. He reported that caring for his mother was very important to him. The GP noticed that Chris had taped up the mailbox and was double bolting the front door. The GP made a referral for a carer assessment to see what support was needed. When contact was made by the service, Chris and Alice requested support with gardening and housework.

In August of 2020, Chris requested an increase in lorazepam from the GP stating that he was suffering crippling anxiety and poor sleep. The GP declined the request. One month

later Chris contacted the GP asking for an increase in Alice's codeine. That same month Chris' brother contacted the GP to relay concerns about Chris' mental health and caregiving ability. The GP visited the home the following day and noted that Chris was providing Alice with personal care, helping her with toileting and washing. Chris was followed up by a mental health care team but responded that he was disappointed that he was not contacted by a member of staff that he knew; he said he would contact the team when he was ready. In October, Chris contacted the GP again requesting an increase in his medication which was declined.

In November, Chris failed to take his mother to an x-ray appointment. His brother contacted the GP repeating concerns that Chris was not providing adequate care for his mother. He also stated that Alice was engaging in self-neglect and hoarding. Alice was bedbound at this point and had not been outside in a long time. Chris reported not sleeping. The GP made a referral to social care and noted that Alice had capacity but was persuaded by Chris. The social worker assigned by social care reached out to Chris' brother who stated that although Chris was trying, he was unable to provide adequate care due to his mental health problems. He said that Chris was not managing his medication or sleeping and was fixated on the neighbours and hearing voices. He felt that his mother needed personal care beyond gardening and housework and that her health was deteriorating. He also relayed concerns about Chris' behaviour including that Chris was limiting his mother's contact with others, that Chris had a direct influence over all of Alice's dealings with professionals and that Chris listened to her calls and most often spoke to the professionals on her behalf. Records indicate that contact by professionals about Alice was often with Chris and that during visits Alice was spoken to with Chris in the room. Chris' brother also noted that he had seen Chris verbally dominate his mother. Around this time a nurse attended the home to draw blood from Alice. Chris refused to let her in and admitted that he was taking his mother's promethazine.

In late November the social worker visited the home along with Chris' siblings. Alice explained that Chris had turned away the nurse the week before because the visit was unexpected. The social worker offered help with decluttering the home; this was declined by both Chris and Alice. Chris had to date prevented professional and the rest of the family from entering all areas of the house. The family felt that the home was a fire risk given the clutter, locked doors and restricted access. On this occasion, Alice agreed to help from carers but stated that she did not want the Adult Safeguarding concern to progress. To facilitate carer support it was determined that an assessment was needed, this was scheduled for a month's time. Following this meeting, Chris' brother challenged his mother on not disclosing to the social worker how bad Chris was doing. Alice responded that she had no choice as she could not be responsible for him going to hospital given his threats that he would end his life if admitted. Chris' brother felt that Chris was controlling Alice and that her fears of him self-harming were not allowing her to push back. During this time the GP was in continuous contact with Chris about the need for him to reduce his lorazepam medication and Alice having laryngitis.

In early December 2020, a contractor working at the home reported to the local authority that the house was overly cluttered. The housing department conducted a visit and

noted that Chris and Alice were living in one room in the downstairs of the home and that they were co-dependent on each other for care. When housing options were discussed, Alice expressed concern that they would be separated. They were told that they would not be separated. Around this time the GP had contact with Chris who stated that he was stressed that Alice was unwell and was still abusing lorazepam. The follow day however, Chris reported that his mother was much better and requested more of her prescription codeine. The GP challenged him on this, and he admitted to using Alice's prescriptions. The GP said that Alice would need to be seen again to establish if she still required the pain killer. On this day, Chris failed to attend a scheduled appointment with a psychiatrist.

The GP followed up his concern in December 2020 about Chris using Alice's medication with a referral and noted that a home visit was needed. He added that Alice reported that if he did not get the medication Chris would cry and say that he wanted to end his life. At this time, Chris reported that he had not left the house in almost two years. In late December, the GP made another request for an urgent medical assessment of Chris due to escalating paranoia and increased use of prescribed medication and alcohol to stay calm. He noted that Chris had threatened to kill himself if admitted to hospital.

Although no professional has to date identified the ongoing OAA in this case, abuse has been disclosed. Thus, it is at this point in late December 2020 that our violence risk assessment takes place.