No, Thank You: Reasons for Withdrawal from Older Adult Abuse Support Services

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Conflict of Interest

Melanie R. Perka is a former employee of Catholic Social Services. The authors have no other conflicts of interest.

Ethical Approval

Ethical approval was granted by Royal Holloway University of London and permission for the study was obtained by the program manager of EARS/SPP.

Data availability statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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Abstract

This study explored the prevalence, reasons, and predictors of service withdrawal by victims in a sample of 151 older adult abuse cases reported to a specialist social work service. Withdrawal occurred in 34% of cases, after an average of 3 months of contact. The most common reasons for withdrawal were victim denial of abuse and unwillingness to engage with the intervention plan. Denial and self-neglect significantly predicted withdrawal, but only denial remained predictive when both variables were entered into the regression model. Results emphasize the need to screen for and address withdrawal risk, with providers targeting denial of abuse specifically.

Keywords: Elder abuse, elder mistreatment, older person abuse, service refusal, service utilization

Older adult abuse (OAA), also known as elder abuse or elder mistreatment, is a prevalent type of interpersonal violence (Yon et al, 2017). In this paper, we define OAA as "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" (World Health Organization, 2022, para. 2). OAA is underreported; only 15% of older adults in the U.S. National Elder Mistreatment study reported to police or other authorities, and researchers have identified many barriers to older adults disclosing abuse (Burnes et al., 2019; Fraga Dominguez et al., 2021). Underreporting may prevent older victims from receiving help and may lead to the continuation or escalation of abuse.

The available evidence also suggests that, once victims are in contact with formal systems, they may refuse the intervention offered, with rates ranging from 13%-58% of victims, or underutilize services offered or interventions in their safety plan (Burnes et al., 2016; Rizzo et al, 2015). Overall, there is limited understanding about the reasons for disengagement and the individuals who are most likely to disengage, despite the importance of client retention in the reduction of the risk of mistreatment (Rizzo et al., 2015). Further knowledge about the factors that explain the degree of engagement with services, and the reasons for disengaging, is important for case prioritization and can also allow service providers to screen for and address factors linked to service disengagement. Although refusal of services has been examined in other areas, such as mental health treatment (e.g., O'Cionnaith et al., 2021) or substance abuse treatment (e.g., Cimarolli et al., 2021) for older adults, identifying the importance of both individual and service characteristics, it remains unexplored in cases of OAA. Within this paper, we will examine cases where a victim chooses either not to engage with services or engages initially with services but later withdraws during the intervention, meaning no further contact with the services involved. We will refer to these facets of engagement as withdrawal.

The available research on abuse reporting and service utilization by OAA victims has linked several variables to victims' help-seeking and acceptance of help, which might also explain withdrawal from intervention. A common framework to explain both service utilization and formal reporting in OAA cases has been Andersen's Behavioral Model of Health Services Use (Andersen, 1968) later modified by Andersen and Newman (1973), with further revisions published in later decades (see Andersen, 1995). According to this model, an individual's health service use is a function of three factors: their predisposition to use the services, factors which enable or impede use, and the individual's need for those services (Andersen, 1995). The latter dimension reflects the cause for service use and is considered as an important predictor of service use and a factor that can be modified through education (Andersen, 1995; Barker & Himchak, 2006; Burnes et al., 2019). Examples of the different factors among OAA victims could be victim demographics, such as gender (predisposing), victim-perpetrator relationship dynamics and living arrangements (enabling), and victim perceptions of abuse, abuse type, and victim's self-reported health status (need) (see Burnes et al., 2016).

In the field of OAA, researchers like Burnes et al. (2016) have used this model as a framework to explain service utilization, conceptualized as "the proportion of interventions pursued out of the initial total safety plan" (p. 1043) and formal help-seeking (Burnes et al., 2019). Some of the predisposing factors that have been linked to service utilization are gender, with women being more likely to utilize services in general (Barker & Himchak, 2006) and in financial abuse cases (Burnes et al., 2016), but more likely to refuse Adult Protective Services' intervention (Gainey et al., 2010). Some of the enabling factors that have been linked to service utilization are the victim's living situation (e.g., the victim living alone predicted service utilization; Barker & Himchak, 2006) and victim-perpetrator relationship (e.g., the perpetrator being a child or grandchild of the victim was linked to lower service

utilization; Burnes et al., 2016). Regarding need factors, the victim's poor health status was found to predict service utilization (Barker & Himchak, 2006) and the victim's perception of being in danger also predicted service utilization (Burnes et al., 2016). Relatedly, a systematic review examining circumstances leading to or preventing help-seeking (Fraga Dominguez et al., 2021) found that victims often sought help when the abuse became more severe, escalated, or victims feared for their safety, and that a lack of awareness about abuse or thinking that the abuse was not serious enough was a barrier to help-seeking.

Based on the limited available literature on older adults' service utilization, refusal, and formal reporting in OAA cases, it appears that characteristics relating to the older adult, such as their health status and their perception of the abuse suffered, their relationship with the perpetrator and other situational factors such as living arrangements, and characteristics of the abuse may all contribute to service utilization. The current study will be exploratory in nature, with the aim of assessing whether some of the variables that have been linked to reporting, service utilization, and/or service refusal may also explain why victims withdraw from formal services. Through an examination of case records from a social service agency the present study will examine the following research questions.

1. How often and at what time point do victims of OAA withdraw from support services?
2. What reasons do victims provide for withdrawing from support services?
3. What are the predictors of victim withdrawal from support services?

Method

To examine service withdrawal a secondary analysis of 151 cases of OAA reported to the Elder Abuse Resource and Supports Team (EARS) over a 27-month period was conducted. EARS is a non-profit organization in Edmonton Alberta, Canada with a mandate

to investigate and intervene in cases of reported OAA. Caseworkers conduct an initial assessment and where appropriate refer onwards or work with police and nurses and put safeguards in place that can include the victim's family. All 151 cases met the WHO definition of OAA and the following inclusion criteria: the victim was aware of the report, abuse was identified, an attempt was made to follow-up, and the victim did not pass away during the intervention. Cases were classified as resolved or withdrawn for research purposes. A resolved case was defined as was one in which the case was closed due to the abuse ending or where a case was referred to another appropriate service. A withdrawn case was one where the victim chose either not to engage or engaged initially with the BCAT but later withdrew during the intervention; meaning they withdrew and had no further contact with the BCAT.

Procedure

Phone calls reporting suspected OAA to the BCAT are answered by case workers at which time an intake form is completed. Cases are later assigned based on case load and risk to a designated social work case worker. Once assigned, the case worker works with the victim and other parties (e.g., family, perpetrator) to safeguard the victim and end the abuse. They record their work in contact notes. There are no regulations mandating duration of care and contact for OAA in Alberta.

Materials

Data was extracted from anonymized case files comprised of two types of documentation. First, the comprehensive intake form which is completed during and immediately after referral and includes information on abuse type and victim and perpetrator demographic information and risk factors. Second, the contact notes which are gathered by the case worker or supervisor after contact is made with someone involved in the case or any action was taken. Cases contained between one and 118 contact notes (M= 6.01, SD=17.81).

Demographics

Victims were primary female (*n*=109, 72.2%) with an average age of 76 years (*SD*=10.92, range= 50-95). In three cases victim were under age 60, but were accepted by EARS due to high levels of vulnerability. Perpetrators were primarily male (*n*=80, 53.3%) with an average age of 48 years (*SD*=15.48, range 16-87). The frequency of abuse type and perpetrator-victim relationship are presented in Table 1; polyvictimization was the most common form of abuse and perpetrators were most frequently the adult-child of the victim.

Data analysis

Analyses were conducted using SPSS v29. Frequency analysis was used to answer research questions one and two. Binary logistic regression was used to examine question three where the outcome variable was case resolution or withdrawal. Two types of predictor variables were selected based on the research literature described in the introduction. First were classification systems commonly used for OAA: abuse type and victim-perpetrator relationship. Second were risk factors that can be modified through intervention also known as dynamic victim risk factors: mental health problems, self-neglect, and denial of abuse (need factors), dependency on the perpetrator, isolation, and living with the perpetrator (enabling factors). Initially each predictor was entered into the logistic regression model alone. Significant variables were then entered together into a logistic regression model. To assess multicollinearity, variance inflation factor (VIF) values were calculated for each predictor. The largest VIF value was 1.41 indicating that multicollinearity was not an issue.

Results

Prevalence and Timing of Withdrawal

Most cases were resolved (*n*=100, 66.2%), with 95 cases resulting in no further abuse (while actively held by EARS) and five cases resulting in referral. One third of cases (*n*=51, 33.8%) involved victim withdrawal either when the social worker tried to initially engage the

victim (*n*=6, 11.8%) or during intervention (*n*=45, 88.2%) . Resolved cases remained active in the BCAT for a mean of 141 days (*SD*=163.82; Median=64.5) with a range of one to 623 days. Similarly, withdrawal cases remained in the system for an average of 107 days (*SD*=168.68; Median=38) with a range of one to 672 days. There was no significant difference in case duration between the two groups, $t(149) = 1.21$, $p=.229$.

Reasons for Withdrawal

The 51 victims who withdrew from EARS support provided seven reasons for withdrawal. The majority of the victims (*n*=33, 64.7%) said that they did not want support. Within this group 26 (78.8%) did not want support because they denied that abuse was occurring, four (24.2%) admitted that they were being abused but refused support, and three (9.1%) gave no reason beyond stating that they did not want support.

The second reason given for withdrawing was that the victim was unwilling to take the steps suggested by EARS, this occurred in 12 (23.5%) cases. For example, one victim said that the suggested changes were too hard and that they did not want their son to leave the house. The third reason, given by two (3.9%) of victims, was that they wanted to handle the situation within the family. The next four reasons were provided by one (2%) victim each and included that: they were unable to continue due to ill health, they were afraid, the abuse had ended, and they were taking steps on their own that they believed would end the abuse.

Predictors of Withdrawal

Each of the eight predictors (Table 1) were entered into a separate logistic regression models where the outcome variable was case resolution or withdrawal; two models were significant. First, the presence of self-neglect by the victim predicted service withdrawal, $X^2(1, N=151)=5.06$, $p=.026$, explaining 4.6% of the variance in withdrawal and correctly classifying 68.2% of the cases. Second, victims who denied that OAA was occurring

predicted withdrawal from services, X^2 (1, N=151)=27.97, p<.001, explaining 32.4% of the variance in withdrawal and correctly classifying 78% of cases.

Both victim self-neglect and victim denial of abuse were then entered into the same logistic regression model. The model was significant, X^2 (2, N=151)=34.22, p< .001, explaining 33% of the variance in withdrawal and correctly classifying 78% of cases. However, victim self-neglect was no longer a significant predictor of withdrawal [B(SE)=.65, OR=1.92]. Victim denial of abuse remained the only significant predictor where those victims who denied that the OAA was occurring were 10.53 times more likely to withdraw from the BCAT [B(SE)=-2.35, OR=.095]].

Discussion

The results should be considered exploratory given the limited previous literature to guide the analysis of research question three and the small sample size. However, although small, the sample characteristics including gender, abuse type, and victim-perpetrator relationship are in line with the research literature. The study contributes several novel findings. The rate of withdrawal was substantial, impacting a third of cases, and was within the range identified for service refusal and underutilization (Burnes et al., 2016; Rizzo et al., 2015). Given the low rate at which OAA is reported to authorities, the frequency of withdrawal adds an additional layer of concern. Taken together, this means that only a minority of OAA cases are seen through to resolution in support services. This highlights the need for future research to identify how withdrawal rates can be reduced.

Notably, time to withdrawal was examined for the first time and results showed no difference in the length of service use between resolved and withdrawn cases. Cases that ended in withdrawal averaged over three months of contact with the service, with some continuing for 22 months. Thus, in addition to the undesirable ending of withdrawal, cases can draw a large number of service resources prior to withdrawal. Future research could

examine whether differences exist in reasons for withdrawal based on length of time in service as this might help to target those that withdraw long into the intervention process.

Some novel reasons for withdrawal were identified. Together denial of abuse and not wanting to take the steps suggested by EARS were reported by almost half of the OAA victims who withdrew. In addition, denial of abuse significantly predicted withdrawal. The convergence between the reason given by victims for withdrawing and the evidence coded from case records suggests that denial of abuse is an important motivation in withdrawal from services. This finding is in line with Andersen's Behaviour Model of Health Services Use (Andersen, 1995) and the literature on help-seeking and acceptance. Denial of abuse relates to the individual's need for those services in Andersen's model, which is conceptualized as an important predictor of service use and can be modified through education. Where denial is present, the victim would likely perceive the need to be low. The help-seeking literature has shown that victims seek help when they, perceive danger, fear for their safety or the abuse increases in severity (Burnes et al., 2016; Fraga Dominguez et al., 2021). Where a victim is denying the abuse, that concern might be absent, thus similar to the model, help-seeking behavior is reduced. Thus, there is strong empirical and theoretical evidence to support denial as a predictor for withdrawal.

Given the significant findings related to denial of abuse that were identified through coding case records, future research should attempt to replicate the results by asking victims directly. This approach could reveal variation among victims who express denial and perhaps identify if denial was masking other reasons for withdrawal. For instance, it may be that victims understood the behavior to be problematic but were unsure or hesitant about agreeing to intervention and were therefore expressing the risk factor of ambivalence (Storey et al., 2021) rather than denial.

The results have several implications for practice. First, given the prevalence of withdrawal and lengthy use of services prior to withdrawal, services would benefit from assessing the presence of denial of abuse at or near to intake. Second, it would then subsequently be prudent to regularly screen for and address any evidence of denial that arises. One possible way to address denial and ambivalence is motivational interviewing (MacNeil et al., 2023). In a small-scale study, MacNeil and colleagues found this to be a beneficial approach to help older adults navigate ambivalence and explore motivations for change. Third, the future directions noted above, exploratory nature of this study, and the sample size indicate the need for further research. One way to facilitate such work would be for practitioners to routinely record reasons for withdrawal. To facilitate this and case management, at the beginning of any file, more rapport building could occur to identify what type of outcome the older adult wishes to work toward. This could bolster their confidence to engage in working on their desired outcome, as well as pave the way to making it easier to explain their reasoning should they wish to cease service participation. This practice could also help to make victims feel that they can return to the service should they change their mind.

The present study sheds new light on the prevalence and reasons that victims of OAA withdraw from support services. The results reveal withdrawal to be a prevalent problem that draws considerable service resources but also highlight areas of intervention that could help to reduce withdrawal rates.

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