

Intervention Research

Conceptualizing Person-Centered Care in Elder Mistreatment Intervention: Use of a Well-Being Framework

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Abstract

Background and Objectives: Person-centered care (PCC) applied to elder mistreatment interventions is an approach to include victim priorities. Although PCC may improve outcomes by supporting choice, victim preferences are often difficult to support, especially in high-risk situations. We studied the adaptation of PCC structures and process to a pilot intervention, aimed at including client preferences in a multidisciplinary team's plans to address complex elder mistreatment.

Research Design and Methods: Case study analysis was used to examine the process of integrating client priorities into a risk-reduction plan. A well-being framework was used to understand the relationship between safety and preferences. Purposive sampling identified a case study of a high-risk victim with history of refusing help who agreed to work with the Service Advocate, a member of a multidisciplinary team.

Results: PCC required a relationship of trust, honed over several weeks by prioritizing the clients' perspective. Client preferences included remaining at home, continuing the relationship with the abuser, and maintaining a sense of mastery. Individualized definitions of "safety" were unrelated to elder mistreatment risk. Assistance included working with the suspected perpetrator, which is not offered by most elder mistreatment interventions, and resulted in some risk reduction. Reasons for refusing help were a desire for control and fear of loss of well-being assets.

Discussion and Implications: Individualized definitions of well-being should be considered in measuring intervention success. Future research could determine guidelines on what levels of elder mistreatment risk are acceptable, and how to monitor clients for safety while supporting autonomy.

Keywords: Case study, Mistreatment, Intervention, Well-being

Elder mistreatment (EM) is a global public health concern with grave societal costs. Defined as an intentional action, or failure to act, by a person in a trusting relationship that results in harm to an older person, EM is categorized into financial exploitation, physical harm, neglect, psychological abuse, and sexual assault (Hall et al., 2016). Estimates indi-

cate 1 in 10 older people are victimized in the United States each year (Acierno et al., 2010), and one in six worldwide (Yon et al., 2017). Victimization is associated with mental health problems, morbidity, and early mortality (Pillemer et al., 2016), and financial exploitation and caregiver neglect are the deadliest forms (Burnett et al., 2016). Economic

impacts include victim losses of almost 3 billion dollars in the United States annually (Metlife, 2011), in addition to undue hospitalization, emergency department use (Dong, 2015), and nursing home placement (Lachs et al., 2002).

Adult Protective Services (APS) are public agencies designated to receive and investigate reports of suspected EM. In most jurisdictions, APS provides short-term assistance to address the immediate crisis and improve safety. In addition to EM, APS responds to self-neglect, defined as “inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks” (Hall et al., 2016). Self-neglect is a distinct yet related phenomenon that increases risk of EM, has similarly adverse outcomes (2013; Dong et al., 2009, 2013), and is the most common phenomenon reported to APS (Acker et al., 2018). APS programs are administered based on state policies, such that agency size and structures vary (42 U.S. Code § 1397m-1; Roby & Sullivan, 2000). Although APS has a social service focus, EM is often viewed through a criminal justice lens, with focus on protecting victims and punishing perpetrators (Elder Abuse Protection and Prosecution Act [EAPPA], 2017; Jackson, 2016). APS caseworkers are encouraged to cross-report to law enforcement if they suspect criminal EM, and to refer to other outside professionals and service providers as needed (Administration for Community Living, 2020). EM reporting is mandatory for specified professionals (e.g., physicians, social workers) in 47 states (American Bar Association, 2022), though there is no evidence that reporting reduces harm (Baker et al., 2016; Fearing et al., 2017; Jackson, 2017; Ploeg et al., 2009). Even with mandatory reporting, only a small proportion of EM is identified and reported (Acierno et al., 2010; Lachs & Berman, 2011).

A quarter of older adults approached by APS refuse investigation and decline any offers to help (Jackson & Hafemeister, 2012; Teaster et al., 2006). Client autonomy, a core APS tenet, guides case workers to seek least-restrictive interventions that adhere to client preferences and values (ACL, 2020). Although adults (aged 18 and older) are assumed to have decisional capacity unless ruled otherwise by a court of law, ambiguities are common. For example, if an individual with high risk is referred to APS but indicates that they do not want help, the APS caseworker is challenged to determine whether and to what extent lack of capacity limits the person’s ability to use reason to assess their safety. A reliable capacity assessment involves a comprehensive battery of tests administered by a trained physician, psychologist, or neuropsychologist (Falk & Hoffman, 2014). Yet, APS workers may have to make an immediate assessment peering through a cracked-open door or over the phone (ACL, 2020).

Although policies and practices vary across APS regions, because APS involvement is voluntary the client’s influence is largely the power to decline help. Thus, APS workers must often choose whether to err on the side of doing too little, by closing a case on someone at high risk who refuses

help, or too much, by starting down the path of assessment and removal of decision-making rights (Bergeron, 2006; Duke, 1997). Even though well-intentioned, protecting a vulnerable older adult by eroding ability to direct life choices can lead to negative outcomes, including increased mortality (Blenkner et al., 1971). Because restrictive measures are a last resort, high-risk older adults who refuse help may end up in a revolving door of recurring referrals (Rowan et al., 2020). Although intermittent “check-ins” may lead to accepting help (Burnes et al., 2014; Susman et al., 2015), repeat referrals drain resources by adding to caseloads (Mixon, 2010). APS caseworkers are encouraged to cross-report to law enforcement if they suspect criminal EM, and to refer to other outside professionals and service providers as needed (ACL, 2020). However, with the role of client autonomy, and rates of service refusal, it is surprising that there has been little systematic effort to elicit victim perspectives and understand what approaches and options older adults would prefer.

What Do Older Adults Want?

Although victim preferences on EM intervention are not well known, several qualitative studies have explored perceptions of EM and barriers to help-seeking. Some older victims of domestic violence, even those who want assistance, are unwilling to jeopardize the relationship with their abuser, for a variety of reasons (Beaulaurier et al., 2007; Finfgeld-Connett, 2014; Hightower et al., 2006). For example, one study that asked racially and ethnically diverse focus groups of older adults about their views suggested that victims may tolerate an abusive relationship as the price for other valued benefits (e.g., companionship, financial security, stability; Enguidanos et al., 2014). These participants shared the views of EM victims in other studies: the intervention was considered worse than the current circumstances, and fear of nursing facility placement was common (Baulaurier et al., 2007; Enguidanos et al., 2014; Hightower et al., 2006).

This is a legitimate concern. APS intervention is an independent predictor of facility placement (Lachs et al., 2002). Facilities have been found to have high rates of resident-to-resident and staff-to-resident EM (Castle et al., 2015; Lindbloom et al., 2007; OIG, 2014), with prevalence rates that are more than double those in the community (Yon et al., 2019). While safety is an underlying goal of EM interventions, preference to remain at home may be the safer option for some.

Older adults identified as victims may be more likely to accept support that elicits their perception of what is working well in their situation, and are responsive to cultural norms and values, care needs, and individual preferences (Beaulaurier et al., 2007; Enguidanos et al., 2014; Hightower et al., 2006). Some want help for their abuser, especially adult children (Sandmoe & Hauge, 2014), or prefer informal assistance from friends and

family (Jackson, 2017), and emotional support that is non-judgmental (Hightower et al., 2006). Such considerations are hallmarks of a person-centered approach.

Person-Centered Care

Person-centered care (PCC) has been recognized in health care as an effective approach for enlisting patients as partners in decision making in the management of complex chronic illness (Ekman et al., 2011). The American Geriatrics Society (AGS) defines PCC as care in which “individuals’ values and preferences are elicited and once expressed, guide all aspects of their health care, supporting their realistic health and life goals” (Brummel-Smith et al., 2016). Priorities may focus on quality of life and caregiver needs, rather than traditional treatment options (Jennings et al., 2018). The application of PCC in medical and long-term residential settings is linked to improvements in mood, well-being, and engagement in activities that lead to better functioning, such as exercise and socialization (Fazio et al., 2018; Kim & Park, 2017; Kogan et al., 2016). These findings support that enhanced choice for older adults leads to improved functioning, memory, and emotional state (Mallers et al., 2014). Moreover, because problems identified by patients are more likely to be resolved (Enguidanos et al., 2011), PCC may reduce revolving door-style recurring use of care. Lack of choice and reduced self-efficacy leads to deterioration of physical function, psychological instability, and behavioral problems (Mallers et al., 2014). Given parallels to EM consequences of health decline and increased psychological suffering (Pillemer et al., 2016), empowering choice through PCC may lead to better EM victim outcomes.

Person-centeredness is a tenet of APS ethical guidelines (ACL, 2020), yet the program model is not based on victims’ preferences. PCC, by definition, requires flexibility to align with the victim’s view and responsiveness to the preferred method for amelioration (Brummel-Smith et al., 2016). One of the challenges of PCC in health care is the power differential between the physician, who is the expert decision maker, and the patient, who seeks help (Brummel-Smith et al., 2016). EM responses may have similar challenges given the focus on protection and vulnerability, especially cogent in cases where victim preferences for unsafe situations are interpreted as evidence of impaired cognitive functioning.

A Person-Centered Framework

To clarify the motives underlying victim preferences, we use the Full Frame Approach (FFA), an innovative paradigm that focuses on identifying and building upon existing sources of well-being while minimizing trade-offs (Smyth et al., 2006). With a focus on trade-offs, this approach is appropriate for illuminating preferences and reasoned strategies that underlie service refusal. The FFA has origins

in domestic violence services, and offers Five Domains of Well-being (Five Domains) for assessing existing assets: *social connectedness* considers number, diversity, and reciprocity of existing relationships; *stability* refers to perceived continuity and “anchors” in life situation; *safety* is the ability to be authentic without risk of abuse; *mastery* is the level of choice over circumstances; and *meaningful access to resources* is concerned with personal dignity when accessing services (Smyth et al., 2006). The Five Domains can be used to guide well-being planning, like safety planning but with a broader view of multiple aspects of well-being, including safety. PCC requires eliciting and understanding priorities of the person, and the Five Domains frames preferences in terms of universal drive for attaining well-being. By identifying what is important from the victim’s perspective, strategies for risk reduction can be balanced with trade-offs in other areas of the person’s life (Full Frame Initiative, 2019). We use the Five Domains, which has not been applied to EM, to examine the relationships between risk and the older adult’s preferences for well-being in a complex case of EM presented to an Elder Abuse Forensic Center.

The Intervention: The Service Advocate Program

Complex EM cases often involve a variety of organizations and professionals, including social and protective services, health care, and criminal justice. Multidisciplinary teams (MDTs) are designed to break down silos by improving cross-agency cooperation and coordination (Connolly, 2010; Yonashiro-Cho et al., 2019). The Forensic Center model reviews cases and consults with frontline workers, most often APS, to provide forensic assessments and document review. The Forensic Center model description and evaluation research are described in detail in other articles (Gassoumis et al., 2015; Navarro et al., 2013; Yonashiro-Cho et al., 2019).

In addition to reviewing and addressing complex cases, MDTs may develop and test innovative solutions to address systemic gaps. One example, developed to better serve clients who refuse help and are repeatedly reported to APS, is the Service Advocate (the Advocate). Protocols for the Advocate program were adapted from the AGS PCC definition, with a focus on developing a partnership between client and Advocate to determine a care plan that facilitates client preferences and reduces harm, with plan execution supported by the MDT (Brummel-Smith et al., 2016). This program was designed to provide more extensive services than what APS is equipped to do, with focus on building rapport with clients through longer-term service engagement and eliciting the client’s perception of what help is needed. To support this, the qualifications included a master’s degree in social work, 2 years’ experience with case management for crime victims, and communication skills such as motivational interviewing. Training involved shadowing various members of the MDT to learn

their service philosophy, approach, and client eligibility. The Advocate works individually with clients that the team identifies as needing additional help, applying PCC to understand problems and potential solutions, and reporting back to the MDT as needed. In addition to traditional supports, the Advocate explores alternative solutions, engages clients to better understand what kind of help they value or oppose.

Although person-centeredness is a tenet of APS, there are no concrete definitions or practice-based guidelines for this form of care in the context of EM. To begin addressing this gap in knowledge, the purpose of this study was to examine the process of person-centered services for EM victims. We specifically aimed to explore how this approach would fare with older adults who refused assistance from APS, to understand their preferences and assess whether PCC could meet the needs and reduce EM risk of older people who would otherwise not engage with the predominant EM response system.

Method

The application of PCC to EM interventions has not been examined, so our approach is an exploratory qualitative study to understand the processes of PCC for an older adult with high abuse risk who refused usual care. We used purposeful sampling to select cases with these criteria: current risk of multiple forms of EM; recurrent reports to APS; preferences that entailed EM risk; refusing assistance from APS (Palinkas et al., 2013). Case study analysis was used to examine the complex processes of supporting victim preferences under these circumstances (Polkinghorne, 1995). The Five Domains framework illustrates person-centered goals, illuminating trade-offs underlying client preferences in relation to well-being.

Data were the Advocate's narrative notes, detailing each interaction with, or on behalf of the client. Data included observations of behaviors and environments, quotes from conversations, text from e-mails, and descriptions of MDT meeting discussions and action plans. All case notes were read by the first author, who redacted identifiers (e.g., names, addresses, phone numbers). Cases characteristics were abstracted into a spreadsheet that delineated client characteristics, suspected EM, client preferences, service activities, and duration of the case. Three cases were selected that met the inclusion criteria, and exemplified effective rapport development with the Advocate, elicitation of preferences, and completion of services. Case analysis was conducted using investigator triangulation, to include diverse perspectives of researchers, the direct service provider, and members of the MDT (Denzin, 1970). Case identification and preliminary examination of service approach, process, and outcomes was first completed by two researchers who interpreted the data using the Five Domains framework. A preliminary case summary was

presented to the Advocate (who provided services and documented the case notes, third author of this article), the Project Manager (who facilitated the MDT meetings and provided follow-up on case activities), and Director of the Forensic Center (the Geriatrician who assessed the client, second author of this paper) for additional interpretation and explanation of decision making that was not apparent from the case notes. Lastly, cases were presented to MDT members to incorporate multidisciplinary views into the interpretation. The case study selected for this article was agreed upon by the authors, as exemplar PCC that could be described while maintaining client anonymity. Approval for the study was obtained from the University of Southern California Institutional Review Board. To protect the identities of the individuals involved in the case, names are aliases and some details have been omitted or altered, while maintaining the essential elements of victim preference and EM risk.

Results

Case Study: Ms. M

Presentation to the center MDT

Ms. M, aged 94, lived alone in her home. She had a terminal illness, and exhibited memory lapses, a history of falls, and skin breakdown with infection. In exchange for caregiving support and personal care, she invited Tom, a man who lived in an alley nearby, to move into her home free of charge. Tom had access to her bank account to manage her monthly income of \$1,000, which he sometimes used for his personal needs. At the time that the case was referred, APS and law enforcement were investigating two separate theft allegations. The Forensic Center's goals were asset protection and arranging for a caregiver along with Long-Term Services and Supports.

During the Advocate's first home visit, accompanied by law enforcement and APS, Ms. M rejected offers for services and repeatedly requested to be left alone. Tom appeared distressed and disclosed self-medicating with alcohol. The Advocate began the relationship with Ms. M by asking how she could help, explaining her role was to listen to what Ms. M wanted and support her preferences. Ms. M had a history of refusing assistance yet agreed to accept visits from the Advocate.

Initial assessment

During the first month of visits, the Advocate noted that Ms. M's physical condition and neglected health care were especially concerning, including several falls with related injuries. Ms. M was often combative, which could make providing care difficult even for an experienced, well-trained caregiver. Tom had no experience and shared his history of mental illness and substance abuse, telling the Advocate that he felt smothered and was especially uncomfortable assisting Ms. M with bathing. Aside from

Tom, Ms. M was isolated with no interest in socializing or leaving her home.

Case plan and implementation

Ms. M told the Advocate that she did not believe that she was being victimized. Her priorities were to remain at home with Tom as her caregiver. The Advocate supported these wishes by bolstering Tom’s caregiving with education and formal respite, which Ms. M approved. After several visits, she accepted help obtaining a fall alert system and agreed to see her physician, on the condition that the Advocate and Tom go with her.

After these initial agreements, Ms. M reverted to refusing help by cancelling doctors’ appointments and declining the fall alert system. Tom did not follow through with enrollment for respite care, and Ms. M argued that they did not need caregiving help. Ms. M failed to recognize the Advocate or recall conversations that had taken place hours prior. She went weeks without bathing or changing her clothes, explaining that she preferred not to move. It was clear that she was in pain, with difficulty ambulating. Tom was often unavailable.

Assessment of Five Domains

Despite the apparent lack of progress during the first month, Ms. M. continued to accept contact from the Advocate allowing insight into her resources within the five domains: *social connectedness*, *stability*, *safety*, *mastery*, and *meaningful access to resources* (Figure 1). Through weekly visits the Advocate observed the relationship with Tom, Ms. M’s source of *connectedness*. It became apparent that they had a friendship that was mutually caring. The reciprocity of their arrangement gave her a sense of purpose and *mastery*. Despite the stress of caregiving, Tom was caring and harbored no apparent resentment for Ms. M’s difficult behavior. Ms. M had *social connectivity* among her neighbors, and occasionally received visits from children

who lived on her street. Ms. M’s home provided a sense of *stability* through the familiar routine, and her personal *mastery* was expressed by accepting or denying entry to visitors. In her home, she had *safety* to be her authentic self. Her arrangement with Tom made this possible.

Trade-offs

Although Ms. M had some success in the five domains, she refused medical care. Her worsening condition affected her ability to ambulate, yet she would not initially share her reasoning for canceling appointments. After 3 months, Ms. M disclosed her fear: that her physician would have her “put in a home.” In Ms. M’s view, seeing a doctor posed a much greater threat than deteriorating health and vulnerability to exploitation: a loss of her home, and every source of well-being.

With this new insight, the Advocate helped Ms. M understand that neglecting her medical care was more likely to result in placement. Assured that her physician had no power to force her relocation, and with incentive to realize her aim to remain in her home for the duration of her life, she agreed to visit the doctor with Tom and the Advocate. As anticipated, the physician was alarmed about Ms. M’s physical condition and possible complications of her terminal illness, and recommended facility placement and extensive diagnostic tests. However, after hearing the Advocate’s plan for caregiving and consistent health care, he agreed to support in-home care.

Role of the MDT

The Forensic Center’s MDT members offered advice and expedited links to services, while the Advocate assured Ms. M’s preferences remained at the forefront. The financial abuse allegations initially presented were found to lack evidence, so Ms. M’s law enforcement and APS cases were closed. Weekly MDT meetings continued to be a forum for updates and discussion. Ms. M’s caregiving situation was

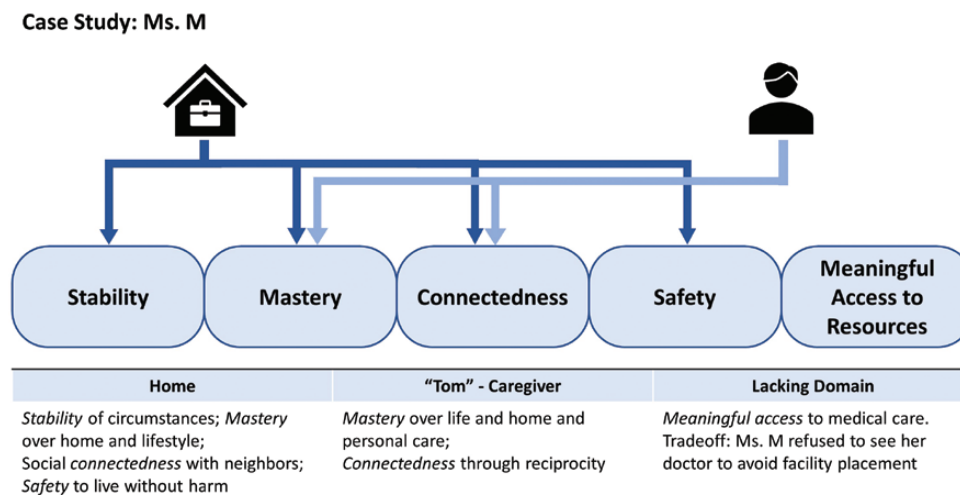


Figure 1. Ms. M’s Five Domains of Well-being.

a frequent topic of review. Ms. M's falls resulted in several trips to the emergency department. She was given a fall alert pendant but could not remember its purpose. Tom's substance abuse continued. With accumulating and persistent evidence of Tom's questionable ability to provide care, her memory lapses, and danger of continued injury, the MDT members recommended a cognitive capacity assessment by the Forensic Center's geriatrician. The assessment found that Ms. M lacked capacity, and a referral for conservatorship (called guardianship in many states) was filed to the Office of the Public Guardian (OPG), with assistance from the OPG representative on the MDT.

Tom appeared to the OPG investigator as a possibility for Ms. M's conservator, until the Advocate described his substance abuse and emotional lability. Eventually a nephew was identified as suitable to oversee finances and care decisions. The Advocate asserted that Tom remained a caregiver to Ms. M. His need for housing, coupled with knowledge of the cognitive and emotional challenges he faced, informed the Advocate's patient but firm approach in motivating him to improve his caregiving. The Advocate provided consistent contact, guidance, and resource connection for Tom. Over time, he began seeking the Advocate's advice and Ms. M's hygiene showed improvement; after repeated refusal of respite care, Ms. M agreed, if she would dictate the substitute caregiver's schedule.

Once the most pressing problems stabilized, the Advocate continued to monitor the case. Ms. M agreed to a referral to hospice and expressed acceptance of her closeness to death. During the last visit, the Advocate found Ms. M sleeping in a hospital bed in the living room. Tom tearfully described burial preparation and his plans to move after her death. Ms. M passed away a few days later, with three hospice nurses and Tom by her side.

Outcomes

Risk of exploitation and neglect were somewhat reduced with her nephew as the decision maker over finances and health care, and by supporting Tom, who remained her caregiver with regular support by the Advocate. Within the Five Domains, Ms. M kept control of decisions while building on her existing sources of well-being. Ms. M's social *connectedness* expanded in several ways including regular contact from the Advocate, whom she came to recognize through repeat contact, despite her cognitive impairment, and reintroduction and periodic visits from her nephew, who monitored her care. Ms. M. maintained *mastery* and *stability* over her life by remaining at home, and experienced improvement in *access to health and social services* with assurance that her preferences were supported.

Discussion

To study the application of PCC to EM, we analyzed one case study from a Service Advocate pilot program, using the Five Domains to explicate the motivation underlying victim

preferences and protective factors. The care plan was based on the client's priorities and facilitated by the Advocate. A Forensic Center MDT supported the Advocate, by advising on ethical and legal challenges, and coordinating care with investigators and service providers.

This case illustrates tensions in supporting a vulnerable person's choice to remain in a high-risk situation and exemplifies the ethical dilemmas for providers seeking to honor an older adult's wishes, in the face of ambiguous capacity to consent and continuing risk. The distinct achievement of this approach was the creation of a plan that largely preserved client wishes *and* ultimately, we argue, resulted in harm reduction. The intervention required becoming aware of what was working well in the view of the client, and the perceived trade-offs for EM risk reduction—details revealed long after the initial assessment, once trust was established. Case plans were adjusted as new information was revealed. The Five Domains illuminated Ms. M's perceived trade-offs, and paths to risk reduction that preserved her sources of well-being.

Ms. M believed, with some justification, that complying with an abuse investigation and health care would result in nursing home placement and the loss of her home. Without PCC, neglecting her health might have defeated her intent to remain at home. She was determined by a geriatrician to lack cognitive capacity and a conservator was appointed, which would likely have resulted in nursing home placement. With the Advocate's and the team's support, Ms. M's wish to die at home with Tom as her caregiver was honored.

Facilitating Ms. M's wish to retain Tom is an example of "negotiated consent," a process of working with impaired older adults such that autonomy and paternalism are not dichotomous, but compatible (Moody, 1988). Negotiated consent, which offers a useful approach in situations where oversight, assistance, and support may be needed to actualize preferences, requires a process to enter the client's world, learn what they want, and understand *why* (i.e., motivation underlying decisions). The Advocate accomplished this through listening, clarifying to better understand Ms. M's view and discerning what she was protecting by refusing assistance, walking a delicate balance of professional judgment, restrained reactions to risk, and honoring the trust and wishes that Ms. M had shared. Both the support of the team, and the luxury of time spent building rapport, aided understanding what motivated Ms. M's stated preferences. This is a difficult, if not impossible, task for time pressured APS workers. Given Ms. M's shocking condition and cognitive impairment, most physicians would see facility placement as the only ethical option.

Use of the well-being framework reveals a reasoned strategy underlying apparent inability to self-protect, despite that Ms. M lacked cognitive capacity. Cognitive incapacity is the most significant risk factor for EM (Pillemer et al., 2016), and for some APS programs is an eligibility

criteria (ACL, 2020), yet may inadvertently result in devaluation of perceptions and wishes expressed by an incapacitated older adult, in the name of safety from EM. The Five Domains offers a different vantage point, showing Ms. M was actively protecting the elements of her life that were most essential and fulfilling. Safety *was* attended, though not from EM, but from nursing home placement and loss of her home. Attempted intervention by health care providers, law enforcement, and APS was perceived as an affront. Capacity assessment was an important tool in assembling solutions for Ms. M, yet her case is a reminder of what has already been empirically supported: incapacity does not invalidate an older adult's preferences (Jennings et al., 2018; Mallers et al., 2014). Furthermore, safety was not the only factor underlying her reasoning, nor the most important: she prioritized mastery and connectedness. Ms. M's social connection with Tom was meaningful because of the reciprocity—an element easily overlooked when viewing EM victims solely as vulnerable and in need of protection. Mastery and reciprocity are elements of life purpose (Ryff & Keyes, 1995) and a sense of fulfillment has been shown to reduce mortality (Alimujiang et al., 2019). EM interventions must prioritize understanding the ways victims derive meaning from their circumstances, to avoid unintentionally undermining these sources.

Defining success in EM interventions is unresolved; it is most often conceptualized as risk reduction, yet this focus rewards erring on the side of invasive interventions and does not represent the price victims pay for safety. To assure interventions do not further traumatize those they seek to protect, it is crucial to consider victim priorities and sources of well-being. Older adults relying upon a single resource (e.g., a home, a person) to meet multiple needs may experience success at maintaining that resource within the domains of well-being, even if risk is only minimally reduced. The Five Domains offers a more comprehensive view of such outcomes. It is notable that for Ms. M, social connectivity was crucial, and supported her mastery over her living arrangement; social support is a complex element of EM, which can be both protective against and increase risk of EM (Wong et al., 2020). There are multiple calls for improved evidence of EM intervention efficacy, especially for randomized control trials (Baker et al., 2016; Fearing et al., 2017; Ploeg et al., 2009). Recent investigations of APS have shown EM risk reduction (Liu et al., 2022), yet without more research to define and quantify success that includes victim perspectives, results of such studies could be misleading and possibly harmful. Moreover, although there is strong and legitimate interest in educating and encouraging providers to identify and report EM, existing screening tools are limited in assessing victim priorities or individualized perceptions (Brijnath et al., 2020), and there is little support to guide professionals after they identify abuse, and little in the way of evidence-based practice to support treatment strategies (Wilber, 2019).

This study's limitation is the inability to infer efficacy of the Advocate program in assisting EM victims. As a qualitative case study, this paper examines process and the application of a well-being framework for interpreting person-centered preferences of one EM victim. While we found that the well-being framework may be an appropriate framework for understanding victim's priorities for the purpose of PCC, it may not be universally applicable to all EM, and should be tested in future evaluation research. More research is needed to study this program model to determine success in engaging clients who refuse usual care and determine to what extent an Advocate program is able to facilitate preferences while reducing abuse risk.

Individuals whose interests are not represented through existing service pathways may have solutions available through PCC. Older adults who recognize they are experiencing abuse and have family or friends who support their desire to make changes are shown to utilize support more readily from APS; those being harmed by an adult child or grandchild are less willing to engage (Burnes et al., 2016). This aligns with our findings that some older people may welcome solutions that allow them to maintain the relationship with the person who is harming them and include them in supportive assistance. Few APS programs offer this type of assistance, but it may be an appropriate option for some clients. This study demonstrates it was an effective strategy for an older adult who would otherwise refuse help and who's suspected abuser is well-intentioned.

Improving the EM response system's capacity to elicit and work within victim preferences requires further examination of potential facilitators and barriers. Including suspected abusers is not common practice, yet this article emphasizes that this is an important aspect of PCC. Practice guidelines and additional resources are needed for cases warranting more intensive support. Broaching adaptations of current practice will include ethical challenges. MDTs provide a layer of safety in testing experimental PCC approaches, by lending multiple perspectives, mutual accountability, and for supporting processes of learning and diffusion within local service networks.

Establishing PCC as a norm of practice will require practitioner–researcher partnerships to outline ethical guidelines, define competencies, and design strategies. Ms. M's case describes some measure of ongoing risk, and service provider attempts to protect her from herself and guide toward safer solutions. There is need for more discussion about how to define harm and risk to incorporate victim well-being and trade-offs, and some agreement of what degree of ongoing EM risk is reasonable to work within. A well-being frame could provide a foundation to develop guidance on managing decision points ethically. Negotiated consent is one strategy that outlines potential pathways toward the convergence of these priorities with risk reduction. Most importantly, victim perspectives are crucially

needed to help define roles and boundaries. A well-being framework, such as the Five Domains, can help elucidate these priorities.

Conclusion

This article shows the potential of PCC to make progress in complex EM where usual care has stalled, and challenges several broadly accepted assumptions. Understanding an older adult's priorities, even those seemingly unrelated, can build trust and clarify pathways for addressing danger. Although it may seem intuitive that interventions directly target EM risk factors, addressing overall well-being may be more effective for those who do not identify as victims of abuse and/or believe interventions threaten their preferences.

Well-being may be a promising focus to align EM responses with older adult preferences. Those who appear to have poor judgment or lack cognitive capacity may be executing a strategy to protect their priorities in the best way they can manage. It is not a question of *if* the priorities of older adults with cognitive deficits are elicited as much as *how* to best do so. Learning what trade-offs older adults are facing or believe they are facing can help define alternative routes to safety. Refusal of services in APS is often interpreted as an expression of autonomous self-reliance; however, it is possible that refusal is driven by incongruence with the service provider's presentation of the issue or the options. Autonomy versus safety is, to some degree, a false dichotomy.

The example of the Service Advocate approach described in this article evidenced the need for practice-based guidelines and strategies for working with clients to design solutions in the nuanced space between refusing assistance and invasive intervention. There are currently no defined boundaries of what can be done for these complex cases. Equipping first responders with limited and inflexible tools may inadvertently cause harm for those we mean to protect. To this point, there are severe limitations in assessing programs based solely on EM risk reduction, without considering the impact on overall well-being and life purpose.

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Conflict of Interest

None declared.

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Data Availability

This study was approved by the University of Southern California's Institutional Review Board. Data are not available for replication purposes because the level detail would compromise confidentiality.

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