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An Assessment of Interventions that Target Risk Factors for Elder Abuse

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An Assessment of Interventions that Target Risk Factors for Elder Abuse

Abstract

Although there is increasing concern about both the prevalence of, and harms associated with, the abuse of older adults, progress in the development of interventions to prevent its occurrence has been slow. This paper reports the findings of a systematic review of the published literature that identified studies in which the outcomes of preventative interventions are described. A total of 8 different intervention trials, published since 2004, are described across the primary, secondary, and tertiary levels of prevention and in terms of the types of risk factor that they target. The current evidence to support the effectiveness of these interventions is not only limited by the small number of outcome studies, but also the poor quality of evaluation designs and the focus of many interventions on single risk factors. It is concluded that work is needed to strengthen the evidence base that supports the delivery of interventions to prevent elder abuse.

What is already known -

- elder abuse is an important public health and societal problem which requires a response from both the primary health care and social service sectors
- current knowledge about the effectiveness of many of these approaches is limited
- there is a need to identify evidence-based interventions

What this paper adds -

- identifies a body of empirical research that evaluates prevention interventions

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- no accounts of multi-modal interventions addressing key risk factors at the level of the elder person were identified
- there is currently insufficient evidence to guide the implementation of interventions to prevent abuse

Indexing words: intervention; prevention; elder abuse; risk factors

Interventions that target risk factors for elder abuse: A systemic review of the literature

Governments and health care providers are increasingly facing a range of different challenges associated with meeting the needs of an ageing population. A specific issue arises in fulfilling their responsibility towards ensuring the safety and wellbeing of older adults, who are often identified as particularly vulnerable to abuse that is perpetrated by both family members and professional caregivers. Indeed, elder abuse is increasingly being recognised as an important public health problem, which requires a response from both the primary health care and social service sectors. Yet, even though a number of different types of intervention have been trialled, including advocacy programmes, support groups, care-coordination, and public education, and multi-disciplinary case management approaches (Dong, 2015), current knowledge about the effectiveness of many of these approaches is limited (Ploeg et al., 2009). The aim of this study is to systematically review the evidence gathered over the last ten years relating to the outcomes of these interventions. This is an important task, not only in relation to the development of evidence-based interventions, but also to decision-making in regard to the wider implementation of those interventions that can be expected to be most effective. We start, however, by briefly outlining what is known about the prevalence of elder abuse in western societies and those factors that appear to be associated with its occurrence.

Defined by the World Health Organisation (2008) as encompassing physical, sexual, psychological/emotional and financial act(s) of deliberate harm and/or neglect, elder abuse can have devastating consequences for the older person. It has, for example, been associated with increased risk of premature death, greater use of health care services (especially emergency service use and hospitalisation), increased

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nursing home placement, disability, chronic pain, financial ruin, psychosocial distress, and poor physical health (Burnes, Rizzo, & Courtney, 2014). There is reason to suspect that it is commonplace, although there are significant challenges associated with any attempt to collect accurate prevalence data in a context in which elder abuse has historically been regarded as an essentially private matter. Cooper et al.'s (2008) review, for example, concluded that over one in three carers working in residential care settings will admit to perpetrating some form of abuse. Of course, and as Schiamberg et al. (2011) point out, even this is likely to under-estimate the true extent of the problem given that it is derived from the reports of caregivers themselves. Inconsistent definitions of 'abuse' have also hampered the collection of reliable data, especially in relation to the different contexts in which it occurs. Abuse can, for example, occur in the home or in a care facility; the perpetrator can be a close relative such as spouse or an adult child, friend, stranger, or health care professional; and abuse can occur as part of a lifelong pattern of family violence or only emerge when the older person becomes frail and dependent.

Elder abuse is best conceptualised as resulting from a complex interaction between the victim and perpetrator, which is influenced by specific individual characteristics, the quality of the relationship, and the influence of the wider social and cultural environment. A review by Johannesen and Logiudice (2013) identified a number of different risk factors for abuse among elders living in the community. Those that related to the elder person included cognitive impairment, behavioural problems, psychiatric illness or psychological problems, functional dependency, poor physical health or frailty, low income or wealth, trauma or past abuse, and ethnicity. Factors associated with the perpetrator were caregiver burden or stress, and psychiatric illness or psychological problems, with factors associated with the relationship categorised as family disharmony, poor or conflictual relationships, and a range of environmental considerations including low social support and living with others. The risk factors most strongly associated with abuse were at the relationship (family disharmony, poor or conflictual relationships) and environmental (low levels of social support) levels. A recent review by Dong (2015) identified physical impairment on the part of the elder as a particular risk factor, with elders with Alzheimer's disease reported to be 4.8 times more likely to have experienced elder abuse than those without. It is also the case that older adults are often placed in high risk situations as a result of the need for the long-term care that is required to manage

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chronic disease (Schiamberg et al., 2011). There is a smaller body of literature which has sought to identify risk factors for elder abuse that are specifically associated with institutional care, however some of the characteristics that have been associated with maltreatment in care home settings are a lack of staff qualifications and training, staff shortages, high personal stress among staff, burnout, negative attitudes, and incorrect or inadequate application of legislative safeguards in the care of older people (World Health Organisation, 2008).

From a public health perspective, any formal attempt to prevent elder abuse should target known risk factors associated with this form of maltreatment, seeking to either reduce their presence or intensity. To that end, the aim of this study is not only to examine the strength of evidence that exists to support the delivery of current interventions to prevent elder abuse, but also to identify the types of risk factor that are targeted. Consideration is also given to whether interventions lie within the primary level of prevention (preventing abuse before it arises and targeting whole populations), the secondary level (mitigating or preventing the further development of abuse by targeting at-risk individuals), and the tertiary level (preventing further occurrences of abuse by targeting known perpetrators). For the purpose of this study, the World Health Organisation's (2008) definition of elder abuse as an intentional or unintentional single act or multiple acts and/or omissions that result in distress or harm to older adults, with this harm being physical, verbal, psychological/emotional, sexual, and/or financial in nature has been adopted.

Method

Search strategy and selection criteria

Preliminary searches were carried out by two researchers, independently, using multi-disciplinary databases[1] which allowed a wide range of relevant articles from low, middle- and high-income countries to be located. A combination of search terms and limiters (e.g. 2004-present, English language, full-text) were applied. The final search terms used (which resulted in the most relevant hits in August 2015) were: (elder* or old* or aged) AND (abuse or violen* or mistreatment or maltreatment or rape) AND (program* or initiative or impact or interven* or evaluat*

[1] the following databases were searched Ebsco (Ageline, Academic Search Complete, PsychInfo, Cinahl Complete, SocIndex, Medline, Medline complete, Social Work Abstracts, Ebook collection (Ebscohost); Embase; Informit; Proquest; Scopus; and Web of Science.

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or outcome or legislat* or law or legal or measure* or treatment or policy or trial) AND (prevent or reduce or improve or help or assist* or effective* or protect*). This resulted in a total of 6,725 identified articles.

The initial screening involved a review of the abstracts by both researchers. Articles were retained if they: (i) described a study (i.e., not a discussion or policy review); (ii) were peer-reviewed; (iii) included outcome data (including qualitative/ descriptive data); (iv) defined elder abuse victims as being at least 60 years of age; (v) were available as full-text; (vi) were in English; (vii) were published during or after 2004; and (viii) had a prevention or intervention focus. Articles were excluded if they did not meet the above criteria, were not relevant (e.g., considered cancer/medical issues in the elderly), provided insufficient detail, were duplicates of studies already included, focused exclusively on elder self-neglect. Articles identified as potentially relevant were then read in their entirety (full-text) by the two researchers to determine their suitability for inclusion. Opinion differed in relation to only two papers, and after each re-reading and discussing inclusion criteria, a consensus was reached. Figure 1 provides a full flowchart of the search process. This resulted in a final pool of only 8 studies which were screened for methodological quality using the Maryland Scientific Methods Scale (Farrington et al., 2002), a system that ranks research designs according to the strength of internal validity. Scores on this scale generally reflect the level of confidence that can be placed in an evaluation's conclusions about cause and effect - in other words, the degree of certainty that any observed changes are a direct result of a particular programme or service. Level 0 studies employ qualitative research methodologies using interviews, focus groups or other qualitative methods. Level 1 studies are correlational study with no comparison group, whereas Level 2 studies report a temporal sequence between the intervention and the outcome (pre-post study), or the presence of a comparison group without demonstrated comparability to the intervention group. Level 3 studies involve a comparison between two or more comparable units of analysis, one with and one without the programme (no random assignment to groups) and Level 4 studies involve a comparison between multiple units with and without the programme, or using comparison groups that evidence only minor differences and include studies in which it has been clearly demonstrated that, before the intervention, there is very little difference between comparison groups. Finally, Level 5 studies utilise random assignment and analysis of comparable units to programme and comparison groups

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and are considered to provide the strongest evidence. The identified studies were then classified as intervening at the primary, secondary, or tertiary level of intervention and a record made of the primary risk factors targeted in the intervention.

<Insert Figure 1 about here>

Results

Most of the studies identified by the search strategy were descriptive and reported only limited outcome data, with only one study utilising a quasi-experimental or controlled design (Teresi et al., 2013). At the level of primary prevention only two studies were identified (see Table 1), both of which targeted the risk factor of inadequate training in professional carers. The first of these, reported by Smith et al. (2010), involved a presentation about elder abuse to nursing assistants, with participants asked to record their reactions. There was no pre-post testing, randomisation of participants, or control comparisons. The second, published by Harmer-Beem (2005), involved training dental hygienists to improve their awareness of the issue. Responses to a pre and post-test postal questionnaire suggested that the training did increase their ability to recognise elder abuse and neglect.

<Insert Table 1 about here>

Only one study was classified as a secondary level intervention (see Table 2). In this study, reported by Hsieh et al. (2009), nursing home staff who were identified as at risk from their scores on a caregiver elder abuse behaviour scale received an educational intervention and participated in group discussion. Comparison with the ratings of a control group revealed that those in the intervention group reported lower levels of behavioural abuse and greater knowledge about abuse.

<Insert Table 2 about here>

Table 3 outlines the five studies which were classified as describing the outcomes of interventions at the tertiary level of prevention. These interventions targeted risk factors in the areas of inadequate training, physical health and disability, breakdown in family relationships, and a lack of case review or co-ordination between

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responsible agencies. The methods to assess effectiveness varied from client satisfaction, the effectiveness of team working, the identification of abuse, and staff gains in knowledge and reporting behaviours. The most methodological rigorous of these (rated as a 4 in the Maryland system) involved a training intervention with professional caregivers to 1,405 residents from 47 New York City long-term care facilities (nursing homes) (Teresi et al., 2013). The programme aimed to improve the identification and intervention of resident-to-resident elder mistreatment, with the intervention group showing higher levels of recognition and documentation of mistreatment following training. The other studies examined intervention to improve co-ordination between responsible agencies and improve team effectiveness (Navarro et al., 2010; Wiglesworth et al., 2006), to identify abuse (Heath et al., 2005), and to address family dysfunction (Holkup et al., 2007).

<Insert Table 3 about here>

Discussion

The identification of elder abuse as a significant and potentially increasing public health and societal problem requires a strategic response. The aim of this study was to identify those preventative interventions that have been shown to have the potential to reduce abuse by addressing those risk factors that are thought to be associated with its occurrence. However, the results of a systematic search of the published literature identified only a few studies that have attempted to systematically evaluate the outcomes of this type of intervention. A lack of information about programme outcomes creates particular problems for policy makers who, it has been suggested, often struggle to make evidence-based decisions about which programmes to replicate, generalise, or scale up. This leads to a situation where many programmes do not progress beyond the pilot or development stage or are limited in scope to the specific context in which they were first developed. The challenge for practitioners is twofold: first, to have greater clarity about the specific outcomes that programmes might be expected to achieve; and, second, to find ways to reliably assess their capacity to bring about change.

Of the interventions identified in this study, only two adopted an evaluation design (experimental or quasi-experimental) that might be expected to determine the

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casual relationship between the delivery of the intervention and the reduction of risk. This suggests that some work is required before current interventions to prevent elder abuse can achieve the level of evidence that would support their implementation on a wider scale. It is also worth noting that most of the interventions identified in this review targeted single risk factors (e.g., knowledge of the issue in care-givers), rather than the broader range of risk factors that interact to create a situation in which abuse is likely to occur. There were no accounts of multi-modal interventions addressing key risk factors at the level of the elder person (e.g., cognitive impairment, poor physical health or frailty, low income or wealth), the perpetrator (e.g., caregiver burden or stress, poor or conflictual relationships), and the setting (e.g., staff training, reporting of abuse). The development of more integrated and comprehensive interventions is clearly one area that requires attention. Indeed, current approaches to intervention appear to largely overlook the multifaceted and multifunctional nature of violence (Anderson & Bushman, 2002), even though it is possible that a range of other services and programmes are available that target other types of risk factor. Given that these were not identified in our searches it would appear; however, that needs in these areas are not explicitly identified as risk factors, and the prevention of abuse is not identified as a goal. Accordingly, there appears to be scope to adopt the approach recommended by Douglas and Skeem (2005), which is based on the identification of specific sets of risk factor that are potentially amenable to change through intervention. It also identifies a need to clearly articulate the rationale or logic underpinning programme activities. Programme logic models are simple statements about the inputs, activities, and intended impacts of each activity on longer term outcomes which are widely considered to be a pre-requisite for effective evaluation (see Kellogg Foundation, 2004), but were not described in any of the studies identified in these searches.

The conclusions of this review are consistent with those of the only previous review of this topic conducted by Ploeg et al. (2009) who concluded that "there is insufficient evidence to support any particular intervention related to elder abuse targeting clients, perpetrators, or health care professionals" (p. 206). Their study identified a total of only 8 different outcome studies that had been published prior to 2008 and the results of our searches clearly show that the evidence base has not grown substantially since this time. The reasons for this are somewhat unclear but may be a result of what remains limited community awareness of this issue. Parallels

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can be drawn here with public education campaigns over recent years that have created greater awareness of the issue of intimate partner violence and led to an increase in interest in the development and evaluation of effective intervention (Mackay et al., 2015).

The current review is, of course, not without limitations. While limiting the search to English language only avoids the need for the translation of papers, it does potentially exclude relevant papers, as does the use of limited search strategies (beyond searching databases). No contact was made with experts in the field to identify unpublished evaluation studies. In addition, no formal assessment of the methodological quality of each of the identified studies was completed, although the design employed in each of the studies is categorised in Table 1. Nonetheless, this study does provide a further illustration of the types of intervention that have been implemented and which hold at least some promise in preventing the harms associated with the abuse of older adults in both homecare and institutional settings. The challenge is to find ways to extend the practice wisdom that underpins the development of these programmes into an evidence base that can be used to support wider implementation.

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Table 1: Primary prevention interventions targeting known risk factors associated with elder abuse

Author(s) (year) country	**Risk factors - targeting who & why**	**Setting; participants; type of abuse (N)**	**Intervention**	**Maryland scale rating for methodological rigour**	**Outcome measure: key findings (Effect size or odds ratio where reported)**	**Limitations**
Smith et al. (2010) USA	Professional caregivers Risk factor: Inadequate training	Setting: Tertiary education Participants: Students in a nursing assistants course (N=78) Type of abuse: Physical, and psychological	Information presented about elder abuse in the form of PowerPoint presentation (information about elder abuse including the extent of the occurrence, what to be aware of when working with the elderly, and reporting) & YouTube video (news report video footage of cases of elder abuse) as part of a didactic presentation about standards and ethics as part of the nursing curriculum.	0 (use of interviews, focus groups or other qualitative methods).	Students recorded their reaction to the material presented in the context of their previous knowledge of elder abuse. Students responded to material in a visceral way and provided evidence through their written comments of deeper thought and reflection of the issue of elder abuse. Of the 37% of students who entered information about their previous knowledge of elder abuse, 28.5% stated they never knew much and that the presentations/discussion increased their awareness; 53.5% knew about elder abuse but hadn't thought much about it; 18% did not hear anything knew from the presentations/discussion.	No pre-post testing; no control group or randomisation used; and no follow up to see if students' self-reported understanding held across time.

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Harmer-Beem (2005) USA	Professional caregivers Risk factor: Inadequate training	Setting: Dental professionals' training programme Participants: Dental Hygienists (N=25) Type of abuse: Physical abuse and neglect.	Pre- and post- 10-item survey conducted. Intervention was abuse awareness (including elder abuse) training to increase reporting behavior Topics covered included ethical and legal responsibilities to report child and elder abuse; factors contributing to abuse; how to date bruising; how to phrase open ended questions to determine child and elder abuse.	2 (the comparability of the comparison groups is seriously compromised and no attempt has been made to control for this).	Mean scores were compared on a 10-item questionnaire pre-post training using t-tests. There was a significant increase in self-reported ability to recognise abuse and neglect, increase understanding of factors contributing to abuse, how to make a report and an increase in the likelihood to make such a report (p=.05)	Non-randomised sample with no follow-up. Participants' perceived likelihood to act on suspected abuse does not necessarily translate to change in behaviour, which is unknown from the study.

Table 2: Secondary prevention interventions targeting known risk factors associated with elder abuse

Author(s) (year) country	**Risk factors - targeting who & why**	**Setting; Participants (N); Type of abuse**	**Intervention**	**Maryland scale rating for methodological rigour**	**Design; Outcome measure; key findings (Effect size or odds ratio where reported)**	**Limitations**
Hsieh, Wang, Yen, & Liu (2009) Taiwan	Professional caregivers Risk factors: Inadequate	Setting: aged care facilities. Participants: Professional caregivers/	The invention programme covered aging and associated problems related to managing residents' health problems, institutional elder abuse, factors	3 (a comparison between two or more comparable units of analysis, one with and one without the program).	Quasi-experimental, case control, pre- post design with between institutional control. Pre and post-tests scores on Caregiver	Non-randomisation of participants. Different institutions used for experimental group and control group – may be

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	training; Work stress; Caregiver abusive behaviour	nursing home staff (N=100) who scored 20 or more on the Caregiver Psychological elder abuse behaviour scale. Half of staff members participated in an eight week education group. Type of abuse: Psychological abuse.	associated with caregivers' abuse behaviour, relaxation and stress management, dealing with stressful care-giving situations, and obtaining personal resources. Each of the 8 weekly sessions consisted of a lecture on the topic (30 min), free sharing and mutual support among group members (40 min), and integrative discussion (20 min).		Psychological Elder Abuse Behavior Scale (CPEAB), the Work Stressors Inventory (WSI), and the Knowledge of Gerontology Nursing Scale (KGNS) compared between intervention group and control group with salary as covariate. Compared with the control group, participants in intervention group scored significantly lower on caregiver psychological elder abuse behavioural scale after the intervention, and higher on knowledge test ($F = 4.02$ and 5.83; $p = .048$ and $.018$, respectively) but there was no significant difference on work stress measure scores pre-post intervention.	influence of different work environment.

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Table 3: Tertiary prevention interventions targeting known risk factors associated with elder abuse

Author(s) (year) country	**Risk factors - targeting who & why**	**Setting; participants (N); type of abuse**	**Intervention**	**Maryland scale rating for methodological rigour**	**Design; Outcome measure; key findings (Effect size or odds ratio where reported)**	**Limitations**
Wiglesworth, Mosqueda, Burnight, Younglove & Jeske (2006) USA	Professionals who respond to suspected victims of elder abuse in the community. Risk factor: Systemic – lack of co-ordination between responsible	Setting: Forensic. Participants: A total of 52 professional staff from a specialist elder abuse centre were surveyed regarding 246 cases referred to the centre during a 1-year period.	Multidisciplinary staff members reviewed cases of suspected elder abuse. All were cases that they had been collaborators on over the past 12 months. The survey questions related to the collaborators' perceptions of how effective the specialist elder abuse centre was in case management outcomes. Collaborators formulated goals and strategies in response to each case presented and developed a time line to review	0 (mixed methods design, but the main analysis relies on qualitative data).	Satisfaction with the involvement of the service was measured using a Likert scale (time taken to get outcome, efficiency, and effectiveness of case discussion process). Qualitative responses to written surveys were analysed to extract themes. These related specifically to efficiency and effectiveness where participants believed the abuse centre responded	Survey responses that were done retrospectively. The professionals had worked closely together in all of the cases and this may have affected their responses.

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	agencies; lack of multi-disciplinary collaboration.	Type of abuse: Physical, psychological, and financial.	progress.		effectively and efficiently in the cases presented.	
Navarro, Wilber, Yonashiro & Homeier (2010) USA	Professionals who work with suspected victims of elder abuse in the community. Risk factor: Poor case management.	Setting: Forensic. Participants: De-identified client records to report on client and alleged perpetrator characteristics, including the type(s) of suspected abuse for all cases (n = 313) reviewed during the first 3 years of	Case review with different professionals from the justice system, health care, protective services, and mental health. The project manager summarises the intervention plan and the team identifies one or two goals, along with a specific time period to receive an update on the case.	2 (the comparability of the comparison groups is seriously compromised and no attempt has been made to control for this).	Participants were surveyed members using a modified Team Effectiveness Inventory (examines mission, goal achievement, empowerment, open and honest communication, positive roles/norms, and a global score reflecting overall team effectiveness) following initial planning (baseline; n = 9), at 12 months (n = 12) and 36 months (n = 16) from baseline. Presenters' experiences were assessed using a customised 15-item instrument. Questions	Survey data. No comparison group.

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		operation (130 meetings), from March 2006 to December 2008. Type of abuse: Physical, psychological, and financial.			included responses about the team process and why cases were selected for presentation. In addition, to assess process and identify lessons learned, one or more evaluators observed each meeting. It was found that during the first 3 years, core team members actively participated in the reviews. It was also found that presenters and team members provided very favourable evaluations of the effectiveness of the Centre.	
Heath, Kobylarz, Brown & Castano (2005) USA	Professionals who respond to suspected victims of elder abuse in the	Setting: In-home geriatric assessments – New Jersey Participants: Two hundred	A nurse practitioner–geriatrician physician team conducted medical and functional assessments at the place of residence of the client.	1 (correlation study with no comparison group).	The in-home geriatric assessment service led to at least one relevant intervention for 81% of clients. 46.4% were referred for home health care	Categorisation of mistreatment might have overlooked some clients; applicability to other settings may be limited; limited to community based sample and those who were adult protective services clients.

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	community. Risk factor: Physical health	eleven adult protective services clients; 74% female; mean age 77. Type of abuse: all forms of mistreatment			services with 4 diagnostic significant findings: uncontrolled pain ($r = 0.45$, $p < .001$); depression ($r = 0.26$, $p < .01$); falling ($r = 0.21$, $p < .002$); sensory impairment ($r = 0.16$, $p < .02$). 35% were placed in alternative living situations and these placements were significantly correlated with caregiver neglect ($r = 0.159$, $p < .02$) and dementia ($r = 0.17$, $p < .02$). 35% involved guardianship actions for clients suffering caregiver neglect ($r = 0.22$, $p < .002$) or financial exploitation ($r = 0.14$, $p < .04$). 25% required urgent medical attention due to significant acute pain though no significant association with mistreatment was found.	

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					41% of clients were hospitalized which was correlated with physical abuse (r = 0.13, p < .05) and with depression (r = 0.27, p < .001), uncontrolled pain (r = 0.22, p < .001) or involuntary weight loss (r = 0.18, p < .008)	
Teresi et al. (2013) USA	Professional caregivers Risk factor: Inadequate training	Setting: Long-term care facilities; Participants: 1,405 residents (685 in the control and 720 in the intervention group) from 47 New York City nursing home units (23 experimental	Delivery of a training programme for staff that: (a) enhances identification and intervention with respect to episodes of resident-to-resident elder mistreatment (R-REM) in long term care facilities; (b) increases staff knowledge related to recognition and treatment of R-REM; and (c) increases staff recognition and reporting of R-REM.	4 (comparison between multiple units with and without the programme, or using comparison groups that evidence only minor differences).	Cluster randomised trial with data collected at baseline, 6 and 12 months. Paired t-tests comparing pre-post knowledge were used to measure enhanced staff knowledge between groups. There was a significant gain in knowledge for nursing staff on 5 out of the 10 items Module 1 (t = -0.696, p < 0.001). Enhanced R-REM recognition was examined using Chi-square analysis	No information about control group in terms of the study. Asking nursing staff to complete further paperwork added to their burden and may have influenced how they completed these. Potential contamination between groups as randomisation occurred within units. There was a significant difference between groups at baseline on functional and cognitive status.

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		and 24 control) in 5 nursing homes. Type of abuse: Resident-to-resident mistreatment (physical; sexual; emotional)			comparing the number of reports from experimental and comparison groups over time. There was a significant gain in knowledge of 4 out of 10 items in Module 2 ($t = -0.964$, $p < 0.001$). The intervention group showed higher levels of recognition and documentation of R-REM. The estimated average reported events per resident per year for staff in the control group was 0.35 compared with 2.06 for the intervention group (about 6 times higher) with results from Possion model showing a significant increase for experimental group compared to control group on reporting R-REM events ($p = 0.0058$).	

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Holkup, Salois, Tripp-Reimer, & Weinert (2007) USA	Families where there is evidence of elder abuse. Risk factor: Family dysfunction. Breakdown in the familial relationship	Setting: community-based, on reservations Participants: 26 families referred for participation in a family care conference. Type of abuse: all forms of mistreatment.	An elder focused family-centred community-based intervention (The Family Care Conference – FCC) incorporating six stages: referral, screening, engaging the family, logistical preparation, family meeting, and follow-up.	0 (use of interviews, focus groups or other qualitative methods).	Community-based participatory research approach was used; Only 2 families were unwilling to participate. No other outcome data reported.	Although the paper outlined an intervention that was used, there was no outcome data reported. The paper remained descriptive of the intervention with no results for the 26 families that were referred given.

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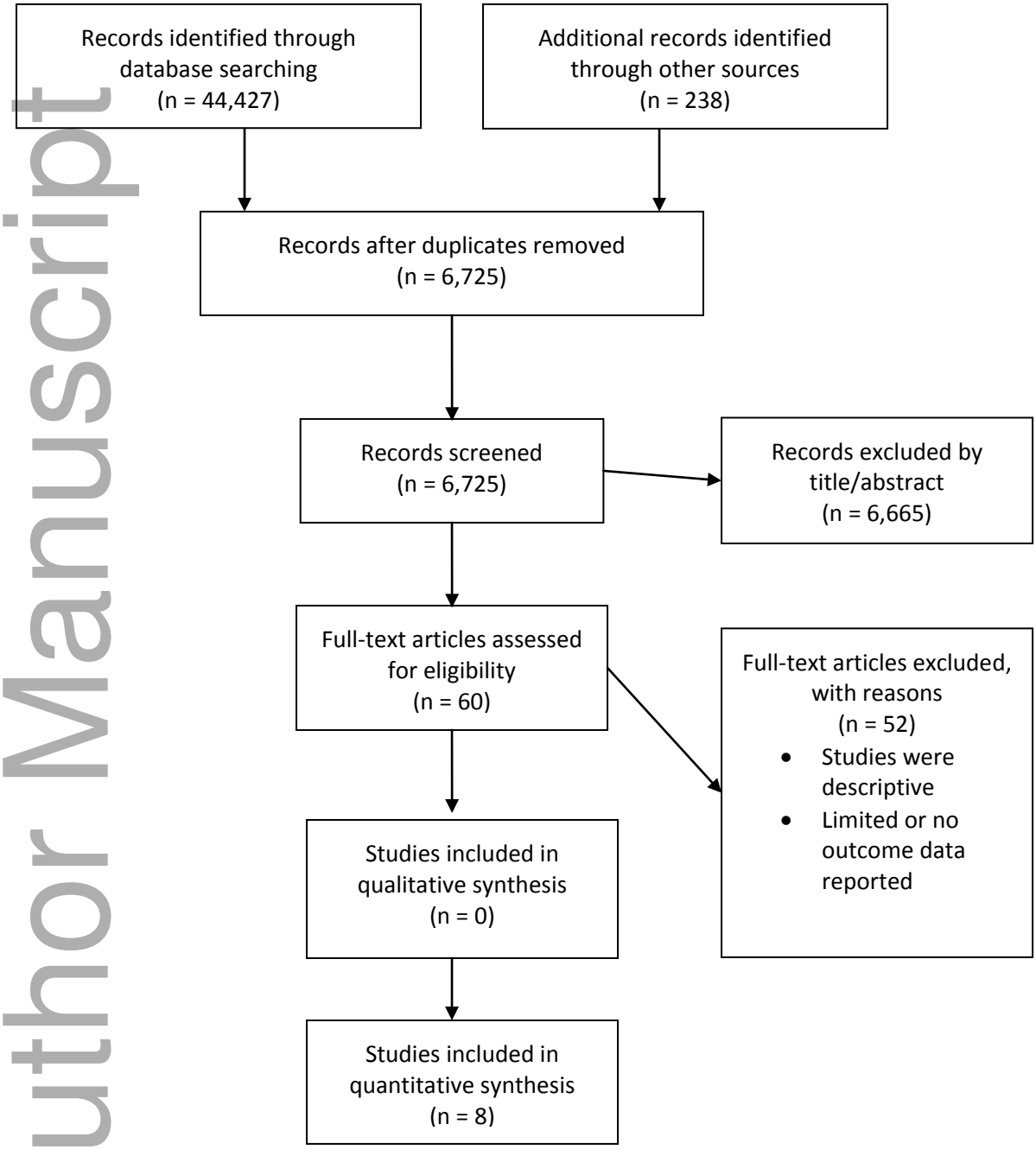

Figure 1. PRISMA flow diagram

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