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Assessing the Impact of the Department of Health (DHS) Division of Aging Services' At-risk Adult Crime Tactics (ACT) Certification on Professionals

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ASSESSING THE IMPACT OF THE DEPARTMENT OF HEALTH (DHS) DIVISION OF
AGING SERVICES' AT-RISK ADULT CRIME TACTICS (ACT) CERTIFICATON ON
PROFESSIONALS

By

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A Thesis Submitted to the Graduate Faculty of Georgia State University in Partial Fulfillment of
the Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA 30303

ASSESSING THE IMPACT OF THE DEPARTMENT OF HEALTH (DHS) DIVISION OF
AGING SERVICES' AT-RISK ADULT CRIME TACTICS (ACT) CERTIFICATON ON
PROFESSIONALS

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Acknowledgements

To:

My family, whose support is omnipresent,

More specifically,

My husband, Richmond Parker, the love of my life,

My mother, my rock, Alma Bolden, who gave me the gifts of curiosity and empathy,

My sister, Dr. Tammy White, my best friend all my life,

My babies, Aiden and Emily Alma, my sunshine and laughter,

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And

Megan Smith, MPH, for her generous willingness to serve on my committee,

And

The faculty and staff of the Georgia State Institute of Public Health

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CHAPTER I

Introduction

Background

Since 1965, violence has been a growing concern for public health professionals in the United States. Though violence is widespread and ever-present, it does appear to affect certain subpopulations disproportionately. Rates of violence inflicted on populaces seem to be directly related to that group's perceived vulnerability (e.g. age [children and elderly], disability, gender, etc.). Furthermore, combinations of these susceptibilities, or risk factors, compound the possibility of exposure to violence (e.g. children who are disabled) (Alriksson-Schmidt, Armour & Thibadeau, 2010).

Elderly Americans, over age 60, represent one such at-risk subgroup. These individuals suffer elder mistreatment (EM) in the forms of physical abuse, sexual abuse, emotional or psychological abuse, financial or material exploitation, abandonment, and/ or neglect (Tatara et al., 1998). Several risk factors discussed in the literature that appear to increase the likelihood of suffering the above mentioned forms of EM include age and income level (Tatara et al., 1998), gender (Amstadter & Cisler et al., 2011; Tatara, 1998), race/ethnicity (Amstadter & Zajac et al., 2011; Beach, Schulz, Castle, & Rosen, 2010), and impairment type and health (Amstadter & Zajac et al., 2011; Heath, Brown, Kobylarz & Castano, 2005; Tatara, 1998). Numerous national

studies have established that roughly one in ten Americans report having been a victim of at least one form of EM (Laumann, Leitsch & Waite, 2008; Acierno, et al., 2010; Amstadter & Cisler et al., 2011). It is important to note, however, that several researchers consider these reported cases to be only the tip of the iceberg (Rovi, Chen, Vega, Johnson, & Mouton, 2009), or in other words, the vast majority of elder mistreatment cases go unidentified and unreported.

These EM statistics are staggering in current numbers, much less when one considers the projected growth for this segment of the American population. The older sector of the American population has been steadily increasing over the past century, but, with the aging of the baby-boom generation (those individuals born in the years 1946 through 1964), America's elderly population, using 2010 as a baseline, is expected to double by 2030 (National Center for Health Statistics, 2010); therefore, by 2030, Americans older than 65 will represent 20 percent of the total U.S. population. Furthermore, after 2030, those 85 and older (a group exceptionally vulnerable to EM) will grow swiftly.

Purpose of Study

The purpose of this study was to assess the impact of the At-Risk Adult Crime Tactics (ACT) specialist training on the professionals who participated in the training. The Public Health Approach to Violence Prevention Theory identifies four necessary, sequential steps for addressing public health problems such as elder mistreatment: (1) monitor the problem; (2) identify risk and protective factors; (3) develop and test prevention strategies; and (4) assure widespread adoption (Centers for Disease Control and Prevention (CDC), 2008). The At-Risk Adult Crime Tactics (ACT) specialist training was an attempt to develop an EM prevention strategy, and this study's purpose was to determine whether the approach was effective.

Research Questions

1) Did knowledge level regarding at-risk adult abuse increase in respondents after ACT training?

Null Hypothesis: Knowledge level regarding at-risk adult abuse did not increase in respondents after ACT training.

Alternate Hypothesis: Knowledge level regarding at-risk adult abuse did increase in respondents after ACT training.

2) Did respondents increase their interagency collaboration after ACT training?

Null Hypothesis: Respondents did not increase their interagency collaboration after ACT training.

Alternate Hypothesis: Respondents did increase their interagency collaboration after ACT training.

3) According to the respondents, did the ACT training change the way they handled cases against at-risk adults?

Null Hypothesis: The ACT training did not change the way that respondents handled cases against at-risk adults.

Alternate Hypothesis: The ACT training did change the way that respondents handled cases against at-risk adults.

4) If the ACT training did change the way that respondents handled cases, were any of the demographic characteristics of respondents correlated with the change?

Null Hypothesis: None of the demographic characteristics of respondents were correlated with the change in the way that respondents handled cases against at-risk adults.

Alternate Hypothesis: All, some, or one of the demographic characteristics of respondents were correlated with the change in the way that respondents handled cases against at-risk adults.

5) Were the workshop topics helpful to respondents?

Null Hypothesis: None of the workshop topics were helpful to respondents.

Alternative Hypothesis: All, some or one of the workshop topics were helpful to respondents.

6) If a particular workshop topic was helpful to respondents, was the service area of respondents correlated with the level of helpfulness of the topic?

Null Hypothesis: The service area of respondents was not correlated with the level of helpfulness for any workshop topic.

Alternative Hypothesis: The service area of respondents was correlated with the level of helpfulness for one, some, or all of the workshop topics.

CHAPTER II

Review of the Literature

Violence

Violence as a Public Health Issue

Violence in the United States has not always been considered a public health problem. In fact, until relatively recently, the attention of the public health infrastructure had been focused mainly on the control and prevention of infectious diseases such as tuberculosis and pneumonia. With the advent of widely-distributed antibiotics in the 1940s, immunization campaigns, and widespread implementation of public health sanitary measures (e.g. clean drinking water and sewage control), mortality rates from infectious diseases decreased dramatically. Consequently, since 1965, death from violence has consistently been one of the top leading causes of mortality in the United States (Dahlberg & Mercy, 2009). Dahlberg and Mercy (2009) go on to conclude that the rise of homicide during the 1980s and 1990s to epidemic levels (e.g. a homicide rate increase of 154% for 15 to 19 year old males between the years of 1985 and 1991) and the growing recognition of behavior modification as a deterrent to public health problems also helped lead the way to the modern American perception of violence as a public health concern.

Types of Violence

More than 52,000 deaths in 2007 were attributed to violence; 18,000 of these fatalities

were victims of homicide (The CDC, 2012b). These losses are staggering, but when added to the other ramifications of violence (e.g. physical and emotional impairment of survivors and erosion of communities), the picture of violence as a public health epidemic becomes much clearer. Though any person, regardless of gender, race, age, religion, or income level is susceptible to violence, there are certain subgroups of the population that appear to be more vulnerable. This paper will address several specific types of violence and some of the subgroups that are most affected by it.

Intimate Partner Violence (IPV). Intimate Partner Violence is “a term...[that] describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.” (CDC, Intimate Partner Violence, 2012). Furthermore, Saltzman, Fanslow, McMahon & Shelley (2002) identified four prevalent types of IPV:

- Physical violence
- Sexual violence
- Threats of physical or sexual violence
- Psychological / emotional violence

Women, however, seem to suffer from IPV disproportionately from men. While one in ten men in the United States has experienced IPV, three in ten women have experienced it (*Understanding Intimate Partner Violence: Fact Sheet*, 2012). Furthermore, in 2007, IPV accounted for 2,340 deaths—70% of which were woman. Delving further, vulnerable female subgroups suffer IPV even more unduly. Chang, Berg, Saltzman and Herndon (2005) concluded that from 1991 to 1999, homicide was the second leading cause of pregnancy-associated injury death (i.e. death occurring during or within 1 year of pregnancy), with those women under age

20 being at the highest risk for pregnancy-associated homicide. Moreover, the study's authors found that pregnancy-related homicide rates were significantly higher (2 to 5 times) amongst women who did not receive prenatal care compared with women who did receive such care (Chang et al., 2005). This may suggest that low socio-economic status further contributes to the vulnerability of a pregnant woman, thus increasing her risk for IPV. Research demonstrating the effect of SES on women shows that women receiving federal aid were two to three times more likely to be victims of IPV in the past year when compared to the general population (Lown, Schmidt & Wiley, 2006).

Sexual Violence. Basile and Saltzman (2002) define sexual violence as a sexual act that is nonconsensual or perpetrated against at least one participant's will. They define the four types of sexual violence as:

- a completed sex act
- an attempted (but not completed) sex act
- abusive sexual contact
- non-contact sexual abuse

As with IPV, women as well as other vulnerable subgroups are more commonly victims of sexual violence. In one national survey, 10.6% of women compared with 2.1% of men admitted to experiencing rape in their lifetimes, and 2.5% of women had experienced some type of unwanted sexual activity in the previous year as compared with .9% of men (U.S. Department of Health and Human Services [DHHS], 2008). Moreover, a victim's age adds to sexual violence susceptibility, as children are much more likely to be victimized by sexual perpetrators. The majority sexual violence victims (60.4% of females and 69.2% of males) were victimized before reaching the age of majority (25.5% of females and 34.9% of males before the age of 12).

Adding to this, children with disabilities are at even higher risk for sexual violence. Alriksson-Schmidt et al. (2010) found that adolescent girls with a disability were twice as likely to have reported being raped as their non-disabled counterparts (19.6% and 9.4%, respectively).

Child Maltreatment. As mentioned previously, children are extremely vulnerable to violence. Leeb, Paulozzi, Melanson, Simon and Arias (2008) defined child maltreatment as “any act or series of acts of commission [physical abuse, sexual abuse, or psychological abuse] or omission [failure to provide (physical neglect, emotional neglect, medical/dental neglect, or educational neglect) or failure to supervise (inadequate supervision or exposure to violent environments)] by a parent or other caregiver that result in harm, potential for harm, or threat of harm to a child” (p. 11). *Child Maltreatment 2008* (2010) reported that nation-wide, approximately 3.3 million referrals were received by Child Protective Services (CPS). Of these, around 772,000 were determined to be victims of child abuse or neglect. Additionally, roughly 1,740 children died from child maltreatment. Remarkably, the younger, and thus, more vulnerable the child, the more susceptible they were to death from maltreatment (e.g. 80% of the 2008 deaths from child maltreatment were children younger than four).

Elder Maltreatment

Overview

Adults over 60 years of age in the United States are increasing in total percentage of the population and will continue to do so as each wave of the post-war, baby-boom generation enters older adulthood. These individuals are not only reaching older age in record numbers, but they are also living well past 60 in greater numbers than ever before. Though this increased life span is a glowing accomplishment for public health, unfortunately, it also opens the door for this large, relatively vulnerable group to become victims of abuse and exploitation. Therefore, though

elder mistreatment (EM) has undoubtedly been a public health problem for years, only recently has it been recognized as such. In fact, providing palpable proof as to the fresh appearance of elder mistreatment into the public health consciousness, the CDC has a disclaimer on its website regarding its definition of elder maltreatment: “The definitions presented on this page are preliminary and for descriptive purposes only. CDC and our partners are working to develop a document containing standardized definitions and recommended data elements for use in elder maltreatment surveillance.” (CDC, 2010) The CDC then proceeds to define elder maltreatment as abuse of any individual over 60 years of age by any perpetrator in which the victim had an expectation of trust.

Types of Elder Maltreatment

In 1998, *The National Elder Abuse Incidence Study* delineated seven types of elder maltreatment:

- Physical Abuse

The National Elder Abuse Incidence Study defined physical abuse as “the use of physical force that may result in bodily injury, physical pain, or impairment. Physical punishments of any kind [are] examples of physical abuse” (Tatara et al., 1998, p. 11). Examples include burning, hitting, slapping, scratching, and biting. The National Elder Mistreatment Study established that past-year prevalence of physical abuse was 1.6% in older adults (Acierno et al., 2010).

- Sexual Abuse

The National Elder Abuse Incidence Study defined sexual abuse as “non-consensual sexual contact of any kind with an elderly person” (Tatara et al., 1998, p. 11). The

National Elder Mistreatment Study found that of those elders sampled, .6% had suffered sexual maltreatment in the past year (Amstadter & Cisler et al., 2011).

- Emotional or Psychological Abuse

The National Elder Abuse Incidence Study defined this type of abuse “as the infliction of anguish, pain, or distress” (Tatara et al., 1998, p. 11). The National Elder Mistreatment Study found that 4.6% of elder adults had been the victims of emotional abuse within the past 12 months (Acierno et al., 2010). Beach et al. (2010) found a much higher rate of psychological mistreatment in a random telephone sample of 903 adults over the age of 60, illuminating a staggering prevalence rate (since turning 60) of 14.3%.

- Financial or Material Exploitation

The National Elder Abuse Incidence Study defined this abuse “as the refusal or failure to fulfill any part of a person’s obligations or duties to an elder” (Tatara et al., 1998, p. 12). The National Elder Mistreatment Study revealed a financial victimization rate of 5.2% in older adults by family members alone (Acierno et al., 2010). Beach et al. (2010) found even higher rates of financial exploitation, revealing a prevalence rate (since turning 60) of 9.7%.

- Abandonment

The National Elder Abuse Incidence Study defined abandonment “as the desertion of an elderly person by an individual who had physical custody or otherwise had assumed responsibility for providing care for an elder or by a person with physical custody of an elder” (Tatara et al., 1998, p.12).

- Neglect

The National Elder Abuse Incidence Study defined neglect “as the refusal or failure to fulfill any part of a person’s obligations or duties to an elder” (Tatara et al., 1998 p. 12).

In 1997, the Texas Department of Protective and Regulatory Services—Adult Protective Services Division (TDPRS-APS) received over 62,000 reports of elder mistreatment. Of these cases, 80% involved neglect of an elder (Pavlik, Hyman, Festa & Bitondo, 2001).

- Self-Neglect

The National Elder Abuse Incidence Study defined self-neglect “as the behaviors of an elderly person that threaten his/her own health or safety” (Tatara et al., 1998, p. 12).

Scope of the Problem

One of the first studies to demonstrate the scale of elder mistreatment in the United States, *The National Elder Abuse Incidence Study* found that in 1996, a total of 551,011 elderly Americans were victims of EM in domestic settings (Tatara et al., 1998). In another national study attesting to the breadth of EM, researchers conducted interviews on a random sample of elderly adults to determine prevalence estimates of EM. The authors found that of the 5,777 older adults, 11.4% had experienced at least one form of elder maltreatment during the past year alone (Acierno, et al., 2010). Consistent with these findings, Amstadter and Zajac et al. (2011) conducted a telephone interview study of 902 adults over 60 years of age residing in South Carolina and found that approximately 1 in 10 of these adults reported mistreatment within the past 12 months. Expounding further, Laumann, Leitsch and Waite (2008) found that 12.7% of their 3,005 participant study (ranging in age from 57 to 85) had experienced physical, verbal, or financial maltreatment.

Risk Factors

Risk factors regarding elder maltreatment in the literature seem to focus on the perpetrator rather than the victim; however there is some evidence in the research pointing to possible risk factors for victims of elder abuse.

Age. In *The National Elder Abuse Incidence Study* (1998), age played a major role in determining rates of elder maltreatment. Regarding neglect, only 2.3% of victims were between the ages of 60 and 64; whereas, more than half of the victims of neglect were 80 or older. The same holds true for physical abuse, emotional abuse, and financial exploitation, where the largest groups in all categories were 80 or older (43.7%, 41.3% and 48% respectively) (Tatara et al., 1998).

Income Level. Income level of the elder victim also took a large part in rates of elder maltreatment (Tatara et al., 1998). The largest portion of each maltreatment type (neglect, emotional/psychological abuse, physical abuse, financial exploitation and abandonment) earned incomes between \$5,000 and \$9,999 per year (66.8%, 37.8%, 49.5%, 46% and 96.1% respectively). There was no clear distinction in the higher income groups as the top bracket encompassed all income over \$15,000 per year.

Gender. *The National Elder Abuse Incidence Study* (1998) showed a clear dissimilarity in rates of neglect and emotional/psychological abuse between women and men (60% vs. 40% and 76.3% vs. 23.7% respectively) (Tatara et al., 1998). Additionally, the National Elder Mistreatment Study found that women suffer greater rates of sexual abuse than men (Amstadter & Cisler et al., 2011).

Race/Ethnicity. Though there has been limited research regarding the role race plays in victimization rates of older adults, two studies were found that highlight the possibility of race

contributing meaningfully to EM. Beach et al. (2010) found that prevalence rates of financial exploitation and psychological mistreatment were significantly higher for African Americans when compared to non-African American equivalents (23% vs. 8.4% and 24.4% vs. 13.2% respectively). In the South Carolina study by Amstadter and Zajac et al. (2011), minority participants had a significantly higher risk of suffering from elder maltreatment in the form of neglect than white interviewees.

Impairment Type and Health. The inability to care for one's self was a strong predictor of elder maltreatment (Tatara et al., 1998). Of all abuse cases reported in the study, 47.9% of the victims were unable to care for themselves and 28.7% were only somewhat able to care for themselves. Furthermore, Heath et al. (2005), in a retrospective cohort study of 211 Adult Protective Service (APS) clients, found that dementia was not only the most prevalent diagnosis but was also positively correlated with neglect and financial exploitation. In this same study, researchers also found that the urinary incontinence was strongly linked with neglect by a caregiver. In the South Carolina study mentioned previously, poor health status amongst older adults was correlated with several types of elder maltreatment (Amstadter & Zajac et al., 2011).

Violence Prevention Theory

Violence, in the form of elder maltreatment is a public health problem, and as such, it should be handled accordingly. The Public Health Approach to Violence Prevention Theory is a scientific, four-step progression that is employed to address widespread health problems that affect specific populations, such as elder maltreatment (CDC, 2008). The steps are detailed below.

The first step is to define and monitor the problem. Before prevention of a public health problem can be managed, it must first be defined. Elder maltreatment, in relative terms, has only

recently been defined, and a concrete, static definition of what constitutes this maltreatment is still forthcoming (e.g. the above-mentioned, CDC disclaimer regarding the definition of elder maltreatment). Many researchers, however, developed reliable definitions for common types of elder maltreatment. Through their various studies (surveys, police reports, Adult Services reports, examination of vital records, etc.), they endeavored to define the scope of this type of violence by “analyzing data such as the number of violence-related behaviors, injuries, and deaths [to] demonstrate how frequently violence occurs, where it is occurs, trends, and who the victims and perpetrators are” (CDC, 2008). Examples of such studies in the literature are well represented above under the sections: types of elder mistreatment and scope of the problem.

The second step is to identify risk and protective factors. Before steps can be taken to prevent a public health problem, a clear picture should be drawn to pinpoint where prevention efforts should be concentrated. The most effective way to make this determination is by studying the factors that provide protection or create risk for the victims. Examples of such studies in the literature are well represented above under the section: risk factors.

The third step is to develop and test prevention strategies. In order to design a successful, evidence-based, prevention program, data must be collected from various community sources (e.g. focus groups or community surveys). After development, of course, the prevention program must be evaluated thoroughly for efficacy. There are several references in the literature regarding prevention programs in the form of screenings for elder abuse in locations frequented by older adults. Fulmer et al., (2012) screened older adults for elder mistreatment in dental and medical clinics. They found that the adults were willing to donate their time and answer very personal questions regarding EM in their lives. Another article assessed most of the current EM screening and assessment instruments in use by healthcare professionals (Fulmer, Guadagno, Dyer &

Connolly, 2004). The authors found no form of consensus on what constitutes an appropriate screening or assessment instrument, creating a lack of efficacy in this strategy for identifying and preventing Elder Maltreatment.

The fourth step is to assure widespread adoption. Once a prevention strategy demonstrates well-researched and documented success, it is ready for widespread distribution and adoption. Effective means of distribution include training, networking, technical assistance, and evaluation.

At-Risk Adult Crime Tactics (ACT) Certification Training

The inability of healthcare providers and other front line professionals to recognize and report elder maltreatment is recognized in the literature. Rovi et al. (2009) stated that training of healthcare professionals to better recognize EM is needed to improve our nation's response to the problem. Furthermore, the authors reiterated a well-known analogy comparing reported EM cases to the tip of an iceberg. Adding to this, Halphen, Varas and Sadowsky (2009) acknowledged that most cases of elder abuse are not identified or reported by clinicians mainly due to their lack of education and comfort on the topic.

The At-Risk Adult Crime Tactics (ACT) Certification Training is an at-risk, adult (elderly or disabled adults) prevention program designed to increase professional awareness of this population and equip primary and secondary responders (all mandated reporters) with the knowledge and skills to address the needs of Georgia's at-risk adult crime victims. Through the ACT certification series, workers in public safety, criminal justice, social services, healthcare and related fields will learn to more easily recognize and report signs of abuse against at-risk adults, understand roles and responsibilities of involved agencies, collaborate effectively with other professionals, utilize a standardized approach for first-responders, identify resources for

professionals and potential victims, increase the number of prosecutions of offenders, and strengthen prevention techniques. Once certified, these professionals will form a new statewide ACT Specialist team to promote community awareness, share crime trends to alert communities, and stay informed of additional training.

This ACT Certification Training is being rolled out by the DHS Division of Aging Services in collaboration with the Administrative Office of the Courts of Georgia, the Georgia Association of Chiefs of Police, the Georgia Bureau of Investigation, the Georgia Peace Officer Standards and Training Council, the Georgia Public Safety Training Center, the Georgia Sheriff's Association, and the Prosecuting Attorneys Council of Georgia. It is hoped that this partnership will facilitate interagency communication and cooperation more efficiently and effectively in order to protect Georgia's most at-risk adults.

CHAPTER III

Methodology

Survey

Overview

The purpose of this research was to assess the impact of the DHS Division of Aging Services' At-Risk Adult Crime Tactics (ACT) Certification Training on the professionals who participated in the training. An invitation was emailed to 482 individuals who had previously completed the ACT Certification Training, inviting them to complete an (approximately) 20 minute, 41-question, online survey. The request was resent two times for a total of three invitations. The survey's introduction, which had a Flesch-Kincaid reading level of 10.7, explained that participation was both anonymous and voluntary. The reading level for the remainder of the survey was 8.7. Documented consent for the survey was not necessary as passive consent was given when the participant clicked that they wished to proceed with the survey. None of the survey questions contained identifiable information, and only the primary investigator had access to the editable survey forms. Furthermore, data from this survey were stored on Georgia State University's firewall protected, multi-tiered, password-accessible computer system.

The survey sought to collect data regarding the effectiveness of ACT training in relation to increased knowledge, increased interagency collaboration, change in case management of at-risk adults, and usefulness of workshop topics. The survey also collected information on seven demographic indicators.

Measures

The survey consisted of 41 questions; the first of which asked if the participant was willing to volunteer for research purposes. The following sections detail the remaining survey questions.

Level of Knowledge. The first section sought to determine the participant's change in average level of knowledge on nine topics related to at-risk adult abuse. For each topic, the participant was asked to select both a pre and post ACT training average level of knowledge. The knowledge level was assessed on a four-level, Likert scale (1 = almost no knowledge, 2 = a little knowledge, 3 = some knowledge, 4 = a lot of knowledge).

Frequency of Contact. The next section (questions 11 through 20) focused on defining the participant's change in interagency collaboration behavior. For each of ten agencies, the participant was asked to select both a pre and post ACT training frequency of contact level. The frequency of contact was assessed on a four-level, Likert scale (1 = never, 2 = seldom, 3 = weekly, 4 = daily).

Change in Handling Cases. The next two questions (21 and 22) dealt with possible changes in the manner in which the participant had handled cases dealing with at-risk adults since completing the ACT training. Question 21 was assessed on a four-level, Likert scale (1 = has not changed the way I work, 2 = has changed the way I work a little, 3 = has changed the

way I work a lot, 4 = has completely changed the way I work). Question 22 was an open-ended question asking for a description of this change.

Workshop Topic Helpfulness. The next portion of the survey (questions 23 through 33) collected data regarding the helpfulness of eleven, ACT training, workshop topics in the participant's professional life. The topics were assessed on a four-level, Likert scale (1 = not helpful, 2 = a little helpful, 3 = very helpful, 4 = extremely helpful). Question 34 was the second open-ended one of this survey. It asked the participant to discuss any past cases to which the information learned in the ACT training could have been applied.

Demographics. The last section of the survey collected demographic information on the participants. Gender, race, age, and educational level were collected. Also included in this section were the participant's service area (urban, suburban or rural), employment agency, and how many years they had been working with their current agency.

Analysis

The Predictive Analytics Software Statistics 18 (PASW Statistics 18) was used for analyzing the survey data.

Research Question 1

In order to answer the first research question (Did knowledge level regarding at-risk adult abuse increase in respondents after ACT training?), a dependent samples t-test was run on the pre and post, level of knowledge means for each of the nine categories to determine if the scores were significantly different. If the p-values for one or more of the paired samples are less than .05, the null hypothesis is rejected for those paired samples.

Research Question 2

In order to answer the second research question (Did respondents increase their interagency collaboration after ACT training?), a dependent samples t-test was run on the pre and post, frequency of contact means of each of the ten agencies to determine if the scores were significantly different. If the p-values for one or more of the paired samples are less than .05, the null hypothesis is rejected for those paired samples.

Research Question 3

In order to answer the third research question (According to the respondents, did the ACT training change the way they handled cases against at-risk adults?), a one-sample t-test was run on the respondents' reported extent of change in the way they handled cases against at-risk adults after ACT training. If the p-value is less than .05, the null hypothesis is rejected.

Research Question 4

In order to answer the fourth research question (If the ACT training did change the way that respondents handled cases, were any of the demographic characteristics of respondents correlated with the change?), a correlation was conducted on the relationship between respondents' reported extent of change and the seven demographic indicators. If the p-value is less than .05 for any of these correlations, the null hypothesis is rejected for that correlation.

Research Question 5

In order to answer the fifth research question (Were the workshop topics helpful to respondents?), a one-sample t-test was run on the respondents' reported levels of helpfulness for each of the eleven, ACT training workshop topics. If the p-value is less than .05 for any topic, the null hypothesis is rejected for that topic.

Research Question 6

In order to answer the sixth research question (If the workshop topics were helpful to respondents, was the service area of respondents correlated with the level of helpfulness of the topic?), a correlation was conducted on the relationship between the respondents' reported levels of helpfulness on each ACT training workshop topic and the demographic indicator, service area. If the p-value is less than .05 for this indicator and any of the workshop topics, the null hypothesis is rejected for that correlation.

CHAPTER IV

Results

This chapter details the results of the statistical analyses conducted to answer the research questions.

Restatement of Purpose

The purpose of this study was to assess the impact of the DHS Division of Aging Services' At-Risk Adult Crime Tactics (ACT) Certification Training on the professionals who participated in the training.

Study Demographics

The survey was sent to 482 ACT certified professionals. Of these 482 invitations, there were 223 survey responses. Of these 223, however, due to blank survey results on 47 survey submissions, 176 surveys were used for the purposes of this research. As shown in Figure 1, the gender demographic of survey respondents consisted heavily of women, with 52 males and 124 females (29.5% and 70.5%, respectively). Furthermore, Figure 2 shows the age percentage breakdown of respondents by gender. Totals for age were 37 under 22 years of age, 33 between the ages of 23 and 29, 62 between the ages of 30 and 39, and 40 over 40 years of age (21.5%, 19.2%, 36%, and 23.3%, respectively).

Figure 1 Gender Demographic

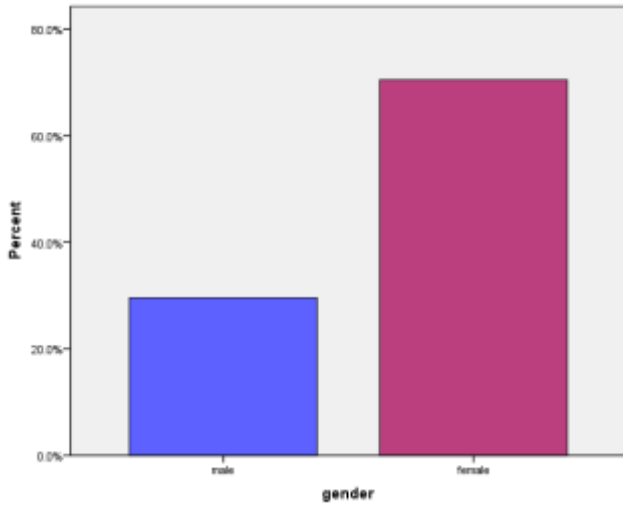
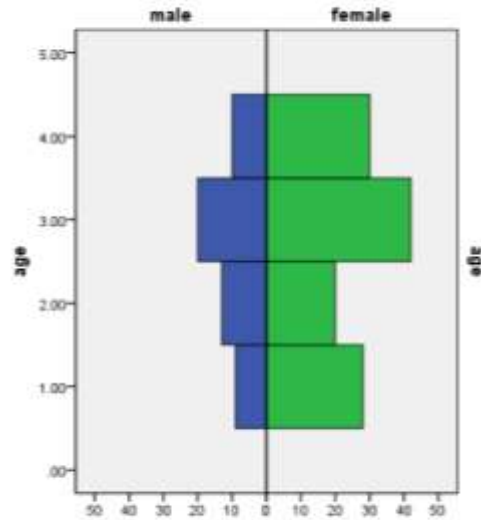


Figure 2 Ages by Gender Demographic



Race percentages were determined to be 24.7% African American, 71.8% Caucasian, .6% Asian, and 2.9% other (Figure 3 below). The percentages regarding identified service areas of the respondents were fairly well distributed with 38.4% serving urban areas, 33.7% serving suburban areas, and 27.9% servicing rural areas (Figure 4 below).

Figure 3 Race Demographic

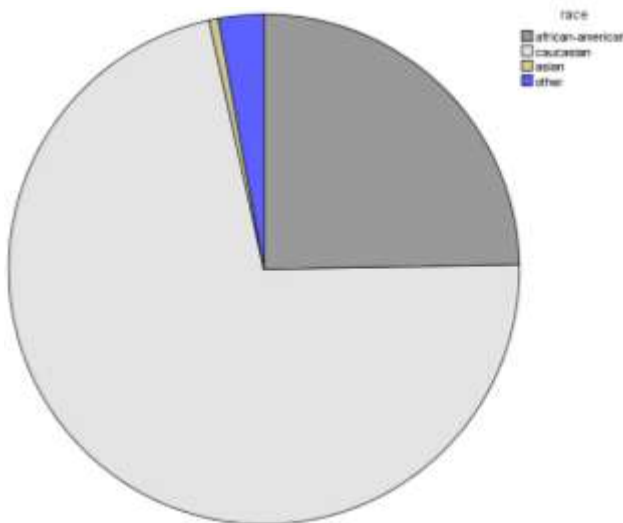
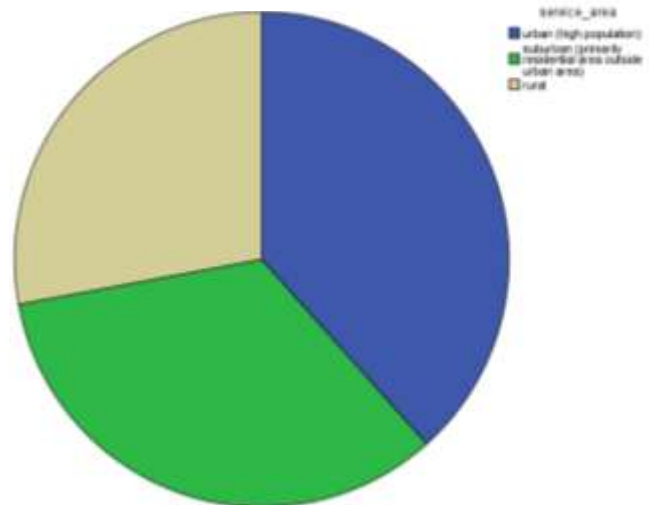


Figure 4 Service Areas



The respondents were a well-educated group with 76.2%, of those that included education level, indicating that they had at least a four-year college degree (7.4% high school graduation or equivalent, 9.1% some college, 5.1% 2-year college degree, 41.5% 4-year college degree, 34.7% graduate or professional degree, and 2.3% no response). Regarding professions of respondents, over 51% were working in law enforcement or with Adult Protective Services (28.3% law enforcement, 23.1% APS, 8.1% HFR, 6.9% LTCO, 5.2% prosecution, .6% criminal justice, 6.4% DBHDD, 1.2% EMS/fire, 4% AAA/ADRC, and 16.2% other). Lastly, there was a fairly even split between those respondents who had been in their current positions long term (47.4% with more than 10 years) and short term (52.6% with 10 or less years).

Pre and Post ACT Training Level of Knowledge

This study's alternative hypothesis regarding research question one stated that knowledge level regarding at-risk adult abuse did increase in respondents after ACT training. A dependent *t*-test was conducted on the respondents' self-identified level of knowledge on nine ACT training categories before they received ACT training and their self-identified level of knowledge on the same nine ACT training categories after they received ACT training to determine whether difference of means of the two scores for each ACT training category were significantly different, with alpha set at .05. There was a significant difference on the before ACT training, collaboration category level of knowledge scores ($M = 2.70, SD = 0.97$) and the after ACT training, collaboration category level of knowledge scores ($M = 3.72, SD = 0.53$), $t(173) = -13.307, p < .001$. There was a significant difference on the before ACT training, GA laws category level of knowledge scores ($M = 2.62, SD = 0.95$) and the after ACT training, GA laws category level of knowledge scores ($M = 3.72, SD = 0.51$), $t(173) = -15.481, p < .001$. There was a significant difference on the before ACT training, evidence category level of knowledge

scores ($M = 2.72$, $SD = 0.98$) and the after ACT training, evidence category level of knowledge scores ($M = 3.63$, $SD = 0.65$), $t(173) = -12.545$, $p < .001$. There was a significant difference on the before ACT training, photographing category level of knowledge scores ($M = 2.57$, $SD = 1.06$) and the after ACT training, photographing category level of knowledge scores ($M = 3.46$, $SD = 0.72$), $t(172) = -11.172$, $p < .001$. There was a significant difference on the before ACT training, reporting laws category level of knowledge scores ($M = 3.03$, $SD = 1.04$) and the after ACT training, reporting laws category level of knowledge scores ($M = 3.74$, $SD = 0.53$), $t(173) = -9.917$, $p < .001$. There was a significant difference on the before ACT training, perpetrators category level of knowledge scores ($M = 2.74$, $SD = 1.06$) and the after ACT training, perpetrators category level of knowledge scores ($M = 3.45$, $SD = 0.74$), $t(173) = -9.461$, $p < .001$. There was a significant difference on the before ACT training, disability category level of knowledge scores ($M = 2.72$, $SD = 0.99$) and the after ACT training, disability category level of knowledge scores ($M = 3.45$, $SD = 0.68$), $t(172) = -11.182$, $p < .001$. There was a significant difference on the before ACT training, cognitive impairment category level of knowledge scores ($M = 2.63$, $SD = 1.01$) and the after ACT training, cognitive impairment category level of knowledge scores ($M = 3.33$, $SD = 0.74$), $t(173) = -10.993$, $p < .001$. There was a significant difference on the before ACT training, resources category level of knowledge scores ($M = 2.52$, $SD = 0.96$) and the after ACT training, resources category level of knowledge scores ($M = 3.44$, $SD = 0.63$), $t(173) = -12.935$, $p < .001$.

Results indicate that the after ACT training level of knowledge scores in all nine categories were significantly higher than the before ACT training level of knowledge scores; thus, the alternative hypothesis for research question one was supported. The mean scores and

the paired differences for the level of knowledge categories are detailed below in Tables 1 and 2, respectively.

Table 1

Mean Scores on Average Level of Knowledge					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Collaboration (before)	2.7011	174	.96906	.07346
	Collaboration (after)	3.7241	174	.53089	.04025
Pair 2	Laws (before)	2.6207	174	.95253	.07221
	Laws (after)	3.7184	174	.51115	.03875
Pair 3	Evidence (before)	2.7184	174	.98310	.07453
	Evidence (after)	3.6322	174	.64718	.04906
Pair 4	Photographing (before)	2.5723	173	1.06298	.08082
	Photographing (after)	3.4624	173	.71936	.05469
Pair 5	Reporting laws (before)	3.0345	174	1.04188	.07898
	Reporting laws (after)	3.7356	174	.52586	.03987
Pair 6	Perpetrators (before)	2.7414	174	1.05721	.08015
	Perpetrators (after)	3.4483	174	.74117	.05619
Pair 7	Disability (before)	2.7168	173	.99160	.07539
	Disability (after)	3.4451	173	.67655	.05144
Pair 8	Cognitive impair (before)	2.6322	174	1.00995	.07656
	Cognitive impair (after)	3.3333	174	.73973	.05608
Pair 9	Resources (before)	2.5172	174	.96003	.07278
	Resources (after)	3.4425	174	.63120	.04785

Table 2

Paired Average Level of Knowledge Differences of Means									
		Mean	Std. Deviation	Std Error Mean	95% Confidence Interval		t	df	Sig (2-tailed)
					Lower	Upper			
Pair 1	Collaboration	-1.02299	1.01409	.07688	-1.17473	-.87125	-13.307	173	.000
Pair 2	Laws	-1.09770	.93530	.07091	-1.23765	-.95775	-15.481	173	.000
Pair 3	Evidence	-.91379	.96081	.07284	-1.05756	-.77003	-12.545	173	.000
Pair 4	Photographing	-.89017	1.04801	.07968	-1.04745	-.73290	-11.172	172	.000
Pair 5	Reporting laws	-.70115	.93258	.07070	-.84069	-.56161	-9.917	173	.000
Pair 6	Perpetrators	-.70690	.98559	.07472	-.85437	-.55942	-9.461	173	.000
Pair 7	Disability	-.72832	.85668	.06513	-.85689	-.59976	-11.182	172	.000
Pair 8	Cognitive imp	-.70115	.84134	.06378	-.82704	-.57526	-10.993	173	.000
Pair 9	Resources	-.92529	.94358	.07153	-1.06648	-.78410	-12.935	173	.000

Pre and Post ACT Training Frequency of Contact

This study's alternative hypothesis regarding research question two stated that respondents did increase their interagency collaboration after ACT training. A dependent *t*-test was conducted on the respondents' self-identified frequency of contact with ten agencies before they received ACT training and their self-identified frequency of contact with the same ten agencies after they received ACT training to determine whether difference of means of the two scores for each agency were significantly different, with alpha set at .05. There was a significant difference on the before ACT training, frequency of contact with the healthcare facility regulation agency scores ($M = 1.95, SD = 0.90$) and the after ACT training, frequency of contact with the healthcare facility regulation agency scores ($M = 2.09, SD = 0.85$), $t(174) = -4.312, p < .001$. There was a significant difference on the before ACT training, frequency of contact with the law enforcement agency scores ($M = 2.43, SD = 1.02$) and the after ACT training, frequency of contact with the law enforcement agency scores ($M = 2.50, SD = 1.00$), $t(170) = -2.898, p = .004$. There was a significant difference on the before ACT training, frequency of contact with the district attorney agency scores ($M = 1.84, SD = 0.95$) and the after ACT training, frequency of contact with the district attorney agency scores ($M = 1.95, SD = 0.99$), $t(171) = -3.408, p = .001$. There was a significant difference on the before ACT training, frequency of contact with the Adult Protective Services agency scores ($M = 2.32, SD = 1.09$) and the after ACT training, frequency of contact with the Adult Protective Services agency scores ($M = 2.51, SD = 1.01$), $t(171) = -4.423, p < .001$. There was a significant difference on the before ACT training, frequency of contact with the paramedic agency scores ($M = 1.67, SD = 0.73$) and the after ACT training, frequency of contact with the paramedic agency scores ($M = 1.74, SD = 0.78$), $t(171) = -2.564, p = .011$. There was a significant difference on the before ACT training, frequency of

contact with the code enforcement agency scores ($M = 1.53, SD = 0.66$) and the after ACT training, frequency of contact with the code enforcement agency scores ($M = 1.61, SD = 0.69$), $t(168) = -3.058, p = .003$. There was a significant difference on the before ACT training, frequency of contact with the Social Security agency scores ($M = 1.68, SD = 0.68$) and the after ACT training, frequency of contact with the Social Security agency scores ($M = 1.77, SD = 0.72$), $t(170) = -2.745, p = .007$. There was a significant difference on the before ACT training, frequency of contact with the DBHDD agency scores ($M = 1.85, SD = 0.91$) and the after ACT training, frequency of contact with the DBHDD agency scores ($M = 2.01, SD = 0.91$), $t(169) = -4.443, p < .001$. There was a significant difference on the before ACT training, frequency of contact with the local resources agency scores ($M = 2.06, SD = 0.89$) and the after ACT training, frequency of contact with the local resources agency scores ($M = 2.17, SD = 0.85$), $t(172) = -2.962, p = .003$. There was a significant difference on the before ACT training, frequency of contact with the elderly law attorney agency scores ($M = 1.39, SD = 0.61$) and the after ACT training, frequency of contact with the elderly law attorney agency scores ($M = 1.52, SD = 0.69$), $t(171) = -4.340, p < .001$.

Results indicate that the after ACT training frequency of contact scores for all ten agencies were significantly higher than the before ACT training frequency of contact scores; therefore, the alternative hypothesis for research question two was supported. The mean scores and the paired differences for the frequency of contact with each agency are detailed below in Tables 3 and 4, respectively.

Table 3

Mean Scores on Frequency of Contact					
		Mean	N	Std. Deviation	Std. Err. Mean
Pair 1	Facility regs (before)	1.9486	175	.89871	.06794
	Facility regs (after)	2.0914	175	.85277	.06446
Pair 2	Law enforce (before)	2.4269	171	1.01702	.07777
	Law enforce (after)	2.5029	171	1.00220	.07664
Pair 3	Dist attorney (before)	1.8372	172	.95342	.07270
	Dist attorney (after)	1.9477	172	.98684	.07525
Pair 4	APS (before)	2.3198	172	1.08529	.08275
	APS (after)	2.5058	172	1.01161	.07713
Pair 5	Paramedics (before)	1.6744	172	.73257	.05586
	Paramedics (after)	1.7384	172	.78445	.05981
Pair 6	Code enforce (before)	1.5266	169	.65525	.05040
	Code enforce (after)	1.6095	169	.69103	.05316
Pair 7	Social secure (before)	1.6784	171	.68303	.05223
	Social secure (after)	1.7661	171	.72210	.05522
Pair 8	DBHDD (before)	1.8471	170	.91024	.06981
	DBHDD (after)	2.0059	170	.91339	.07005
Pair 9	Local resource(before)	2.0636	173	.89019	.06768
	Local resource (after)	2.1734	173	.85180	.06476
Pair 10	Eld law attorn (before)	1.3895	172	.60650	.04625
	Eld law attorn (after)	1.5233	172	.68785	.05245

Table 4

Paired FOC Differences of Means									
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig (2-tailed)
					Lower	Upper			
Pair 1	Facility regulations	-.14286	.43831	.03313	-.20825	-.07746	-4.312	174	.000
Pair 2	Law enforce	-.07602	.34310	.02624	-.12782	-.02423	-2.898	170	.004
Pair 3	District attorney	-.11047	.42510	.03241	-.17445	-.04648	-3.408	171	.001
Pair 4	APS	-.18605	.55169	.04207	-.26908	-.10301	-4.423	171	.000
Pair 5	Paramedics	-.06395	.32710	.02494	-.11319	-.01472	-2.564	171	.011
Pair 6	Code enforcement	-.08284	.35221	.02709	-.13633	-.02935	-3.058	168	.003
Pair 7	Social Security	-.08772	.41787	.03196	-.15080	-.02464	-2.745	170	.007
Pair 8	DBHDD	-.15882	.46608	.03575	-.22939	-.08826	-4.443	169	.000
Pair 9	Local resources	-.10983	.48772	.03708	-.18302	-.03664	-2.962	172	.003
Pair 10	Elder law attorney	-.13372	.40410	.03081	-.19454	-.07290	-4.340	171	.000

Extent of Change in Handling Cases against At-Risk Adults

This study's alternative hypothesis for research question three stated that the ACT training did change the way that respondents handled cases against at-risk adults. A one sample t-test was conducted on the mean score of respondents' self-reported extent of change in the way they handle cases dealing with at-risk adults since participating in ACT training. This average extent of change was measured on a 4-level, Likert scale with '1' meaning 'no change' and '4' meaning 'complete change.' This mean score of their extent of change was measured against the population mean of 1 (no change).

The average extent of respondents' change after ACT training ($M = 2.49, SD = 0.823$) was significantly different than the population mean ($\mu = 1$), $t(174) = 23.895, p < .001$, two-tailed, thus lending support to research question three's alternative hypothesis. The mean for average extent of change and the sample t-test results are detailed below in Tables 5 and 6, respectively.

Table 5

Mean Extent of Change				
	N	Mean	Std. Deviation	Std. Error Mean
Extent of Change	175	2.4857	.82251	.06218

Table 6

One-Sample t-Test on Extent of Change						
	Test Value = 1 (has not changed the way I work)					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
Lower					Upper	
Extent of Change	23.895	174	.000	1.48571	1.3630	1.6084

Extent of Change and Demographics Correlations

This study's alternative hypothesis for research question four stated that all, some, or one of the demographic characteristics of respondents were correlated with the change in the way that respondents handled cases against at-risk adults. Since the mean score of respondents' self-reported extent of change was significantly different than the population mean, a correlation analysis was conducted to examine the relationship between this average extent of change and the seven demographic indicators. With alpha set at .05, there was a significant negative relationship between the average extent of respondents' change and education level, $r(173) = -0.173, p = .022$. Furthermore, with alpha set at .05, there was also a significant negative relationship between the average extent of respondents' change and age, $r(169) = -0.160, p = .037$. This result demonstrates support for the alternative hypothesis of research question four. The remaining five demographic indicators (service area, position, gender, race, and years in current position) did not demonstrate a significant relationship with extent of change (see Table 7 below).

Table 7

Correlation Between Extent of Change and Demographic Indicators								
		service area	position	gender	race	education	years in position	age
Extent of Change	Pearson Correlation	.000	-.114	-.042	.000	-.173	-.003	-.160
	Sig. (2-tailed)	.995	.136	.583	.999	.022	.973	.037
	N	171	172	175	173	175	174	171

This study's alternative hypothesis for research question five was that all, some or one of the workshop topics were helpful to respondents. A one sample t-test was conducted on the mean score, regarding the respondents' reported level of helpfulness, for each ACT workshop

topic. This average level of helpfulness was measured on a 4-level, Likert scale with '1' meaning 'not helpful' and '4' meaning 'extremely helpful.' This mean score of the topics' level of helpfulness was measured against the population mean of 1 (not helpful).

The average level of helpfulness for the Georgia law topic ($M = 3.23$, $SD = 0.667$) was significantly different than the population mean ($\mu = 1$), $t(174) = 44.318$, $p < .001$, two-tailed. The average level of helpfulness for the financial exploitation topic ($M = 3.33$, $SD = 0.713$) was significantly different than the population mean ($\mu = 1$), $t(174) = 43.156$, $p < .001$, two-tailed. The average level of helpfulness for the suspicious deaths topic ($M = 3.05$, $SD = 0.843$) was significantly different than the population mean ($\mu = 1$), $t(174) = 32.105$, $p < .001$, two-tailed. The average level of helpfulness for the crimes in facilities topic ($M = 2.99$, $SD = 0.851$) was significantly different than the population mean ($\mu = 1$), $t(174) = 30.916$, $p < .001$, two-tailed. The average level of helpfulness for the indicators of abuse, neglect and exploitation topic ($M = 3.29$, $SD = 0.774$) was significantly different than the population mean ($\mu = 1$), $t(174) = 39.183$, $p < .001$, two-tailed. The average level of helpfulness for the collaborating agencies topic ($M = 3.18$, $SD = 0.788$) was significantly different than the population mean ($\mu = 1$), $t(174) = 36.628$, $p < .001$, two-tailed. The average level of helpfulness for the community resources topic ($M = 3.07$, $SD = 0.781$) was significantly different than the population mean ($\mu = 1$), $t(174) = 35.151$, $p < .001$, two-tailed. The average level of helpfulness for the investigative practices topic ($M = 3.13$, $SD = 0.823$) was significantly different than the population mean ($\mu = 1$), $t(174) = 34.243$, $p < .001$, two-tailed. The average level of helpfulness for the normal aging topic ($M = 2.84$, $SD = 0.870$) was significantly different than the population mean ($\mu = 1$), $t(173) = 27.985$, $p < .001$, two-tailed. The average level of helpfulness for the communicating with individuals with disabilities topic ($M = 2.89$, $SD = 0.841$) was significantly different than the population mean (μ

= 1), $t(174) = 29.767, p < .001$, two-tailed. The average level of helpfulness for the prosecuting cases topic ($M = 2.86, SD = 0.1.01$) was significantly different than the population mean ($\mu = 1$), $t(174) = 24.316, p < .001$, two-tailed.

Results indicate that the average level of helpfulness for each of the eleven ACT workshop topics was significantly higher than the expected population mean of ‘1’ (not helpful). These results support the alternative hypothesis for research question five. Each topic’s mean level of helpfulness and the sample t-test results are detailed below in Tables 8 and 9, respectively.

Table 8

Means for ACT Training Topics’ Levels of Helpfulness				
	N	Mean	Std. Deviation	Std. Error Mean
Georgia Law	175	3.2343	.66693	.05042
Financial Exploitation	175	3.3257	.71291	.05389
Suspicious Deaths	175	3.0457	.84294	.06372
Crimes in Facilities	175	2.9886	.85089	.06432
Indicators of Abuse	175	3.2914	.77362	.05848
Collaborating Agencies	175	3.1829	.78838	.05960
Community Resources	175	3.0743	.78064	.05901
Investigative Practices	175	3.1314	.82343	.06225
Normal Aging	174	2.8448	.86956	.06592
Communicating Ind w/ Dis	175	2.8914	.84056	.06354
Prosecuting Cases	175	2.8629	1.01344	.07661

Table 9

One Sample t-Test on Levels of Helpfulness						
	Test Value = 1 (not helpful)					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Georgia Law	44.318	174	.000	2.23429	2.1348	2.3338
Financial Exploitation	43.156	174	.000	2.32571	2.2193	2.4321
Suspicious Deaths	32.105	174	.000	2.04571	1.9200	2.1715
Crimes in Facilities	30.916	174	.000	1.98857	1.8616	2.1155
Indicators of Abuse	39.183	174	.000	2.29143	2.1760	2.4069
Collaborating Agencies	36.628	174	.000	2.18286	2.0652	2.3005
Community Resources	35.151	174	.000	2.07429	1.9578	2.1908
Investigative Practices	34.243	174	.000	2.13143	2.0086	2.2543
Normal Aging	27.985	173	.000	1.84483	1.7147	1.9749
Communicating Ind w/ Dis	29.767	174	.000	1.89143	1.7660	2.0168
Prosecuting Cases	24.316	174	.000	1.86286	1.7117	2.0141

ACT Topic Level of Helpfulness and Service Area Correlations

This study’s alternative hypothesis for research question six is that the service area of respondents was correlated with the level of helpfulness for one, some, or all of the workshop topics. Since the mean score, regarding the respondents’ reported level of helpfulness, for each ACT workshop topic was significantly different from the population mean, a correlation analysis was conducted to examine the relationship between these levels of helpfulness for each topic and the demographic indicator, service area. With alpha set at .05, there was a significant positive relationship between the reported level of helpfulness on the community resources topic and service area, $r(170) = .159, p = .037$, lending support to the alternative hypothesis for research question six.

Table 10

Correlation Between Level of Helpfulness of Community Resources & Service Area or Position				
		comm. resources	service area	position
Community Resources	Pearson Correlation	1	.159	.035
	Sig. (2-tailed)		.037	.645
	N	175	172	172

CHAPTER V

Discussion

This study, in accordance with the third step of the Public Health Approach to Violence Prevention Theory, strived to determine the impacts of the At-Risk Adult Crime Tactics (ACT) Certification Training on various professionals who participated in the training. The survey yielded interesting findings.

Summary of the Study

The first research question sought to determine if knowledge level regarding at-risk adult abuse increased in respondents after ACT training. The data revealed that the knowledge level of respondents did indeed increase for all nine ACT training categories regarding at-risk adult abuse (communicating with collaborative agencies in abuse situations, Georgia laws and legal options related to abuse, gathering evidence in abuse cases, photographing locations and individuals, information about mandatory reporting laws, interviewing possible perpetrators, working with individuals with intellectual disability, interviewing individuals with cognitive impairment, and availability of local resources). In fact, though for this study's criteria, alpha was set at .05, the differences in pre and post ACT training, level of knowledge means for all nine training categories were actually significant with alpha set at less than .01, suggesting an

extremely strong improvement in knowledge levels. In other words, respondents felt that ACT training had substantially improved their working knowledge of at-risk adult abuse.

Similarly, the second research question wanted to pursue if ACT training had affected respondents, however, this time the query regarded job performance after ACT training. This question sought to determine if respondents increased their interagency collaboration after ACT training. This increase was determined by how often respondents recounted contacting various agencies both before and after ACT training. The data revealed that respondents did indeed increase their interagency collaboration with all ten agencies (healthcare facility regulation, law enforcement, district attorneys, APS (Adult Protective Services), paramedics, code enforcement, Social Security, DBHDD (Department of Behavioral Health and Developmental Disabilities), local resources, and elder law attorneys). Similarly to results for the first research question, though alpha was set at .05 for this study's purposes, the differences in pre and post ACT, frequency of contact means for nine out of ten agencies (paramedics was $p = .011$) were significant with alpha set at less than .01, signifying a particularly robust increase in interagency collaboration amongst respondents. In other words, respondents felt that ACT training had greatly improved their interagency collaboration practices.

Correspondingly to question two, research question three also sought to differentiate between respondents' job performance before and after ACT training. This question asked if ACT training had changed the way in which respondents handled cases against at-risk adults. This change was determined by the respondents' self-reported extent of change since completing ACT training. The data suggested that after ACT training, respondents had significantly changed the way in which they handled cases against at-risk adults. As with results from the previous two research questions, data yielded significant results in extent of change with alpha set at less than

.01. Thus, respondents indicated that ACT training had meaningfully changed their job performance in handling cases against at-risk adults.

Research question 4 sought to determine if the significant finding regarding respondents' extent of change in the way they handled cases against at-risk adults was correlated with any of the survey's seven demographic indicators (service area, position, gender, race, education, years in position, and age). Data indicated a negative correlation with two of these seven demographic indicators: education and age. As the age of respondents increased, the extent of change in the way they handled cases against at-risk adults after ACT training decreased. Likewise, as the education level of respondents increased, the extent of change in the way they handled cases against at-risk adults after ACT training decreased. Simply put, ACT training appeared to have less of an influence on a respondent's extent of change if that respondent was older or more educated. It is important to note that respondents' position was also strongly related to their extent of change, though not significantly. This is probably due to the robust correlation between education of respondents and their position.

For the fifth research question, data were analyzed to find if workshop topics were helpful to respondents as determined by respondents' self-reported, level of helpfulness for each of the 11 ACT training, workshop topics (Georgia law, financial exploitation, suspicious deaths, crimes in facilities, indicators of abuse, collaborating agencies, community resources, investigative practices, normal aging, communicating with individuals with disability, and prosecuting cases). The data revealed that the level of helpfulness for each of these workshops was significant. Furthermore, once again, though alpha was set at .05 for this study, level of helpfulness results for every workshop topic were significant with alpha set at less than .01. In a

word, respondents felt that every one of the ACT training, workshop topics were very helpful to them in their professional lives.

For the last research question, data were analyzed to determine if the significant findings regarding level of helpfulness for each of the ACT training, workshop topics were correlated with the demographic indicator, service area. Data indicated only one significant finding: a positive correlation between the reported level of helpfulness of the community resources topic and service area. As the service area of the respondents became less populated, their reported level of helpfulness for the community resources topic increased. In other words, respondents in more rural service areas appeared to have derived a greater, perceived benefit from this community resources topic than their counterparts in more urban areas. This could be due to the fact that community resources are more readily available in densely populated areas; whereas, less populated, rural areas tend to have fewer, less prominent, and less funded resources in their communities. Consequently, this ACT topic may be of greatest benefit to professionals dealing with at-risk adults in rural communities.

It is important to note that all survey indicators regarding the need for increased training of the various professionals (increased level of knowledge, increased interagency collaboration, change in the way that cases against at-risk adults were handled, and the helpfulness of all of the workshop topics) corroborate previous research studies calling for improved, targeted educational efforts in professions closely associated with EM: Strasser et. al (2011) documented this need in APS workers in Georgia, and Strasser, Payne & King (2010) also detailed this need in Georgia coroners.

Study Limitations

Though the results of this survey appear to cast a positive light on the possible positive impacts of ACT training for professionals who deal with at-risk adult issues, there are limitations to this study that should be noted. The following section will address these limitations.

One limitation of this study is that the results are only preliminary. This survey was the first one completed by the first group of ACT training participants. The Public Health Approach to Violence Prevention model's third step calls for each prevention program to be thoroughly evaluated for efficacy; therefore, though this study's results seem quite positive regarding the effectiveness of ACT training, one must keep in mind that these results are merely initial findings. The survey process must be repeated with multiple groups of future ACT training graduates before this study's results can be validated. Furthermore, validation would also require evidence beyond the scope of a self-reported survey. In order to truly substantiate claims that ACT training prevents EM and other at-risk adult abuse, research must be conducted to document the link between this prevention program and improvements in EM outcomes (e.g. increased detection, timely prevention of repetitive abuse, and increased efficacy in victim identification).

The size of the survey population presents another limitation of this study. Of the 482 professionals who participated in the ACT training, only 176 surveys were submitted or completed thoroughly enough to be used for this study's purposes. Though slightly over thirty-six percent represents a fair electronic survey response rate, a larger percentage of trainee participation would not only increase confidence, but might also help to decrease demographic incongruities (as elaborated below). In comparison, Strasser et al. (2011) conducted a study using an electronic survey to question 175 Adult Protective Services (APS) caseworkers to

determine their baseline knowledge of older adult protection laws in Georgia. Survey responses were obtained from ninety-two of these APS professionals, yielding a substantially better response rate of 53%. Furthermore, Strasser, Payne & King (2010) lead a study on Georgia coroners to determine these professionals' current and needed knowledge regarding various topics related to elder abuse. These researchers also sought to determine the training preferences of the respondents. The response rate of the professionals in this study was slightly over 58% (116 out of 198).

Another limitation of this study is the discrepancies in two demographic indicators of survey respondents: gender and race. Of the 176 survey respondents, only 52 were male; whereas, 124 were female. As many of the professions represented in this study are strongly male-dominated (i.e. law enforcement), there is no apparent reason why over seventy percent of respondents are female. Similarly, slightly over seventy-one percent of respondents were Caucasian; whereas less than twenty-five percent were African American. Once again, there is no apparent reason for such an irregular distribution. These skewed demographic representations serve to limit the overall efficacy of this research.

Recommendations

As mentioned earlier, this research must be repeated with several more groups of trainees before the impact of the ACT training can be validated. Additionally, a larger group of respondents would be beneficial for substantiating efficacy. Furthermore, collecting the same demographic information from ACT training participants as collected from survey respondents may serve to determine if any future demographic discrepancies encountered are due to survey limitations or are merely population characteristics inherent in ACT trainees.

Another recommendation is to take the level of knowledge section of this survey and, in addition to surveying the ACT trainee attendees one year after graduation, give the ACT participants a pre-test on their level of knowledge before training and a post-test immediately after training to verify actual participant increase in knowledge as well as the perceived participant increase in knowledge obtained from the survey. Oftentimes after an individual acquires new knowledge and utilizes that knowledge over an extended period of time, they lose the ability to judge their original level of knowledge.

Conclusion

Despite the limitations of this study, this research is vital to the prevention of EM. It is obvious from the research that the proliferation of EM is exacerbated by the inability, due to ignorance or insecurity, of front-line professionals to identify and report it. This research study is a first-step towards validating the efficacy of the At-Risk Adult Crime Tactics (ACT) Certification Training, a violence prevention program that may be one of the first EM prevention programs effective enough to begin to curb the rising rates of EM across the United States. Continued research on this, and other such programs, is necessary to address the needs of maltreated, elderly Americans so we can ensure they will not remain a marginalized group, suffering in silence.

References

- Acierno, R., Hernandez, M., Amstadter, A., Resnick, H., Steve, K., Muzzy, W., & Kilpatrick, D. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the national elder mistreatment study. *American Journal of Public Health, 100*(2), 292-297.
- Amstadter, A., Cisler, J., McCauley, J., Hernandez, M., Muzzy, W., & Acierno, R. (2011). Do incident and perpetrator characteristics of elder mistreatment differ by gender of the victim? Results from the national elder mistreatment study. *Journal of Elder Abuse & Neglect, 23*, 43-57. doi: 10.1080/08946566.2011.534707
- Amstadter, A., Zajac, K., Strachan, M., Hernandez, M., Kilpatrick, D., & Acierno, R. (2011). Prevalence and correlates of elder mistreatment in South Carolina: the South Carolina elder mistreatment survey. *Journal of Interpersonal Violence, 26*(15), 2947-2972. doi: 10.1177/0886260510390959
- Arliksson-Schmidt, A., Armour, B., & Thibadeau, J. (2010). Are adolescent girls with a physical disability at increased risk for sexual violence?. *Journal of School Health, 80*(7), 361-367.
- Basile, K., & Saltzman, L. U.S. Department of Health and Human Services, National Center for Injury Prevention and Control. (2009). *Sexual violence surveillance: uniform definitions and recommended data elements*. Retrieved from Centers for Disease Control and Prevention website:
http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitionsl-2009-a.pdf
- Beach, S., Schulz, R., Castle, N., & Rosen, J. (2010). Financial exploitation and psychological mistreatment among older adults: differences between African Americans and non-

- African Americans in a population-based survey. *The Gerontologist*, 50(6), 744-757. doi: 10.1093/geront/gnq053
- Centers for Disease Control and Prevention (2008). *The public health approach to violence prevention*. Retrieved June 4, 2012, from <http://www.cdc.gov/ViolencePrevention/overview/publichealthapproach.html>
- Centers for Disease Control and Prevention (2010). *Elder maltreatment: definition*. Retrieved June 4, 2012, from <http://www.cdc.gov/ViolencePrevention/eldermaltreatment/definitions.html>
- Centers for Disease Control and Prevention. (2012a). *Intimate partner violence*. Retrieved June 4, 2012 from <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>
- Centers for Disease Control and Prevention. (2012b). *Violence prevention*. Retrieved June 4, 2012, from <http://www.cdc.gov/ViolencePrevention/>
- Chang, J., Berg, C., Saltzman, L., & Herndon, J. (2005). Homicide: A leading cause of injury deaths among pregnant and postpartum women in the United States, 1991–1999. *American Journal of Public Health*, 95(3), 471-477.
- Dahlberg, L., & Mercy, J. (2009). History of violence as a public health problem. *American Medical Association Journal of Ethics*, 11(2), 167-172.
- Fulmer, T., Guadagno, L., Dyer, C., & Connolly, M. (2004). Progress in elder abuse screening and assessment instruments. *Journal of the American Geriatrics Society*, 52(2), 297-304.
- Fulmer, T., Strauss, S., Russell, S., Singh, G., Blankenship, J., Vemula, R., Caceres, B., Valenti, M., & Sutin, D. (2012). Screening for elder mistreatment in dental and medical clinics. *Gerodontology*, 29, 96-105. doi: 10.1111/j.1741-2358.2010.00405.x

- Gaudiosi, J. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2010). *Child maltreatment 2008*. Retrieved from U.S. Department of Health and Human Services website:
<http://www.acf.hhs.gov/programs/cb/pubs/cm08/cm08.pdf>
- Halphen, J., Varas, G., & Sadowsky, J. (2009). Recognizing and reporting elder abuse and neglect. *Geriatrics*, *64*(7), 13-18.
- Heath, J., Brown, M., Kobylarz, F., & Castaño, S. (2005). The prevalence of undiagnosed geriatric health conditions among adult protective service clients. *The Gerontologist*, *45*(6), 820-823.
- Laumann, E., Leitsch, S., & Waite, L. (2008). Elder mistreatment in the United States: prevalence estimates from a nationally representative study. *Journal of Gerontology*, *63B*(4), S248-S254.
- Leeb, R., Paulozzi, L., Melanson, C., Simon, T., & Arias, I. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2008). *Child maltreatment surveillance: uniform definitions for public health and recommended data elements, version 1.0*. Retrieved from Centers for Disease Control and Prevention website:
http://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf
- Lown, E., Schmidt, L., & Wiley, J. (2006). Interpersonal violence among women seeking welfare: unraveling lives. *American Journal of Public Health*, *96*(8), 1409-1415.
- National Center for Health Statistics, (2010). *Older Americans 2010: key indicators of well-being*. Washington, DC: Federal Interagency Forum on Aging Related Statistics.

- Pavlik, V., Hyman, D., Festa, N., & Dyer, C. (2001). Quantifying the problem of abuse and neglect in adults - analysis of a statewide database. *Journal of the American Geriatrics Society, 49*(1), 45-48.
- Rovi, S., Chen, P., Vega, M., Johnson, M., & Mouton, C. (2009). Mapping the elder mistreatment iceberg: U.S. hospitalizations with elder abuse and neglect diagnoses. *Journal of Elder Abuse & Neglect, 21*(4), 346-359. doi: 10.1080/08946560903005109
- Saltzman, L., Fanslow, J., McMahon, P., & Shelley, G. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2002). *Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0*. Retrieved from Centers for Disease Control and Prevention website: [http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/Intimate Partner Violence.pdf](http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/Intimate%20Partner%20Violence.pdf)
- Strasser, S., Kerr, J., King, P., Payne, B., Beddington, S., Pendrick, D., Leyda, E., McCarty, F. (2011). A survey of Georgia adult protective service staff: implications for older adult injury prevention and policy. *Western Journal of Emergency Medicine, 12*(3), 357-364. Retrieved from http://www.emorycenterforinjurycontrol.org/uploads/2205_final_pdfWestJEM-VolumeXII-issue3_FINAL.pdf
- Strasser, S., Payne, B., & King, P. (2010). Elder abuse: what coroners know and need to know. *Journal of Elder Abuse and Neglect, 25*(1), in press. [refereed]
- Tatara, T., Kuzmeskus, L., Duckhorn, E., Bivens, L., Thomas, C., Gertig, J., Jay, K., Hartley, A., Rust, K., & Croos, J. The American Public Human Services Association, National Center on Elder Abuse. (1998). *The national elder abuse incidence study*. The National Center on Elder Abuse.

U.S. Department of Health and Human Services, National Center for Injury Prevention and Control (2012a). *Sexual Violence*. Retrieved from Centers for Disease Control and Prevention website: <http://www.cdc.gov/ViolencePrevention/pdf/SV-DataSheet-a.pdf>

U.S. Department of Health and Human Services, National Center for Injury Prevention and Control (2012b). *Understanding intimate partner violence*. Retrieved from Centers for Disease Control and Prevention website:
http://www.cdc.gov/ViolencePrevention/pdf/IPV_Factsheet-a.pdf