International Health Trends and Perspectives

Arabic-speaking older immigrants' perceived acceptability of interventions for preventing elder abuse

Research Paper

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ABSTRACT

Objective: Although research has identified interventions to address risk factors for elder abuse, it is unclear which interventions are relevant to specific immigrant communities. This study examined how Arabic-speaking immigrants in the Greater Toronto Area perceived the acceptability of interventions for elder abuse and explored gender differences in these perceptions. **Methods**: Older women and men (N = 37) who self-identify as Arabic-speaking immigrants residing in the Greater Toronto Area rated the acceptability of 14 interventions. The literature describes these interventions as addressing the risk factors for elder abuse as reported at the levels of older adults, the family, their relationship, and the social environment. Four items, adapted from a validated measure, were used to assess the interventions' acceptability. The data were analyzed using descriptive statistics (objective 1) and independent sample t-test (objective 2). **Results**: Arabic-speaking older immigrants perceived five interventions to prevent elder abuse in their community as highly acceptable: case management, community outreach, advocacy, community-outreach programs, and peer-support programs. Gender differences were found for four interventions: two interventions (case management and community outreach) targeted older adults, one intervention (education) targeted the family, and one (advocacy) focused on the social environment. **Conclusion**: Findings can inform service providers, managers, and policymakers about which interventions must be prioritized to address elder abuse in the Arabic-speaking immigrant community.

KEYWORDS

Acceptability; Arabic; Elder Abuse; Interventions; Older Immigrants

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INTRODUCTION

With the increase in the population of older adults, the World Health Organization (WHO) has recognized elder abuse as a public health and societal concern worldwide (WHO, 2020). From an ecological perspective, factors that create vulnerabilities for elder abuse are associated with the victims, the abusers, the relationships between them, and the social environment. The individual changes often experienced with aging, such as cognitive impairment, poor physical health or frailty, mental health problems, and low-income result in the older adults' physical, emotional, social, and financial dependence on others. The abusers are often family members (spouse, children, or grandchildren) providing assistance to older adults. Caregiving workload and perceived burden, and other life stresses as well as abusers' mental health and substance use contribute to abuse. Relationships between older adults and their family members that are characterized by weak affective bonds or

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disharmony can generate conflicts and subsequent abuse. Social environments where older adults and family members have no or limited social and instrumental support increase the risk of elder abuse (Burnes et al., 2021; Day et al., 2017; de Sousa et al., 2021).

Different public- or community-health interventions have been developed to address specific risk factors and, thereby, to prevent elder abuse and promote older adults' health and well-being. These interventions can be categorized into those targeting risk factors that are related to the older adults, and those focusing on factors related to the family, the relationships between older adults and their family members, and the social environment. The first category of interventions includes: (1) education aimed to inform older adults about abuse and strategies to prevent or manage it; (2) rehabilitation programs aimed to enhance older adults' physical functioning; (3) psycho-social interventions aimed at teaching older adults assertive behaviours, communication skills that strengthen their relationships with family members or caregivers, problem-solving strategies, and empowerment skills; and (4) multidisciplinary services that entail screening and provision of counselling or legal assistance. Interventions targeting family members involve psychotherapy to manage mental health or substance-use problems, referral to community or social services to improve access to instrumental support, and home visits to monitor occurrence of abuse through surveillance. Mediation led by community workers to facilitate conflict resolution is an example of interventions focus on the relationships between older adults and their family (Baker et al., 2016; Day et al., 2017; de Sousa et al., 2021; Fearing et al., 2017; Marshall et al., 2020; Storey et al., 2022). Public health awareness campaigns (Dong et al., 2014) are examples of interventions targeting risk factors in the social environment.

Recent reviews of studies that evaluated the effectiveness of interventions for preventing elder abuse have reached different conclusions. Burnes and colleagues (2021) included 52 studies in their systematic review, and de Sousa and colleagues (2021) selected seven studies for their mixed-method systematic review. Both research teams reported that, in general, the interventions had positive outcomes represented in a reduction of abuse occurrence. By contrast, after conducting a review of 12 systematic reviews, Marshall and colleagues (2020) concluded that evidence on intervention effectiveness was insufficient and mixed. Such conflicting views provide limited guidance for selecting, implementing, and evaluating interventions aimed at preventing elder abuse and promoting health and well-being in community-dwelling older adults including older immigrants. In the case of limited guidance, and consistent with principles of person engagement in the design of interventions or healthcare, it is important to examine older people's perceptions of interventions; such perceptions have been found to affect their health-seeking behaviours, engagement, and enactment of interventions, as well as the interventions' effectiveness. (Sidani & Fox, 2020; Sidani & Braden, 2021). Informed by an academic-community collaborative approach to research, this study involved older immigrant women and men in identifying interventions for preventing elder abuse that are acceptable to the Arabic-speaking community in Canada.

In Canada, the Arabic-speaking population is growing fast: it has increased by about 30% since the 2011 census, with the largest proportion settling in Ontario (Statistics Canada, 2017). Arabic-speaking immigrants come to Canada from a range of countries, but most commonly from Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Mauritania, Morocco, Palestine, Sudan, Syria, Tunisia, and Yemen. Older immigrants from these countries experience common socio-cultural and political challenges before (e.g., war) and after (e.g., discrimination) migration, as well as share common beliefs and values that increase their vulnerability for elder abuse, and affect their help-seeking behaviour, and shape their perceptions of interventions for preventing elder abuse (Dominguez et al., 2019; Mydin & Othman, 2020).

Within the Arabic-speaking community, family members are expected to be loyal (Usta et al., 2021) and support each other (Gierveld et al., 2015). Multigenerational households are viewed favourably, providing a venue for older adults to assist their children in various life responsibilities such as raising grandchildren, and for children and grandchildren to look after older adults. Religious doctrines and cultural values emphasize the importance of treating older adults with affection and respect (Usta et al.,

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2021). Cultural and religious beliefs can also influence older adults' perception of interventions to prevent elder abuse. Older adults' strong sense of obligation to support their family often results in the need to uphold the "good name of the family" and in self-blame about their parenting style. Therefore, older adults may not accept certain interventions to prevent abuse (Mydin & Othman, 2020), such as those targeting family members.

Research has reported gender differences in the experience of elder abuse and in the perception of interventions. Older women are more likely to be abused (Herron & Rosenberg, 2016), and to experience emotional and physical abuse (Amstadter et al., 2011). Women and men differ in how they cope with stress, and consequently in their perceptions of acceptable interventions. Because women are more likely to talk to others to cope with stress (for example, associated with abuse), they view psychological, emotion-focused interventions as appealing. Men, in general, tend to seek quick solutions for their stress, and consider pharmacotherapy or solution-focused interventions (e.g., coaching or occupational support) as acceptable (Liddon et al., 2018; Rodenburg-Vandenbussche et al., 2018; Sonik et al., 2020). The extent to which Arabic-speaking older immigrant women and men differ in their perceived acceptability of interventions for preventing elder abuse has not been examined.

STUDY OBJECTIVES

The objectives of this study were to: *(1) examine Arabic-speaking older immigrants' perceived acceptability of interventions for preventing elder abuse*, and *(2) explore gender differences in the perceived acceptability of interventions*. Acceptability refers to the desirability of interventions to older adults and reflects favourable attitudes toward interventions. The formulation of these attitudes is based on older adults' understanding of the interventions and appraisal of their attributes (Sidani & Fox, 2020). The attributes include the intervention's appropriateness (i.e., how suitable is the intervention to the individual and/or the community), effectiveness (i.e., how helpful is the intervention in preventing abuse and promoting health and wellbeing), and risk (i.e., how severe are the risks or discomfort associated with the intervention) (Lengel & Mullin-Sweat, 2017; Sidani et al., 2018). Making interventions that are perceived as acceptable and therefore in alignment with older immigrant women and men's preferences can enhance their uptake (Hawkins et al., 2017), reduce wasted treatment/intervention efforts and costs (Sidani & Braden, 2021), and address health disparities (Sonik et al., 2020).

METHODS

Study Design

This paper presents the results of the second phase of a mixed-method project that aimed to identify risk factors for elder abuse and to examine culturally relevant interventions for elder abuse in the Arabic-speaking community. The project's protocol has been published (Guruge et al., 2019). This paper focuses on examining the Arabic-speaking older immigrants' perceived acceptability of interventions to address elder abuse. Data were collected with validated items that were translated into Arabic.

Setting and Sample

The study was conducted in the Greater Toronto Area (GTA). More than half of the Arabic-speaking immigrants (close to 500,000) who live in Canada settle in Ontario, with the largest proportion residing in the GTA (Statistics Canada, 2017).

Complementary strategies were used to recruit older immigrants. All recruitment documents were translated into Arabic. Flyers were posted in community settings frequented by Arabic-speaking immigrants, such as food stores, religious centres, and community recreational centres. Staff at partnering community agencies informed attendees at community events about the study. In addition, participants were asked to share information about the study within their social networks.

To be eligible to participate in the study, people had to be 60 years of age and older; reside in the GTA; self-identify as Arabic-speaking immigrant; and have personal experience of elder abuse or know others in the Arabic-speaking immigrant community who had experienced it.

A total of 37 older immigrants participated in the study. The sample consisted of 19 women and 18

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men. The sample size was adequate (Cohen, 1992) to examine the interventions' acceptability in the total sample (objective 1) and to detect moderate-to-large gender differences in perceived acceptability (objective 2).

Interventions to Prevent Elder Abuse

The selection of interventions to prevent elder abuse was guided by relevant scientific evidence (i.e., results of systematic reviews; Burnes et al., 2021; de Souza et al., 2021), grey literature (i.e., unpublished reports on the implementation and evaluation of programs; obtained from our partnering community agencies), and feedback by community leaders and service providers at partnering community agencies offering services to Arabic-speaking immigrants. Service providers and community leaders were instrumental in identifying additional interventions, and in reviewing the interventions' descriptions for clarity. Additional interventions represented those used in current practice and those proposed by Arabic-speaking older immigrants to service providers and community leaders.

A total of 14 interventions were selected. These were categorized as interventions that addressed risk factors for elder abuse experienced at the levels of the older adults, the family, the relationship between older adults and family, and the social environment. Six interventions that focused on risk factors experienced by older adults included: psychoeducation, training English-as-a-second-language (ESL) teachers to tailor classes to older immigrants' needs, access to information about outreach programs available in the community, peer-support programs, case management, and community-outreach programs. Three interventions targeting the family consisted of education, psychosocial counselling and/or support, and a multi-component intervention. Two interventions focused on the relationship between older adults and family, cultural context support, and family mediation, whereas three interventions—social support for older adults, advocacy, and community outreach—targeted the social environment.

We generated descriptions of the interventions to help older immigrants understand what the interventions are about—this understanding is essential to enable older immigrants to appraise the acceptability of the interventions (Sidani & Fox, 2020). Service providers and community leaders reviewed the descriptions for accuracy and clarity. The descriptions explained the goals (i.e., what the intervention aimed to achieve) and the components or activities comprising the interventions (what the interventions involve), using simple terms as illustrated in Table 1.

Variables and Measures

Participants' socio-demographic characteristics

Standard questions, developed by Statistics Canada, were used to gather information on participants' age, gender, marital status, number of children, level of education, length of time in Canada, and English-language proficiency.

Acceptability of interventions

Items were adapted from the Treatment Perception and Preferences (TPP) scale (Sidani et al., 2018) to measure the acceptability of the 14 interventions for preventing elder abuse. As per the scale developers' suggestion, the adaptation involved the generation of descriptions for the interventions under consideration, and the specification of the outcomes of interest (i.e., prevention of abuse and promotion of health and well-being) in the items. In this study, we selected four items of the TPP scale based on service providers' and community leaders' input. The items reflected the treatment attributes that were relevant and easy to understand by Arabic-speaking older immigrants. We selected items in a way that maintained content validity and enhanced face validity—that is, comprehension and clarity of items' content—while reducing response fatigue.

The items operationalized the following interventions' attributes: effectiveness in reducing elder abuse in the community, effectiveness in improving well-being of older adults who experience abuse in the community, appropriateness for older adults who experience elder abuse in the community, and severity of risk (i.e., extent to which older adults exposed to the intervention may feel worse or experience more abuse). A five-point response scale was used in the rating, ranging from not at all (0) to very much (4). A total scale score was computed as the mean of the items' scores to quantify the level of

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perceived of each intervention. Total scores greater than 2, which is the midpoint of the rating scale, indicated acceptability (Sidani et al., 2018).

In this study, the four items demonstrated internal consistency reliability, evidenced by Cronbach's alpha coefficients of 0.55 to 0.87 across the 14 interventions. The Cronbach's alpha coefficient was less than 0.70 for items for rating only two interventions (ESL teacher training and information about outreach programs), which is attributable to the very low variance on the item assessing severity of risk; most participants rated these two interventions as associated with no-to-very-low risk. The items for rating the remaining interventions demonstrated good reliability evidenced by alpha coefficients greater than 0.70, as also reported by Sidani and colleagues (2018).

Data Collection

Consenting participants attended group sessions, which were held at locations of convenience to participants. The sessions involved women only, men only, or a mix, based on participants' comfort. Bilingual research assistants (RAs) facilitated the sessions. They explained the planned research activities; distributed the questionnaire which included, for each intervention, a description of its goals and components or activities (Table 1), followed by the items to rate its acceptability; read aloud the description of an intervention and asked participants to follow through by reading it in the questionnaire; clarified aspects of the intervention as needed; requested that participants complete the acceptability rating items individually; and provided assistance as needed. The RAs repeated the same procedure for all 14 interventions and offered short breaks to minimize response fatigue. The questionnaire was translated into Arabic by bilingual RAs, and health, social, and settlement service providers working with the Arabic-speaking community, and Arabic-speaking community leaders; they also reviewed the translated version for accuracy and appropriateness of wording.

Data Analysis

To analyze the socio-demographic data we used descriptive statistics. This included frequency (and percentage) distribution for categorical variables, and measures of central tendency (mean) and dispersion (standard deviations) for continuous variables. To address objective 1, participants' ratings of the interventions' overall acceptability (i.e., total scale score) were analyzed descriptively (i.e., mean and standard deviation). To examine gender differences in perceived acceptability of the interventions (objective 2), independent sample t-test was used. Cohen's d was computed to quantify the size of the differences, with values less than 0.40 indicating small, 0.41 to 0.65 moderate, and more than 0.65 as large differences (Cohen 1992).

Ethics Consideration

The project protocol was approved by the Research Ethics Board at Toronto Metropolitan University (formerly Ryerson University) (REB #: 2017-048). Eligible older immigrants were asked to meet the bilingual RAs before the group session started. The RAs explained the study's objectives, activities, benefits, and risks; clarified the voluntary nature of participation and participants' rights; answered any questions that attendees had; and obtained their written or oral consent (based on individual preference).

RESULTS

Participants' Sociodemographic Profile

The sample (n = 37) consisted of 19 (51.3%) women and 18 (48.7%) men, with a mean age of 67.65 (+ 8.35; range = 54 to 93) years. About two thirds (67.7%) were married; the remaining participants were widowed (25.8%), single (3.2%), or divorced (3.2%). The majority (90.3%) had children (range = 1 to 8; mode = 3) who live in Canada. The participants' highest level of education varied: 33.3% did not complete high school; 13.3% completed high school; 13.3% had a college diploma, whereas 40.1% had a university degree (bachelor's, master's, or PhD). The majority (80.6%) of participants have been in Canada for less than or equal to 21 years (i.e., arrived in Canada in 2000 or after), and 19.4% have been in Canada for more than 21 years (i.e., arrived in Canada before 2000). Almost all participants spoke Arabic at home and 67.8% reported good-to-excellent proficiency in the English language.

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Participants Perceived Acceptability of Interventions

Table 2 presents the mean acceptability scores for the six interventions targeting risk factors experienced by older immigrants. The mean scores are greater than 2 (midpoint of the rating scale), indicating that older immigrants, on average, considered all these interventions as acceptable within the Arabic-speaking community. They perceived the interventions as appropriate, effective in reducing abuse, and associated with minimal risk. However, they rated case management, community-outreach programs, peer-support programs, ESL teacher training, and information about outreach programs (mean scores > 3) higher than psychoeducation.

The mean acceptability scores for the three interventions targeting the family appear in Table 3. Although Arabic-speaking older immigrants viewed all these interventions as acceptable, the mean scores hovered around the midpoint of the rating scale (i.e., 2). The multi-component intervention was perceived less favourably than education, and referral to counselling and/or support.

The mean acceptability scores for the two interventions focusing on the relationship between older adults and family are in Table 4. Both interventions were perceived as acceptable, with cultural context support rated slightly higher than family mediation.

Table 5 presents the mean acceptability scores for the three interventions addressing the social environment. Community outreach and advocacy (mean score > 3) were rated slightly higher than social support for older adults.

Gender Differences in Perceived Acceptability of Interventions

The mean scores for older women's and older men's perceived acceptability of the four categories of interventions are presented in Tables 2 to 5. Statistically significant differences were found for four interventions. Of these, two interventions targeted older adults (i.e., case management and community outreach), one targeted the family (i.e., education), and one focused on the social environment (i.e., advocacy). The between-group differences were large (effect sizes > .65); women had larger mean scores than men.

Although not statistically significant (p-level > .05), there were moderately sized (effect size range: .58 to .62) gender differences in the perceived acceptability of the following interventions: information about outreach programs (targeting older adults), cultural context support (targeting the relationship), and multi-component intervention (targeting the family). Older women's mean scores were higher than older men's mean scores. Gender differences in the acceptability of the remaining interventions were not statistically significant and were of a small size (effect sizes < .40).

DISCUSSION

Informed by an academic-community collaborative approach, this study engaged older immigrants in the identification of interventions for preventing elder abuse that are acceptable to the Arabic-speaking community, with the goal of making these interventions available in public or community health, social, and settlement service settings. Offering interventions that are desirable to Arabic-speaking older immigrants is the hallmark of person-centred and culturally relevant and safe care, which is expected to reduce health disparities (Sonik et al., 2020). Making available and accessible interventions that older immigrants view favourably improves their help-seeking behaviours. That is, they will seek, initiate, and actively participate in or implement the interventions. Older immigrants exposed to and engaged in interventions that align with their beliefs and values, and that are responsive to their preferences, are likely to be satisfied. Satisfaction enhances perseverance in the use of interventions or the performance of health-related behaviours, which in turn, promotes health and well-being (Sidani & Fox 2020).

In general, older immigrants rated all 14 interventions as acceptable within the Arabic-speaking community for preventing elder abuse. This general finding may suggest that Arabic-speaking older immigrants perceived a pressing need for ways to address elder abuse in their community. As well, older immigrants may not be familiar with interventions for elder abuse and viewed the

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interventions under consideration as potentially acceptable in meeting this need.

An interesting trend was observed in Arabic-speaking older immigrants' appraisal of the interventions. Overall, the mean acceptability scores for interventions focusing on the family (abuser) and on the relationship between older adults and family were lower than the mean scores for interventions targeting older adults and the social environment. This finding differs slightly from Begley and colleagues' (2012) results. In their qualitative study conducted in Ireland, older adults proposed two strategies targeting the family and the relationship to decrease the risk of elder abuse: providing support for family caregivers to reduce tension within the family and the feeling of isolation among family caregivers; and creating awareness through education. The trend seen in our study may be related to strong cultural and/or religious beliefs, and the commitment of Arabic-speaking older immigrants to support their family, which perhaps generates a sense of self-blame about parenting style and the desire to maintain good family ties (Mydin & Othman, 2020).

It is also plausible that Arabic-speaking older immigrants may be more comfortable seeking help regarding elder abuse from health, social, and settlement workers instead of the police for two main reasons. First, Arabic-speaking communities generally come from countries with authoritarian regimes where policing priority is not to serve and protect, but to enforce the dictator's rules (Gause 2011). Second, there are incidences where older immigrants get separated from their children because of authorities' interventions. Arabic-speaking older immigrants may therefore prefer to keep their concerns within the private sphere, and abstain from reporting elder abuse to authorities for fear of such separation. Instead, older immigrants expressed a desire for interventions that enable them to engage with service providers and with the local community, and to actively participate in community events where they can cultivate multigenerational relationships.

Further qualitative research is required to explore if and how these beliefs and behaviours could have shaped Arabic-speaking older immigrants' perception of interventions targeting the family and the relationship, as well as aspects of these interventions they viewed unfavourably.

Most interventions focusing on older immigrants, and on the social environment were considered as very acceptable, evident by mean scores of 3.0 or more. The five highly valued interventions were: case management (mean score of 3.30), community outreach (3.27), advocacy (3.26), community-outreach programs (3.23), and peer-support programs (3.13). These interventions that are highly valued by Arabic-speaking older immigrants are, to some extent, comparable to those proposed by older adults in Ireland to prevent elder abuse. The latter interventions consisted of healthcare professionals' involvement in assessing elder abuse and providing or referring them to appropriate services, staying connected with the community and friends through participation in social clubs or home visits by the church community, and providing information or education and informal support to older adults (Begley et al., 2012). Excluding advocacy, the interventions perceived as highly acceptable to older adults involve the delivery of health, social, and settlement services and related information (e.g., medical and paramedical emergency phone numbers in Arabic) aimed at maintaining their physical functioning or health and thereby, their independence. This independence, in turn, can promote their ability to stay connected with their social network and community, thereby enhancing, or ensuring receipt of much-needed instrumental, emotional, and social support, and reducing their sense of isolation.

The gender differences reported in this study reflected the differences in the perceived level of the interventions' acceptability, more than the differences in the category or type of interventions. In other words, while both older women and men viewed the interventions as acceptable, the women's mean rating scores were, in general, higher than the men's mean rating scores. Although there is no specific explanation for this finding, it is plausible that Arabic-speaking older immigrant women, who are more likely than men to experience or see other women experience abuse (Herron & Rosenberg, 2016), need assistance and support, and as such expressed high endorsement of the interventions under consideration. For instance, older immigrant women who participated in this study indicated to the RAs that they would like to address their concerns in a larger setting where both men and women from the

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Arabic community are present. However, they often mentioned that men did not take their opinion seriously.

LIMITATIONS

The sample included well-educated women and men, with a good level of English proficiency. Therefore, their perceived acceptability of elder abuse interventions may not be representative of Arabic-speaking older immigrants with a different socio-demographic profile, including those unable to speak English or to use public transportation to attend data collection sessions. Participants were also asked to rate a large number of interventions (n = 14). Although the RAs who facilitated the data collection sessions followed the pace that participants were comfortable with in reading the interventions' descriptions and responding to the acceptability items (and ensuring that participants had a break), there is a potential for response fatigue. Such fatigue could have contributed to comparable ratings for all interventions. Further, the order for presenting the interventions was not randomized, which, in combination with response fatigue, could have affected the ratings of the interventions presented last.

CONCLUSION

Arabic-speaking older immigrants perceived five interventions to prevent elder abuse in their community as highly acceptable. The interventions were: case management, community outreach, advocacy, community-outreach programs, and peer-support programs. Consistent with the principles and process of the academic-community collaborative approach, the next step involves the engagement of older immigrants, health, social, and settlement service providers and their managers, as well as researchers in the co-development of the interventions' protocol and the co-production of related intervention materials (Hawkins et al., 2017).

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Table 1. Interventions for preventing elder abuse

Category / Target	Intervention	Goal(s)	Components or activities
Older Adult	Psycho-education	1. increase older adults' awareness of factors leading to abuse 2. improve their ability to solve problems that may lead to abuse, and 3. empower them to report their experience of abuse	Two types of sessions: *Conversational:* cover topics related to the process and changes in functions with aging; strategies to maintain healthy aging; factors potentially leading to and consequences of abuse; strategies (e.g., problem solving) and community resources (e.g., home care) *Hands-on:* discussion and demonstration of specific skills (e.g., problem solving) related to addressing factors leading to abuse
	ESL teacher training	to help the teachers revise ESL sessions to align with older adults' needs for learning English and talking with others	Training will cover: needs expressed by older adults for learning English (e.g., learn English in an informal setting with a focus on words / expressions related to daily life operations and functions). Teachers revise the structure and format of ESL sessions and operationalize the ideas into action protocols.
	Information about outreach programs	to inform older adults about existing outreach programs	• Compile a list of services or outreach programs that focus on meeting older adults' physical, emotional, social, financial, and legal needs • Translate the list and brief description of the services or outreach programs into Arabic
	Peer-support programs	to promote peer support among older adults	Older adults and representatives from community centres focusing on Arabic-speaking people collaborate in an effort to form the older adult peer-support program and train older adult volunteers in their role responsibilities, which include: identifying and visiting older adults with limited physical functioning to check on their condition, discussing their needs or services, and socializing with them
	Case management	to identify older adults who experience abuse and provide the required services	Case management integrates health, social, and legal services, including: 1. referral to community-based integrated services

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			2. comprehensive assessment of older adult's physical, mental, cognitive, social, living condition; factors that put the older adult at risk for abuse or older adult's concerns 3. engagement of older adults in the development of care plans 4. provision of needed health and other services
	Community-outreach programs	to assist older adults with their activities of daily living and with accessing required services	1. having Arabic-speaking outreach workers available to facilitate older adults' access to services, and to communicate with service providers; 2. training volunteers or outreach workers to assist older adults who have a low income, who live alone, who have a disability or are in poor health and who are without social support in navigating and using public transportation, shopping, or other life activities
Family	Education	1. to increase awareness of physical and emotional changes that take place with age, factors leading to abuse, and strategies to addresses these changes; and 2. to improve problem-solving skills	Educational sessions covers: 1. topics related to aging; changes in physical and psycho-social / emotional functioning; health condition or illness of older adult and its consequences on physical, mental, social functions; factors potentially leading to abuse; strategies (e.g., problem solving) and community resources (e.g., respite care); 2. discussion and demonstration of strategies for dealing with older adults' changes in physical, emotional, and social functions, and of skills for recognizing and preventing intergenerational conflict and power relations, and for collaborating with the older adult in problem solving
	Referral to psycho-social counselling and/or support	to assist family members in addressing problems and care for older adults who experience physical, mental, or cognitive impairment	Family members self-identify problem and seek professional (healthcare providers or social workers) or community leaders' assistance who facilitate referral for needed services (e.g., psychotherapy, family therapy, emotional control or stress / anger management, respite care, and engagement in pleasant activities (for either the older adult or the family

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			members), Medication Management Support Services (MMSS) Program
	Multi-component intervention	to raise awareness about elder abuse within the community	*Part 1* focuses on public education. Community leaders and/or organizations openly discuss elder abuse at regular events, and/or police officers organize education panels in schools and community centres, to inform community of legal consequences of abuse. *Part 2* consists of home visits by social workers to: assess the presence of abuse; discuss the problem with the older adults, and their family; collaborate with the older adults and their family in developing a plan to prevent abuse and to promote the well-being of all family members; and refer older adult and family to agreed-upon health, social, financial, and/or legal services.
Relationship	Cultural context support	1) to clarify cultural beliefs, values, and expectations related to how older adults should be treated, and 2) to explore ways to manage inter-generational conflict	Schools organize an event that is attended by family members (of all generations) to discuss the older adults' status within the Arab community (based on cultural beliefs, values, and expectations), intergenerational conflict, and ways to manage the conflict.
	Family mediation	to assist older adults and family member resolve concerns they may have within their family	*Part 1:* Bilingual school teachers serve as mediators among family members (children, grandchildren, and grandparents) experiencing conflict related to language issues *Part 2*: older adults, family members, and supportive community member (e.g., spiritual leader) attend a meeting during which the community member facilitates the discussion about concerns or problems faced by the older adults and their family members, and the development and execution of a plan of action agreeable to all parties
Social environment	Social support for older adults	1. to make a neighbourhood safe for older adults to engage in physical and social activities and 2. to provide opportunities for older adults to socialize and support each other	Meetings to involve neighborhood / community representatives and older adults in identifying and finding solutions to concerns about safety and to inform / train older adults in navigating community spaces Community representatives and older adults work together to find a space that

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			can be safely used by older adults to socialize and to organize informal get-together events and engage in leisure activities
	Advocacy	to increase the community's awareness of abuse	*Part 1* focuses on the development of community committee to organize events aimed to: 1) have older adults relay their concerns and fears; 2) increase the community awareness of elder abuse; and 3) develop and implement strategies to prevent elder abuse in the community. *Part 2* involves the development of a partnership between public and private sectors to finance and/or facilitate transportation services for seniors. *Part 3* is concerned with forming a group of older adults and community representatives to visit leaders / politicians to increase their awareness of elder abuse and its consequences and to advocate for funding for services that prevent abuse.
	Community-outreach	1. to reduce the sense of social isolation among older women and men, and 2. to enhance social interaction and/or intergenerational appreciation	Involvement of the community (schools, faith organizations, centres, businesses, social services) in preparing gift bags and organizing a day event for youth (e.g., students) to deliver the bags to older people's homes

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Table 2. Mean (SD) acceptability scores for interventions targeting older immigrants

Intervention	Total Sample	Women	Men	T-test (p-level)	Effect size
Psycho-education	2.93 (0.64)	3.00 (0.73)	2.87 (0.55)	0.58 (.56)	0.19
ESL teacher training	3.08 (0.58)	3.17 (0.66)	2.98 (0.48)	0.96 (.34)	0.31
Information about outreach programs	3.07 (0.58)	3.23 (0.68)	2.90 (0.41)	1.78 (.08)	0.58
Peer-support programs	3.13 (0.72)	3.22 (0.87)	3.04 (0.52)	0.77 (.44)	0.25
Case management	3.30 (0.59)	3.48 (0.58)	3.11 (0.55)	1.99 (.05)	0.65
Community-outreach programs	3.22 (0.64)	3.44 (0.62)	2.97 (0.59)	2.33 (.02)	0.78

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Table 3. Mean (SD) acceptability scores for interventions targeting family

Intervention	Total Sample	Women	Men	T-test (*p*-level)	Effect size
Education	2.67 (0.83)	2.67 (0.98)	2.67 (0.66)	- 0.01 (.98)	0.00
Referral to psychological counselling and/or support	2.52 (0.96)	2.68 (1.08)	2.33 (0.81)	1.08 (.28)	0.35
Multi-component intervention	2.38 (0.87)	2.63 (0.90)	2.10 (0.76)	1.88 (.06)	0.62

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Table 4. Mean (SD) acceptability scores for interventions targeting the relationship

Intervention	Total Sample	Women	Men	T-test (*p*-level)	Effect size
Cultural context support	2.83 (0.87)	3.07 (0.95)	2.55 (0.69)	1.84 (.07)	0.61
Family mediation	2.68 (0.86)	2.94 (0.95)	2.39 (0.66)	2.03 (.05)	0.66

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Table 5. Mean (SD) acceptability scores for interventions targeting the social environment

Intervention	Total Sample	Women	Men	T-test (*p*-level)	Effect size
Social support for older adults	2.87 (0.66)	2.97 (0.72)	2.77 (0.60)	0.89 (.19)	0.29
Advocacy	3.26 (0.56)	3.44 (0.59)	3.05 (0.47)	2.15 (.03)	0.72
Community-outreach	3.27 (0.62)	3.39 (0.57)	3.14 (0.67)	1.19 (.24)	0.39

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