Abuse, Neglect and Mistreatment of Older People:
An Exploratory Study

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By

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Foreword

The National Council on Ageing and Older People is pleased to present this exploratory study, *Abuse, Neglect and Mistreatment of Older People*. The Council hopes that this report will serve to increase awareness of the issue of elder abuse in Ireland and assist in the development of appropriate responses when cases of such abuse come to light.

In April 1996, the Council s predecessor, the National Council for the Elderly, prepared and submitted a preliminary briefing on the subject of elder abuse to the then Minister for Health Mr Michael Noonan TD. However, on the advice of experts in the field it also agreed that it should examine and evaluate the issue in greater depth. The Council therefore commissioned this study to explore questions of elder abuse in the light of the Irish and international literature and the views of service providers.

The researchers were asked:

- to review the literature on elder abuse;
- to survey parties relevant to the issue of elder abuse in order to describe the correct mechanisms for identifying and responding to cases of abuse as they occur in Ireland, and to collate views on the best means of developing an infrastructure for dealing with elder abuse;
- to formulate recommendations on the development of such an infrastructure, with suggestions for appropriate policies at national, regional and local levels.

While it is clear therefore that the study does not pretend to indicate the precise incidence of elder abuse in Ireland, it will be equally clear that much work remains to be done to properly address and respond to actual or alleged cases of abuse when they occur. This report and the Council s comments and recommendations appended to it, seeks to provide guidance on the mechanisms required to address the problem of elder abuse in Ireland in an effective and comprehensive manner.

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Introduction

1. Disclosures that older persons are being abused, neglected and mistreated have prompted scientific and governmental activity throughout the world. Although the vast majority of older people enjoy the benefits of family life, there has been a growing awareness, during the past twenty years in particular, that older people are sometimes abused, neglected or mistreated. Progress on building a response to elder abuse has been difficult, however, as the issue is shrouded in secrecy, denial and guilt. The present study was carried out following a request by the Minister for Health and Children for information on elder abuse in Ireland. This request followed the documentation of a number of particularly disturbing cases in the media and discussion about a small number of pioneering case studies in the Irish professional literature.

2. Based on the study, the National Council on Ageing and Older People believes there is an obvious need for an official response to the problem in Ireland. The international literature suggests that around three per cent of older people in the community suffer from some form of domestic abuse, neglect or mistreatment at any one time. The literature also indicates that an unspecified level of abuse occurs in institutional settings. While there has been no comprehensive study of the prevalence of elder abuse in Ireland, the present study catalogues disturbing accounts from Irish service providers.

3. The accounts provided by service providers underline the complexity of the problem. Elder abuse is not limited to a particular setting, type of older person or type of perpetrator, and in many cases, the victim suffers multiple forms of abuse with multiple causal factors.

4. The Council is aware of the negative effect that sensationalist reporting of research on elder abuse may have. The Council is concerned therefore that any future response to the issue is conducted in a considered and restrained manner, with due acknowledgement of the sensitivity of the issue.

A definition

5. The Council agrees with the researchers that elder abuse whether in the home or an institution should be seen as distinct from other forms of adult abuse, such as domestic violence and the abuse of people with learning disabilities. We therefore advise that abuse suffered by persons aged 65 years or more, whether in the home or in an institution, be provided for in any official response to the problem. While the study of elder abuse has much to learn from responses to other forms of adult abuse, it is vital that the abuse of older people is dealt with separately, to ensure clarity when defining and measuring the problem and to help focus responses to abuse.

6.	At a conceptual level the Council favours the following definition:

Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. (Action on Elder Abuse 1995)

The definition is sufficiently broad to cover the many behaviours which constitute abuse and the settings in which it may occur. For the definition to be useful, however, it is necessary to specify which types of behaviour constitute abuse or neglect. The Council considers the following actions to warrant the terms abuse and neglect:

- Physical abuse (the infliction of physical pain or injury, physical coercion, physical restraint, chemical restraint)
- Psychological abuse (the infliction of mental anguish)
- Material abuse (the illegal or improper exploitation and/or use of funds or resources)
- Sexual abuse
- Active neglect (refusal or failure to undertake a caretaking obligation, including a conscious and intentional attempt to inflict physical or emotional distress on the older person)
- Passive neglect (refusal or failure to fulfill a caretaking obligation, excluding a conscious and intentional attempt to inflict physical or emotional distress on the older person).

At a broader level, abuse also occurs when the civil rights of older people are violated within the health and social care context. This may occur when older people are not provided with comprehensive, accurate and accessible information about their rights and options (such as alternative forms of medical treatment). It can occur when older people are not consulted about decisions affecting their lives (e.g. changing medication, or transferring them between locations without consultation). It can also occur when poor or negligent care is delivered by statutory providers, or when appropriate services are not available.

As noted in the report, the term elder abuse should exclude self-neglect and abuse by strangers, so that efforts can be concentrated on a conceptually distinct area. The definition must not be overstretched to include broader social problems such as low incomes, poor housing and age discrimination. However, it must be recognised that all these factors may adversely affect the well-being of older people.

7.	The above suggestions are no more than a framework within which a working definition can be formulated. The steps required to develop a working definition and other procedures suitable for Ireland are described below.

Developing an infrastructure to deal with elder abuse in Ireland
8.	The Council believes there is an immediate need to establish a Working Party on Elder Abuse to advise the Department of Health and Children on responses to elder abuse. The Working Party should consist of interested parties from all relevant sectors mandated to represent the views of their organisations. The Council believes that participation by the following sectors is essential:

- Older people s representative groups
- Long-stay institutional care staff
- Representatives of private long-stay care providers
- Carer s organisations
- Hospital care professionals
- Community care professionals
- Government departments
- Health boards
- Local authorities
- An Garda S och na
- Financial institutions
- The Health Promotion Unit of the Department of Health and Children
- The Social Services Inspectorate at the Department of Health and Children
- The Department of Health and Children
- The Department of Social, Community and Family Affairs
- The Department of Justice, Equality and Law Reform
- Legal professionals
- Voluntary service providers
- Experts from the elder abuse, child abuse and domestic violence fields.

9.   The Working Party should have responsibility for advising the Department of Health and Children on policy, procedures and guidelines on elder abuse in Ireland. The Council accepts the definitions of these terms used by the researchers. A policy is a general statement of intent and covers definition, types of abuse, indicators and the legal framework; procedures provide specific instructions on actions to be followed by staff when attempting to identify cases and when attempting to intervene; guidelines provide additional helpful information about elder abuse and will be useful in, for example, campaigns to raise awareness of the problem.

10. At a more specific level the Working Party should provide advice to the Department of Health and Children on the development of the following types of procedure:

- Case-finding procedures and screening instruments to identify those at risk of abuse
- Assessment protocols for the detection of abuse
- Recording and reporting procedures, and referral practices
- Uni-professional and multi-professional interventions to deal with validated cases
- Review procedures to evaluate the impact of interventions on the health and social status of older people who have been abused
- Legal procedures regarding the legal status of both abuser and abused.

The procedures developed should not be so rigid as to inhibit good practice. They should be developed gradually and in an experimental fashion to see what works best in the Irish context. Intervention procedures should emphasise the need for co-operation between different professions and co-ordination between different administrative structures. The Working Party should also develop a plan for the training of relevant staff in the implementation of procedures and should specify the form and content of such training. The Working Party should have the power to

evaluate and modify procedures where necessary. This would require the power to commission pilot projects and outcomes research.

11.   At a national level, the Council agrees with the researchers that a public education programme designed to raise awareness of elder abuse in Ireland should be carried out. The campaign should be based on information provided by the proposed Working Party on elder abuse.

12.   The Working Party will have to liaise with other bodies if its recommendations are to be implemented. The Working Party should therefore advise on the local structures, particularly at health board level, necessary to implement its recommendations effectively. Without wishing to pre-empt the work of the Working Party, the Council wishes to reiterate its long standing concern that local community care services in particular are strengthened to meet the needs of older people. There is evidence that access to these services is limited and variable within and among regional health boards (Ruddle, O Donoghue and Mulvihill 1997). Given the large projected growth in the older population over the next twenty years, community care services will require considerable expansion in order to function properly. It must also be stressed here that community care should do more than keep people out of institutions. The Health Strategy explicitly states that the objective of such services is *To maintain older people in dignity and independence at home* (Department of Health, 1997). The Council therefore wishes to reiterate four particularly relevant recommendations from its recent review of *The Years Ahead* Report (Ruddle, O Donoghue and Mulvihill 1997).

First, we recommend that social work services for older people be developed within health board community care programmes (as has been done in Donegal). The services should have responsibility for the following areas of social need:

- Protecting the rights of individual older people against exploitation, mistreatment or abuse (including financial, physical, sexual and psychological abuse). The community care social worker (in conjunction with other key staff, particularly the Public Health Nurse) should have responsibility for identifying cases and co-ordinating interventions to diminish the risk of any future abuse. This may include removing the victim from home, at least temporarily. Support and/or therapy for victims would also be an important part of the work.
- Providing support and advice to carers for older people with dementia. The social and psychological strains on dementia carers are well established and the particular skills of social workers should be used to reduce these strains.
- Developing boarding out services whereby older people who cannot remain in their own homes are placed with families who are recruited, trained and supported to care for them.
- Advising older people on their entitlements for social welfare, housing and health and social care services.
- Developing other support services for older people, in co-operation with other professionals, as may from time to time be required.

Second, we recommend the development of a seven day, 24-hour community nursing service. Many problems experienced by older people and their carers require the immediate and specific attention of a nurse. A 24-hour service, with on-call nurses available at all times,

would allow for an immediate response to such problems outside normal working hours. This service will place a burden on resources, but such developments are required to meet an outstanding need. Immediate priority should be given to the development of an on-call system operating from 8.00am to midnight, seven days a week.

Third, we recommend the development of psychological counselling services for older people by the health boards. There are many psychological problems arising from the changes associated with late life (e.g. bereavement, retirement, ill-health, cognitive disorders and abusive family situations) which would benefit from some form of counselling. At present there are few or no psychological services available to older people, and few psychologists trained to deal with the problems of old age. The postgraduate courses in clinical and counselling psychology should incorporate modules on old age to ensure trained professionals are available in future.

Fourth, major investment is needed in community care services for older people with mental disorders and their carers including:

- 24 hour a day, seven days a week community services
- Specialised day centres for people with severe dementia, with transport to the centres available when needed
- Day hospitals capable of treating older people with mental disorders, again with transport when needed
- Flexible respite care services, capable of accepting patients at short notice, for day or night care
- In-home respite care services.

13. In relation to institutional care, the Council accepts the recommendations in the report on the need for a standardisation of the inspection system for public and private institutional care settings, and across health board regions. Central to this will be a standard, national training programme for inspection staff, and the development of national procedures and guidelines to cover both inspection and intervention in cases of abuse. The Council believes that the proposed Working Party on elder abuse should advise the Department of Health and Children on these issues. The implementation of recommendations should then pass to the new Social Services Inspectorate at the Department of Health and Children.

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Introduction

There is an increasing awareness throughout the world that some older people are victims of abuse, neglect and/or mistreatment. A growing body of literature and research on elder abuse is evidence of a gradual recognition of the problem and of the need for a response. The overall aim of this study is to examine the issues surrounding elder abuse, neglect and mistreatment (hereafter referred to simply as elder abuse) and to recommend advice for future action in Ireland.

The study arises from a request by the Minister for Health and Children to the National Council on Ageing and Older People for advice on the issue. This interest is to be welcomed as there is obvious need in Ireland for an official response to the problem. Little Irish research on the subject has been carried out, although a few pioneering studies have established the existence of cases in Ireland. This study provides an overview of current thinking about elder abuse based on material drawn mainly from American, British and Canadian sources. The study also describes a survey of the views, experience, and ideas of service providers in Ireland.

1.1   Social problems and their discovery

A predominant theme in the literature on elder abuse is the finding that much abuse goes unrecognised and is hidden from public awareness. The first report of a special investigation conducted by the Select Committee on Ageing of the US House of Representatives was entitled *Elder Abuse: An Examination of a Hidden Problem* (US House of Representatives 1981). The report of the Council of Europe Study Group on Violence against Elderly People (1992, p. 65) also indicates the necessity to penetrate the veil of silence which too often surrounds this phenomenon . The campaign conducted by *Community Care* magazine, launched in May 1993 (1993, p. 17) was entitled Elder Abuse: Break the Silence . The slowness to accept the existence of elder abuse is common to other forms of family violence such as child abuse and domestic violence. Despite the fact that children throughout history have been subjected to the kind of treatment we now call abuse, the problem has only recently been discovered (Parton 1985; Gordon 1989). Confronted by the startling finding that absolutely no articles had been published on child abuse before 1962, Nelson (1984) poses the question:

> What transformed a condition into a social problem and a social problem into a policy issue? Eighty six million dollars for child abuse, a problem which did not even warrant an entry in the *Readers Guide to Periodical Literature* until 1968. How did this happen?   how did child abuse, a small private sector charity concern, become a multi-million dollar public social welfare issue? (p. ix)

In Ireland a similar process of gradual awareness took place in relation to child abuse, culminating in 1993 when the Kilkenny Incest Case took the headlines and was followed by a landmark report on the ensuing investigation (Report of the Kilkenny Incest Investigation 1993). Child care in Ireland has subsequently become a major political issue which is unlikely to disappear from the public agenda (Ferguson 1995). In Ireland the message that physical, sexual and mental abuse of women and children in their own homes by known men

is unacceptable is only beginning to become part of the public agenda (Women s Aid 1995, p. 2). With regards to the abuse of older people, it is unclear whether Ireland is ready to examine and deal with the problem in an open and honest fashion. Nelson (1984) points out that:

> In organisations as in society at large, action depends on structural readiness for change , that elusive but essential combination of political, social and organisational preparedness which makes the consideration of a problem possible. (p. 24)

1.2 Prevalence of elder abuse

Prevalence refers to the number of cases in the population at any one time and is usually expressed in terms of the number of cases per 1,000 persons. There are a number of problems with prevalence surveys of elder abuse including the adequacy of the survey instrument, lack of consistency in the measures used and the limited array of items used to assess the types of elder abuse. The prevalence rate of elder abuse in the American, Canadian and UK studies so far carried out is generally around three per cent.

The first large-scale, random sample survey of elder abuse involved 2,000 older people and was carried out in the Boston (USA) metropolitan area (Pillemer and Finklehor 1988, p. 55). The researchers looked for a number of different types of abuse: physical violence; psychological, emotional and mental abuse; and neglect. The results of the survey translated into a prevalence rate of 32 maltreated older people per 1,000 older persons in the region. A rate of 20 per 1,000 was observed for physical violence. The authors estimated that if a national survey produced similar numbers, between 701,000 and 1,093,560 cases of elder abuse would have existed in the US at the time. Striking findings in this study were the high rates of spousal abuse occurring in older couples and the finding that men were as likely as women to be victims. The study also found that substantial under-reporting of elder abuse existed. The authors commented that even in Massachusetts, a State with one of the most active programmes in the nation for identifying elder abuse , only one in 14 cases come to public attention.

A second major study on the prevalence of elder abuse was carried out in Canada using a telephone survey of 2,000 randomly chosen older people living in private houses (Podnieks *et al.* 1989). The categories used were physical violence, chronic verbal aggression, neglect and material abuse. The rates of maltreatment from this study translate to 40 per 1,000 older people. The rates were 2 per 1,000 for physical violence, 11 per 1,000 for verbal aggression, 4 per 1,000 for neglect, and 25 per 1,000 for material or financial exploitation.

There has only been one study on the community prevalence of elder abuse in the UK (Ogg and Bennett 1992a; Bennett and Kingston 1993). To overcome some of the difficulties encountered with research methodology, a routine government social survey was used — the Office of Population Censuses and Surveys (OPCS) Omnibus survey. This is a representative simple random sampling survey which takes place in 100 different sites throughout Britain. The sample contained 593 adults aged over 60. Three categories of abuse were surveyed — physical, verbal and financial. Of the 593 over-60s surveyed, five per cent reported having been verbally abused, two per cent reported physical abuse and two per cent reported financial abuse. The study also included questions to 1,366 people who were in regular close contact with an older person, using the same definitions of physical and verbal abuse. This produced higher rates of verbal abuse (nine per cent) but a low rate for physically abusing an older person (0.6 per cent).

Elder abuse in institutional settings has received less attention in previous research than abuse in the community (Phillipson 1993). This is despite some evidence that older people living in institutions are more likely to be at risk than the 95 per cent that live in the community (Glendenning 1993, p. l). The history of British institutional care, for example, is littered with reports prompted by the discovery of the mistreatment of elders (Biggs *et al.* 1995, p. 78).

The first random sample survey specifically designed to assess the scope and nature of physical and psychological abuse in nursing homes was undertaken in the US by Pillemer and Moore (1989, pp. 314-320). Staff in each participating nursing home were randomly selected for telephone interviews; 577 in total were interviewed. Staff were asked to report on actions they observed other staff commit and then on actions they had taken personally. Reports of abuse by others indicated that 36 per cent of staff had seen at least one incident of physical abuse in the preceding year and 81 per cent had observed at least one psychologically abusive incident. Ten per cent of respondents reported that they had committed one or more physically abusive acts and 40 per cent reported that they had committed at least one psychologically abusive act within the preceding year. The researchers concluded that patient abuse in nursing homes was sufficiently extensive to merit public concern.

A Council of Europe report on elder abuse (1992) states that a problem common to all European countries is the absence of a policy for monitoring and recording statistics on violence within the family in general and specifically violence against older people. In child abuse cases in Ireland, the Child Care Act 1991 places a duty on health boards to identify children who are not receiving adequate care and protection and to co-ordinate information from all relevant sources relating to children in its area (section 3.2.a). However, no such mechanisms currently exist in relation to elder care in Ireland.

There were 413,882 people aged 65 years or more living in Ireland in 1996 (Central Statistics Office 1997). Of these approximately five per cent live in a long-stay care institution and 95 per cent live in the community. Translating the international prevalence rates to the Irish context implies that around 12,000 older Irish people living in the community may be victims of some form of abuse at any one time.

1.3   Definitions of elder abuse and neglect

A recurring theme in the literature on elder abuse is the difficulty in defining the terms abuse and neglect. Difficult issues include the intentions of the abuser, the type of actions and effects that warrant the term abuse, and the issue of self-abuse and neglect. At a conference in the United States in 1986 the failure to reach agreement on a definition was noted (Pillemer and Finklehor 1988). European efforts also reflect a definitional confusion (Hydle 1989). The Council of Europe Study Group on Violence against Elderly People highlighted the definitional differences in the twenty-two countries surveyed (Council of Europe 1992).

The debate has led to many different responses. Riley (cited in Seymour 1990) who was responsible for drawing up guidelines for Kent Social Service Department comments that the definitional problem should not be a reason for inaction. Kingston (cited in McCreadie 1991), of the North Staffordshire Health Authority, points out a number of lessons which can be learned from the USA. He suggests that rather than becoming entangled in the ongoing debate about conceptualisation and definition, the way forward in terms of policy is to agree a

definition at any rate in the short term, using this definition to require all health and social service authorities to have a policy and procedure on elder abuse.

> We should not become obsessed with attempts to provide definitive statements on elder abuse to the extent that this quest precludes any action. It should be remembered that the definition of child abuse also poses similar difficulties with concepts such as good enough parenting or neglect, serving to act as markers in a complex field. (Ogg and Bennett 1991a, p. 6)

1.3.1   Conceptual definitions

Conceptual definitions detail the crucial attributes of the concept, distinguishing them from other concepts. One of the most commonly accepted conceptual definitions of elder abuse was proposed by Johnson (1986, pp. 167-196). The definition is very wide and abstract: a state of self or other inflicted suffering unnecessary to the maintenance of the quality of life of the older person .

In this definition, suffering is defined as — intense and sustained pain and anguish . This definition ultimately focuses on whether the older person has experienced pain and suffering to determine whether mistreatment has occurred. It allows for a differentiation between what is normal and culturally acceptable behaviour from what is abusive. This issue is one of the most difficult facing the attempt to define elder abuse. Eastman (1984) also refers to the importance of considering family and cultural norms. Bookin and Dunkle (1985, p. 11), however, consider that defining elder abuse in terms of its effects upon the older person:

> puts the focus of intervention on the harm done to the elder and away from any cultural biases about the appropriateness of specific behaviours occurring within the family.

Several writers address the role of attitudes and subjective value judgements in defining elder abuse (Filinson 1989; Pritchard 1992; Francis 1993; Basu 1992). The 1992 Council of Europe report recommends that: consideration should also be given to the fact that the difference between acceptable and abusive actions is a question of conscience. This implies that in the last analysis, definition depends on the subjective value judgement of each researcher and practitioner involved. (p. 18).

Another significant factor in the process of defining elder abuse is that of communication between members of professional networks. Professional conflicts may arise when definitions vary within professional perspectives and even within the same profession (Pritchard 1992; Bookin and Dunkle 1989). Phillips (1989, p. 87) sees unresolved role conflicts among health professionals as one of the roots of the problem with case identification. A study of decision making by professionals in reporting abuse provides a unique insight into the factors that have an impact on the decision to define a case as abuse. Elements such as perceiving that the abuse is unintentional, that the victim is at fault or that the intervention would prove difficult, were found to override objective measures by which abuse was to be detected (Phillips and Rempusheski 1985). In a further study, the co-operativeness of the abuser and their good relationship with the practitioner led to a reluctance to label a situation as abusive (Phillips and Rempusheski 1986).

Thus the hidden nature of abuse may not be the result of elderly fear but rather of practitioner perception of the problem. (Filinson 1989, p. 22)

The concept of inadequate care has been proposed as having significant advantages over the use of the terms abuse and neglect (O Malley *et al.* 1983; O Malley *et al.* 1984). Inadequate care is defined as the presence of unmet needs brought about by actions of the caretaker or their failure to intervene or respond adequately to established needs for care (Fulmer and O Malley 1987). The proposers of the definition of inadequate care claim that it is easier to reach an agreement on this concept and that there is less reluctance to identify cases (Fulmer and O Malley 1987). The main difficulty with this definition is that it confines the label to situations in which a caretaker or carer intends to do harm and assumes the older person is dependent. This view is not supported by research findings which often highlight the dependency (financial, emotional and sometimes physical) of the perpetrator on the person being abused (Pillemer and Finklehor 1988; Pillemer 1985). Eastman (1984, p. 37) also emphasises that older people can be abused by relatives without suffering from any condition leading to dependency. Reaching agreement on what is adequate care also poses many of the same dilemmas associated with defining abuse and neglect.

As a solution to the confusion described above, multi-purpose definitions were proposed by Aber and Zigler (1981) and supported by Valentine and Cash (1986), McCreadie (1991), McDonald *et al.* (1991) and Bennett and Kingston (1993). Three different sets of definitions with different purposes are recommended:

- Legal definitions: to guide decision making and specify what acts or conditions justify initial State intervention into private family life
- Case-management definitions: to guide clinical decision making that would specify eligibility for services and establish a baseline against which services are evaluated and clinical decisions about families are made
- Research definitions: to guide scientific research that would provide the basis for studying causal relationships.

1.3.2   Problems with legal definitions
There are many problems with the use of legal definitions of elder abuse. The limitations and ineffectiveness of the law in protecting the victims of elder abuse arise from a number of factors. The inability or unwillingness of the victims to complain, the difficulty of obtaining the necessary evidence to prove the offence beyond reasonable doubt, the victim s fear of retaliation and the inappropriateness of certain legal procedures are among those most commonly cited (Eastman 1984; Sharpe 1988; Basu 1992; McDonald *et al.* 1991; Law Commission 1993; Griffiths *et al.* 1993).

Conceptualising elder abuse in legal terms and the use of police definitions is incorporated in the guidelines of the London Borough of Enfield on the Abuse of Vulnerable Adults. These definitions are then cross referenced with those using more social work/health terminology. Eastman (1993, p. 20) states that, while there is an important debate about how far the definition of what constitutes abuse criminalises the abuser, the use of police definitions strengthens the position of the older person.

A recent national strategy on eliminating violence against women prepared by Women s Aid (1995) recommends that the Garda authorities set out clearly, that domestic violence is no

less a criminal offence than assaults that take place between strangers on the street and must be treated with the same seriousness (p. 7). Clearly this is an area for further debate in the field of elder abuse. An important part of this debate focuses on the advantages and disadvantages of using a criminological framework to deal with caregiving problems. Several writers have argued that such a framework may be inappropriate when elder abuse arises in a caregiving context (Griffiths and Roberts 1995; Hugman 1995).

1.4   Some general definitions of elder abuse

The following are some general definitions of elder abuse that may be useful to Irish policy makers when dealing with the issue:

> Abuse may be described as physical, sexual, psychological or financial. It may be intentional or unintentional or the result of neglect. It causes harm to the older person, either temporarily or over a period of time. (Social Services Inspectorate of the UK Department of Health 1993)

> Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. (Action on Elder Abuse 1995)

> Abuse is the physical, psychological or financial mistreatment of an older person by an individual, who has a relationship with them. The abuse is a violation of a person s human and civil rights causing distress. The violation can manifest itself once or repeatedly. (SAVE Project, Lewisham Social Services 1995)

1.5   Categories of elder abuse

Attempts to distinguish between different categories of elder abuse have not been completely successful, with much inconsistency in terminology. Some researchers define abuse in terms of actions or behaviours on the part of the abuser and others use lists of injuries or other damage done to the older person. McCreadie (1991) emphasises the importance of distinguishing between the behaviour of the abuser and the effects on the abused person or the indicators of mistreatment. This approach is supported in several texts on elder abuse (Fulmer 1989; Breckman and Adelman 1988; Decalmer 1993; Basu 1992). In an attempt to define the main categories of elder abuse, the framework devised by McCreadie (1991) will be used.

1.5.1   Physical abuse

There is total agreement that this is a category of abuse. It receives the most attention in the literature and recognition is developing from a dependence on the presence of gross physical signs to the recognition of more subtle features such as finger marks due to harsh gripping (Bennett and Kingston 1993, p. 32). The kinds of behaviour usually involved include assault (hitting, slapping, pushing, burning, shaking), physical coercion and physical restraint. Several writers include the misuse of medication within this category, for example over-sedation or withholding drugs to bring on a crisis and precipitate admission to hospital (Tomlin 1989; Eastman 1984; McDonald *et al.* 1991; Johnson 1991). The effects of physical abuse include bruising, burns, fractures, lacerations, abrasions, hair loss, dislocations, scratches and imprint injuries.

1.5.2   Psychological abuse

There is widespread agreement that this is a category of abuse, but confusion about terminology and definition remain. It is characterised by verbal aggression such as name-calling, harsh orders, humiliation, intimidation, threats, provocation of fear. In this form of abuse, the real scars are often out of sight and, as well as existing in its own right, it also permeates other forms of abuse (Francis 1993). Since the concept of psychological abuse is difficult to define there has been a concentration on verbal aggression as a major manifestation. However, it is important to realise that psychological abuse does not have to be verbally expressed and older people can be as distressed by non-communication, being ignored and made to feel discounted. The effects of psychological abuse include depression, helplessness, loss of sleep, tearfulness, loss of appetite and fear.

1.5.3   Financial abuse

Most of the literature on financial abuse focuses on actual appropriation of an older person s property and cash. This behaviour can include theft from social welfare pension, threatening the older person if money is not given, convincing the older person to share resources, intimidation to sign over property and the changing of wills. The misuse of an older person s resources and the withholding of information about assets that could be used to benefit the older person may also be included here. Financial abuse is difficult to detect and is closely related to the legal framework. Many commentators point out that financial abuse is a murky area of the law (Marchant 1993, p. 18). It is perfectly possible for the wrong arrangements to exist without abuse taking place when older people may no longer be capable of taking full responsibility for managing their affairs, illustrating the complexity of definition. In terms of effects, financial abuse may lead to an inability to pay bills, lack of amenities, eviction notices for non-payment of rent and a general deterioration in standard of living.

1.5.4   Neglect

As a category or type within the broader framework of elder abuse, neglect is often misunderstood. There has been inconsistency surrounding the distinction made between abuse and neglect, with some writers not making the distinction at all and others making it in different ways. Galbraith (1989, p. 38) suggests that:

> The term neglect as a separate and distinct categorisation should be omitted from the elder abuse dialogue and should be considered as another form of abuse.

However, Fulmer and Gould (1996, p. 90) state that no evidence exists to suggest that neglect should be accepted as a sub-type of abuse. One of the difficulties in establishing neglect is that of determining who is responsible for the older person s care needs. Cultural norms in relation to family obligation may leave older people s relatives open to an accusation of neglect , but legally there are insurmountable problems in establishing that a family member owes a duty of care to the plaintiff, where the law imposes no such statutory or common law duty (Breckman and Adelman 1988; Griffiths *et al.* 1993).

There is general agreement that neglect involves the failure of an individual responsible for caretaking to respond adequately to established needs for care (Fulmer and O Malley 1987). Hall (1989) studied a sample of 288 cases of elder mistreatment validated by the Texas Department of Human Resources, listing forty-three acts or situations appearing in validating the cases. Contrary to the expectation that life-threatening acts or conditions would dominate the reports, they found that the most common problems related to care of the person and the immediate living area, and problems relating to lack of medical attention were the most

commonly reported. The study emphasises the difficulty of operationalising the concept of neglect clearly but also points to the importance of recognising that there may be a core of deterioration or limitation of an elder person which then makes the more extreme forms of maltreatment easier for other people to commit . Some of the effects of neglect include poor hygiene, malnutrition, pressure sore formation, dehydration, untreated medical problems, exposure to danger, lack of supervision and abandonment.

One of the much debated issues in defining neglect has been the inclusion of self-neglect as a category. Cases in which older people neglect themselves are fertile ground for debates about the rights of individuals to autonomy, self-direction and self-determination and the protection of those who are legally incompetent to care for themselves. In the USA all states have some form of adult abuse and protection laws with statutory force given to professional action. There are many questions raised as to the appropriateness of such measures given the inclusion of self-neglect as a category (Thobaben 1989). Fulmer and Gould (1996) in their article on assessing neglect include self-imposed neglect in their schematic chart. However, in a further discussion they acknowledge that the issue is riddled with value judgements and has not been resolved for adults of any age in US society. Some protocols in the UK include self-neglect in their definition. The policy and procedures manual on the mistreatment of older people from County Durham is one example (Durham 1994). However, Pillemer (1994, p. 5) states that:

> Studies are especially weakened by their inclusion of the category self-abuse or self-neglect . These oxymoronic terms are meaningless and should be discarded. Certainly they have no place in elder abuse research.

A core body of knowledge has emerged about the disorder known as Diogenes syndrome, characterized by self neglect, domestic squalor, social withdrawal and lack of concern about one s living conditions, with a majority of cases living alone. Effective management of this syndrome is particularly difficult. In a recent review Cooney and Hamid (1995) call for a co-ordinated approach with agreed policies and procedures for the appropriate care of such patients. It is noteworthy that the Eastern Health Board in Ireland is currently researching this issue with a view to developing such policies, separately from any considerations on elder abuse.

1.5.5   Sexual abuse
The work of Ramsey-Klawsnik (1991) in the United States and Holt (1993a; 1993b) in Britain as well as the inclusion of an article on the topic in the Community Care campaign series (Neate 1993) places the sexual abuse of older people in a category of its own. The UK Social Services Inspectorate (1992) defines sexual abuse as coercion to sexual activity . Sexual abuse needs to be specifically included in definitions of elder abuse. Evidence is increasing that elder sexual abuse is becoming an issue for our society (Holt 1993a). Sexually abusive behaviour involves a range of activities as follows, (Ramsey-Klawsnik 1991):

- Molesting the older person, including sexual touching or kissing
- Oral, vaginal or anal rape with a penis, fingers or objects
- Forcing the older person to perform sexual acts on the perpetrator
- Sexual harassment
- Threatening the older person with rape or molestation
- Forcing the older victim to view pornographic material

- Exhibitionism by the abuser
- Harmful genital practices: obsessive washing, unnecessary inspection.

Examples of the effects of sexual abuse include: trauma about the genitals, breasts, rectum, mouth; presence of sexually transmitted disease; injury to other parts of the body during violent restraint; human bite marks.

1.5.6   Sociological abuse

This category is not always agreed upon and its manifestations are often included in other categories, in particular under the headings of psychological abuse or neglect (Breckman and Adelman 1988; Pritchard 1992; Basu 1992; UK Social Services Inspectorate 1992). Johnson (1986) uses the term sociological abuse to refer to deprivation of social contact leading to isolation, exclusion from family gatherings, from possible supports, from visitors or outings.

1.5.7   Societal abuse

Gill (1981) proposes a more radical definition of child abuse, which includes societal abuse , drawing attention to the fact that a broad range of social and public policies can adversely affect children by perpetuating poverty, inadequate nutrition, substandard housing, and dangerous environments. Similar issues may apply to older people. Phillipson (1993) questions why abuse within the domestic setting has appeared on the agenda of local and central government, suggesting that a more generalised problem deserving attention is that of age discrimination and marginalisation of certain groups of older people. He points out that we must pay attention to risks arising from ideologies about older people and the resources at their disposal (1993, p. 87). However, Hugman (1995) views the characterisation of low levels of services, inadequate pensions or poor housing as elder abuse as:

> overstretching the term and likely to have a devaluing   effect on the extent to which professional organisations can convince politicians of the reality of violence or threat faced by many individual older people. (p. 505)

1.6   Additional components in the definition of elder abuse

A number of other issues must be addressed if some degree of precision and clarity can be achieved when defining elder abuse (McCreadie 1991, 1994, 1996).

1.6.1   Age

The special categorisation of elder abuse, as distinct from other types of family violence, is a widely debated issue. Some writers suggest that elder abuse should not be afforded a separate category but Finklehor and Pillemer (1988) argue persuasively for the special categorisation of elder abuse. Their first reason focuses on the increasing frailty experienced by older people, in particular those over seventy-five, which can increase their vulnerability to abuse. Secondly, the devalued social status of older people and the reality of ageism both adversely affect the ability of professionals to detect maltreatment. Thirdly, concern about elder abuse has arisen in the context of specialist services for, and professionals working with, older people. A system already exists for the delivery of special services to older people. Most research studies have taken sixty-five years of age as a cut-off point beyond which abuse may be considered elder abuse (McCreadie 1994).

1.6.2   Setting

It is sensible to distinguish between abuse in an institutional setting and abuse of people in their own homes, when defining elder abuse (McCreadie 1994). For a full discussion on abuse and mistreatment in institutional care *see* Chapter Four.

1.6.3   The abuser/perpetrator
Research highlighting the complexity of abuse implies that it is not helpful to restrict abuse to actions by carers, family members or relatives. In particular the introduction of the word carer into the definition can lead to confusion (McCreadie 1996).

1.6.4   The abused/victim
The fact that research has uncovered situations in which frailty or dependence does not appear to be an issue highlights the danger of restricting the definition to those defined as vulnerable because of illness or disability. Elder abuse effects a wide variety of older people (McCreadie 1996).

1.6.5   Types of abuse
The different types of abuse that should be included in a definition of elder abuse were discussed earlier in this chapter. Of particular importance here is the exclusion of self-neglect, societal abuse and assault or theft by strangers.

1.6.6   Intention
There is some debate as to whether the intentionality of the act should be part of the definition or is simply relevant to intervention (McCreadie 1991). Johnson (1991) points out, however, that explanations offered by the abuser should not be confused with legitimation.

1.6.7   The views of older people
The search for a comprehensive operational definition of elder abuse has almost always omitted older people themselves. We do not know how older people perceive abuse and whether their perceptions are consistent with professionals classifications. This vital issue is the topic of a study by Moon and Williams (1993). The study suggests that older respondents weighed the intention of the person, circumstancial factors and the specific nature of the act. It also found considerable ethnic group differences in perceptions. This study raises important questions about the development of the operational definition of elder abuse when considered from the perspective of older people.

1.7   Conclusions
In any discussion of the issues around the definition of elder abuse, a crucial aspect is the specific social, political and historical context in which the issue arises. Several writers have addressed this in relation to social problems generally (Spector and Kituse 1973) and in particular with regard to the discovery of child abuse (Pfohl 1977; Parton 1985; Gelles 1975; Nelson 1984). The concept of elder abuse is an evolving one and responses to it are part of a very complex scenario in which abusers and victims, but also those who wish to intervene or legislate, are jointly enmeshed (Sprey and Matthews 1989, p. 59). A recent study of the politics and history of family violence argues for the necessity of a historical and political approach to understanding the phenomenon, which changes not so much in its incidence as its visibility. This has direct relevance to elder abuse:

> family violence has been historically and politically constructed   the very definition of what constitutes unacceptable domestic violence and appropriate responses to it, is developed and then varied according to political needs and the force of certain political movements   violence among family members arises from family conflicts, which are not only historically influenced but political in themselves, in the sense of that word as having to do with power relations. (Gordon 1989, p. 3)

At a practical level the way forward is to agree a definition which can be used in the short term. Based on the information presented in this chapter the key points regarding a definition of elder abuse are as follows:

- When using terminology, sensitivity to meaning and connotations is required. The current terms elder abuse and elder abuse and neglect have gained a widespread acceptance in the literature and should be maintained for the foreseeable future.
- A definition which provides a precise description of elder abuse is difficult to derive. Definitions are often impractical because of a lack of precision about the actions and damage involved.
- For the present, a definition used by the British organisation Action on Elder Abuse is proposed:
    > *Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.*
- It is vital that explicit criteria by which behaviour may be judged to be abusive/non-abusive are provided in a definitional framework. Possible criteria include legal standards, professional/workplace ethics and community standards of tolerable conduct.
- Elder abuse may take a number of forms. The most important of these are: physical; psychological; financial/material; sexual; sociological. Neglect by others should also be considered within the same definitional framework.
- The literature cites a host of behaviours that may be considered abusive. A definitive taxonomy of behaviours has not yet been agreed.
- There are also difficulties in agreeing the effects on the victim which may be considered evidence of abuse. Bruising, for example, is not always caused by physical abuse.
- Elder abuse should be seen as distinct from other forms of adult abuse (e.g. domestic violence) but every effort should be made to learn from the literature on these forms of abuse.
- Elder abuse can occur in both domestic and institutional settings. In both these settings the perpetrators may be professional carers.
- An elder abuser may be any individual who has a relationship with the victim.
- Victims are not necessarily ill, frail or dependent.
- Elder abuse should be considered distinct from self-neglect, societal abuse, and assault or theft by strangers.

Risk Factors for Elder Abuse

In the previous chapter, the definitional dilemmas surrounding elder abuse were illustrated. The limitations imposed by the differences in definitions, terminology and meaning of elder abuse have extended to problems in the exploration of causal theory. The argument that family violence cannot be separated from the norms of society or from its overall political conflicts affects research findings and the search for explanations. Opinions about the causes of family violence are the source of intense debate, with implications for policy shifting according to the dominant political mood. Political attitudes have determined the very meanings of family violence (Gordon 1989). There are many explanations of causal factors and it is likely that more than one component may be present. Risk factors may have relatively different significance at different times.

2.1   Theories of interpersonal violence

Theories that attempt to explain the causes of elder abuse have drawn heavily from the literature on other forms of family violence such as child abuse and spouse abuse. In turn, the richness of the theoretical resources in the field of family violence is due to the extensive research on aggression and violence in non-family settings (Gelles and Strauss 1979). The focus of this report will be on risk factors or causes of elder abuse. The distinction between theories and risk factors is very important. Specific risk factors (e.g. stress) are often treated in the literature as theoretical explanations, but should properly be seen as part of a wider theory. The risk factors outlined below may be incorporated into one of a number of theories that attempt to explain elder abuse (McDonald *et al.* 1991).

2.2   Risk factors associated with elder abuse

2.2.1   *Transgenerational family violence*

Gelles and Straus (1979) suggest that in some families the association of love with violence becomes a fundamental part of the individual s personality and world view . This provides a role model and script for intra-family violence, in particular between parent and child and husband and wife. Pillemer s 1986 study of the causes of elder abuse found little evidence that perpetrators were themselves victims of child abuse. However, there are several reasons why inter-generational family violence may be difficult to detect. Victims do not readily admit to abusive behaviour in the past, they may not define previous behaviour as abusive, or may not remember it. In some cases the abuser may be the victim s spouse (Breckman and Adelman 1988, p. 21).

Steinmetz (1988) explored the inter-generational transmission of behaviours used to resolve problems or gain and maintain control. The analysis claims a high correlation between a caregiver s abusive behaviour and the older person s previous (and in many situations current) use of physical violence. A key psychological motivation for the abusive caregiver in such cases seems to be retaliation against previous or ongoing violence by the older person. In addition, Coyne *et al.* (1993) in a study of the abuse of dementia patients, found that 25 per cent of caregivers who in earlier years had been abused by the care recipient reported that they now abused the patient in their care. This compared with only 10.6 per cent of caregivers who had no previous history of abuse.

The inter-generational hypothesis has been much debated in the field of child abuse. The conclusions of Egeland (1993) and Kaufman and Zigler (1993) are a timely warning for the field of elder abuse.

> Undoubtedly a history of abuse is a considerable risk factor associated with the aetiology of child maltreatment, but the pathway to abusive parenting is far from inevitable and involves many complex interactions between genetic and environmental factors. (Kaufman and Zigler 1993, p. 218)

2.2.2   Dependency

The belief that dependency is a major cause of elder abuse has been a significant hypothesis in the literature but one about which there is some dispute (Davidson 1979). The persistence of the view that the victims of elder abuse are likely to be physically or mentally impaired has had significant consequences in terms of policy formulation and practice. The main consequence has been the tendency to link elder abuse with child abuse, particularly in the realm of dependency on the caretaker for basic survival needs and the resultant stress on the care giver (Steinmetz 1988, p. 33). This parallel runs the danger of undermining the status of older people as independent responsible adults and the development of ageist laws and services (Finklehor & Pillemer 1988, pp. 248 - 249., Gilbert 1986, pp. 55 - 61, Faulkner 1982, pp. 69 - 80, Bolton & Bolton 1987, pp. 229 - 424). However, incorporating the dependency of the older person as a causal factor for abuse and neglect can also be misleading in the development of screening devices for case identification, missing those at risk, who are not dependent (McDonald *et al.* 1991).

Data from a case-control study (Pillemer 1985) attempted to shed light on the relationship between dependency and elder abuse . The study found that abused elders were no more likely to be seriously ill or impaired in the activities of daily living than the controls. The study also found significantly less impairment in some areas and concluded that, the hypothesis that the impairment and dependency of an older person leads to physical abuse must be called seriously into question (Pillemer 1985; p. l51).

In addition, a large study of caregivers to victims of Alzheimer s Disease examines the correlation between violent feelings and actual violence by caregivers. The results show that the relationship between caregiving demands (level of activity limitation of care recipients and amount of help provided) and violent feeling disappeared when other variables were controlled and are described as spurious (Pillemer and Suitor 1992, p. 169). In the UK a further study has considered the causation of elder abuse and neglect. The findings do not support the dependency characteristics of the abused person as a cause of abuse (Homer and Gilleard 1990). These findings shift the focus from the dependency of the victim to that of the abuser as a critical factor. In many cases, the abuser is dependent on the victim for housing, household repair, transportation and finance, with financial dependency being the crucial factor.

2.2.3   Psychopathology of the abuser

Pillemer (1985) found that mental disorder may be one reason why perpetrators of elder abuse are dependent on and live with their victims. In a later study Pillemer and Finklehor (1989) again found that abuser deviance was an important causal factor. They concluded that elder abusers appear to be severely troubled individuals with histories of anti-social behaviour or instability (p. 186). An important characteristic of many elder abusers appears

to be substance abuse, with a particular focus on alcoholism. These findings have been supported by a number of other researchers (Homer and Gilleard 1990; Ogg and Bennett 1991b; McDonald *et al.* 1991; Bennett 1990; Wrigley 1991). However, Eastman (1984, p. 39) highlights the influence of pathological family cultures as a cause of violence and cruelty by abusive family members. This moves the focus away from the individual problems of elder abusers and on to broader social causes. Nelson (1984) stresses the importance of this viewpoint:

> abuse and neglect do not come in discrete increments separable from family stress and social inequities like poverty, racism and patriarchy. (p. 136)

2.2.4   Stress
From the mid 1970s the phenomenon of elder abuse has usually been framed in the context of the stress imposed by caring for an older relative (Eastman 1982; Davidson 1979; Burston 1975, Kruse 1989; Steinmetz 1988; Eastman 1984; Steinmetz and Amsden 1983). The predominant image of elder abuse is of the mentally and physically dependent older person, who becomes a difficult burden to a resentful daughter or son and who abuses or neglects the older person in response to frustration. This focus has led to an increasing reference to carers in public policy documents on elder abuse.

There are many different strands in the discussion about carers, one of which is the growing research on the impact of caring and a large literature on burden and stress (Twigg and Atkin 1994). The focus on stress mirrors the general interest on the stress faced by carers, the emergence of the carer lobby, and concern about the plight of carers, who were long seen as hidden and taken for granted. It has also been proposed by Pillemer and Finklehor (1988, p. 55) that the caregiver stress approach presents elder abuse in its most compelling light, in order to gain public attention.

In relation to research findings, there is evidence that the individual s perception of stress and feeling of burden are stronger predictors of the presence of elder abuse than more objective measures such as demographic variables and the amount of tasks involved in care (Steinmetz 1988, p. 218). Phillips (1988) also suggests that a focus on caregiving is important, especially in the caseloads of nurses where she sees it as an important feature of almost all cases of elder abuse encountered.. In relation to informal carers, however, recent research has tended to downplay the importance of stress, and has instead emphasised the quality of the relationship between abuser and victim (Homer and Gilleard 1990, p. l361). McCreadie (1996, p. 49) concludes that carer stress in itself is quite inadequate in explaining most abuse though it may often be a contributory factor (p. 50).

An important finding from the research is the role that aggressive behaviour by the patient plays in triggering a similar response in the carer. Steinmetz (1981, pp. 6-10) refers to the dilemma of the double direction violence . In a detailed study of 104 co-resident adult child carers caring for 119 older kin, Steinmetz examined behaviours that were used to maintain, gain or regain control . Eighteen per cent of the elders used physical violence — sometimes a recent phenomenon, sometimes a continuation of a life-long pattern. Pillemer and Suitor (1992) also found that violence by the care recipient was not only a risk factor for fear of violence but also for actually committing violent acts. They labelled disruptive behaviour and aggression by the care recipient interactive stressors and these emerged as very important risk factors.

Coyne *et al.* (1993) further explored the relationship between dementia and elder abuse. One-third of caregivers reported that the patient had directed abuse towards them during the course of providing care. Caregivers who had been physically abused were more likely than those who had not, to abuse those they cared for. However, the character of the pre-morbid relationship between carer and patient was very important, particularly a history of abusive behaviour by a family member prior to the onset of illness. We therefore conclude for the purposes of this report that a consideration of stress as a risk factor should focus on the carer s perception of stress, the importance of the relationship between the carer and the care recipient, the existence of disruptive behaviour and aggression by the care recipient, and on depression in the caregiver.

External stressors (e.g. poverty, inadequate housing, unemployment and lack of options) have also been considered as factors contributing to elder abuse (Giordano and Giordano 1984). While there has been little support for the impact of external stressors on the situation of abused older people, Phillipson (1993, p. 87) calls for an acknowledgement of the social construction of abuse as an important next step.

2.2.5   Social isolation
Social isolation and family privacy are important factors which can insulate the family from both social control and assistance in coping with intra-family conflict. Sebastian (1983, p. 182-191) sees this accounting for the weaker restraints against aggression in the family than in other social settings. Phillips (1983, pp. 379-392) investigated the relationship between self assessed social networks and abuse by assessing two factors — the subjects perception of the actual number of individuals who offer emotional support and the amount of support given by each, and the subjects perception of the actual number of individuals who give practical help and the amount of help given. Three facets of the older person s social network were significantly lower in families for victims of abuse (friends who call on the phone , people who correspond and people to call on in times of trouble). Godkin *et al.* (1989) also report that those who are abused or neglected have lower social contacts than normal and have often suffered recent losses in their support system. The research does not necessarily show that social isolation causes abuse but poses questions about whether abuse increases isolation and whether the abuser limits the victim s access to the outside world (Breckman and Adelman 1988, p. 34).

2.3   Conclusion
The causes of elder abuse have been examined in this chapter. The review illustrates how slender and tentative is knowledge on the subject at this time. Sprey and Matthews (1989) sum up the situation:

> On the explanatory level, we argue that no single theoretical approach is suitable to account for events as diverse as physical and verbal coercion, exploitation, neglect or self-neglect. The quest for the causal explanation of the mistreatment of older people merely reflects the mistaken assumption that because all events have causes, there must be one cause for everything. Regrettably, things are not that simple. (p. 59)

Identification

This chapter examines the detection of cases of elder abuse and the development of protocols to aid in identification.

3.1   Barriers to detection

The idea that there are barriers to detection is a common theme in the literature on elder abuse. The barriers operate at a number of different levels. At the individual or micro level, elder abuse victims are often isolated from social networks and contacts with professionals. Gaining access to victims is difficult, sometimes because of the deliberate actions of the abuser. Victims are also reluctant to report abuse for a number of reasons, including shame, humiliation, fear of reprisal and fear of the negative consequences of a professional intervention (e.g. placement in institutional care). Some workers make the mistake of expecting that abuse and neglect will be simply mentioned by the person if it is serious enough (Penhale 1994b).

Barriers to detection at a macro level are also important. Societal attitudes to older people and the ageing process can contribute to negative stereotypes and adversely affect detection (Penhale 1994a; Breckman and Adelman 1988; Bookin and Dunkle 1989). The belief that family privacy is paramount, coupled with the view of the family as a safe haven, can be a barrier to intervention and lead to a lack of awareness of the increased risk of conflict that the very intimacy of family life may produce.

The views of an individual professional about what actually constitutes abuse in the domestic or institutional setting are also a key factor influencing the process of identification. A study of decision-making by professionals in reporting abuse provides a unique insight into the factors influencing case detection and identification (Phillips and Rempusheski 1985). This study focused on the conceptualisation among health care providers of abuse and neglect, the use of definitions occurring in the literature in actual practice and the decision processes involved in identifying poor elder/caregiver relationships (p. 134). The study shows that cultural stereotypes, personal values and the professional values of the health care provider may all influence the actions of the professional. In addition, Anderson (1989, pp. 117-126) found that professional background can influence perceptions of the magnitude of the problem of elder abuse.

3.2   Screening for risk of elder abuse

One of the goals of risk screening is to alert professionals and provide an opportunity to prevent serious damage. In the UK a number of screening tools have been devised. The High Risk Placement Worksheet has been developed for use by those making placement decisions for vulnerable older persons. Its purpose is to signal potential problems resulting from the characteristics of the older person, caregiver or family system (Kosberg 1988). A Cost of Care Index has also been developed. This tool explores the perceptions of potential or actual caregivers about the cost of caring. It has been used in the identification of potential problems and risks in the relationship between caregiver and cared for (Kosberg and Carl 1986).

A number of problems with current screening protocols have been identified. They often focus on the dependency or frailty of the abused person (particularly older women), and on abuse by adult children. This ignores mounting evidence that many elder abuse victims are not frail or dependent, and that much abuse is committed by spouses. The screening tools also do not distinguish between risk for abuse and risk for neglect, and tend to ignore abuse and neglect in institutions. Few have been tested for their ability to predict abuse.

> To summarize, the state of the art in screening for neglect and abuse would strongly indicate that practitioners will have to proceed with considerable caution by not blindly following given protocols and by being flexible in the incorporation of newer research as it becomes available (McDonald *et al.* 1991, p. 86)

3.3   Interview skills

Identification of elder abuse is a process that requires trained observation and clinical judgement. A comprehensive assessment requires the involvement of a variety of service providers with specialised expertise and skills. Several writers emphasise the importance of skills in gathering information in a sensitive way, the development of a trusting relationship between service providers and clients and an understanding of the victim s thoughts and feelings about the abusive situation. Guidelines to good interviewing skills emphasise the importance of ensuring privacy when interviewing and of interviewing the victim and abuser separately. It is also important to allow adequate time for issues to emerge, to build trust over time and to take a non-judgemental approach to any information proffered. During the interview it is generally best to progress from general to specific questions.

The emphasis on persistence and patience are a common thread in interviewing guidelines (Breckman and Adelman 1988; Bennett and Kingston 1993; Basu 1992; O Brien 1996). Recognising and understanding the strong feelings aroused in dealing with cases of elder abuse is also essential to any professional involvement. Feelings such as anger, sadness, disgust, disbelief, and a desire to rescue need to be faced. Feelings of frustration and helplessness are also common. The importance of sharing with colleagues and supervisors, increasing knowledge, reducing stress and caring for one s own physical and mental health are vital (Basu 1992).

3.4   Indicators of abuse

Several writers describe what are referred to as alerting features which should trigger concern or suggest abuse and neglect (Cochrane and Petrose 1987; Lachs and Pillemer 1995; Tomita 1992). The general features included are:

- Delays between an injury or illness and seeking medical care
- Implausible, vague, bizarre or inappropriate explanations for injury or illness
- Frequent visits, reported attendances at accident and emergency departments
- History of shopping or doctor hopping
- Laboratory findings that are inconsistent with the history provided
- Inconsistency in history from victim and suspected abuser.

At a more specific level there are indicators for different types of abuse and neglect which are listed below. These lists are useful for alerting practitioners to symptoms that could otherwise be missed but it should be born in mind that they cannot determine conclusively that mistreatment is occurring:

Identifying elder abuse is typically a lengthy process that requires trained observation and clinical professional judgement based on information obtained. Observation and clinical interviews remain the most significant factors in identifying elder abuse. (Basu 1992, p. 11)

3.4.1 Indicators of physical abuse
- Bruises (on different surface areas; may reflect shape of a weapon; whether clustered or not)
- Laceration (particularly to mouth, lips, gums, eyes, ears)
- Abrasions
- Scratches
- Burns (inflicted by cigarettes, matches, ropes, irons, immersion in hot water)
- Sprains
- Dislocations, fractures
- Marks left by a gag
- Hair loss (possible hair pulling)
- Missing teeth
- Eye injuries (black eye, detached retina).

3.4.2 Indicators of sexual abuse
- Trauma about the genitals, breasts, rectum, mouth
- Injury to face, neck, chest, abdomen, thighs, buttocks
- Presence of sexually transmitted disease
- Human bite marks.

3.4.3 Indicators of psychological abuse
- Demoralisation
- Depression
- Feelings of hopelessness/helplessness
- Disrupted appetite/sleeping patterns
- Tearfulness
- Excessive fears
- Agitation
- Resignation
- Confusion
- Unexplained paranoia
- Strong ambivalent feelings toward abuser.

3.4.4 Indicators of financial abuse
- Unexplained or sudden inability to pay bills
- Unexplained or sudden withdrawal of money from accounts
- Funds diverted for someone else s use
- Damage to property
- Unexplained disappearance of possessions
- No funds for food, clothes, services
- Absence of required aids, medication
- Refusal to spend money
- Disparity between living conditions and assets

- Extraordinary interest by family member in older person s assets
- Making dramatic financial decisions.

3.4.5   Indicators of neglect
- Dehydration
- Malnutrition
- Inappropriate clothing
- Poor hygiene
- Unkempt appearance
- Under/over medication
- Unattended medical needs
- Exposure to danger/lack of supervision
- Absence of required aids — glasses, dentures etc.
- Pressure sores.

3.5   Problems in identification

Different categories of abuse present different dilemmas in the context of identification. The long hard learning process which led to the current knowledge in the field of child abuse, based on extensive research and experience, has only begun in the field of elder abuse.

The distinction between normal ageing and disease is an essential foundation to the recognition and assessment of possible cases of abuse. Bruising, for example, is common in older people, and it cannot be used as a definitive indicator of abuse (Homer and Gilleard 1990, pp. 1359-1362). Fractures as an indication of physical abuse can also pose a serious dilemma. The occurrence of spontaneous fractures of the long bones in older nursing home patients, without risk factors and with no known trauma has been reported (Kane *et al.* 1991). The authors describe six cases in which the patients were non-weight-bearing for at least two years and sustained fractures of hip and long bones of the leg and arm. Accusations by the family concerning physical abuse by staff were a feature of four of the six cases. The authors conclude that truly spontaneous fractures do occur in nursing home patients and that recognition that they are a complication of prolonged bed rest may lessen accusations of abuse or neglect.

Sexual abuse of older people is difficult to identify but as knowledge becomes available case identification is increasing. Ramsey-Klawsnik (l991), for example, found that many suspected victims have severe impairments (e.g. dementia) and are unable to credibly and reliably report abuse. Offenders who force older people into unwanted sexual activity often have abusive or sadistic personalities, are unlikely to admit wrongdoing and often intimidate victims into silence (Ramsey-Klawsnik 1996).

Behavioural observation may be one way to identify hidden psychological abuse. Observation of interaction between the older person and family members may identify behaviour such as speaking in harsh tones, interrupting the older person or making it difficult for professionals to speak to the older person alone (Ramsey-Klawsnik 1996). The assessment of verbal content, communication styles and the appearance of undue fear or anxiety in the older person is also useful (Rathbone-McCuan and Voyles 1982).

Identification of financial abuse is receiving increasing attention, as this form of abuse becomes recognised as a prevalent type in its own right. It has been questioned whether the

practices uncovered in research into financial management of the affairs of older people with dementia can all be included as an aspect of elder abuse. The issue of intent is clearly one which must be addressed here. It is suggested that when an older person has been financially abused:

> the perpetrator is as likely to be the complexity of the legal and administrative framework, rather than relatives and professionals, the majority of whom are well meaning. (Langan and Means l996, p. 310)

The legal and cultural issues surrounding inheritance, for example, and the practical problems faced by agencies dealing with financial issues relating to older people with dementia are just two of the complex challenges to those attempting to detect financial abuse (Langan and Means 1996). A further difficulty is the lack of conceptual clarity surrounding financial abuse. Wilber and Reynolds (1996, pp. 61-80) suggest four criteria that distinguish between abuse and acceptable exchange of wealth: the extent to which an older person relies on others for care and help with decision making; the relationship between the older person and the suspected wrongdoer; the relative costs and benefits to the two parties involved; the type of influence used, for example fraud or coercion.

The identification of neglect is perhaps the most difficult task, given that indicators such as malnutrition, dehydration, weight loss and pressure sore formation have so many possible causes other than neglect (Bennett and Kingston 1993). It is critical to understand the intersection of neglect with the ageing process and disease. Positive identification of neglect must distinguish the effects from the potential ravages of a disease process. A second stage in the assessment process, once the presence of neglect has been established, involves addressing the level of intent and identifying the perpetrators. Neglect by a formal care provider, for example, could involve issues of malpractice, and breach of contract and litigation may ensue. The involvement of a multi-disciplinary team in this aspect of assessment as well as extensive interviews with the care providers and the older person is recommended (Fulmer and Gould 1996; Fulmer 1989).

3.5.1 Self-reporting
Victim reluctance to report is a well recognised barrier to case finding. A UK Social Services Inspectorate report (1992) found that the rate of self-disclosure in cases of elder abuse was low. In some cases the suggestions of abuse were later denied. Older people are most likely to admit they have been abused if they feel they have a close relationship with a care professional. Special relationships formed during therapy or rehabilitation that allow for the discussion of unvoiced concerns are of particular value. Education and training of all those involved with older people, the empowerment of older people themselves and the development of mechanisms such as Helplines may contribute to an increased rate of self-reporting (Bennett and Kingston 1993).

3.5.2 False reporting
It is agreed that false reporting of elder abuse does exist (Bookin and Dunkle 1989). The reasons for this include: malevolent intentions; misunderstanding of conditions whose symptoms mimic those of elder abuse (e.g. dementia); referral made as a means of retaliation or revenge; and lack of knowledge about the effects of certain medications. The issue of false reports over a three year period in North Carolina was examined by Shiferaw *et al.* (1994). Of 123 cases, 93 were not confirmed, 23 were confirmed, and investigation was not

completed for seven cases. Unconfirmed reports were more likely to involve those in nursing homes and those with physical illness. The researchers cite anecdotal evidence that unconfirmed allegations in nursing homes were due in part to disgruntled employees who filed false charges . They also point to a discrepancy between those who report abuse and those who investigate in terms of their respective definitions.

3.6   Policies for identification of abuse and neglect
A number of protocols for assessment have been devised to identify abuse or neglect after it has allegedly occurred. Protocols are procedures and guidelines which support policies with respect to elder abuse and neglect. The functions of policies and protocols are to:

* sensitise workers to elder abuse and neglect and promote education
* develop a consistent response to cases
* facilitate accurate data collection (Watson *et al.* 1995, p. 64)

Most assessment protocols include guidelines on confirming cases of elder abuse and neglect, involving check-lists or lists of symptoms of abuse, reviewing the older person s physical, psychological, social, medical and support systems and the use in some cases of standardised tests. Some assessment protocols include possible intervention strategies (McDonald *et al.* 1991, p. 87). The flaws of existing assessment protocols include:

* a focus on caregiver stress at the expense of marital violence or the psychological problems of the perpetrator
* the confusion between indicators of risk and actual abuse
* the difficulty of detecting neglect: few protocols emphasise the need to first consider systematically whether a symptom is the result of disease or ageing
* the reliance on professional judgement rather than the collection of objective data
* the oversimplification of complex human situations into categories in a static assessment form
* an assumption of considerable knowledge from professionals, which may be inappropriate to their area of expertise
* a lack of applicability — attempting to apply a protocol devised for the domestic setting to a nursing home setting may cause major problems (McDonald *et al.* 1991).

Important advice in relation to the use of assessment protocols is contained in the following quotation:

> Until a number of identified problems can be resolved satisfactorily, a reasonable stance for the practitioner is to use assessment instruments judiciously, preferably in conjunction with other professionals for shared decision making and responsibility; to be aware that factors other than evidence influence the assessment process; and to call attention to the need for continuously updating, evaluating and standardising current assessment protocols. (McDonald *et al.* 1991, p. 91)

3.7   Record keeping
Rosenblatt (1996, pp. 145-161) discusses the importance of good record keeping in relation to cases of elder abuse. The information that must be documented is summarised under the following headings: demographic data; psychological data; caregiver data; items in medical history suggestive of problems, for example, doctor hopping; observations that suggest risk

for mistreatment, visible markers of abuse/neglect noted on body map or photographed; laboratory data and x-rays to support diagnosis of mistreatment; documented summary of care plan. The author sees it as a challenge to convince many professionals of the importance of documentation as the basis of good patient care. Although formulated in the context of the system in the USA with mandatory reporting in most states and the responsibility of Adult Protective Services teams, these are useful pointers for the Irish context.

3.8   Conclusion

The above discussion makes it clear that the identification of cases of elder abuse and neglect is a difficult and complex task. Filinson (1989) summarises the realities of direct practice in the identification of elder abuse in which clear signs are seldom evident:

> typically, clinicians struggle with situations in   which it is difficult to identify clear signs of damage, where the intentions of the perpetrators are neither demonic nor evil, where the identification of a responsible party is difficult and where the elder is unable or unwilling to participate on the identification process. (p. 87)

Abuse in Institutional Settings

There has long been concern about the risk of elder abuse in institutional settings. In Britain the publication of *Sans Everything: A Case to Answer* (Robb 1967) was the beginning of serious attention to institutional abuse. The first scientific publication on the topic was entitled Old folks and dirty work: the social conditions for patient abuse in a nursing home (Stannard 1973). This article, using data gained by participant observation, examined the everyday conditions of work that keep nurses from seeing or hearing about abuse, and allow them to deny its occurrence.

Abuse in institutional settings needs to be dealt with separately because it often has unique causes, manifestations and effects and will require a unique approach to detection and intervention. Biggs *et al.* (1995) have outlined the special characteristics of institutional care. First, residents and staff may have very different conceptions of the role of the institution: for residents it is a home but for most staff it is a work place. Second, older people in institutional care live their private lives in a public setting which is quite different from the domestic home they are used to (Wilcocks *et al.* 1987). Third, the institution has a special relationship with the outside world, in that it is more public than a private home, but also more cut-off from the outside world. Biggs *et al.* note that these tensions can be resolved by awareness of the special nature of institutional care. They warn however that:

> when the pressures of work, both personal and institutional, dominate residents requirements, in a closed environment with scant respect for resident autonomy and privacy, mistreatment is always waiting in the wings. (Biggs *et al.* 1995, p. 78)

4.1   Context

While the future development of the Irish health services is in the direction of community-based care, there will always be a need to provide some form of long-stay residential care to older people. Exact figures about the number of older people in long-stay care at any one time are not available but it is clear that the percentage (approximately 5 per cent) is much lower than is commonly thought. In recent years the long-stay sector has seen a number of changes. The number of older people in geriatric and psychiatric hospitals has fallen while the number in private nursing home beds has increased. In the future, an increasing number of older people may receive long-stay care in community hospitals.

Table 4.1 below shows the number of older Irish people resident in different long-stay settings, and is based on the 1995 survey of long-stay units carried out by the Department of Health. As a small number of private nursing homes were not included in the survey, the real figures for such facilities are slightly higher than those recorded below.

Table 4.1: Number and percentage of older Irish people in long-stay care in 1995.

Type of setting	Number	Percentage
HB geriatric home/hospital	5,058	1.23

HB welfare home	1,191	0.29
HB district/community hospital	1,620	0.39
Voluntary geriatric home/hospital	2,988	0.72
Private nursing home	5,531	1.34
Psychiatric hospitals and units*	3,300	0.80
Total in long-stay care	19,688	4.77
Total over 65 years in 1995	412,500	100

*Relates to 1991
Sources: Department of Health (1997b) and Moran and Walsh (1992).

Approximately two-thirds of patients in long-stay settings are female. Sixty-two per cent of residents are aged 80 years or more compared to 20 per cent of the older population as a whole. An analysis of patient dependency shows that 65 per cent of residents are in the high or maximum dependency categories. Private nursing homes are the most common long-stay setting followed by health board geriatric homes and hospitals.

4.2   Definition

A key to the definition of institutional elder abuse is the expectation that certain standards of care are to be delivered by professional carers. One must also consider the organisational culture surrounding the context in which care is delivered (McCreadie 1996). In many ways these considerations change the focus from interpersonal dynamics to professional standards . However, it is important not to underestimate the importance of person-to-person relationships in institutional care and abuse (Gilleard 1994, p. 94).

Gilleard (1994) proposes that there are three distinctive categories of abuse in institutional settings. These are abusive behaviour (e.g. hitting, pulling, shaking), abusive practices (e.g. force-feeding, restraint, over-medication, neglect) and abusive attitudes (e.g. humiliation, neglect, lack of privacy, hostile comments). A similar categorisation has been used in relation to child care institutions: abusive behaviour (physical, emotional, sexual, neglect), programme abuse (when institutions rely on harsh or inhuman techniques to modify behaviour) and system abuse (when the system of child care is stretched beyond its limits and incapable of caring for children appropriately) (Gill 1982).

In one of the few surveys on the prevalence of physical and verbal abuse of older patients in nursing homes in the USA the following indicators of physical abuse were used:

- excessive use of restraints
- pushing, shoving, grabbing, pinching a patient
- slapping or hitting a patient
- kicking, hitting with a fist
- hitting, trying to hit a patient with an object.

The items measuring psychological abuse were:

- inappropriately isolating a patient
- insulting, swearing at a patient
- yelling at a patient in anger
- denial of food and privileges
- threatening to hit or throw something at a patient.

The most frequent type of physical abuse seen by staff was excessively restraining a patient (21 per cent of respondents observed this). Pushing, grabbing, shoving and pinching were observed by 17 per cent of respondents and two per cent had seen staff kick a patient. Ten per cent of respondents reported that they themselves had committed one or more acts of physical abuse. Excessive restraint was again the most frequently reported (six per cent). Pushing, grabbing, shoving, pinching and hitting and slapping were committed by three per cent respectively. No one reported kicking or hitting a patient with a fist. Psychological abuse was observed by 81 per cent of respondents and admitted to by 40 per cent of respondents. The most frequently observed and reported behaviour was yelling at a patient.

In another US study, the work lives and dilemmas of nursing aides was examined (Foner 1994). Physical abuse by nursing aides was rare but psychological abuse was common. Examples of such abuse included taunting and teasing patients, making jokes in front of them at their expense, gruff tones, ignoring calls for help, insensitivity to residents right to privacy, indifference and apathy while providing personal care. However, the results of the research emphasise that:

> this mixture of compassion and exasperation is a powerful reminder that aides relations with patients cannot be reduced to simple all-or-nothing evaluations —and a reflection of the complex tangle of attachments, obligations and antagonisms involved in nursing home care. (Foner 1994, p. 250)

Gilleard (1994) also emphasises the dilemma of definitions in relation to practices such as bathing activities, use of restraint, and feeding patients who refuse to eat. Without clear empirical guidelines definitions are ambiguous and the demonstration of the use of a particular practice is rarely sufficient to warrant terming the practice abusive .

Abuse in institutional care also includes financial exploitation. Theft of money by staff; mismanagement by administrators (e.g. charging for services, collecting money for deceased residents) and embezzling a resident s funds are examples of such behaviour. A study of a social services authority in the North of England examined key issues relating to financial management and older people with dementia. In responses relating to both residential and nursing homes, the issues considered included the management of residents money by home owners, the problem of getting access to funds and the difficulty of getting money from relatives who siphoned off residents money and kept back some of their personal allowance (Langan and Means 1996).

Sexual abuse as a form of institutional abuse in its own right is becoming increasingly significant. Of interest in this context are two recent reports in the media in Ireland. The first concerned a case of the sexual abuse of an 89 year-old woman by the proprietor of a nursing home in which she was resident which came before the Central Criminal Court in Dublin (*The Irish Times* 1991). The second concerned an allegation of sexual assault on a male patient in a

County Clare hospital for older people. The alleged perpetrators were two male members of staff (*The Irish Times* 1996).

4.3   Risk factors
Explanations for abuse in institutional settings are largely speculative. Some possible avenues for further explanation are the following factors:

- lack of staff training and education
- culture and structure of the organisation
- pathological characteristics of care staff
- work-related stress and professional burn-out
- patient characteristics that might predispose them to being victims of abuse (Gilleard 1994).

Situational variables that affect the quality of staff-patient interactions appeared to be the strongest predictors of abuse. These factors were: poor job satisfaction; beliefs that the patients were like children ; staff burn-out and conflict with the patients. In addition, stress in the personal lives of staff was associated with psychological but not physical abuse (Pillemer and Moore 1989, p. 318).

Unpublished work (Clough 1988) lists some of the contributory causes for abuse:

- failure to agree within the managing agency about the purpose and tasks of the home
- failure to manage life in the home in the appropriate way. When things went wrong, they were not sorted out
- poor quality buildings and shortage of staff
- lack of knowledge of guidelines around which the home was organised
- staff capacity and lack of training
- low staff morale
- low status ascribed to the work
- failure by management to see a pattern of events, treating instances of abuse in isolation.

An important extrinsic factor that may account for institutional abuse is the supply and demand of nursing home beds. Shortage of beds means that even homes with a reputation for poor quality care may be filled. The patient characteristics identified as risk factors for institutional abuse include mental impairment and dependence. Staff characteristics include burn out, low levels of education and negative attitudes towards older people (Pillemer 1986, pp. 227-238). High levels of staff-patient conflict and patient aggression towards staff are also highlighted in other studies (Eastley 1993, p. 845: Lee-Treweek 1994, pp. 2-4).

In discussions of elder abuse in institutional settings, there has been a tendency to mask the gender issues pertinent to institutional care and abuse. Such abuse is predominantly abuse between women. The factors which contribute to this are the dependency and a lack of autonomy which entry into an institution can bring, the low status and unskilled female workforce, depersonalisation of institutional care regimes, difficulties with inspection and a culture in which everyday violence becomes invisible (Aitken and Griffin 1996, pp. 79 - 102).

Finally, there are certain factors in the organisational culture of institutions which can lead to a corruption of care. Important here are the stripping of the personal identify of the residents; the powerlessness of staff as employees whilst having absolute power as carers ; under-estimation of the difficult nature of some forms of personal care work; failure of management; models of work organisation that stifle complaints, professional isolation and routine; and hierarchic patterns of practice (Wardaugh and Wilding 1993, pp. 4-31).

4.4   Detection

Detection of abuse in institutional care poses many of the difficulties found in the domestic setting, in particular the reluctance of the victims to complain. However, most older people in institutions will at least have the support of regular visitors, who may be in tune with the ambiance of the home and notice subtle changes in a relative s behaviour (Bennett and Kingston 1993).

Detection of institutional abuse poses many difficulties, as the more serious acts are hidden and a police-like investigation must often be conducted in order to gather evidence (Beaulieu and Belanger 1995). Barriers to the reporting of institutional abuse of children in care are of relevance here. These barriers are outlined in the report on the Inquiry into the Operation of Madonna House in Dublin (Department of Health 1996). The report refers to absence of procedures for reporting and investigating abuse, viewing abuse as a problem of an individual member of staff and not of the institution, the closed nature of institutions, belief systems surrounding institutions, the responses of staff to disclosure and staff relationships that inhibit members talking about their knowledge.

A report prepared by the UK charity Counsel and Care (Bright 1996) points to the need for staff to feel able to blow the whistle on fellow members of staff. Loyalty to colleagues and fear are cited as reasons for reluctance to report bad practices, as are fears of recrimination and dismissal. In order to address the issue of whistle-blowing the legal charity Public Concern at Work was set up in the UK. The organisation deals with providing advice and assistance to employees and others with serious concerns about public dangers and malpractice. The advisory service helps to set up ways to encourage employees to raise concerns, mechanisms for ensuring that information received is properly addressed and procedures for ensuring that those who raise concerns are treated fairly.

In the UK the role of Inspection Units is also of major importance. The Registered Homes Act (1985) lays down regulations to secure standards of care. Inspection Units are responsible for inspecting residential and nursing homes and are independent of or described as at arms length from local Social Service Departments. The powers of Inspection Units in the event of suspected abuse are many and include notice to require the improvement of practice within a certain time limit, planned closure and emergency closure (McCreadie 1996, p. 65).

In general the inspection of old people s homes is very complex. Important here are the consistency of inspections; the development of checklists; identifying reliable and hard indicators of performance; developing tools for identifying opinions of residents and relatives; and conscious attempts to facilitate whistle-blowing (Gibbs and Sinclair 1992, pp. 535-550). In regard to this last point, no system of inspection will fully guard against hidden, unacceptable practices. It is necessary that residents, staff, and the general public know how to contact an inspector, what kind of practice is unacceptable and what action the inspector

can take. In Ireland, the *Health (Nursing Homes) Act* 1990 makes provision for the registration and inspection of nursing homes. This is discussed in more detail in Chapter Seven. The setting up of a Social Services Inspectorate at the Irish Department of Health and Children will undoubtedly have an important impact as will the implementation of the recommendations of recent reports (*see* Chapter Seven).

4.5   Abuse at home by formal carers

Many older people in the community have to rely on domiciliary care, which involves help with personal care tasks. Elder abuse by paid carers is beginning to receive attention. The growing home care industry is a sector which has given rise to some reports of abuse in an unregulated area of service provision. The isolation of such workers, coping with difficult client behaviour, demanding and critical families and lack of training and support are issues to be addressed (Hudson-Keller 1996, p. 225; Aitken and Griffin 1996, p. 101).

4.6   Conclusion

The report on the Inquiry into the Operation of Madonna House (Department of Health 1996) provides a very applicable summary relevant to elder abuse in institutional care. Summarising the literature review, the authors conclude that abuse in care settings:

> cannot be viewed solely from the perspective of the individual acts of abuse and neglect by individual perpetrators, but must be understood to result from a number of inter-related system factors. These include, in particular, the needs of the individual children, the personality and skills of carers, the ethos, policies, support, supervision and general resources of the specific and wider child care systems, as well as the perceptions of the community at large, all of which determine the potential for abuse. (p. 41)

Intervention

A recent review of social perspectives on elder abuse states that responses to elder abuse and neglect are in a rather crude and formative developmental stage (Penhale and Kingston 1995, p. 242). A review of the literature identifies three major strands of debate.

5.1 Elder abuse as a distinct category of abuse

Internationally the need for special responses to elder abuse, distinct from the mainstream of adult family violence interventions, is a widely debated issue. There are three existing models which might be used. The first is based on child welfare procedures and is usually linked with extensive powers of investigation and intervention, mandatory reporting statutes and the conceptualisation of elder abuse as a problem of caregiving. A second option takes a generic approach to adult abuse issues, using the same procedures for older people and other vulnerable groups (e.g. people with learning disabilities). A third option is based on spouse abuse procedures. This is generally a more flexible and less paternalistic approach which emphasises self-help and empowerment as well as criminal sanctions.

In general, it is agreed that the distinct causal factors and manifestations involved in elder abuse make it necessary to devise distinct interventions. A 1990 Council of Europe report concerning violence within the family, for example, outlines specific measures for children, women and older people. Elder abuse interventions have also been differentiated from interventions designed for adults with learning disabilities (Hildrew 1991; Penhale 1993b). Finklehor and Pillemer (1988, pp. 244-254) argue for the special categorisation of elder abuse, justified by the special characteristics of older people, their devalued social status which increases vulnerability to abuse and lastly, the existence of a service system and specialised professionals who relate to older people and respond to problems. Others point to the validity of viewing elder abuse as a separate area whilst encouraging the development of links with the vulnerable adult lobby (Bennett 1994). This is in accord with practice guidelines from the UK Social Services Inspectorate (1993) which advocate that abuse to older people should be considered separately.

Despite this agreement on the need for a distinct approach, a survey of social services departments, health authorities and National Health Service Trusts in the UK (Action on Elder Abuse 1995) found that many organisations had generic adult abuse policies, and that not all differentiated between those over and under sixty-five years of age. An earlier survey of statutory care providers found that there was an equal division between those developing elder abuse policies and those working on adult abuse in general (Penhale 1993b). The survey was summarised as follows:

> No clear pattern emerged as to a distinct preference for either elder abuse or adult abuse a few respondents mentioned that they had commenced with one area of abuse (e.g. older people or those with learning disabilities) and were or would be looking to extend their work further. Other respondents indicated that they had commenced with one area of work and then changed to another (e.g. widening and narrowing the focus). (p. 14)

In general there is a growing recognition that adult abuse policies, particularly those that focus on adults with a learning disability, are not sufficient to cover elder abuse (McCreadie 1996).

5.2 Ethical issues

There are a number of fundamental moral issues faced by practitioners intervening in the area of elder abuse. These ethical dilemmas of everyday practice are addressed by several writers (Pelaez 1989; Gilbert 1986; Ogg and Bennett 1992b; and McDonald *et al.* 1991). The three ethical principles commonly referred to are beneficence, autonomy and non-maleficence.

According to the principle of beneficence, people should act in such a way as to remove and prevent harm or provide benefits. When an older person refuses service, however, the principles of ending the harm or respecting the right to self-determination can conflict in ways which are most difficult to resolve. The principle of client autonomy is central to the codes of practice of all care professions, meaning that professionals can act only with consent and must also respect confidentiality. Gilbert (1986, p. 55) however, questions whether refusal of consent in coercive circumstances, for example, fear of reprisal or fear of institutionalisation, could be voluntary and considered final. The principle of non-maleficence governs acting in a manner which does not inflict harm on others. This principle comes into conflict with an intervention which may result in institutionalisation or extensive investigation without offering the necessary services.

5.2.1 Mental capacity

The practitioner faces a major moral dilemma concerning choice for older people with cognitive impairment who wish to remain in an abusive situation or refuse services. A major UK report (Law Commission 1995) proposed a new statutory definition of what it means to be without capacity to make a particular decision. The definition states a person is without capacity if at the material time he or she is:

- unable by reason of mental disability to make a decision for himself on the matter in question; or
- unable to communicate his decision on the matter because he is unconscious or for any other reason (Law Commission 1995, paragraph 11.7).

The definition of incompetency poses fundamental problems in itself and can add to the complex predicament of the practitioner trying to intervene. The issue of mental capacity is a key one in relation to general legislation, which may be relevant to elder abuse, (e.g. enduring power of attorney, testamentary capacity, wardship). However, many countries have also enacted special adult protection legislation, notably the United States (Wolf 1994, pp. 11-19) and Canada (Robertson 1995; McDonald *et al.* 1991).

In the UK the Law Commission (1995 paras 9.19-9.34) proposed step-by-step intervention to protect vulnerable people who are at risk which would include power of entry and application to the court for an assessment order or a temporary protection order. It is important to note that the exercise of these powers is qualified by the proviso that the person concerned must be found to be without capacity. The Commission also recommended that the Secretary of State prepare a code of practice to provide guidance on the assessment of whether a person is or is not without capacity to make a particular decision. This indicates the centrality of the concept to the issue of intervention. Even though there is to be no legislation resulting from the Law Commission s report, the recommendations are of relevance

to the discussion of intervention strategies in Ireland, particularly in the light of the Adult Care Order legislation proposed in the recent white paper *A New Mental Health Act* (Department of Health 1995a, see paragraph 7.14.4 of this report).

5.3   Barriers to intervention

Decisions about intervention can be complicated by a number of issues (Penhale 1994b). First, the possibility that the victim may refuse assistance. Second, the limited number of reasonable options available to the care worker (whether because of the intractable nature of the situation or because of a lack of resources). Third, the care worker s low level of expectations about what can be achieved through intervention. Fourth, an inappropriate assessment of the situation by the care worker. Fifth the limitations imposed by legislation in the area. The reluctance of older people and abusers to initially seek assistance, professional reluctance to report, and lack of knowledge of the criminal justice system are also factors (McDonald *et al.* 1991).

The decision-making process which culminates in an intervention decision is generally complex. Health care workers may be caught in a cycle of indecision characterised by active worry and self-doubt which may delay intervention even in serious cases of risk to the older person. In other cases, the health care provider can find the reasons for the abuse so understandable that no intervention is considered. A further problem is an inability to arrive at an intervention decision because of a fear of the perceived consequences and the perceived constraints inhibiting action. In these situations the overriding concern of the care worker is often self-protection, which may lead to a premature closing of the case, referral to other professionals or a protracted period of observation and recording (Phillips and Rempusheski 1986).

5.4   Models of intervention

A number of different approaches to intervention with elder abuse have arisen in different countries. The main categories are described below with an illustration of the models in practice where appropriate.

5.4.1. Adult protection programmes

The adult protection approach refers to a system of preventive and supportive services for vulnerable adults within a framework of special adult protection legislation, following the model of child welfare legislation, which creates considerable powers of investigation and intervention. Mandatory reporting statutes are a significant feature of adult protection legislation in the United States. In Canada, the provinces of Newfoundland, New Brunswick, Nova Scotia and Prince Edward Island have adopted this approach although there is some difference in the scope of the legislation between them. Nova Scotia and Newfoundland impose a duty to report suspected cases. New Brunswick and Prince Edward Island have a voluntary code. The major criticism of such an approach has been its adoption of the child welfare model in the development of legislation (Faulkner 1982; Gilbert 1986). An overview of adult protection legislation states:

> The criticisms of the special adult protection legislation, both in Canada and the United States, have been so extensive and so severe that its credibility is damaged, perhaps irreparably. (Robertson 1995, p. 62)

New initiatives in British Columbia with the enactment of the Adult Guardianship Act in 1993 are highlighted as a possible way forward. The complete revamping of British Columbia Law includes a system of voluntary reporting and a higher level of due process protection; it follows the fundamental principles of self-determination and using the least intrusive and restrictive intervention (Robertson 1995). The new model includes a framework for the development of Community Response Networks (CRN) with the local health, social service, and legal agencies, non-profit and government, pooling their resources to respond to reports of abuse and neglect of adults. A multi-disciplinary team of people designated by each agency in each CRN investigates and offers support and assistance, including the implementation of guardianship laws if necessary. It is planned that every geographic area in British Columbia will have a CRN (McKenzie *et al.* 1995, pp. l8-26).

Bergeron (1989, pp. 218-228) outlines the response of the Division of Elderly and Adult Services to reports of abuse, neglect and exploitation in the State of New Hampshire, USA. The New Hampshire law involves mandatory reporting. Once a report is received the social worker must respond with an investigation in three days. A major problem with this model is the lack of integration of the adult protection service with those service providers who report and respond to cases. In order to overcome this a Task Force on Elder Abuse was set up to initiate a process of sharing responsibility in an effort to overcome the difficulties associated with delegating investigation to a separate agency. The Task Force consisted of a core group of service providers aiming to create a common approach to elder abuse and neglect in the region.

Wolf and Pillemer (1988, pp. 257-274) describe the evaluation of model projects for intervening with cases of elder abuse. One of these, in Rhode Island, was described as a distinct mandatory reporting model and tended to receive the highest number of referrals of physical abuse. It also had closer ties to the police but also had the greatest difficulty in inter-agency co-ordination because of the large number of referrals, the speed with which cases had to be referred to other agencies and the rapid nature of the short-term intervention strategies used. By contrast, another model used in Worchester used a style of practice that involved lengthy case work over a long period of time. While this may have been less cost-efficient it is likely to have been more acceptable to the victims (Wolf and Pillemer 1988, p. 273).

5.4.2   Risk model and the welfare model
Stevenson (1996), in her review of what the field of elder abuse has to learn from child protection interventions, outlines aspects of what she terms the model of risk . The primary focus on risk places workers in an ambiguous position and proceduralisation is part of the response.

A key aspect of the risk approach is the focus on registration of those at risk: this has become an entrenched part of child protection. There has been much debate and research about the efficacy of this approach in child care which could well prove relevant to elder abuse (Gibbons and Bell 1994). In particular the wide variation in criteria used to identify those at risk and the failure to register cases of serious neglect are potential pitfalls. Studies of the risk model have brought about a concern that the emphasis on risk has led to a lack of attention to cases needing support and also to the idea of prevention. This has in turn drawn attention to the importance of precision in defining the terms support and prevention . Another danger of the risk model is the tendency to focus on specific incidents and attempts to

measure the gravity of the injuries. This, as Stevenson points out (1996, p. 17), is less useful in cases of inadequate care or neglect over time. In contrast to the risk model, Stevenson (1996) argues that a welfare approach is more appropriate for elder protection, where:

- goals of intervention are defined in terms of help and support, not only in terms of averting risk
- a holistic view of family need and difficulty is taken
- help and support is provided over significant periods of time if required (p. 18).

5.4.3 Advocacy model

Advocacy is a relatively new approach to working with older people. Among the factors influencing the development of an increasing interest in advocacy are the development of charters of rights, legal provisions geared towards empowering the individual (e.g. enduring power of attorney), policies giving a greater say to consumers and the general perception that there is a need to devolve authority to older people and their carers (Biggs *et al.* 1995). A broad definition of advocacy refers:

> to those activities that involve speaking for or acting on behalf of an individual or a group in order to ensure that their needs are met and their rights respected. (McDonald *et al.* 1991)

A differentiation between legal and social advocacy is important, the former being the representation provided by a lawyer, the latter speaking or pleading on behalf of another using non-legalistic means.

In Ontario, Canada the concept of social advocacy is established in certain programmes. The Psychiatric Patient Advocate Office, for example, was established in 1982 and is mandated to investigate alleged incidents of abuse and the institutional responses to them. The Adult Protective Services Programme is a further development which involves advocacy on behalf of developmentally handicapped adults. A third programme provides formal legal advocacy through a specialised legal aid clinic in Toronto (the Advocacy Centre for the Elderly), providing legal advice and representation before the courts (McDonald *et al.* 1991). In North Shore British Columbia, Canada, an advocacy model of intervention has also been developed. Although not focused exclusively on older people or on abuse, the service provides practical support from volunteers to older people experiencing legal problems, a strong voice for social advocacy on issues affecting older people and paralegal services in the area of family law, which receive a considerable number of referrals from older people (McKenzie *et al.* 1995, p. 21).

In some advocacy programmes there is a strong emphasis on voluntary supports to older people. Reis and Nahmiash (1995, pp. 666-671) outline an intervention model to combat elder abuse and neglect in a large suburban area of Canada. An innovative element of intervention was the use of non-professional volunteer buddies who followed a group training programme and met weekly with abused victims and/ or abusers in their homes. The aims of this scheme were:

> To decrease isolation, help inform the senior victims of their rights, assist and empower abused seniors and accompany them through the problem-solving process.

The Senior Advocacy Volunteer Program in Madison, Wisconsin, also uses voluntary supports, providing direct links to services, interpersonal and systems advocacy and emotional support. An evaluation of the programme indicated that older people benefited from emotional and concrete help as well as self-awareness about their own interpersonal relationships (Wolf and Pillemer 1994).

Empowerment is a central element of advocacy. Empowerment consists of enabling people to know what choices they have and making those choices feasible (McCreadie 1996, p. 88). Reis and Nahmiash (1995, p. 669) describe the use of empowerment groups with victims of elder abuse. These usually consist of six to ten abused older people meeting on a weekly basis, facilitated by a nurse and a social worker. The groups were formed to decrease isolation, to discuss methods and resources for dealing with abuse and also to foster feelings of personal control in the victims so that they might be better able to resist abuse in the future. A similar programme — the Victim Support Group of Mount Sinai Medical Center — New York has also been described (Wolf and Pillemer 1994). A closely related approach to the advocacy model of intervention is the use of mediation. The basis for a mediation project is that early resolution of relational conflicts can contribute to the prevention of elder abuse. It involves the use of trained volunteers with conflict resolution skills (Craig 1994).

In summary, the values and the limitations of the advocacy and mediation approaches are as follows: the strength is in the emphasis on participation of older people; the limitation is that reliance on participation may, at least initially, be unrealistic. These approaches can be used as a first line of intervention which requires additional measures, especially for those at immediate risk of abuse (Biggs *et al.* 1995, p. 109).

5.4.4   *The staircase model*
The staircase model (Breckman and Adelman 1988) is based on the receptivity of the victims to helping themselves and is designed for use with competent older people. The model is portrayed visually as a staircase — the bottom of the staircase represents life with mistreatment . The staircase has three steps or stages — reluctance, recognition and rebuilding. Intervention strategies using the framework provided by this model are followed through to each stage and include:

- breaking through denial
- decreasing isolation, guilt, self-blame
- education about options
- help with emergencies
- providing advocacy.

The goal of such strategies is a life without mistreatment. The authors are careful to point out that sometimes victims move in a descending direction on the staircase (e.g. from denial to recognition) and then back to denying that abuse is a problem. They reassuringly advise that the cognitive and behavioural changes are not lost and that breaking through denial the second time is not as difficult as the first.

5.4.5   *Domestic violence model*
The interventions described above have usually taken a distinct approach to the problem of elder abuse, but some intervention programmes also draw strongly on the programmes developed to deal with domestic violence.

These programmes generally have the following characteristics: clientele are viewed as victims of crimes; services include emergency shelters, hot lines, criminal justice advocacy and support group counselling (Breckman and Adelman 1988). In Ireland, Women s Aid, in their research into violence against women in intimate relationships (Kelleher 1995) recommend intervention that includes the following major elements of support: advocacy, a crisis Helpline, self-help groups and adequate safe refuges run on an empowerment model. The main reason for considering the use of a domestic violence approach to elder abuse is the fact that most elder abuse is committed by a spouse. Pillemer and Finklehor (1988, pp. 51-57) found that as many more older people live with their spouses than with children, the spouse was more likely than offspring to be the abuser. More than half of the elders reporting abuse in the study had been abused by spouses.

The domestic violence model for dealing with elder abuse is very new and consequently few evaluations of service effectiveness exist. There may be a particular difficulty in its application to the category of neglect. The problems of a service response in cases of domestic violence are documented in the Irish context and need to be seriously considered (Kelleher *et al.* 1995) if the model is to be applied to the elder abuse field. However, there are a number of encouraging examples in the international literature of attempts to apply the domestic violence model to elder abuse and these are discussed below.

5.4.5.1 Helplines
Action on Elder Abuse is a national organisation in the UK, launched in 1993, which exclusively addresses the issue of elder abuse. In 1995, the Elder Abuse Response Line was launched as a confidential information and support service for anyone concerned about the abuse of an older person. It was a pilot project which was promoted in four areas of the country. Promoting the service involved the use of posters, including those for use on buses and hoardings and contact with local media. Exhibitions were also mounted.

The project was managed by the helpline manager, a part-time co-ordinator and a team of trained volunteers. The training/preparation course for volunteers was held for one day a week over five weeks after an introductory session and individual interviews. Volunteers were also appraised during training and went through a probationary period once they were operating the helpline. The main skills required of the volunteer helpline worker were the ability to:

- respond sensitively to anyone concerned about abuse
- respond to callers in a calm, mature manner
- listen effectively
- maintain confidentiality
- possess effective verbal communication skills
- cope with distressing information
- have a commitment and ability to use the opportunities provided for development of skills, knowledge and self-awareness, and
- have a commitment to the policies of Action on Elder Abuse and the Elder Abuse Response Line in particular.

The project was monitored and an independent evaluation of its impact was undertaken after one year. During the project the helpline received 550 calls of which almost 60 per cent were

about specific incidents of abuse — 16.5 per cent of calls were from victims. The recommendations of the evaluation of the project were that it should consider extending its coverage to the whole country; remain a national independent service; be staffed by volunteers, supported and managed by paid staff; that it should be a confidential freephone service and be publicised so that those in care homes are aware of its existence (Action on Elder Abuse 1997). Following these recommendations, the Elder Abuse Response Line was launched as a national service in November 1997. The service is open on a free phone number and operates from 10.00am to 4.30pm every weekday.

5.4.5.2 The elder shelter
The development of emergency shelters for abused and neglected older people is an important option which might be imported from the domestic violence model. Cabness (1989, pp. 71-82) describes a shelter in Washington DC which aims to protect and also build residents self-esteem through counselling, support groups, health promotion and inter-generational activities.

Hill (1996) also describes the efforts of a community group in South Carolina, USA, to establish a safe haven for older victims of abuse. The community were stirred by the plight of an 82 year old woman who was beaten by her caretaker with a shoe, and was found by a Home Health Nurse with her eyes blackened and swollen. The elder shelter was set up by a non-profit corporation and commenced with the contracting of two beds at a licensed nursing home. In 1992 a needs assessment revealed a requirement for four emergency shelter beds with an average length of stay of twenty-five days. As the number of cases dealt with by adult protective services increased, it became obvious that a two-bed shelter was insufficient. In 1996 the company was negotiating for the use of housing at a closed Navy base, with a view to accommodating as many as sixteen persons.

A Finnish variation of the elder shelter is described by Perttu (1996). The service is designed both for victims of elder abuse and for people with physical handicaps, and is based in a nursing home with both long- and short-term beds in a city near Helsinki. The shelter is situated in the short-term care ward. The services provided included a shelter at the nursing home, a telephone helpline and a support group. In the two years of the project 31 women and five men have used the nursing home as a shelter. The telephone helpline received 178 phone calls — 77 per cent concerned elder abuse. Four to ten people participated in the support group. While the small numbers do not offer a basis for generalised conclusions, the experiment demonstrated the use of a nursing home as a shelter that can offer rest and security especially in communities where there are no other shelters. There is a possibility of perhaps a similar project at a welfare home, community nursing unit, nursing home setting in Ireland. Shelters have been central in addressing the needs of battered women — not only for a safe place but as a means of developing support networks and increasing the input from outsiders who can help to redress the power imbalances that flourish in isolation.

The Ontario Network for the Prevention of Elder Abuse in Toronto, Canada, conducted a study to examine the viability of an emergency shelter as a needed, appropriate and effective response to the problem of elder abuse in Metropolitan Toronto (Michalski 1995). A key recommendation of the study was that emergency accommodations targeted to elder abuse victims should be developed with both women and men in mind as potential consumers. The conclusion of the study report states:

An emergency shelter or safe haven for seniors represents one such alternative that has been tried in a limited number of locations with some degree of success. On balance, the present research has demonstrated the need for that type of service in Metropolitan Toronto. Such a service, if developed, will not be a panacea (a shelter) can provide the security and support that the elderly in crisis may need. (p. 128).

5.4.6 A community-based project

A recent intervention programme in London took an eclectic approach to dealing with elder abuse but contained many of the principles of the advocacy approach. The SAVE programme ran over the years 1992-1995 in the borough of Lewisham and aimed to: research the incidence of elder abuse in Lewisham; raise awareness of the issue of elder abuse; provide training on elder abuse; and look at ways of helping older people who may be experiencing abuse. The SAVE project was committed to an inter-agency community response to elder abuse and to explore the relationship between elder abuse and domestic violence involving older people. The agencies involved included the police, the health authority, social services, voluntary sector agencies (e.g. Carers Lewisham), Victim Support and the Pensioner s Forum. The project is currently being evaluated but it is estimated that information about abuse was provided through direct contact with over 2,000 people in Lewisham while 20 groups of older people had some input, and training and briefings were provided to 25 different agencies and disciplines.

5.5   Policies and procedures

Guidance in the form of policies and procedures is a first stage in the development of a response to elder abuse. A key message here is the need for co-operation and co-ordination. The Social Services Inspectorate in the UK, in its practice guidelines on elder abuse in the domestic setting, recommend the development of policy on both an inter-departmental and inter-agency basis (1993, p. 9). An earlier report of the Inspectorate (1992) noted the lack of priority given to formulating policies both national and local about elder abuse. This led to staff working without guidelines and older people depending on the good practice of individual staff. Protocols in the context of identification are discussed in Chapter Three of this report. In relation to protocols for intervention, there is a dearth of material in the elder abuse literature. What material there is tends to be based on the caregiver model of abuse and gives little in-depth analysis of the strategies that should be used in different situations. There is also little analysis of the efficacy of the intervention strategies suggested (McDonald *et al.* 1991, p. 93).

In the UK there has been a general trend towards the development of policies and procedures which follow examples in the field of child protection. The focus is on the detailed specification of risk profiles, the danger to the child (Stevenson 1996) and the actions to be followed when a case is suspected (Action on Elder Abuse 1995). In the Irish context a number of recent reports have all included in their recommendations the issuing of guidelines on the development of policies and procedures dealing with child abuse and domestic violence, abuse in institutional care and sexual abuse in hospitals. Further details are provided in Chapter Seven of this report. A recent Irish report on the relevance of child abuse guidelines to the protection of children and to service delivery in Ireland warns that guidelines may be prescribed without due regard to the complexity and intractability of the whole area of child protection (Buckley 1996, p. 60).

5.6 Inter-agency co-ordination

In the field of child protection a very strong emphasis has been placed on inter-professional co- operation. A recent review of reports into the deaths of children from non-accidental violence or neglect points out that the issue of inter-agency communication stands out above all others in thirty-five inquiry reports. A major point is that communication is much more than the structural handling of information and emphasis is placed on the importance of psychological factors in inter-professional communication (Reder *et al.* 1993). Hallett s (1995) study of inter-agency co-ordination in child protection contributes some vital insights.

- inter-agency collaboration was largely confined to information exchange — little evidence of joint investigation.
- a high degree of consensus characterised the routinised form of co-ordination and led to a less radical response.
- conservatism was evident in the desire to avoid tragedy and scandal.
- there was no radical agenda for change to remedy child abuse.

Horgan (1996) has looked at the issue of team work in child protection in Ireland, and points out the lack of an agreed forum for inter-agency policy discussions. The role of Child Care Advisory Committees under the *Child Care Act* 1991 is ambiguous. The current mechanisms do provide a useful foundation for such collaboration but a more systematic approach to policy, practice and training is needed. O Doherty (1996, pp. 11-12) also discusses how the efficiency of such committees would be advanced, with useful pointers for the elder abuse field.

5.7 Services

This overview has summarised a number of models for intervention as distinct from listing a range of services which is possible. McCreadie (1996, p. 100) emphasises a very important point:

> The appropriateness of any particular service will depend on the type of abuse, the reasons for the abuse, and the views and decision making capacity of the parties.

Such distinctions are increasingly recognised with an emphasis on the need for guidance on what to use, with whom, and under what circumstances. Intervention strategies usually contain the following components:

- legal action, for example criminal justice
- education, for example through caregivers and raising community awareness
- advocacy, for example on behalf of individuals and at policy level
- therapeutic, for example counselling and crisis intervention
- linkage to community service.

Bennett and Kingston (1993) considered interventions with those abuse victims who are competent and those who have physical and/or mental impairment. For the former a strategy based on advocacy, choice and empowerment is outlined. This includes services such as support groups, emergency shelters, giving accurate advice and information, legal advice and empowerment. For the latter, in particular those with cognitive impairment, the intervention process can be complicated. They suggest a choice between community interventions using

the case management model of imaginative and flexible packages of care or residential placement intervention .

In the staircase model of intervention a wide range of intervention services including counselling, legal and financial services, housing alternatives and telephone reassurance are possible. Intervention with abusers involves consideration of a number of factors. Abusers with caregiving stress and those with malevolent motives are to be distinguished. Factors such as the type of mistreatment, duration, willingness to accept help, past and present interventions with the abuser and the safety risk to the professional in helping the abuser are very important and will determine the specific interventions used (Breckman and Adelman 1988).

Finally, it must be emphasised that one intervention model is unlikely to prove successful with all cases. In recognition of this the Ontario Association of Professional Social Workers outline eight decision trees to provide general reference points and initiate the decision making process. They preface their elaborate and helpful scheme by stating that no standard formulas deal with the complexity of elder abuse (Basu 1992).

5.8 Evaluating interventions with abused older people

The lack of research on the effectiveness of interventions is not unexpected, given the current concentration on raising awareness and developing procedures. However, there is a need for evaluation research to find out what works . It is important to be aware of the influence of the perspective of those evaluating the effectiveness or success of interventions. Success from the service provider s view may not be the same as the abused person s view. An ideal research design for intervention studies should have:

- sufficient sample size
- definitions that do not overlap
- qualitative and quantitative methodology
- a wide variety of abusive situations
- accurate scales and tests
- a comparison of programmes
- information from the abused older adult
- ethical guidelines (Spencer 1995, pp. 143-155).

5.9 Conclusion

This chapter gives a broad overview of intervention strategies, models and dilemmas facing the practitioner. Given the dearth of evaluation research, McDonald *et al.* (1991) conclude that few facts exist and that we must guard against applying myths to practice. The challenge ahead is emphasised in the remainder of this study, which focuses more on the Irish situation.

CHAPTER SIX

Emergence of Elder Abuse as a Social Problem in Ireland

This chapter examines the issue of elder abuse in Ireland from the perspective of the construction of a new social problem. It follows a framework recently used in an examination of abuse in the contemporary period in Britain (Biggs *et al.* 1995). The thesis that social problems exist in a process of collective definition (as outlined in Chapter One) is important.

> Social problems are not the result of an intrinsic malfunctioning of a society but are the result of a process of definition in which a given condition is picked out and identified as a social problem. A social problem does not exist for a society unless it is recognised by the society to exist. (Blumer 1971, p. 301).

Elder abuse as well as other forms of violent family interaction have suffered from selective inattention , a mechanism by which we simply choose to overlook that which we find upsetting (Steinmetz 1988, p. 3). In Ireland, there has been increasing recognition of child abuse and domestic violence and this has paved the way for attention to other forms of violence within the family, including elder abuse. Demographic change, the growth of community care policies and the growth of professional groups concerned with older people have been significant factors in the emergence of elder abuse as a social problem.

6.1 Child abuse

A number of factors are integral to the process of the acknowledgement of child abuse as a problem. These include social attitudes to children and families, the influence on professional practice of contemporary theories and knowledge, political initiatives and legislation, public inquiries and the continuous feedback between each factor (Reder *et al.* 1993). The growing emergence of child abuse as a social problem in Ireland is having a major impact on public receptivity to recognising violence within the family in all its forms and, more significantly, to the changing role of State intervention in family life. The Irish Constitution*, Bunreacht na h ireann* 1937, Article 41, has placed the family on a lofty constitutional pedestal.

> The State recognises the family as the natural primary and fundamental unit group of society and as a moral institution possessing inalienable and imprescriptable rights, antecedent and superior to all positive law. (*Bunreacht na h ireann* 1937, Article 41.1.a)

Allocating an entire article to the family is unique in European terms (Martin 1995, p. 12). This constitutional enactment reflected the influence of Catholic social teaching and underlined the concept of the privatisation of the family as a deep seated principle within Irish culture. Despite the constitutional constraints, recent Governments have commenced a programme of family law reform and are, to a certain extent, moving towards a more interventionist policy. The emergence of concern about child abuse began in the 1970s in Ireland. The publication by the Department of Health of national guidelines on the procedures in relation to child abuse (Department of Health 1987) has been crucial in changing professional awareness and has led to the Irish State taking a more active approach to child protection policy (Ferguson 1995). The structures for inter-agency co-ordination and case

recording which are being developed in the field of child protection will undoubtedly be of value in the field of elder abuse.

The first major piece of child welfare legislation to be enacted since the foundation of the State in 1922 was the *Child Care Act* 1991. Its slow and phased implementation changed in March, 1993. At the Central Criminal Court, a man was sentenced to seven years imprisonment for having a 16 year long incestuous relationship with his daughter. As the details of the case emerged Irish society was shocked by the extreme physical and sexual abuse suffered by the victim at the hands of her father and also by his violence towards his wife. This resulted in a major investigation into the case ordered by the Minister for Health and Children, the first inquiry of its kind in Ireland. The Report of the Kilkenny Incest Investigation (1993) was extremely significant in that it resulted in an immediate commitment from the Government to release the funds necessary to implement the *Child Care Act* in full by 1995. The public disclosure of the X case in 1992 and the tragic case of Kelly Fitzgerald (Interim Report of the Joint Committee on the Family 1996) also helped push child protection into the political limelight. In relation to institutional care, allegations of sexual abuse and other misconduct made against a number of staff at Madonna House Children s Home in Dublin in 1993, led to an inquiry into the operation of Madonna House. The abridged version of the report (Department of Health 1996) made important recommendations for protecting the welfare of children in residential care and for improving standards in the sector generally.

6.2   Domestic violence

Attention to the abuse of adults is growing. In particular there is a new commitment to confront the problem of violence against women (Safety for Women Conference 1992). The first attempt to document violence against women in an Accident and Emergency hospital setting in Ireland took place in 1993. The report (Cronin and O Connor 1993) looked at 119 female admissions made up of 81 separate women who disclosed abuse. A breakdown of the ages of these women indicates that 13 women were over 51 years of age and 3 were over the age of 65.

> The medical staff felt that older women were more reluctant to disclose due to embarrassment and shame. They also felt that in the case of women over 65 years staff were less likely to suspect assaults and more likely to believe that the injury was the result of a fall. Close co-operation between organisations working on assault of women and those working with the elderly must be developed if we are to have any realistic assessment of the number of elderly women suffering physical and sexual abuse in the family. (Cronin and O Connor 1993, p. 5)

A similar project in another hospital identified 45 cases of domestic violence referred to the social worker at the Accident and Emergency Department. Forty-two of the victims were women. The majority were aged between 20 and 40 years: two were women over 65 years (Kelleher *et al.* 1995).

The terms of reference of the Kilkenny Incest Case investigation were broadened by the investigation team to include adult abuse and the management of such cases (1993, p. 11). Their recommendations include the provision of refuge places, counselling services, telephone helplines and the development of protocols for the management of domestic violence. The report also highlights the need for adequate professional training and community education as

well as legislative reform in the areas of Protection Orders and Barring Orders. Many of these recommendations have direct relevance in the field of elder abuse. The setting up in 1993 of the Domestic Violence and Sexual Assault Investigation Unit at Garda Headquarters (Serious Crime Squad) in Dublin is also relevant. The Unit has been effective in evaluating police practice regarding domestic violence.

In June 1995 Women s Aid published a National Strategy on Eliminating Violence against Women (Women s Aid 1995). In September 1995 the results of a study commissioned by Women s Aid was published (Kelleher *et al.* 1995). The research was commissioned against the background of the beginnings of a public discourse on violence against women in Ireland and some important legislative and policy changes. The study provides the first systematic data on violence against women in Ireland and illustrates that the prevalence of violence against women in the home is extensive.

In March 1996 the *Domestic Violence Act* (Department of Justice 1996b) came into effect. The Act makes several changes to the legislation which will be of help to the older victims of abuse (*see* Chapter Seven for details of some of these provisions). In October 1996 the report of the Working Party on the Legal and Judicial Process for Victims of Sexual and other Crimes of Violence Against Women and Children was published. In 1997 a working group, chaired by Eithne Fitzgerald TD, published a report on legislation, services and supports dealing with violence against women (Office of the T naiste).

6.3   Demography

Writing about elder abuse in the Irish context and commencing with a summary of the demographic situation is not to suggest that advanced age necessarily carries with it an increased risk of being maltreated (Sprey and Matthews 1989). However, a review of trends which indicate a general rise in the population over 65 years of age and a substantial rise in those over 85 years of age, would indicate that, if elder abuse is acknowledged as a social issue, then its identification is likely to increase in the future (Ogg 1993). Continued high levels of fertility in Ireland have resulted in a population that is not proportionately old by European standards. There were 413,882 persons aged 65 years and over living in the Republic of Ireland according to the 1996 census, representing 11.4 per cent of the general population. Recent projections, however, indicate that the older population will grow by almost 120,000 persons in the period 1991-2011 (Fahey 1995).

The living arrangements of older people, in particular co-residence with a relative after a period of residential separation, may raise pressures pertinent to elder abuse (Stearns 1986). This may be particularly the case with older women who, because of their tendency to outlive spouses, may be more likely to spend some part of their old age residing with a single child or family household of a married child. For all that, however, Ireland has been more concerned with its bulging young population, and the associated problems of unemployment and emigration, than with the position of older age groups (O Shea 1993). The population projections indicate why this situation needs to change.

6.4   Emphasis on community care

The report of an Inter-Departmental Committee — The Care of the Aged (Department of Health 1968) radically challenged official thinking on the care of older people which was dominated by institutional remedies rooted in the nineteenth century Poor Law. The report proposed that objectives of services should be to enable older people to continue to live in

their own homes. The Working Party on Services for the Elderly, set up in 1986 and reporting in 1988, (Department of Health 1988) accepted the same objective and reviewed the role and function of existing health and welfare services in serving these objectives. The commitment to community care is further strengthened by the Department of Health s 1994 health strategy document *Shaping a Healthier Future* in which a target of at least 90 per cent of persons aged 75 years or more living in their own homes is outlined (1994a, p. 67). This emphasis on deinstitutionalisation and home living has produced increasing concern with the role of informal carers and the potential for inadequate care and abuse. Indeed, the conceptualisation of carer stress as a causative factor in elder abuse has been crucial in the debate on elder abuse. A further effect of the emphasis on community care has been to increase the importance of a broad range of community professionals, (e.g. Public Health Nurses, Occupational Therapists, Physiotherapists) in the care of older people. In Ireland the only community care profession without a significant input into the care of older people remains social work.

6.5   Elder abuse in Ireland
The report of the Working Party on Services for the Elderly (Department of Health 1988) has been the official blueprint for the development of older people s health and social care services over the past decade but contains only scant reference to elder abuse. It addresses elder abuse only in the context of caregiver-stress, stating that:

> In a small number of cases, intense strain on the carer can result in the physical or emotional abuse of elderly people. (p. 98)

The report goes no further in terms of analysis or recommendation other than to state that:

> The need of dependent elderly people and their carers for a service to help these problems has not been officially recognised up to now. (p. 98)

This analysis is very conservative but represents a small step towards legitimation of the problem.

A small number of articles have appeared in professional journals in Ireland. The first reported on, three cases of elder abuse admitted to an acute geriatric assessment unit in the space of one month . (O Neill *et al.* 1990). Another article, Old age abuse in the domestic setting — definition and identification , resulted in media coverage including a prime time news item (O Loughlin 1990). A third article Abuse of elderly people — pathological carers described case histories, one involving physical and sexual abuse, the other severe neglect (Wrigley 1991).

The 1990/1991 co-ordinated research programme of the Council of Europe included Violence Against Elderly People as one of the topics of concern. The Study Group members included Ms Mary Horkan of University College Dublin, who provided the information on the Irish situation. The information collected in 1990 was published in 1992 (Council of Europe 1992). In 1991, a report entitled Awaiting advocacy — elder abuse and neglect in Ireland , was completed (O Loughlin 1993). Its purpose was to draw attention to the issue, summarise the latest research and developments internationally, outline issues in relation to service planning and delivery and propose a national response involving the expertise of those in other areas of intra-family violence. The report was submitted to the National Council for

the Elderly and the Department of Health in 1991. A wider distribution was possible in 1993 through its publication by the Irish Association of Social Workers. Each of the above publications highlighted the lack of attention to the problem and the need for a more comprehensive response in Ireland. These publications also indicate that elder abuse exists to some extent in this country.

Media coverage has been limited but important in increasing public awareness. Two articles featured in the national press in 1990. In 1991, three national newspapers reported in graphic terms a case of fatal abuse by her son of a 79-year-old woman, which came before the Dublin Circuit Criminal Court. The Family Law Reform Group, AIM, in their 1991 pre-budget submission, drew attention to the plight of older parents abused by adult children. This received attention in national newspapers. The first National Conference on Elder Abuse was organised by the Irish Association of Social Workers in November 1993. Unfortunately this was cancelled as bookings were so few. However, a front page report in *The Irish Times* about the cancellation provoked considerable interest. This resulted in a special report on Elder Abuse on national television news bulletins, which included an interview with an older woman, who had been the victim of severe physical abuse by her son. The Irish Association of Social Workers continues to draw attention to the issue, passing motions at Annual General Meetings in 1993 and 1994, which were subsequently forwarded to the relevant Government Departments. The motions called for a Working Party on Elder Abuse and Law Reform in relation to vulnerable older people.

These attempts at provoking an official response have had some success. The Green Paper on Mental Health (Department of Health 1992) proposes new measures to deal with older people who are mentally infirm and are victims of abuse.

> Cases have come to light of the abuse, exploitation and neglect of elderly people who are mentally infirm or people with mental handicap. There is clearly a need to provide a legal means of protecting these people in the least restrictive manner possible. (p. 104)

In August 1995 Mr Michael Noonan TD, Minister for Health, launched a White Paper on new mental health legislation (Department of Health 1995a):

> The government are of the view that there is a need to provide new legislation powers to intervene to protect mentally disordered persons who are abused, exploited or neglected. (Department of Health 1995a, paragraph 8.6)

The legislation proposed will provide for an adult care order. The courts will be empowered to make such an order, which will provide for the placement of a person in the care of a relative, a health board or a voluntary agency. The enactment of such legislation was proposed in 1996. In the event of such legislation there will be an obvious need for a national effort in relation to the definition and identification of elder abuse and the whole issue of the evidence required by a court to ensure that an adult care order is appropriate.

6.6   The causes of elder abuse in Ireland
In October 1994, O Loughlin completed a thesis entitled Elder Abuse: A New Reality About Old Age in Ireland? (1994). The thesis addressed the causal factors responsible for elder abuse, focusing on a series of Irish cases. Five causal factors were investigated:

transgenerational family violence; dependency (both abuser and abused); psychopathology of the abuser; stress (caregiver stress and abuser life stress) and social isolation. A total of 14 cases of elder abuse were included in the study. These were identified between June 1992 and December 1993 in the context of O Loughlin s work as Social Worker in a Department of Geriatric Medicine in a Dublin Hospital. While the sample of cases may be accused of being non-representative, the following approach was used to avoid the problem:

> Rather than ask the question: How much Elder Abuse is there?, it is perhaps more appropriate to look at the characteristics of those abused older people and their family situations as they are known to social and health care services. (Bennett and Kingston 1993, p. 153)

The study provides a rich set of data which will hopefully shed some light on elder abuse in Ireland. The ages of the victim (57 per cent over 75) and the fact that 13 of 14 victims were women gives a profile that is close to others reported in the literature (Tomlin 1989; Eastman 1984). The profile of the perpetrators indicates that adult children — six sons and five daughters — comprised the largest group. There were three cases of spouse abuse, illustrative of the phenomenon of life long violence graduating into the realm of elder abuse (Mastricola-Morris 1989; Homer 1994). Abusers also included nephew and grandsons. It is interesting that most abusers were the children of the victims, given that the international literature indicates that spouse abuse is at least as common. To explain this there is a need for further research, examining the interaction of household circumstances and elder abuse in Ireland.

While all five causal factors were involved in these cases, the evidence supporting the dependency of the abuser for financial support and housing was the most common single factor occurring in ten cases. Also important was the high rate of alcohol abuse among abusers (nine abusers, all male). When coupled with drug problems and hospitalisation for psychiatric care the evidence for the importance of the psychopathology of the abuser in this study was very convincing (11 of the 14 cases). However, caregiver stress and abuser life stress also played an important role. Social isolation and a lack of connection with a wider network of family relationships was evident in eight cases.

O Loughlin s study was an attempt to redress the dearth of research on elder abuse in Ireland. In April 1995 it was summarised in a national newspaper. This led to renewed interest in the topic, particularly among professionals. The findings of this small study have been presented at the Annual Conferences of the Irish Association of Social Workers, the Irish Association of Occupational Therapists, the Irish Nurses Organisation, the Irish Gerontological Society and the Irish Medical Organisation.

A further Irish study has been carried out on the abuse of older people with dementia (Cooney and Wrigley 1996). Twenty-six carers took part in the study. These were in contact with a psychiatry of old age service in North Dublin. Eight carers admitted to chronic verbal aggression, six to physical abuse and four to some form of neglect. The findings showed higher rates of abuse of dementia sufferers by their carers than that experienced by the general population aged over 65 years.

6.7   Conclusion
Irish research on elder abuse is still in its formative stage but one message comes through strongly from the few studies so far carried out: elder abuse does occur in Ireland, and is most

likely occurring at the same rate seen in other countries. In Blumer s thesis (1971) social problems require public legitimation if they are to receive the required action. A key component of public legitimation is consideration by Government Departments and the legislature. The commissioning of this current report on Elder Abuse by the National Council on Ageing and Older People in response to a request from the Minister for Health and Children is a further step in the process of bringing hope to the hidden victims of elder abuse in Ireland. It seems as if the social problem of elder abuse may be winning the struggle for recognition.

Elder Abuse in Ireland: Legal and Policy Frameworks

7.1   Introduction

The purpose of this chapter is to review current frameworks for dealing with elder abuse in Ireland. The difficulty of finding any substantive law relative to elder abuse has been noted by several writers in the UK (Williams 1995; Griffiths *et al.* 1993). The dearth of legal literature specifically dealing with elder abuse has been explained by the fact that the law concentrates on individual requirements rather than categories such as chronological age. The importance of considering the extent to which existing law can be used before introducing special elder abuse legislation is emphasised in McDonald *et al.* (1991, pp. 37-47). The potential problems in developing an appropriate legal response to elder abuse include the temptation to seek a quick solution in response to increasing pressure on policy makers and legislators, the tendency to take legal models from other areas and apply them in the context of elder abuse and lastly, the danger of viewing a legal response as a panacea.

In the UK, the current legal or quasi-legal processes are little used. A number of reasons are cited for this:

- the reluctance of many victims to become involved in legal processes
- professional attitudes (e.g. lawyers, the police, social workers)
- the way in which elder abuse has been defined
- the complex problems arising from mental incapacity of some victims of elder abuse
- the inappropriateness of criminal prosecutions in many cases (Griffith *et al.* 1993, pp. 63-75).

Many different laws could be applicable in cases of elder abuse. The complexity of the subject has been dealt with in a detailed and specialised way by a forthcoming publication by the National Council on Ageing and Older People. The publication clarifies the legal position in relation to those aspects of the law relevant to older people, including specific references to elder abuse. This chapter has been informed by the publication. The following is an outline guide to the various areas of legislation which are relevant to dealing with elder abuse and neglect in Ireland. Readers are referred to the Council s forthcoming publication for a more comprehensive review.

7.2   The Constitution

Certain articles of the Constitution are particularly relevant to elder abuse, exploitation and mistreatment. These articles provide a basic framework for the legal status of elder abuse victims and perpetrators. The most relevant sections for the purposes of this report are as follows:

40.3.1	The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
40.3.2	The State shall, in particular, by its laws protect as best it may from unjust attack, and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.

40.4.1	No citizen shall be deprived of his personal liberty save in accordance with the law.
41.1.1	The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptable rights, antecedent and superior to all positive law.
41.1.2	The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.
45.4.1	The State pledges itself to safeguard with especial care the economic interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.

Article 45.4.1 belongs to the Directive Principles of Social Policy section of the Constitution and therefore does not have the same legal status as the others. The Directive Principles are intended for the general guidance of the legislators and are not absolutely binding in the way that other articles of the Constitution are.

7.3   General legislation

This type of legislation is service-oriented and covers issues such as access to health care, hospital charges and GP services, housing, social welfare, nursing home and residential care.

7.3.1   Health services

The *Health Act* 1970 (Department of Health 1970) governs access to free GP services, free hospital out-patient and in-patient services as a public patient, a range of appliances and free or subsidised prescription medicines. These services may be especially useful in organising assessment and monitoring of cases of elder abuse and neglect, encompassing as they do a wide range of services (e.g. accident and emergency departments, GP home visits and attendance at day hospitals). Under sections 51 and 56 of the Act everyone is entitled to public in-patient and out-patient services. Attendance at accident and emergency departments is free of charge to medical card holders and also to other categories including those with a GP referral letter. This may be important in cases of elder abuse where attendance at accident and emergency departments may be vital.

7.3.2   Community care

Health boards are obliged to provide public health nursing services to medical card holders but they are not, at present, obliged to provide other support services for older people and their carers in the community, other than the General Medical Service Scheme services described in the 1970 *Health Act*. While a range of services are available, some of which may be key elements of intervention in cases of elder abuse, the absence of a statutory basis for the services may lead to limited availability and differing criteria for eligibility.

7.3.3   Housing and property rights

The housing and property rights of older people are a complex and vital aspect of dealing with elder abuse in particular in the area of finance and material exploitation. Some aspects of the housing and property laws are particularly pertinent to this field. First, if a person holds a life estate in property they cannot be forced to leave the property during their life time, even if the property is sold. Second, sale of the property would include payment of interest on capital derived from the sale to the person holding the life interest. The 1976 *Family*

Home Protection Act (Department of Justice 1976) prevents the sale of the family home by the spouse who owns the home, without the prior written consent of the non-owning spouse.

Many legal issues arise when an older person has to share his or her home with for example a son or daughter or a lodger. An older person cannot apply for a barring order under the *Domestic Violence Act* 1996 (see 7.8 below) against an adult child, if that child has greater interest in the property, even where the older person transferred the property to that adult child, has rights of residence or a life interest. A safety order can be applied for (*Domestic Violence Act* 1996) where an older person is abused by another adult with whom they live (e.g. spouse of an adult child). However, a safety order (*Domestic Violence Act* 1996) cannot be granted where there is a relationship based on a contract (e.g. a person employed to care for an older person in the home).

Sometimes an older person may take in a lodger. The legal form of this is where the lodger has a licence to occupy but there is no interest in the property. Cases of abuse by a lodger have come to light. The licence to occupy does not give security of tenure. The older person may end the lodger s lease if there is a landlord/tenant relationship or may get an injunction to remove the lodger.

In relation to local authority housing, succession to a tenancy in local authority housing normally passes to a surviving spouse or a son or daughter if both parents are dead, provided the son or daughter has lived in the house for two years. The local authorities examine each situation individually where more than one member of the household remains. The legislation governing local authority housing is the *Housing Acts,* 1966 (as amended by the 1988 and 1992 Acts). Local authorities provide housing for people in need and those who cannot provide accommodation from their own resources. Of special relevance to elder abuse and neglect is the assessment of housing need on medical or compassionate grounds (*Housing Act* 1988, section 9).

7.3.4   Social welfare law
The rules governing entitlement to social welfare benefits are contained in the *Social Welfare (Consolidation) Act*, 1993 as amended, and in numerous statutory instruments. There are a number of points relevant to the categories of neglect and financial exploitation. In cases where a Social Welfare recipient is not maintaining his wife and children, it is possible for an application to be made for separate payments. The application is usually assessed by a Social Welfare Officer.

The Department of Social, Community and Family Affairs can also make payments to a third party acting on behalf of a social welfare claimant or beneficiary. The rules governing this are Statutory Instrument 417/94. There are two categories of agents. Type 1 is where another person i.e. the agent , is nominated by the social welfare recipient to receive that benefit on his behalf (S.I. 417/94, para 114). This can be either a temporary or permanent arrangement. In the case of a permanent arrangement, a medical certificate is required if the pensioner is less than 80 years old. The signature of the pensioner must be witnessed. The agent undertakes to give the pension to the person entitled to the payment .

The second category of agent (i.e. Type 2 agent) is governed by S.I. 417/94, para 115 and is an application made by the agent to exercise on behalf of the pensioner any right and power to which she may be entitled and to receive and deal with any sum payable . This is

obviously a much more extensive power to act on behalf of another. It is terminated if the beneficiary is made a Ward of Court. Currently there are 26,000 Type 1 agencies and 2,000 Type 2 agencies in operation (Personal communication, Department of Social, Community and Family Affairs).

Arrangements for the management of state pensions of older people require review, particularly in the area of mental incapacity and the appointment of agents under S.I. 417.

7.4   Powers of Attorney

A Power of Attorney authorises someone to act on behalf of another in certain situations. There are two kinds of power. A general or common law power is automatically revoked if the donor becomes mentally incapable. An Enduring Power of Attorney (EPA) under the *Power of Attorney Act* 1996 (Department of Justice 1996a) can be made (donated) by a mentally competent individual to represent their interests should they become mentally incompetent. The donor must notify two persons of the execution of an EPA and in order for it to come into force, if the donor is becoming mentally incapable, it must be registered. The registration process involves a number of safeguards, which include a statement from a doctor that the donor had mental capacity at the time of the execution of the EPA, application to the High Court, notification of the donor and others entitled to notice. The court has a supervisory role in determining the validity of Enduring Power of Attorney, in giving directions about management of property and affairs and in ordering the cancellation of the power where, for example, fraud or undue pressure was used to create the power.

The EPA may give the attorney certain general powers, or the power to do specific acts. The attorney may make certain personal care decisions. A personal care decision could involve issues such as where the donor should live, with whom the donor should live and whom the donor should see and not see. These decisions, which must take into account the wishes of the donor in-so-far as possible, could be vitally important when dealing with cases of the abuse of older people with a mental impairment.

7.5   Wards of Court

Legislation dealing with wardship is contained in the *Lunacy Regulation (Ireland) Act*, 1871 and Order 67 of the Rules of the Superior Courts 1986. A petition under Section 15 of the 1871 Act requires medical evidence of two doctors and the medical visitor that the person to be made a Ward of Court is totally incapacitated. The application, which is made by way of a petition, must be handed to the prospective ward. It is possible for the prospective ward to object within seven days, by signing a notice of objection.

The President of the High Court has jurisdiction in cases of wardship. A declaration order, declaring that the proposed ward is of unsound mind, includes an order that the ward be detained in a certain residence until further order of the judge. The appointment of a Committee of the person and of the estate has limited powers and investments of assets and management of property is directed by the judge. The supervisory role of the court is significant. The use of Wardship procedures in cases of abuse has been discussed in case reports, which refer to the unacceptable delay in using such procedures (Wrigley 1991, pp. 31-32). Under Section 12 of the *Lunacy Regulation (Ireland) Act* 1871 an urgent case may be dealt with in which the report of the medical visitor constitutes the petition and only one further independent medical report is required.

It has been established in the Irish courts that a person who is of unsound mind and in need of protection may be made a Ward of Court whether or not he/she has property (Irish Law Reports Monthly 1988: Vol. 8, pp. 251-259).

7.6   Legislation relevant to abuse in institutional care
The *Health (Nursing Homes) Act* 1990, the Nursing Homes Regulations of 1993 and Nursing Homes (Subvention) Regulations of 1996 provide the legal and practical framework for long-stay care in the private sector. The Act and regulations provide for a system of registration, regulation and inspection of private nursing homes and also specify the situations where financial subventions for long-stay patients may be provided by the State. The subvention scheme increases the intervention options for older people whose welfare requires removal from or leaving their home because of abuse. The recent amendment to the subvention regulations (Statutory Instrument 225 of 1996) enables a health board to pay a rate exceeding the maximum rate of subvention payable under previous regulations and may give increased choice, when placement is required. The boarding out of dependent persons in a private house under arrangements made by a health board is also governed by the *Health (Nursing Homes) Act* 1990 and the Boarding Out Regulations (Statutory Instrument 225 of 1993).

In relation to the regulation of private nursing homes, the Nursing Homes (Care and Welfare) Regulations, 1993, (Statutory Instrument 226 of 1993) cover detailed requirements for standards of care. Article 5 governing welfare and well being is particularly relevant. Article 19 refers to detailed personnel records and includes a requirement to record the following: medical condition at time of admission; adequate daily nursing records; record of all drugs and medicines prescribed and administered; a record of any accident or fall; a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration; a record of any substantial complaint made by the dependent person or a person acting on his or her behalf and of the outcome of the investigation. Article 23 deals with Inspection of Nursing Homes by designated officers. These officers must be permitted to enter and inspect the premises, where the officer has reasonable cause to believe that a person in the nursing home is not or has not been receiving proper care, maintenance or medical or other treatment (Article 23c). The proprietor or staff must provide facilities for the conducting of interviews and the carrying out of examinations by designated officers (Article 23d). It is important to note that current inspection procedures may place a conflict of interest upon certain inspection officers. Some officers are involved in the placement of patients, as well as the inspection of their conditions. In situations where there is a shortage of beds it is possible that the inspection officers may be swayed in their evaluation of the facility, because of the lack of available alternatives.

Interviews pursuant to Articles 23c and 23d must be permitted to be conducted with the dependent person or staff in private. Inspections shall be made not less than once in every period of six months (Article 24). Article 26 governs complaints procedures in detail. A dependent person or a person acting on his or her behalf may make a complaint to the Chief Executive Officer of the local health board or a designated officer (Article 26.1). The complaint may be made in writing or verbally at the discretion of the Chief Executive Officer (Article 26.3). The complaint must then be considered and investigated by a designated officer (Article 26.5). When a complaint is upheld, a direction may be issued to the proprietor (Article 26.7). The complainant should be informed of the outcome of the consideration and investigation (Article 26.9).

It is important to note that the provisions of the 1990 *Health (Nursing Homes) Act* were not applicable in the case of Clonmannon Retirement Village in which older residents were alleged to have been subjected to various forms of exploitation. The definition of nursing home in the Act excludes a retirement home where it is presumed that residents are not dependent. The situation was only resolved by an investigation under the Companies Act. This highlights a gap in the legal provision for what may be a growth area in Ireland.

In relation to financial protection in institutional care, the 1996 *Power of Attorney Act* excludes certain persons from appointment as an attorney. Those excluded include the owner or employee of a nursing home in which the donor is a resident, unless that person is also the spouse, child or sibling of the donor. The 1993 Nursing Homes Care and Welfare Regulations also require that the registered proprietor of a nursing home ensures that provision is made for the safe keeping of the personal possessions and valuables of a dependent person and that a record is kept signed by the person or a person acting on his or her behalf (Article 8a).

Where intervention in elder abuse cases necessitates admission to long-stay care in the publicly funded sector, the financial implications are significant. Long-stay patients in public institutions may have charges imposed under the Health (Charges for In-Patient Services) Regulations of 1976 and 1987 (Department of Health 1976, 1987). These charges can never exceed the means of the person less an amount of at least £2.50 per week. The sum of £2.50 or more is for the personal comforts of the patients (Statutory Instrument 180 of 1976).

In recent years there has been a great deal of concern expressed publicly about the management of the money belonging to patients in long-stay care institutions in the geriatric and psychiatric sector. The main issues are that interest on savings is not distributed to patients, the amount charged by the health boards for administering the accounts, and the lack of individual accounts for patients. The accumulated interest on funds was estimated at £8 million in 1994. The Department of Health and Children is conducting a review on how the health boards are holding money belonging to long-stay patients.

7.7 Principles governing relationships with health care professionals

In relation to the relationship between older people and health professionals, the main points of importance are the concept of a duty of care under the law of tort and the implied contract, that the patient will be treated with reasonable care and skill. Some professions have specific regulations: the *Medical Practitioners Act* 1978 regulates doctors, the *Nurses Act* 1985 regulates nurses and the *Dentists Act* 1985 regulates dentists.

Alleged professional misconduct is investigated in these professions through Fitness to Practice Committees. It is likely in the near future that many other health care and allied professions (e.g. physiotherapy, social work, psychology, care workers) will be similarly regulated following the introduction of Statutory Registration. The Codes of Ethics of many professionals govern what is considered good practice and breach of these codes could lead to charges of negligence. Professional misconduct and professional negligence are also key concepts which may give rise to complaints to relevant regulatory bodies or legal action for negligence. In cases of professional negligence, the concept of vicarious liability means the employer (usually the health board) is responsible to the victim for actions of the employee.

7.8 Domestic violence legislation

The *Domestic Violence Act* 1996 provides for safety, barring and protection orders in cases of violence committed in the home. The legislation also gives the health boards powers of intervention in cases of domestic violence. The various orders may be made if the safety and welfare of the applicant or a dependent require them.   Welfare is defined as including the physical, emotional and mental welfare of the victim of abuse.

A protection order is an interim order aimed at protecting the applicant and/or a dependent in the period between applying for a safety order and a decision being made. An older person may apply for a safety order where the abuser/perpetrator is a spouse, cohabitee, adult child or some other adult living with him/her. A safety order can be applied for without necessarily applying for a barring order.

A barring order prevents the abusive person from residing at the home of the applicant and also from threatening or provoking fear in the applicant or watching a place where the applicant lives. Application can be made by a spouse, cohabitee, or parent of the abusive person. However, where the abused person is not a spouse of the applicant, and has greater ownership interest in a property, it is not possible to apply for a barring order. An older person cannot, for example, seek a barring order against the spouse of an adult child living with him or her or another relative living with him or her.

Under the 1996 Act, Section 6, health boards can apply for safety and barring orders on behalf of an abused person. An application can be made in circumstances where a health board:

- becomes aware of an alleged incident or series of incidents which in its opinion puts in doubt the safety or welfare of a person
- has reasonable cause to believe that the aggrieved person has been subjected to molestation, violence or threatened violence or otherwise put in fear of his or her safety or welfare
- is of the opinion that there are reasonable grounds for believing that, where appropriate in the circumstances, a person would be deterred or prevented as a consequence of molestation, violence or threatened violence by the respondent or fear of the respondent from pursuing an application for a safety order or a barring order.

As yet there is no health board policy regarding which personnel have responsibility for applying for safety and barring orders on behalf of an abused person. There is also no policy on the designation of places of safety.

The role of the Garda in cases of domestic violence is outlined in a document on Domestic Violence Intervention (1994, revised 1997). According to the document the role of the Garda is primarily one of protection through law enforcement. A pro-arrest policy is in place, but it is also acknowledged that the wishes of the victim should be taken into consideration. The Garda policy also acknowledges the special sensitivities required and the vulnerability of the injured party, particularly to intimidation by the perpetrator. The policy emphasises the value of advice, information and support to the victim. There is a growing emphasis on training in this area for Garda at induction and when in service. Only a small number of cases currently go to prosecution.

7.9   Criminal law

Criminal law does not distinguish between older people and younger people as victims of abuse. There are many criminal offences which could be part of the categories and behaviours commonly included under the term elder abuse. The relevant criminal law which covers these offences is now the *Non-Fatal Offences Against the Person Act* 1997. The offences which are most likely to be involved are assault, assault causing harm, threats to kill or cause serious injury, coercion, harassment, poisoning, endangerment and false imprisonment.

Criminal law provides for a wide range of sexual offences and has been significantly updated in recent years. The laws governing sexual offences deal with incest, aggravated sexual assault, sexual assault and rape under section 4 , which provided for the removal of doubt as to whether a husband could be prosecuted for raping his wife (Criminal Law (Rape) Act 1981 and the Rape Amendment Act, 1990).

It may be possible for witnesses to give evidence by live television link (Criminal Evidence Act, 1992). The Criminal Law (Sexual Offences Act, 1993) deals with protection of mentally impaired persons from sexual abuse. The law on sexual offences is currently under review by the Department of Justice, Equality and Law Reform (Department of Justice, Equality and Law Reform, 1998)

7.10   Contract law

The law of contract may be used to address problems of financial exploitation or abuse. The courts may rule that a contract is void or that restitution be made in cases of, for example, duress, undue influence or the absence of mental capacity on the part of the older person when the other party if aware of this.

7.11   Tort law

A tort is defined as a civil wrong. An abused person may use the civil law as the most useful solution. The areas of abuse which may be covered by the law of torts include reasonable cause to fear direct harm, actual application of force against will, breach of a duty of care, and infliction of physical restraint without lawful authority. Other examples where the law could usefully be developed are in the tort of wrongful interference, where physical and psychological harm has been indirectly caused by an intentional act of the dependent, or the tort of defamation (Griffiths *et al.* 1993, pp. 70-71).

7.12   Mental Treatment Act, 1945

The treatment of people with mental health problems is still governed by the *Mental Treatment Act*, 1945. A White Paper, *A New Mental Health Act* was published in 1995 but no legislation has yet been published following the paper. The proposals in the White Paper will be discussed in section 7.14.4. The rules governing the admission of involuntary patients are relevant to elder abuse. Under the 1945 Act, a person may be detained if he or she is a person of unsound mind and is not under proper care and control or neglected or cruelly treated by a relative or other person having care or charge of him. In practice, the rate of involuntary admissions for older people is low and the provision for those abused or neglected is rarely used. Current thinking in relation to detention would oppose detentions with no time limit.

The Inspector of Mental Hospitals visits and inspects psychiatric hospitals and investigates complaints. An annual report is published and provided to the Minister for Health and Children. The schedule used for the inspection is extensive and includes items such as

complaints procedures, aspects of privacy and dignity of patients, access to personal money and service policies on issues such as accidents to patients, patients property, seclusion and restraint.

7.13   The role of the Coroner
Notification to a Coroner of a death is usually made, for example where:

- death is not due to natural causes
- the deceased was not seen or treated by a doctor within a calendar month
- the cause of death is sudden or unknown
- there were suspicious circumstances, violence or misadventure
- death is due to drugs or poisons
- death is due to negligence or malpractice
- death occurred within 24 hours of admission to hospital
- there is any doubt.

The Coroner can decide if an inquest/post-mortem should be conducted. This is obviously very significant in cases of elder abuse and/or neglect.

7.14   Policy frameworks for elder abuse in Ireland
The Irish policy statements with relevance to elder abuse are discussed below.

7.14.1 Report of the Working Party on Services for the Elderly, 1988
As discussed in Chapter Six, the 1988 report of the Working Party on Services for the Elderly (*The Years Ahead   A Policy for the Elderly*) acknowledged the existence of cases of elder abuse within a caregiver stress framework. Arising from this the Working Party recommended that community care social work departments be expanded to provide a domiciliary counselling service to dependent older people and their families. This recommendation has not been implemented. A recent review of the report of the Working Party (Ruddle *et al.* 1997) shows that only the North Western Health Board provides a community care social work service. The report calls for the establishment of a community social work service in all the health boards with powers for the following:

- Protecting the rights of individual older people against exploitation or abuse (including financial, physical, sexual and psychological abuse). The community care social worker (in conjunction with other key staff, particularly the Public Health Nurse) should have responsibility for the identification of cases and the co-ordination of interventions to remove older people from abusive situations.
- Providing support and advice to carers for older people with dementia. The social and psychological strains on dementia carers are well established and would benefit from the particular skills of social workers.
- Developing boarding out services whereby older people who cannot remain in their own homes are placed with families who are recruited, trained and supported to care for them.
- Advising older people on their entitlements for social welfare, housing and health and social care services. (p. 20)

It should also be noted that crisis counselling, follow-up support to victims and their families, and treatment services for perpetrators of elder abuse are other areas that need development.

7.14.2 The National Health Strategy: Shaping a Healthier Future, 1994
This document sets out the three principles which should inform all aspects of the Irish
health services: equity, quality of service and accountability. Also important is the emphasis
on health and social gain; a commitment to the development of social services to deal with
problems like family violence; a commitment to increase the number of specialist departments
of medicine of old age; and a commitment to the replacement of unsuitable accommodation to
meet the needs of older people.

7.14.3 Code of Practice for Nursing Homes, 1995
A Code of Practice for Nursing Homes was introduced by the Department of Health in 1995.
The Code of Practice is considered to be a statement of best practice in long-term care. It was
written in a context where the 1990 *Health (Nursing Homes) Act* and the 1993 *Nursing
Homes (Care and Welfare) Regulations* set out the minimum standards that could be expected
from nursing homes. The Code outlines a philosophy of care and then describes principles of
best practice in a range of nursing home activities. These include contracts of care, the
involvement of residents in decision making, restraint, the use of medication, the privacy and
personal autonomy of the patient, financial affairs, and the management of affairs of patients
who are not legally competent. The Code also describes best practice in dealing with
complaints. While the Code is primarily intended for nursing homes, it is hoped that it will
have an important influence on care in all long-stay hospitals and homes.

It is also important to note that the Irish Registered Nursing Homes Association (1997) have
recently produced a Charter covering the rights of older people in nursing homes. This
Charter covers many of the issues described above.

7.14.4 White Paper: A New Mental Health Act, 1995
The White paper attempted to define more precisely the content of new mental health
legislation in the best interests of mentally disordered persons and in line with international
commitments. One of the main issues is the involuntary admission to a psychiatric hospital
of a person of unsound mind because he or she is neglected or abused. This is viewed as no
longer acceptable (paragraph 2.3, p. l7). The proposal to introduce adult care orders is set out
as follows (paragraph 8.6, p. 86):

> The Government are of the view that there is a need to provide in the new legislation
> powers to intervene to protect mentally disordered persons who are abused, exploited
> or neglected or are at risk of abuse or exploitation and to make provision for their care
> according to best standards of practice.

The main dilemmas of the proposed legislation will be the nature of the evidence required
regarding abuse, neglect or exploitation; the broader definition of mental disorder proposed;
and conflicts over mental competency and self determination of older people implicit in the
modelling of the proposed order on the *Child Care Act*, 1991 (paragraph 8.7, p. 84). There is
also an intention to provide in the new legislation the following measures of relevance to the
protection of older people:

- a Commissioner of Mental Health with a role in inspection and quality assurance
- a Code of Practice for the care of mentally disordered
- defining the grounds which justify seclusion and restraint
- a Mental Health Review Board to review detention orders.

7.14.5 Report of the Task Force on Violence against Women, 1997
The Task Force was set up by the Government in October 1996 and chaired by Minister of State Eithne Fitzgerald TD. This report focused on domestic violence and put forward comprehensive proposals for the development of co-ordinated and coherent services for women who have experienced or have been threatened with violence. It also puts forward proposals for preventive strategies and intervention programmes for perpetrators. The Task Force proposed the key elements of a national strategy as follows:

- development of a comprehensive range of services
- ensuring the ready availability of accurate advice and information
- adoption of written procedures and training programmes
- taking the needs of women from marginalised groups into account at all times
- establishment of mechanisms to enable service providers to work together
- provision of consistent and effective responses by the judicial system
- putting preventive strategies in place, developing intervention programmes for offenders and public education programmes.

7.14.6 Report of the Kilkenny Incest Investigation, 1993
The terms of reference of this investigation were broadened to include adult abuse and the management of such cases. The recommendations relating to domestic violence include the provision of refuge places in each health board area with appropriate back-up services, a telephone helpline service, the development of protocols for GPs, hospital and health care staff, inter-disciplinary training and in particular, liaison between health care and Garda personnel and community and professional education programmes.

7.14.7 Report of the Inquiry into the Operation of Madonna House, 1996
While this report reviewed the operation of Madonna House, a children s residential centre in Dublin (now closed) in the light of allegations of misconduct made against certain members of staff, some of the recommendations may be of relevance to institutional care of older people. Recommendations on the development of written policy specifying the responsibility of staff, on in-service training for staff, and on the implementation of the policy in cases of abuse are of particular relevance. In the investigation of complaints, the report states that investigations are complex and time consuming but represent an opportunity to uncover a wide range of practices that would not otherwise come to light. National standards to guide the inspection process are suggested along with training for those carrying out the inspection to provide an understanding of the complexity of institutional care centres.

7.14.8 Report of Independent Review Group, 1996
The review by a religious order made recommendations on the response to complaints of sexual abuse made against clinical staff. Common, written protocols for dealing with allegations of sexual abuse by members of staff are to be drawn up by a working group including management of hospitals, clinical professions involved and the Department of Health and Children. The protocols would be part of every contract of employment and available to members of the public. The development of a national panel of people to assist when allegations are made, constituted by the Department of Health and Children will give access to independent and experienced people.

7.14.9 Report of a Committee of Inquiry, Kelly — A Child is Dead, 1996

This is a report of a committee of inquiry set up by the Western Health Board in May 1995 to inquire into the circumstances of the late Kelly, whose parents pleaded guilty to the charges of willful neglect: Chapter Four reviews the case under a number of headings: adherence to established procedures; assessment; case conferences; inter-disciplinary communication and co-operation; supervision; management. The relevance of many of the points made to elder abuse and even more significantly, elder neglect is considerable. This report should be essential reading for all concerned with formulating elder abuse policy and good practice guidelines.

7.14.10 Report of the Working Party on the Legal and Judicial Process for Victims of Sexual and Other Crimes of Violence against Women and Children, 1996

This comprehensive report contains a total of 84 recommendations. Readers are referred to the full report for details. However, a number of recommendations are worthy of mention for their explicit relevance to elder abuse. A national study is proposed, which will pay particular attention to the needs of women and children in socially marginalised and isolated contexts, including elderly women . Other significant recommendations include:

- training on domestic violence for all professional groups
- funding public education campaigns
- extension of the probation service to deal with family law
- access to secure refuges, that are accessible to women with disabilities
- the issuing of guidelines for the reporting of sexual and other abuse perpetrated against adults with disabilities.

7.15 Conclusion

A broad overview of the legal framework relevant to elder abuse has been provided in this chapter. In the absence of comprehensive legislation which specifically addresses elder abuse there is a plethora of existing legal provision which is relevant. The review of policy frameworks is of necessity brief and intended as a guide. A number of policy documents and reports contain recommendations and information which are very relevant to dealing with elder abuse in Ireland. It is important to consider the extent to which existing law can be used before introducing special elder abuse legislation. It is also important to appreciate the rights of individual older people under the law. Unlike children, older people are treated as adults by the law: they are only rarely in need of care and their autonomy should be respected and protected as far as is possible.

CHAPTER EIGHT

Survey of Service Providers

This chapter describes a survey of the views of those professional and occupational groups involved in working with older people in Ireland. The survey examines issues concerning the identification of elder abuse and neglect, intervention, inter-professional collaboration and co-ordination and suggestions for a way forward. The study took place in the context of a growing public and professional awareness of violence and abuse within the family and in institutional care settings in Ireland as outlined in Chapter Six.

8.1   Methodology
To gain the views of service providers six specific methods of data collection were used.

8.1.1   Interviews with representatives of relevant organisations
A written request to professional associations and organisations requesting that they nominate one or two representatives to take part in a semi-structured interview. This method resulted in interviews with representatives of 19 organisations, listed below:

- Accident and Emergency Department, Beaumont Hospital
- Accident and Emergency Department, St. James s Hospital
- Association of Home Help Organisers
- Carers Association
- Domestic Violence and Sexual Assault Investigation Unit
- Dublin Corporation Housing Welfare Department
- Institute of Community Health Nursing
- Irish Association of Alcohol and Addiction Counsellors
- Irish Association of Occupational Therapists
- Irish Association of Social Workers
- Irish College of General Practitioners
- Irish Nurses Organisation
- Irish Society of Chartered Physiotherapists
- Irish Society of Consultants in the Psychiatry of Old Age
- Irish Society of Physicians in Geriatric Medicine
- Psychiatric Nurses Association of Ireland
- Psychological Society of Ireland
- Rape Crisis Centre
- Women s Aid, Dublin, Dundalk and Bray.

An interview schedule was used with representatives of the above organisations with particular reference to the topics of identification, intervention, inter-agency co-ordination and strategies for dealing with elder abuse. Those nominated by their respective organisations were interviewed on the following topics: the extent to which elder abuse was encountered by their professional/occupational group; common responses to cases of abuse; suggestions for dealing with elder abuse. The use of a semi-structured interview schedule was chosen to enable the respondents to express themselves in their own words and allow for a more qualitative exploration of the topic. Five specific topics were addressed as follows:

- *Identification* Does elder abuse exist in Ireland?
  What are barriers to detection?
  What types of abuse are encountered?
  What are the causes and risk factors involved?
  What settings does it occur in?
  How do cases come to light?

- *Intervention* What are the obstacles?
  What model/framework of intervention is used?
  What activities are central to the response?

- *Inter-agency co-ordination* Are cases referred on to others?
  If so, who are they referred to?
  Is there a specific policy on referral?
  Are case conferences held?

- *Training* Is training on elder abuse available?
  Is a formal protocol used in training?

- *A way forward* What steps should be taken to deal with elder abuse in Ireland?

8.1.2 Written responses from relevant organisations

A letter was sent to a further list of organisations requesting written views on the above issues. This resulted in written responses from the following organisations:

- Alzheimer s Society of Ireland
- Co-ordinators of Services for the Elderly, Eastern Health Board
- Irish Association of Older People
- Irish Nutrition and Dietetic Institute
- Irish Registered Nursing Homes Association.

Responses were not forthcoming from seven organisations as follows:

- AIM, the Family Law Reform Group
- Association of Community Welfare Officers
- Department of Social Welfare
- Federation of Active Retirement Associations
- Irish Countrywomen s Association
- Irish Dental Association
- Trust.

8.1.3 Interviews with representatives of organisations dealing with domestic violence

An extra set of interviews was carried out both in person and by telephone with those organisations dealing with domestic violence. The reported silence and invisibility of battered older women (Seaver 1996) was explored in interviews with organisations concerned with domestic violence in Ireland. The information was sought in order to explore if older women are outside the domestic violence intervention system or to what extent efforts have been made to meet their needs. This was seen as crucial to the recommendations of this report.

Organisations were contacted by phone and appointments mutually agreed. This aspect of the study was only a preliminary exploration of an important topic.

8.1.4 Postal questionnaire to the Chief Executive Officers of the health boards

A postal questionnaire was sent to the Chief Executive Officers of each health board regarding policy/protocol formulation. Non-respondents were contacted by phone and a further copy of the questionnaire was forwarded. Responses from all but the North Western Health Board were received. The questionnaire contained the following questions:

1.   Does your health board have a policy/procedure concerning elder abuse?
2.   If you do not have a policy/procedure are you at any one of the following stages in production?
    a.   No policy but draft procedural guidelines have been produced
    b.   No policy but have set up a working party on the issue
    c.   No policy yet but working on a policy
    d.   No policy but having seminars on elder abuse
    e.   No policy but follow child protection procedures
    f.   No policy but discussing the need for a policy
    g.   No policy but aware of the problem
    h.   No policy but want to address the issue
    i.   Do not see the need for a policy
3.   Any other comments.

8.1.5 Interviews with those responsible for the inspection of nursing homes

An interview with an administrative officer in one health board with special responsibility for registration and inspection of nursing homes under the *Health (Nursing Homes) Act* 1990 was carried out. An interview was also carried out with an Area Medical Officer and a Public Health Nurse experienced in implementing the *Act* in relation to inspection of private nursing homes. The main focus of the interviews was to identify how the legislation was implemented, what training and guidelines governing the tasks existed and if possible case examples of abuse uncovered as a consequence of inspection. To guide the interview, a copy of a draft guide to Nursing Home legislation was obtained from the Department of Health (April 1995).

8.1.6 Interview with group of older people

A discussion group was held with a group of older people who were regular attenders at a day centre. The purpose was to explore older people s awareness of elder abuse and their suggestions for how to deal with it.

8.2   Results of survey

8.2.1 Barriers to identification

This was a topic about which respondents spoke very freely, addressing most of the factors outlined in the literature review. Of significance is the emphasis given by respondents to victim reluctance to report, victim shame and fear. The following quotations are typical of responses from a wide variety of respondents:

> *They don t want to say it is happening within families for fear of repercussions.*

Elderly people have a lot of shame about members of the family abusing them. They might be very frightened of the consequences because the abuse could increase.

You have the person who for reason of fear would not have the abuse reported.

Then there is a kind of drawing back— and she knowsthat she better not say anything. She might say, oh, they took it . But she will not say who they are.

Victim reluctance to report emerged as the most frequently cited barrier to identification and detection. Professional denial and lack of knowledge were also mentioned. Some respondents spoke of the difficulty of trying to refer cases or highlight the issue and finding a lack of awareness and reluctance to acknowledge the problem. Responses that illustrate this were:

I actually brought it to the attention of the authorities that there was abuse of the elderly but it was not listened to.

I never thought that people wanted to know what was going on there. You see some people — they do not want to know.

When we are telling the nurses — now sometimes they do not want to believe it.

Attitudes to older people and to the privacy of the family were seen as contributing to the under-detection of cases of elder abuse, compounding professional denial and victim reluctance to report:

It takes so long for them to do anything. Is it because it is a family thing or what?

If someone came and said there was child abuse going on you would not say, let s wait and see . You would pick up the phone and at least discuss it with another colleague. I think we really tend to see it as not such an emergency situation as for children.

Is it with families that you cannot say my son is not caring . All the energy is put in to child abuse —there is no energy for older people. I do not think people out in the community know of it as an issue. I do not think that about it. They would find it very hard to believe the issue of abuse, that it exists at all.

8.2.2. Categories of abuse

As outlined in Chapter One, labelling the categories of abuse and distinguishing between the behaviour of the abuser and the effects on the abused person lends greater clarity to the issue of definition. To illustrate the wide range of types of abuse mentioned, the following table recording manifestation of abuse was completed. While not totally comprehensive, it includes the manifestations of abuse based on the literature review. The number of times mentioned by respondents is recorded.

Table 8.1: Manifestations of elder abuse mentioned by service providers (Total number of incidents = 26)

Physical

Pushed, grabbed, shoved older person	2
Slapped the older person	5
Kicked, bit, or hit with fist	2
Hit or tried to hit with something	1
Misuse of medication	1
Physical restraint	1

Psychological

Insulted or swore at older person	2
Ignoring, not communicating	1
Provocation of fear	7
Threats of punishment	1

Financial

| Coercion to obtain resources | 3 |
| Misuse of older person s money | 8 |

Neglect

Inadequate care of older person and of immediate living area	6
Not caring for health or seeking medical care	1
Withholding, or inadequate provision of, food, hygiene, clothing	5
Leaving older person alone for a long time, abandoned	2

Sociological abuse

Confined to one room	5
Restricted social contact	1
Denied visitors	1

Sexual abuse

| Forced to engage in sexual activity without consent | 1 |

8.2.3   Risk factors

Respondents indicated a high level of awareness of the possible risk factors which were outlined in Chapter Two. In their discussion of these they pointed out the lack of a single cause and illustrated the overlap and coexistence of many factors in cases with which they were familiar. Given that so many respondents were involved with dependent older people perhaps the focus on carer stress is understandable. Emphasis was placed on the relationship between risk factors and the complexities of family dynamics and a long history of poor relationships.

8.2.4   Abuse in institutional care

The majority of respondents considered that abuse could occur in an institutional care setting. However, there were some disagreements: two respondents clearly stated that the emphasis should be on the domestic setting. Many perceived standards to have improved since new legislation was adopted. Responses to the issue of definition indicated some lack of distinction between an abusive environment and abuse to a person .

Table 8.2: Types of abuse mentioned in institutional care

Psychological abuse	name calling
	threatening punishment
	verbal abuse
Neglect	problems with food preparation and feeding
	problems with toileting patients and continence management
	care of patients personal hygiene and laundry
	problems with development of pressure sores
	staff becoming blas , less responsive to patients needs
	care becoming routinised
	concern about adequate care for those who are highly dependent
Sexual abuse	problems with providing intimate care, suggestion of male orderly interfering with underclothing of an older woman in one case

The causes of abuse in institutions most frequently mentioned were:

- shortage of staff; inadequate staffing levels
- high turnover of care attendants/ nurses aides
- problems with difficult patients
- societal attitudes to older people, particularly those who cannot manage without help
- the difficulty of whistle blowing , seen as telling tales, squealing
- the reluctance to report on someone in a different profession or occupation, perhaps higher in rank.

Respondents were particularly concerned about what has been referred to as an abusive environment (Clough 1996). This concept refers to the organisation of life in the home particularly the management of the institution and staff motivation for the task, training and morale. Respondents were concerned that consideration of abuse and mistreatment in institutional settings should not be analysed in the same way as in the domestic setting. The point most commonly made was that the manner in which the institution is run is of huge significance to the lives of those who live there. A quote from one respondent provides a good summary of this section of the survey:

> *It starts from the mentality that governs the institution. It is more about the philosophy of care. It starts with management. In an institutional setting you have to have clear guidelines for all those who work there. If everything else is right they (those who abuse residents) will be flushed out very quickly. Staff have to be allowed to express their difficulties.*

8.2.5   How cases come to light
In exploring this issue a specific question was asked about self-reporting by the victim. Given the responses outlined in 8.2.1 emphasising victim reluctance to report, it is not surprising that the level of self-reporting was low. Most respondents referred to a case of self-reporting by the victim, which they considered unique or unusual.

In the cases where I have been involved, it has not been the older person (with the exception of one) who has reported. One lady told me she phoned Women s Aid Helpline. I cannot think of one case of reporting by the victim and I am here five years.

Cases of abuse came to attention mostly through contact with direct service providers while on routine visiting. There was a lot of emphasis on abuse coming to light when the people were already known to service providers before the abuse was detected. Service providers mentioned most frequently were: Public Health Nurses and Home Helps. Respondents also referred to the role of the Meals-on-Wheels service, the local chemist, and solicitors.

There was some awareness of masked requests for help by the abused person:

In Housing Welfare Departments, abuse usually comes up in another way.

The problem only came to light in the assessment of medical problems. She had become very withdrawn.

When you are going to visit somebody, you know by the way they are with you. You may have to go back several times, they eventually tell you in bits.

Disclosure by a close family member, by neighbours or by members of the public was rarely mentioned. There were no cases reported by the police. None of the respondents used a formal procedure for looking at cases of elder abuse. It is clear that knowledge of the older person and their family by service providers, developed during routine work, was the most important way for cases to come to light. Without any formal procedure, this depended to a large extent on the sensitivity and awareness of the professional involved. The question of how cases are detected has implications for the development of resources and training in this area.

8.2.6   Obstacles to intervention

There were a number of themes evident in comments on obstacles to intervention. Victim refusal of services was highlighted by several and is best illustrated by a number of direct quotations:

I said to her: How about trying to get to an Al-Anon meeting?. Ah no , she said, she is so reluctant to do anything .

When I spoke to her she would not have anything done.

Reporting to the police is the last thing the family wants.

Absence of protocols and guidelines compounded the uncertainty:

We need clear guidelines — it would take away a lot of the anxiety.

If we had guidelines, it might be much easier for the nurses to come in and talk about it.

There is a feeling of, what do we actually do? where do we go? I mean, whose job is it?

Lack of knowledge of the legal framework was also mentioned. This resulted in respondents making comments about uncertainty and self-doubt, which could impact on intervention decisions:

There is a little bit of denial, a bit of fear about getting in to something that you are not equipped to handle. I think that we are not given enough information on the ground about new legislation that has an impact on these situations.

Respondents generally indicated uncertainty about who to call on, particularly in a community care setting. The hospital setting was perceived as more supportive. The lack of a social work service for older people in the community was highlighted very frequently. This obviously reflects people s experiences of the role of social workers in the area of child protection. The lack of intervention options and skills required to deal with elder abuse was noted but this may reflect the early stage of development in this field. A good sense of the interviews is given by the comment:

There is not so much a problem in identifying cases as knowing what to do.

8.2.7 Interventions used when responding to elder abuse

Most respondents reported that they would have a discussion with a senior manager or refer a suspected case of elder abuse to someone seen to have more knowledge or skills to deal with the case. The first action would usually be to contact other professionals (e.g. GP, PHN, social worker) to share information and assess the case. The services offered were usually those which were already familiar to service providers. Respite care and removal to institutional care were frequently mentioned. However there was an acknowledgement that in some cases these options may not be acceptable to the older person and may be the reason for victim reluctance to report.

There was also evidence of reluctance to use respite care and institutions. The use of respite care as a response to physical abuse was commented on by two respondents. While acknowledging that it may have prevented something worse happening there was concern that it did not really confront the situation. Removal to institutional care was also questioned as the most common approach to protect those who are mentally incompetent. Action that related directly to financial abuse included contacting the Department of Social Welfare, the Bank Manager and the Garda . Increasing existing services and extra monitoring were offered in the hope that stress or isolation might be relieved.

Although case illustrations covered a wide variety of situations the types of services most often mentioned were support services, respite care and institutional care for the victim in a hospital or nursing home. Most respondents had not experienced a large number of cases; some did not discuss any particular case at all. Therefore the type of interventions focused on the individual case. There was no example of groupwork with abused or abuser, community education programmes, the use of domestic violence legislation, legal interventions other than wardship proceedings, casework/counselling with couples in marital difficulty, addiction counselling, family therapy, courses or training programmes to address elder abuse, or involvement in any formal documentation or research on the topic.

8.2.8   Inter-agency co-ordination
The key issues emerging from the discussion of this important topic were as follows:

- the absence of any mandated or formal machinery by which agencies are directed to co-ordinate activities
- co-ordination, characterised by many informal relationships and interactions at a case level
- the importance of familiarity and trust, as playing a key part in who was contacted. This was most evident in the area of information exchange at the referral stage
- a perception that there is more of a team approach in the hospital setting than in the community setting, more co-operation, more working together
- little experience of case conferences as a key mechanism for dealing with cases of elder abuse
- evidence of the potential for problems with the contribution of varied professions in inter-agency work, lack of clarity about roles; issues of role-overlap; status and power differentials.

8.2.9   Suggestions for a way forward
Findings from this small survey of service providers illustrated that there are a number of key components which respondents believed should be part of a strategy for dealing with elder abuse in Ireland.

A small number of those interviewed were concerned that number of cases, in particular those involving serious physical injury, were very few. A cautious approach was proposed with an emphasis on establishing, as a priority, the extent of the problem of elder abuse. These respondents tended to emphasise a more general improvement in attitudes to older people and to service development than carving out elder abuse . There was a sense of questioning as to whether elder abuse was really a problem.

Others, more convinced that elder abuse exists and is hidden , concentrated on the importance of public awareness and a campaign to raise awareness about the issue. They felt that the Government should invest in such campaigns in the hope that it would counteract the reluctance of older people to come forward, which they perceived as a major barrier.

There was a clear demand for training with emphasis on awareness training at undergraduate level and basic level courses. Collaboration with professional bodies and vocational training agencies was seen as essential. The development of a core curriculum on elder abuse was viewed as a major task. Many respondents felt that this required guidance and planning from a working party/task force, to develop a model syllabus.

There was a consistent call for guidelines and protocols; this was very much in keeping with the responses noted to questions about barriers to intervention. The issues which guidelines might address related mostly to procedures, such as the roles of different professionals and options for interventions. Respondents were almost unanimous in their view that such guidelines should be developed at national level by a group convened by the Department of Health and Children. Such a step was seen as putting elder abuse on the agenda .

It was clear the respondents saw the need for some agency to assume the responsibility for the protection of older people from abuse. In the current situation of organisational change in health boards some concern was expressed as to how the responsibility for dealing with cases

of elder abuse would be dealt with. This was particularly directed to the changing role of the Director of Community Care/Medical Officer of Health and developments in the field of child welfare and protection.

While several disciplines (e.g. PHNs and GPs) were seen to have a function in dealing with elder abuse, there was almost unanimous concern expressed at the lack of a professional social work service for older people at community care level. While elder abuse was acknowledged as an important topic, most respondents expressed concern that a way forward involved focusing on broader issues. The two areas most frequently mentioned were: counteracting ageism and the development of services to support carers of older people. This reflected a perception that these factors were risk factors for elder abuse. There was little mention of legal options, the development of Helplines , refuge/shelters or other forms of community-based projects which were discussed in Chapter Five of this report. In general, the suggestions made were not backed up by examples of models in other countries or particular knowledge about projects or research findings. There was little reference to examples of guidelines or protocols, experience of training programmes or policy development internationally. Therefore the suggestions for a way forward were in general terms rather than suggestions about particular examples that might be followed or studied.

8.2.10 Interviews with those working in the field of domestic violence
The following points made by those working in the field of domestic violence indicate that older women are beginning to see and name the abuse in their lives and are coming to an awareness that may help them to resist the abuse with more confidence. For the first four months of 1996 calls to the Women s Aid National Freephone Helpline were analysed by the age profile of the caller. The Helpline receives approximately 10,000 calls per year. There is no way of knowing how well this number reflects the actual number of women living in abusive situations. The telephone call is often a first step for women seeking advice and support: 12 per cent of callers were aged 51-64; 1.3 per cent of callers were aged 65 and over. Women s Aid (Dundalk) dealt with approximately 1,000 calls to the Helpline from September 1995 to September 1996: 184 callers were aged 50-60; six callers were aged 60-70. The new domestic violence legislation came into effect in 1996 (*see* Chapter Seven for details). Since its enactment, the number of domestic violence cases coming before the courts has almost doubled.

The numbers of women reporting rape and sexual assault have risen over the past ten years although rape as a crime is under-reported. There is no statistical information on the spectrum of violence to women in respect of different age groups. In 1995 calls to the Dublin Rape Crisis Centre concerning rape and sexual abuse were over 6,000. The age of those calling gives a profile of predominantly younger women (75 per cent under 29 years of age). The average age of clients seen for long-term and crisis counselling was 27 years. However, the Rape Crisis Centre has publicly expressed its concern for older women who have been victims of rape and sexual assaults. During the interviews for this report the crime of rape within marriage was mentioned. The *Criminal Law (Rape) (Amendment) Act* 1990 abolished the exemption of husbands from prosecution for the rape of their wives. The experience of the counsellors in dealing with a 73-year-old woman in the context of rape by her husband and other experiences with older women pointed to some special considerations for working with older women:

- the impact of sexual assault for an older woman can be particularly difficult.

- older women are more vulnerable to physical injury and infections.
- disclosure is very difficult and hampered by stereotypes about older women (e.g. forgetfulness; that they are deluded).
- for older women, sex was often a taboo subject when they were growing up.

8.2.11 Survey of policy development in the health boards

Of the seven health boards who responded to the questionnaire on policy development the responses were as follows:

- none of the health boards has a policy or set of procedures designed for elder abuse.
- all respondents to this survey were aware of the issue of elder abuse.
- one health board (Eastern) has draft procedural guidelines but these are for the institutional setting only.
- one health board (Midland) has set up a working party to produce guidelines.
- elder abuse is being considered by working groups reviewing services for older people in three further health boards (South Eastern, Southern and Western).
- one health board (Mid-Western) uses the child protection procedures as elder abuse policy.

While these developments are welcome there is a danger that a series of individual sets of guidelines and procedures will be produced by individual health boards, which may be neither consistent nor uniform.

8.2.12 Survey of those involved in the registration and inspection of institutional care

As outlined in Chapter Seven the main provisions of the 1990 *Health (Nursing Homes) Act* are to bring voluntary and private nursing homes under a common system of registration and inspection and to provide regulations to govern standards of care. The tasks undertaken by those involved in the registration and inspection of nursing homes include:

- deciding on the application for registration
- inspection of the home prior to registration
- determining that the person in charge is a fit person to carry on or be in charge of the home
- dealing with the application for registration within a two-month time limit
- inspection of all homes at least once every six months
- obtaining a comprehensive view of a nursing home and the standard of care
- reviewing facilities and care provided
- interviewing residents or members of staff where there is cause to believe that a person is or has not been receiving proper care
- preparing a comprehensive report
- investigating complaints.

At present, these tasks are carried out in each community care area by designated officers of the health board: an Area Medical Officer, a Superintendent Public Health Nurse and an Environmental Health Officer. Those who were interviewed by the researcher included an Area Medical Officer with full time responsibility as Co-ordinator of Services for the Elderly and a Superintendent Public Health Nurse. The geographical area included twenty-three nursing homes with approximately eight hundred and fifty beds. There are a number of issues

arising from interviews, a review of the legislation, regulations and code of practice for nursing homes issued by the Department of Health (1995b).

- Inspection involves gathering information, which can be measured against stated and agreed standards.
- The individual carrying out the inspection must have clear direction and support from those on whose behalf they carry out the task.
- The inspection process should be publicised widely and information made available.
- Inspection requires some consensus between inspectors and those inspected about values and practice. This requires training of the inspectors as a group and joint meetings with service providers. There is no established training programme on how to carry out inspections. Methods such as direct observation of staff interaction with service users and interviews with service users, families and friends are particularly important and take considerable skill.
- A commitment to the inspection task requires adequate provision of staff. There is a need to examine the number of homes to be inspected by one inspector. An average time of three full person days per statutory inspection has been estimated by one writer in the UK (Wing 1992, pp. 76-101). The difficulty in the Irish context is the fact that the tasks of inspection are delegated to those who are already in senior management posts with the pressures of very high workloads.
- As noted previously there is a danger that inspection officers who are also involved in the placement of long-term care patients will experience a conflict of interest. This is particularly likely when there is a shortage of long-term beds and/or the patient in question, for whatever reason, is perceived to be difficult to place.
- The 1990 *Health (Nursing Homes) Act* excludes public institutions managed by or on behalf of the Minister or a health board within the definition of nursing home . The Code of practice for Nursing Homes (Department of Health 1995b), while intended for nursing homes, aspires to influence all long-term care institutions. A commitment to ensuring that all those in long-term care receive adequate care and are protected from abuse would be strengthened by extending the provision of the 1990 Act to the public sector. The role of health board visiting committees , who currently monitor the public sector should be incorporated into the role of inspection under the new legislation.

8.2.13 Group interview with older people in a day care centre
The goal of conducting this group discussion was to hear about older people s views on the topic of elder abuse. One of the difficulties encountered was the fact that the participants may have had too little involvement in the topic. They may also have had insufficient time to think about it. A clear definition of the concept of elder abuse was given at the start of the group meeting. Several times during the discussion it was necessary to redirect back to the topic. Impressions during the session and on reviewing the tape were that the key concern for the group was about safety and protection from violence and crime by strangers. There was general agreement about the difficulty of reporting abuse by a family member because of a fear of retaliation and the inclination to cover it up . One participant shared her experience of taking legal action against a stepson to prevent him coming to her home and terrorising her when he was under the influence of alcohol. The rate of self-disclosure on the topic of elder abuse was low although two other members of the group were described as victims by the manager of the day centre after the interview.

8.2.14 Accounts of elder abuse reported during interviews with service providers

A number of accounts of elder abuse were related during interviews with service providers. They were related spontaneously during the interviews and are transcribed in the Appendix. Selected examples of these accounts are outlined below to illustrate the reality of elder abuse encountered by a small number of professionals in the course of day-to-day work. The many dimensions of elder abuse are illustrated and particularly the existence of many different types in any one example. The examples illustrate the complexity of real situations and the depth of suffering involved both for the victim and abuser. The examples also illustrate the dilemmas faced by those who encounter elder abuse.

The first examples are descriptions of physical abuse, one involving a daughter and one a spouse:

> *She had an only child. An only daughter who abused her terribly. She hit her with an iron. She hit her with a broken bottle. She went to America 11 years ago. Her mother is now 82 years old. She would not write. There is a row even on the phone.*

> *There was a husband and wife and he was beating her and she would not say. A few times we went and she had black eyes and terrible bruises. He was a big man. This is what you say — This is the only life they have ever known .*

The next account describes psychological abuse which seems to be occurring in a pathological family environment. In the first case the perpetrator is the spouse. In the second the abuse seems to involve a number of offspring and also involves financial abuse:

> *We had a woman who died this time last year and her husband was a big overweight bully. He screamed and shouted at her all the time. She would not do anything about it. The woman was terrified. They were 60 years married. The children were grown up and they did not want to know them either. They were so sick of all this. This screaming and name calling and really putting them down.*

> *They sold the property and made them great promises. They turned the garage into a bed sitting room. Then the family starts to grow up. One man said to me, they are getting grand now so they don t want them around . They were isolated. There is a lot of psychological abuse from the family who isolated them out there in that little place. They brought them out and used their money to develop the home and eventually got them into Health Board care. They used their money. Now that to me is all kinds of abuse.*

The following account illustrates psychological abuse in an institutional setting:

> *In one case the patient was very upset. He needed help to get up from the chair. He told me what the nurse said to him when she came down at night and it was quite verbally abusive. He was very upset and I felt I had an obligation to report it. It was more than a passing remark. I had heard this person being nasty to patients before and that is why I reported it.*

This example illustrates financial abuse, with a suggestion of social neglect:

They got his money (£17,000 compensation). He sold his house and moved in with the son and daughter-in-law. All the money went very fast on home improvements. There was a lot of drink involved. They did not abuse him other than the money. They took his pension, isolated him in a room, a small box room. They say it was because he would be dribbling at the table and the teenagers could not bring in their friends.

The next account involves chemical abuse, through the inappropriate use of medication.

We had one recently where the sister was a psychiatric patient and the carer. In order to keep the other sister quiet she was giving her more and more medication until her speech was slurred and what have you. She did not know she was doing bad. We proved it in the end. We got the chemist to check and they were looking for extra tablets.

This account involves physical neglect:

We had a case of the total physical neglect of a woman by her daughter. She was an adopted daughter. The mother had dementia. There were marital difficulties in the household. The daughter and her partner had been separated but he had come back and she became pregnant for the third time. She did not realise that she was neglecting her mother. She would leave her in the bed. I think there was financial dependence as the mother had two pensions and I think she owned the house. She did not have a basin to wash the mother. She used to get so dehydrated and was in Casualty several times. It just got worse and worse. Eventually she got into long-term hospital care. She needed to be protected.

The following example involves sexual abuse:

A case of sexual abuse: an old man and woman nearly 90. He had some kind of condition. He was very sexually demanding and his wife was a severe arthritic. The poor woman was in an awful state. It was not his fault really because he had to have some kind of treatment. They got both of them into a home in separate rooms. The old lady told the nurse.

The next account also involves a suggestion of sexual abuse in conjunction with physical violence:

This woman was in Casualty last week. She presented with lacerations. She was a widow who lived with her son. She disclosed that he abused her, assaulted her recently. In the past she lived with another son who was also abusive as was her husband until he died. Her son drinks. She had a laceration to her shin. She said that he had kicked her. She was 72. She also claimed that one night she was tired and did not want to go upstairs and she lay on the couch and he lay on top of her and kissed her and she was ashamed. She wanted to see a Social Worker not because of the injury but to ask about applying for separate accommodation. She came to the Casualty by bus with another son three days after the injury.

This example illustrates a situation where carer stress appears to be a major causal factor, but is complicated by the nature of the relationship between the people involved:

We had a lady who sold her house in another area to come with the daughter. The lady was in the early stages of dementia. The two grandsons had a rare disease. The daughter said to us I ll kill her, I hate her, I will kill her . She is screaming for help. We have a Home Help in there every day mainly because she goes out and leaves the mother and she won t feed her or anything. She will go out and leave her all day. She does not want to be around her. Her daughter has a lot of anger in herself from her relationship with her mother when she was younger.

The following account shows the involvement of alcohol as a precipitating factor for some abuse:

I was talking to a lady. She is in her 60s. She was upset and she told me that her husband came in drunk the night before. She is confined to a wheelchair. He was trying to put her out of the house the night before with drink. She said, the way it is now at our age it is not worth my while doing something .

The next account describes a situation where a perpetrator of neglect seems to have some form of mental disorder:

I had a case two years ago. It was a nightmare. A mother was living with her son. He had a psychiatric condition but it was never formally diagnosed. It was a very strange set up. They were well known to the services locally. He denied access and denied her any privacy with visitors. He was very abusive towards anyone who tried to intervene. There was evidence of neglect. She was sleeping in a chair. He refused all services and would not allow any changes. She was poorly mobile and had pressure sores. It was really weird. The son was really strange, spooky. I know that in the end they were trying to protect her through Ward of Court Procedures but she died.

The next account involves several forms of abuse in an institutional setting:

A private nursing home: the proprietor was not giving the nurse in charge the materials that she needed to care adequately for the patients. We blew the whistle. We knew what was going on for a while. I went down to her one day and I said that I was going to do a round. I had another nurse with me. I went into the kitchen and I opened the oven and it was cold shepherds pie sitting there. There was very little food in the kitchen cupboards. I looked in the store and found detergents mixed up with food. I saw a lot of things. I turned patients over and saw terrible bed sores. That was what made us go right down quickly. The poor old lady died.

When I went into the office there were clothes to be ironed all over the place. A nephew was sleeping in the same room. The conditions she brought us into were awful. I went in one morning at 8.45am and I could not understand the smell. Nobody did any washing until 12.00pm. The patients were badly cared for —tied into chairs. It was indescribable. It was fierce. It was going on for so long. There was one old lady and she was 90. She was very nice. She said that all her stuff was going missing, that the proprietor had hit her, that she could not get her Bible. We investigated and it was correct. Her stuff had been out in the shed. She was transferred to another nursing home. She was too old to go to court. We did not ask her.

This account is illustrative of material abuse involving a Home Help:

In a sheltered housing scheme there was a vulnerable man who had a leg amputated. He was not very bright. The problem was brought to my attention by the PHN. His money was disappearing and it emerged that the person that was involved was the Home Help. The Home Help Organiser contacted me. This man had quite a considerable period of time in hospital. His pension had built up. He had £3,000 accumulated on discharge from hospital. There was an account in joint names of the Home Help and the man. There was a lot of problems getting his account book. There was a lot of money taken from the account. The Bank Manager came down to the flat and set up a new account in his name only. It was very difficult and the Home Help was dismissed.

The following account seems to illustrate a situation where the victim is reluctant to disclose the abuse and is trying to protect the perpetrator:

There was a son and the mother. The son had a drink problem. She had bruises but they were fighting each other. Her behaviour was as good as his. We did something about it. She was put into a nursing home because the son was drinking the money and he was not feeding the woman. She was in her eighties. Half the time he was not leaving in any food. He had control of the money. She was housebound. He had great intentions. She would not let him down in front of the nurse. But the Home Help does not see the stuff in the fridge and that is the proof of it so the old lady went into a home.

Conclusions and Recommendations

Knowledge about elder abuse and neglect is growing as are calls for an official response. While many older people in Ireland have a positive experience of later life, there is evidence that some are exposed to the most tragic forms of ill treatment. The catalogue of suffering documented in this report and in others relating to the Irish situation provides a challenge to any suggestion that elder abuse is not happening in Ireland.

The early chapters of this report have explored, through a comprehensive literature review, the major aspects of the topic. The aim was to provide information to guide future action for the development of services to protect older people from abuse and mistreatment. The review provided a background and informed the survey research element of this report and both help to give direction to the conclusions reached. To overcome some confusion in terminology the following framework is used: a policy is a general statement of intent and covers definition, types of abuse, indicators and legal framework; procedures provide instructions on actions to be followed by staff; guidelines provide additional helpful information (Action on Elder Abuse 1995).

9.1   The survey

The survey of service providers carried out for this research project was limited because of time and resource constraints. Nevertheless, certain themes emerged from the survey and these are a useful guide to those attempting to deal with the problem of elder abuse. The key issues arising in Chapter Eight may be summarised as follows:

- Service providers are aware of a wide range of abuse, neglect and mistreatment of older people in Ireland.
- Victim reluctance to report, family privacy, professional denial, lack of knowledge by professionals and attitudes to older people are all important barriers to the identification of elder abuse.
- Abuse in the institutional care setting also occurs in Ireland. Organisational practices and poor staff morale are among the factors that are responsible for this. It is difficult to detect because of a reluctance to blow the whistle .
- Cases of elder abuse tend to come to light through routine contact with older people and is rarely self-reported.
- There is a lack of intervention options for elder abuse in Ireland, allied to a low level of professional training in dealing with the problem.
- There is a clear demand for training and the development of a core curriculum on elder abuse at undergraduate and postgraduate levels for professionals working with older people.
- A public awareness campaign is required.
- There is a need for an agency to assume responsibility for the protection of older people and there is concern about the amount of organisational change occurring in the health boards. These organisational changes make it difficult to identify which organisations, programmes and professionals are responsible for matters related to elder abuse.

9.2   The discovery of elder abuse

The theme that elder abuse is unrecognised and hidden pervades much writing on this topic. There is a growing interest in how social issues are recognised and move quickly up the policy agenda, creating policy changes. Child care and the abuse of women and children are beginning to become part of the popular and political agenda in Ireland. Chapter Six presents some analysis of the process in relation to elder abuse. The key issue is that a social problem becomes recognised only when a group of individuals organise to change the situation and achieve some recognition for their efforts. The mere existence of abuse and mistreatment of older people does not mean that efforts will be made to solve it. Dealing with elder abuse depends on a cultural willingness to accept the problem. It calls for an examination of cultural attitudes and the ways ageism is evident in our society. An examination of ageism must focus on individual attitudes, the structuring of organisations and the macro-policies which lead to conditions that permit abuse to occur.

9.3 A Working Party on Elder Abuse
It is time for Ireland to make a meaningful response to the problem of elder abuse.

In relation to national administrative arrangements, we recommend the establishment of a Working Party at Government level to co-ordinate the development of policy on elder abuse, and to give national guidance on procedures and guidelines.

The Working Party should have close links with the work of the Task Force on Violence against Women, so that the experience of this group can be used. Membership of the Working Party should be broad based. Representation from the following sectors is essential:

- Older people s representative groups
- Long-stay institutional care staff
- Representatives of private long-stay care providers
- Carers organisations
- Hospital care professionals
- Community care professionals
- Government departments
- Health boards
- Local authorities
- An Garda S ochan
- Financial institutions
- The Health Promotion Unit of the Department of Health and Children
- The Social Services Inspectorate at the Department of Health and Children
- The Department of Health and Children
- The Department of Social, Community and Family Affairs
- The Department of Justice, Equality and Law Reform
- Legal professionals
- Voluntary service providers
- Experts from the elder abuse, child abuse and domestic violence fields.

The proposed work of the Working Party is described in detail in the following sections.

9.4 A definition of elder abuse
The definition of elder abuse is the subject of continual re-examination as the complexities come to light. It is impossible to develop knowledge about elder abuse without first

developing common definitions. Action must not necessarily be hampered by the definitional debate.

The Working Party should therefore issue guidance on what constitutes elder abuse after consultation with interested parties.

In doing this care should be taken that the definition of the perpetrator is not restricted to the carer or relative . The definition of the victim should not be restricted to dependent or disabled older people. The definition should also distinguish between abuse in domestic and institutional settings clearly outlining similarities and differences. The definition must exclude self-neglect and abuse by strangers so that efforts can be concentrated on a conceptually distinct area. The definition must also not be overstretched to include more generalised problems which also deserve attention such as inadequate services, poor housing, low incomes, age discrimination.

Research on elder abuse has been hindered by inconsistent use of definitions. Different professions and occupational groups attach different meanings to the term. The views of older people themselves are seldom heard.

To proceed with definitions at least in the short term, we recommend that the search for a comprehensive meaning of elder abuse is not feasible and most definitions of this nature are impractical because they fail to define what the behaviour consists of and the nature of harm or damage.

The criteria against which a behaviour is judged to be abusive have been elaborated (Stones 1994).

To differentiate mistreatment from tolerable behaviour the main criteria should include: legal standards, regulated professional or workplace ethics and community standards of tolerable conduct. We recommend that this framework be incorporated into any working definition to be used in Ireland.

This must be followed by specifying intolerable behaviours in a comprehensive inventory. The work of Stones (1994) is exemplary in this regard.

9.5   Prevalence
There are many difficulties surrounding estimates of the prevalence of elder abuse; these also pertain to child abuse and domestic violence. The limited number of studies (*see* Chapter One) show a statistically low prevalence rate, generally around the three per cent mark.

As there are many problems gaining accurate data we recommend that any future Irish study of the prevalence of elder abuse should consider whether it is likely to achieve more precision than previous work. Development of survey instruments internationally should be closely monitored before proceeding with such a study.

Prevalence studies of abuse and neglect are needed for planning interventions. Particular attention must be paid to subject selection, sample size and experimental bias.

For the present it would be more appropriate to develop comprehensive recording mechanisms for cases that are already known to social and health care services. This should be done by the Working Party in consultation with interested parties.

9.6 Theories and risk factors

The risk factors for elder abuse are discussed in Chapter Two. The theoretical explanations of elder mistreatment and the critically important issue of causation provide the foundation for policy development. Based on the evidence of Chapter Two it is vital to recognise that there may be many different explanations for why elder abuse occurs. Failure to recognise this may lead to inappropriate solutions (e.g. an unwarranted focus on carers). There is a critical need for professional education on the circumstances under which different forms of abuse arise.

The Working Party, in co-operation with professional bodies and the educational institutions, should therefore undertake an education programme on the antecedents of elder abuse for relevant professionals, based on existing knowledge.

This programme should pay attention to risk factors in the broad social forces which marginalise older people (e.g. ageism, denial of resources and opportunities) as well as risk factors related to individuals. Incorporating risk factors into a case recording format would provide useful information for future research and analysis. The programme should also provide guidance on the type of information about risk factors that should be recorded in confirmed cases of elder abuse. This will assist the future development of knowledge in the Irish context.

9.7 Identification

Recognition and identification of cases of elder abuse is a major task. The literature review and responses from service providers lay the basis for a number of recommendations. Victim reluctance to report is an issue of concern in many forms of domestic violence and abuse in the institutional care setting. In order to overcome this there must be an investment in changing attitudes by bringing the issue of elder abuse out of the privacy of the home , both domestic and institutional. Fear of the outcome of reporting elder abuse can only be overcome by providing the public with information about what professionals actually do and the build up of trust.

Advice on the task of raising public awareness about elder abuse should be provided by the Working Party to relevant Government Departments.

The lessons of the Zero Tolerance campaigns, which challenged societal attitudes towards the assault of women and children by men, are important in this regard. In particular such campaigns highlight the necessity of an empowering of older people and present a strong message about challenging abuse.

Some workers make the mistake of expecting that abuse and neglect will be mentioned by the person if it is serious enough. The development of standard assessment protocols can guide the practitioner through a series of symptoms that could be missed.

The Working Party in consultation with interested parties should therefore develop policies and guidelines for the identification of elder abuse, taking into account the issues outlined in Chapter Three.

In developing assessment protocols it should be noted that care professionals must be allowed the time to work sensitively with suspected victims over a period of time. This will help build up trust and increase the likelihood of disclosure.

There is also a need for research on the recognition of cases of abuse. Practitioner perception of elder abuse is an important component in case detection. Further research is required in order to identify the factors influencing the decision to label a case as one of elder abuse. Of particular importance is the practitioner s understanding of family obligations, the caring role and marital relationships in old age. The Working Party should consider commissioning research on this issue.

9.8   Abuse in institutional care

There are certain factors that apply to institutional settings that distinguish them from domestic settings (*see* Chapter Four). Policies, procedures and guidelines must take this into account. A priority must be the public sector, which is currently subject to less stringent attention than private nursing homes. The registration and inspection of homes as governed by the 1990 *Health (Nursing Homes) Act* as a first line of prevention against all forms of abuse should be extended to include institutions in the public sector. The task of inspecting public sector homes is, however, somewhat different from that of the private sector. This is because of the greater complexity (size, range of activities) of public institutions; the different management structures (e.g. public institution practices may be subject to union agreements, or the influence of health board management/members); and the difficulty in monitoring a large number of residents in large institutions.

There is an urgent need for research on reliable measures of quality in this sector and on the role of existing visiting committees who inspect health board homes on a yearly basis. The Working Party should consider commissioning research on this issue.

In relation to the inspection process for all types of institutional care, the principles and preconditions for inspection need to be clearly set out by the Working Party, with an emphasis on measurable standards, consistency and visibility. A national training programme for inspection staff is essential. A commitment to the task of inspection requires recruitment of adequate numbers of staff of the highest calibre in personal and professional terms with direct experience of working in the caring professions. It is also essential that inspection staff are not involved in the placement of patients in long-term care, so that the potential for a conflict of interest is avoided.

 These recommendations are directly relevant to the new Social Services Inspectorate at the Department of Health and Children. The Inspectorate, which is being established on an administrative basis initially, is to concentrate on child care issues. The pilot inspection of children s residential centres will provide knowledge that will hopefully inform inspection of residential/institutional care for other groups such as older people.

We recommend the establishment of the Social Services Inspectorate on a legislative basis and the broadening of its remit from child care.

The complexities of providing intimate care on a continuous basis must be more thoroughly understood in order to tackle the issue of abuse and mistreatment. It is particularly important to examine the stressful work of nursing assistants/care attendants. The Department of Health and Children is currently working on protocols for dealing with allegations of abuse by staff in institutional settings. These protocols will be of immense interest to the issue of elder abuse, and should be analysed in relation to the issues raised in the current report.

9.9   Intervention

There are some general conclusions to be drawn from the issues discussed in Chapters Five and Eight in relation to intervention. The development of procedures and the question of the special categorisation of elder abuse continue to be controversial. Because of the special status of older people in society, demographic issues and other factors such as isolation or increased physical frailty, which may increase vulnerability, we believe that elder abuse should be treated as a distinct social problem. There are a growing number of services and specialised professionals concerned specifically with older people within which responses can be developed. In the complex process of social problem discovery and agenda setting there is a sense that an increasing number of individuals are concerned about the abuse of older people as a quite distinct issue, indicating that there may now exist that vital ingredient of public receptivity necessary for change.

We do not believe that responses to elder abuse should be positioned within policies on the protection of all vulnerable adults.

The term vulnerable adults refers to a very diverse group of clients and includes those who suffer from mental illness including dementia, those with a physical or sensory disability, those who have a learning difficulty, those who have a severe physical illness, as well as older people who are victims of abuse, neglect or mistreatment (Lewisham Social Services 1995). It is important to note that with the exception of the older grouping, the client groups are defined mostly by their dependency and health-related problems. There is a danger, therefore, that elder abuse will also be considered a health-related problem of dependency.

As a way forward we advocate that elder abuse is recognised as a separate issue and that the development of policies and procedures reflect this.

There are a growing number of services organised specifically for older people within which responses can be developed. It is important to develop links with those dealing with domestic violence, given the growing evidence of the continuation of domestic violence into old age. It is also accepted that there are valuable lessons to be learned from child protection and the protection of vulnerable adults. Given the high proportion of emotional problems, addiction and mental health problems in abusive situations, closer colloboration with mental health and addiction services is vital.

9.9.1   *Multi-dimensional nature of elder abuse*

In terms of designing interventions it is important to recognise the wide range of behaviours which now come under the general heading of elder abuse . Responding to elder abuse should include recognition of its multi-dimensional nature. Intervention must also be guided by factors such as the frequency of abuse, the severity of the effect and the variety of forms.

9.9.2   Protocols: procedures and guidelines
Providing guidance for those intervening in cases of elder abuse is a daunting task.

The Working Party should therefore develop protocols to assist those working in the field.

The following points should be incorporated:

- A caregiver stress model and its implied intervention of providing respite services to carers is clearly not sufficient for the different types of abuse.
- Abuse must be clearly distinguished from neglect and self-neglect.
- Frameworks should be developed to provide guidance on the content of the intervention, the process (educational, therapeutic) and the modality (individual, family, couple or group) (McDonald *et al.* 1991 p. 94).
- Intervention protocols can only provide guidance by identifying options and anticipated problems. What is needed is an informed selection of approaches according to the particular situation.
- The desire for certainty is not compatible with the acceptance of risk (Buckley 1996, p. 49) which is a necessary component of intervention.
- The protocols must clearly identify the roles and responsibilities of different professionals in different circumstances.
- They should also provide guidance on the detail of record keeping, and on the place of records in the monitoring of an intervention.

9.9.3   Mental capacity
As outlined in Chapter Five the issue of mental capacity poses fundamental problems for the practitioner intervening in elder abuse situations. Mental incompetency has not been clearly defined. A code of practice to guide assessment of capacity is urgently required. The recent UK publication by the Law Society and the British Medical Association (based on civil law in England and Wales) is a worthwhile model (British Medical Association and Law Society 1995).

We therefore recommend that the Irish Law Society and the Irish Medical Association collaborate to issue a code of practice to guide the assessment of mental capacity in an Irish context.

9.9.4   Inter-agency co-ordination
Co-ordination has been noted as an important issue. Any future frameworks devised on this issue should take into account the importance of issues like power structures and the conflicting perspectives involved in inter-professional communication. The lessons from child protection, such as the publication by the Department of Health (1987) of guidelines for the notification of child abuse between health boards and the Garda show that official guidance can only form a background. The need for inter-agency training is paramount if effective collaboration is to be achieved.

9.10   Training and education
Training workers in the field of elder abuse is likely to become an important issue for health and social services in Ireland. One model of particular importance is the pilot project on domestic violence initiated by Women s Aid in the Accident and Emergency Department of St. James s Hospital, Dublin and subsequently introduced at Beaumont Hospital, the

Rotunda Hospital and the Meath Hospital in Dublin. The course content provides a useful framework that could be adapted to the particular issues that arise with older people (Kelleher *et al.* 1995, p. 20, Cronin and O Connor 1993). A number of other training programmes have been developed for the education of professionals, caregivers, older adults, members of the general public and children about issues related to elder abuse and neglect. The need for training and education was clearly voiced in the survey of service providers and in many cases viewed as a priority ahead of the development of procedures and guidelines.

We advocate that the education issues related to elder abuse and neglect in Ireland are addressed by the Working Party as a matter of urgency.

Some of the strategies could involve:

- the collaboration of several professionals to produce comprehensive educational packages on elder abuse and neglect for professionals
- information for caregivers in the home and institutional setting
- development of a programme for older adults
- development of a manual to help community groups with educational activities and a project to educate children about elder abuse
- consultation with professional bodies on the core content of a curriculum which would be required of all students graduating from an established institution. The core content should include knowledge, attitudes and skills required to work with older persons who have been abused or are at risk.

9.11 Elder abuse and the law

Chapter Seven outlines the many aspects of the law which could be drawn on to respond to individual complaints of elder abuse. A forthcoming publication by the National Council on Ageing and Older People on the law and older people will be of help in informing professionals about available remedies.

Rather than calling for new legislation we advocate that efforts are directed to increasing awareness of the legal profession about elder abuse, addressing the ethical dilemmas of mental capacity and decision making and making the law more accessible to older people and to professionals working with them.

We also recommend that existing provisions under statute and common law are properly enforced or else revised so that they can be applied in cases of elder abuse. This is particularly relevant in relation to the prevention of elder abuse in institutional care. We recommend that legislation governing the inspection/regulation of institutional care settings be reviewed by the Working Party so that its effectiveness can be clarified.

There is also much potential in existing private law for application to cases of elder abuse. The 1996 *Domestic Violence Act* is a significant step forward in affording protection to victims. This is evidenced by the increasing number of applications by parents for barring orders against their children.

To ensure that the Domestic Violence Act is fully utilised in cases of elder abuse we recommend that it be monitored by the Working Party.

9.12   Developing innovative areas of work

Chapter Five outlines a number of different intervention models with examples of good practice. The chapter highlighted the value of taking an open-minded and creative approach to possible interventions, particularly when considering the use of existing services and facilities. There are three areas in particular that we would highlight for consideration for future development in Ireland. They have the advantage of having been evaluated as demonstration projects elsewhere and we feel they offer a valuable way forward in this relatively new area, particularly in the development of intervention programmes and researching their effectiveness.

We recommend that the SAVE Project of the London Borough of Lewisham be considered as a model of an inter-agency community response to elder abuse and developed in a community care area as a pilot scheme. We also recommend that a telephone helpline be set up as a pilot scheme in a number of regions, modelled on the UK Elder Abuse Response Line of Action on Elder Abuse and similar Helplines in Ireland for other client groups, for example Parentline, Women s Aid National Helpline and the Rape Crisis Centre. Finally, we believe that the development of a shelter for victims of elder abuse should be seriously considered.

Further research is required on the feasibility of these types of intervention in Ireland. We recommend that the Working Party on Elder Abuse commission such research, with a view to providing guidance to relevant Government Departments and local agencies.

9.13   Co-ordination of response to elder abuse

The report of the Working Party on Services for the Elderly, *The Years Ahead* (Department of Health 1988) made many recommendations on an appropriate framework for co-ordinating services for older people (Chapter Three). Administrative arrangements were proposed to strengthen co-ordination through:

- the formation of district teams
- a Co-ordinator of Services for the Elderly in each community care area
- advisory committees on the development of services in each health hoard
- administrative arrangements to co-ordinate policy at national level among relevant Government Departments.

The implementation of these recommendations has been reviewed by the National Council on Ageing and Older People and progress appears to be very limited (Ruddle *et al.* 1997). We therefore propose that other structures be considered, when attempting to co-ordinate elder abuse services. Proposed initiatives to promote the rights of children and protect their welfare are detailed in a recent document (Department of Health 1997b). These might also be a useful model for elder care. The initiatives include:

- a designated officer in each community care area to co-ordinate the response to individual cases of child abuse (i.e., a child care manager)
- the establishment of Child Protection Committees at health board level (Regional Child Protection Committee) and at community care level (Child Protection Committee).

The Regional Committee develops policy and the more local committees provide a forum for local level sharing of knowledge and experience. These will operate as sub-committees of the Child Care Advisory Committees established under the 1991 *Child Care Act*.

The report of the Task Force on Violence against Women (Office of the T naiste 1997) may also be relevant to the elder abuse field. The report recommends the development of a co-ordinated partnership approach at three levels through the establishment of:

- local networks to provide women with support and information on services
- regional planning and committees to plan services at health board level
- a Steering Committee at a national level chaired by a Minister of State with a cross-departmental portfolio and responsibility for policy on violence against women.

We recommend that the Working Party on Elder Abuse provide advice and guidance to relevant Government Departments and local agencies about the development of an organisational infrastructure to deal with elder abuse.

Without wishing to preempt the work of the proposed Working Party, we believe that the structures relating to child abuse and violence against women described above can inform those dealing with elder abuse.

Specifically, we recommend that responding to cases of elder abuse and protection of older people will require the appointment of a designated officer in each community care area to co-ordinate the response to individual cases and to receive notifications of cases of elder abuse.

We also recommend that advisory committees should be developed at health board level to focus on dealing with elder abuse, in particular reviewing development of policies/procedures, training needs, research and raising public awareness.

In relation to social work services, we endorse the recommendation by the National Council on Ageing and Older People, in its review of the implementation of The Years Ahead Report (Ruddle et al. 1997) that a community social work service for older people be established in all the health boards. The service should be responsible for protecting the rights of older people against exploitation or abuse, for identifying cases and for co-ordinating interventions.

9.14   Conclusions

As elder abuse begins to find its way into public consciousness the caution highlighted by Buckley (1996) in an article about child abuse guidelines in Ireland is very relevant. There is a danger that a narrow focus on elder abuse might channel resources away from the wider issues of promoting the welfare of older people, deny a service to those people who do not conform to the designated definition of abuse , and lesson the recognition of the many other social issues affecting older people in our society. There are many adversities suffered by older people. Elder abuse must be part of the debate about the causes and consequences of violence in Irish society. The social conditions that permit abusive behaviour in the family and in the institutional setting can only be transformed by a political climate committed to eliminating them.

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APPENDIX 1

Accounts of Elder Abuse Provided by Service Providers

- All the family were business people. The woman had cancer. Every day they were with her — sign this, sign that . They were trying to sell the house. She wanted the house for her handicapped son, and they did not want him to get it. They wanted the Home Help to witness the will. There was so much, the poor woman was distracted. One of the daughters appeared to be caring. It turned out that she had to pay her to look after her.

- We had a lady who sold her house in another area to come with the daughter. The lady was in the early stages of dementia. The two grandsons had a rare disease. The daughter said to us, I ll kill her, I hate her, I will kill her . She is screaming for help. We have a Home Help in there every day mainly because she goes out and leaves the mother and she won t feed her or anything. She will go out and leave her all day. She does not want to be around her. Her daughter has a lot of anger in herself from her relationship with her mother when she was younger.

- She had an only child. An only daughter who abused her terribly. She hit her with an iron. She hit her with a broken bottle. (She went to America 11 years ago). Her mother is now 82 years old. She would not write. There is a row even on the phone.

- They got his money (£17,000 compensation). He sold his house and moved in with the son and daughter-in-law. All the money went very fast on home improvements. There was a lot of drink involved. They did not abuse him other than the money. They took his pension, isolated him in a room, a small box room. They say it was because he would be dribbling at the table and the teenagers could not bring in their friends.

- In nursing homes they leave the dirty washing out for the relatives. If the clothes are badly soiled that is all left out for them. I mean you pay £1,000 a month for that?

- I know of one case and I never thought that people wanted to know what was going on there. The Home Help went in and the woman had a couple of bruises. She was a very slight woman and we did not know what was going on first. The woman was not prepared to say. One morning I met the daughter who was very agitated. She was a professional woman. I do not think she had much quality of life with the mother. I think that the mother was holding on and the daughter was frustrated. But there were a few times when the woman had bruises and I thought the professionals were a bit reluctant to take it on.

- There was a son and the mother. The son had a drink problem. She had bruises but they were fighting each other. Her behaviour was as good as his. We did something about it. She was put into a nursing home because the son was drinking the money and he was not feeding the woman. She was in her eighties. Half the time he was not leaving in any food. He had control of the money. She was housebound. He had great intentions. She would not let him down in front of the nurse. But the Home Help does not see the stuff in the fridge and that is the proof of it so the old lady went into a home.

- There was a husband and wife and he was beating her and she would not say. A few times we went and she had black eyes and terrible bruises. He was a big man. This is what you say — This is the only life they have ever known .

- We had a woman who died this time last year and her husband was a big overweight bully . He screamed and shouted at her all the time. She would not do anything about it. The woman was terrified. They were 60 years married. The children were grown up and they did not want to know them either. They were so sick of all this. This screaming and name calling and really putting them down.

- This morning I had a case of this old man. He is confined to the house. The Meals-on-Wheels rang to say they could not deliver any more. They had delivered 21 meals and had not been paid. The son is looking after the money. So the Home Help is there and there is no money and it is embarrassing for the old man.

- The woman moved in with her daughter and it was her husband who was abusing. The old woman told the Home Help. She had been so battered by this fellow. This poor old lady took her daughter in for company and did not realise what this man was like. She told the Home Help that her daughter used to sit up in the bedroom all day.

- I was talking to a lady. She is in her 60s. She was upset and she told me that her husband came in drunk the night before. She is confined to a wheelchair. He was trying to put her out of the house the night before with drink. She said The way it is now at our age it is not worth my while doing something.

- We have just dealt with the Community Welfare Officer. This man has no sheets. This is the man that the family have the money. She knows about the abuse.

- This lady lived alone and was on the waiting list for a hip operation for a long time. She was one of the silent ones. When she went in for surgery we found that all her medical problems were badly out of control. None of her medications had been collected. She could not do anything. She struck me as being very miserable. There was a lot of vocal abuse. There was evidence of lack of care. No food in evidence. I felt there was a whole care agenda that was so different from the well-cared-for older person. She was a world apart. She had become very withdrawn.

- An old lady who was psychologically abused. She was looked after by an aggressive nephew. When I asked her about getting a pair of shoes, she said, Oh no, don t ask him . There was fear. And when I asked her to come in as an out-patient she said, No, I am grand . She never wanted me to contact him. When we wanted to do a home visit there was no way she would hear of it, she was genuinely terrified. She was deprived of contact. Friends would visit her when she was in the hospital. They would never come when she was at home. He left her with no money in the hospital. The nurses were going to approach him. She nearly freaked altogether.

- In one case the patient was very upset. He needed help to get up from the chair. He told me what the nurse said to him when she came down at night and it was quite verbally abusive. He was very upset and I felt I had an obligation to report it. It was more than a

passing remark. I had heard this person being nasty to patients before and that is why I reported it.

- They sold the property and made them great promises. They turned the garage into a bed sitting room. Then the family starts to grow up. One man said to me, They are getting grand now so they don t want them around.   They were isolated. There is a lot of psychological abuse from the family who isolated them out there in that little place. They brought them out and used their money to develop the home and eventually got them into Health Board care. They used their money. Now that to me is all kinds of abuse.

- A case of sexual abuse: an old man and woman nearly 90. He had some kind of condition. He was very sexually demanding and his wife was a severe arthritic. The poor woman was in an awful state. It was not his fault really because he had to have some kind of treatment. They got both of them into a home in separate rooms. The old lady told the nurse.

- We had one recently where the sister was a psychiatric patient and the carer. In order to keep the other sister quiet she was giving her more and more medication until her speech was slurred and what have you. She did not know she was doing bad. We proved it in the end. We got the chemist to check and they were looking for extra tablets.

- A private nursing home: the proprietor was not giving the nurse in charge the materials that she needed to care adequately for the patients. We blew the whistle. We knew what was going on for a while. I went down to her one day and I said that I was going to do a round. I had another nurse with me. I went into the kitchen and I opened the oven and it was cold shepherds pie sitting there. There was very little food in the kitchen cupboards. I looked in the store and found detergents mixed up with food. I saw a lot of things. I turned patients over and saw terrible bed sores. That was what made us go right down quickly. The poor old lady died. When I went into the office there were clothes to be ironed all over the place. A nephew was sleeping in the same room. The conditions she brought us into were awful. I went in one morning at 8.45am and I could not understand the smell. Nobody did any washing until 12pm. The patients were badly cared for — tied into chairs. It was indescribable. It was fierce. It was going on for so long. There was one old lady and she was 90. She was very nice. She said that all her stuff was going missing, that the proprietor had hit her, that she could not get her Bible. We investigated and it was correct. Her stuff had been out in the shed. She was transferred to another nursing home. She was too old to go to court. We did not ask her.

- Private nursing home: I would not recommend re-registration. We just said No . The standard of care was terrible. The place was run like something 30 years ago. We were never told of actual physical abuse; it was just neglect. We went to court. It was the documentation that was so important — exactly what we had seen.

- I had contact with a person after discharge from hospital. The family member was the agent to collect the Pension and came to Dublin from Cork every weekend. Off they went with the money. The Home Help service alerted me to what was happening. They were aware the person had no money for food. The man did not want anything done. I spoke to him on several occasions. Then he died. The dilemma was knowing what was going

on, seeing it happen and keeping to the decision of the older person. In the end nothing was resolved.

- Joint tenant Purchasing Schemes in Local Authority houses: because exploitation of the older people was so common the Corporation now won t agree to such arrangements. Older people were left in one room and not allowed access. I have several cases of problems with joint ownership. In one situation a man was left in one room and it was freezing. The rest of the house was okay. In the other case the older person was deaf and dumb. In both situations the older person was rehoused in Senior Citizens accommodation. Legally their names were left on the tenancy. But they never went back.

- I had an elderly man who assaulted his wife. Now he assaulted her all his life and she did nothing. She went in for a heart by-pass operation. When she came out of hospital he assaulted her. That was the trigger that made her come forward. She had been abused right through her life and really felt her life was threatened. She got a Senior Citizens flat.

- The patient was in her 70s. She was in a Rehabilitation Unit following a stroke. She was in Intensive Care. Her daughter told us that the reason she had a stroke was that her husband had tried to strangle her. The daughter said it and the mother then admitted it. The daughter went on to say that he had abused the children and he would not ever let them speak to anybody. He made the wife sign over her pension book. They had never done anything about it. The consultant felt that this lady could not be discharged home even though she wanted to. It came out that she had gone to various hospitals and there was evidence of fractured ribs. The GP was not aware of it. She still wanted to go home. Her husband was intimidating the rest of the family. He threatened to go to the daughter s place of work. She became very strong during her hospital stay. She went home to live with her daughter. In the meantime the husband continued to intimidate her and threatened to commit suicide if she did not return home. In hospital she was protected and she admitted the abuse. It did create dilemmas when it was against her will at first that she should not go home to her husband again.

- The other case I came across was a mother made to sell her house and put the money into buying a bigger house. Her accommodation was a bedroom upstairs. As soon as she could not do the stairs she was put into long-term care and all her money was gone.

- A son was looking after his mother. He used to wash her feet in cold water every day. He became the main carer. He used to manually evacuate her bowels ever day. He would not let anyone else near her. He kept her in the darkness with the light on at times. He was the carer but a single son. She went home to that environment and people were aware of it. In the ward he used to do her feet — aromatherapy or something like that. Then he started to control her medication.

- I had a case two years ago. It was a nightmare. A mother was living with her son. He had a psychiatric condition but it was never formally diagnosed. It was a very strange set up. They were well known to the services locally. He denied access and denied her any privacy with visitors. He was very abusive towards anyone who tried to intervene. There was evidence of neglect. She was sleeping in a chair. He refused all services and would not allow any changes. She was poorly mobile and had pressure sores. It was

really weird. The son was really strange, spooky . I know that in the end they were trying to protect her through Ward of Court Procedures but she died.

- I had another incident where a woman told me that her daughter had been hitting her. This was a very with it woman. She could have done something herself. The daughter did not live with her. I did not know what to do. I rang the Garda . She just wanted a magical solution.

- This woman was in Casualty last week. She presented with lacerations. She was a widow who lived with her son. She disclosed that he abused her, assaulted her recently. In the past she lived with another son who was also abusive as was her husband until he died. Her son drinks. She had a laceration to her shin. She said that he had kicked her. She was 72. She also claimed that one night she was tired and did not want to go upstairs and she lay on the couch and he lay on top of her and kissed her and she was ashamed. She wanted to see a Social Worker not because of the injury but to ask about applying for separate accommodation. She came to the Casualty by bus with another son three days after the injury.

- The nurse was trying to do continence promotion with a lady. When she got talking to the carer she realised that the carer used to hit out at the elderly person simply because she did not understand (the carer was a sister).

- In a sheltered housing scheme there was a vulnerable man who had a leg amputated. He was not very bright. The problem was brought to my attention by the PHN. His money was disappearing and it emerged that the person that was involved was the Home Help. The Home Help Organiser contacted me. This man had quite a considerable period of time in hospital. His pension had built up. He had £3,000 accumulated on discharge from hospital. There was an account in joint names of the Home Help and the man. There were a lot of problems getting his account book. There was a lot of money taken from the account. The Bank Manager came down to the flat and set up a new account in his name only. It was very difficult and the Home Help was dismissed.

- A woman was living with her son. The housing department were about to repossess the flat for non-payment of rent. It was his home as well. The mother was bed bound. There was a suggestion that he had sexually abused her. The home care team paid extra attention and they were more available as was her GP. The Department of Social Welfare withdrew her son as agent to collect her pension. There were rent arrears and ESB arrears. The money was obviously mis-spent.

- We had a case of a woman who was literally confined to bed and would not go to hospital. She lived with one son and another son half-lived there. They drank all her money and she was up for eviction. At the last minute it was stopped. There was over £800 in arrears. The Corporation Social Worker was involved. The mother defended her sons to the last. We had other suspicions that he might be doing things to her of a sexual nature — but they were only suspicions. She had a fleet of nurses going in to her even at the weekends. In her case the cure was to move her into hospital which she did not want. She wanted nothing to do with hospitals. Maybe there was some sort of bullying there as he was dependent on her for the flat.

- We had a case of the total physical neglect of a woman by her daughter. She was an adopted daughter. The mother had dementia. There were marital difficulties in the household. The daughter and her partner had been separated but he had come back and she became pregnant for the third time. She did not realise that she was neglecting her mother. She would leave her in the bed. I think there was financial dependence as the mother had two pensions and I think she owned the house. She did not have a basin to wash the mother. She used to get so dehydrated and was in Casualty several times. It just got worse and worse. Eventually she got into long-term hospital care. She needed to be protected.

- I spoke with someone this morning. After at least twelve years of her husband s drinking she finally threw him out after Christmas. Where is he now? He is living with his elderly mother. Do we have any notion of what this woman is tolerating? You have no guarantee that he will not be the same. I mean violence was not an issue but horrendous verbal abuse.

- I worked with a couple some years ago. This couple were in their early seventies. They described how they would go to bed at night fully dressed, shoes and all on them, so that they could make a hasty escape. This was before the new legislation. The police was hugely supportive to them and advised them to get an injunction. It was very wearing for them. We supported them through the pre-intervention programme for those living with someone who is addicted to alcohol.

- A niece came to live with an elderly person. She extended and renovated the house and it greatly increased in value. Then she wanted the deeds of the house. The old lady developed a problem with incontinence. A cycle of abuse started. One day she would beat her and the next day she would become very caring and concerned. The event that precipitated her report to the nurse was a slap that blackened the whole side of her face. What she said happened did not tally — she was supposed to have a sun tan in Ireland in the middle of May. She was admitted to the hospital. The pressure was huge on her not to say anything when she was in hospital. Her niece literally lifted her out of the hospital, bundled her up one day and took her home. I brought the Garda into her own home.

- I became aware of a case in a nursing home. The older person disclosed to a relative that a male orderly had been removing underwear/incontinence wear. There were suspicions of some kind of sexual abuse. All I know is that the staff member was dismissed from the job. This was a case that was told to me. I was not actually involved in dealing with it.

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This report is the outcome of many years of concern about the silence in Irish society regarding the abuse of older people. It is written with the conviction that a social problem is a social construct. For elder abuse to become a social problem it requires that many individuals feel a conflict over what is and what ought to be, that they organise to change the condition and that these efforts receive public recognition. The commissioning and publication of this report required leadership, a willingness to accept the problem of elder abuse and a commitment to ensure that it will become an issue which will receive government attention in a way that focuses on both its individual and social context.

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Anne O Loughlin

APPENDIX 3

National Council on Ageing and Older People

The National Council on Ageing and Older People was established in March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1.   To advise the Minster for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

      (a)   measures to promote the health of older people;

      (b)   measures to promote the social inclusion of older people;

      (c)   the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

      (d)   methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

      (e)   methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

      (f)   meeting the needs of the most vulnerable older people;

      (g)   means of encouraging positive attitudes to life after 65 years and the process of ageing;

      (h)   means of encouraging greater participation by older people;

      (i)   whatever action, based on research, is required to plan and develop services for older people.

2.   To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

      (a)   undertaking research on the lifestyle and the needs of older people in Ireland;

      (b)   identifying and promoting models of good practice in the care of older people and service delivery to them;

      (c)   providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;

      (d)   liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3.   To promote the health, welfare and autonomy of older people.

4.   To promote a better understanding of ageing and older people in Ireland.

5.   To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

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