



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



open your eyes

There's No Excuse for **Elder Abuse**



 European Year for Active Ageing
and Solidarity between Generations 2012



HSE ELDER ABUSE SERVICES 2011

APRIL 2012



Violence
Assessment
Abandonment
Neglect
Exploitation
Intimidation
Fraud



Abuse
Assault
Mistreatment
Exploitation
Intimidation
Fraud
Abandonment
Victim

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Foreword

It is a fact that our older population in Ireland is increasing and that people are living longer. This is a cause for celebration for all of us. Though growing older brings many opportunities, it can also present challenges that need consideration and planning in order to minimise risk and lessen any impact on quality of life. In some instances, old age can lead to greater vulnerability, not only to disease and disability, but also to various forms of abuse and exploitation. Older people can often be a prime target for negative stereotyping and discrimination based solely on their age.



Mr. Frank Murphy, Chair, National Elder Abuse Steering Committee.

The Madrid International Plan of Action on Ageing specifically acknowledges elder abuse as a problem that requires both national and international attention. The action plan states that, in order to work towards a sustainable society for all ages, society as a whole should combat age discrimination and age related violence. Elder abuse prevents older people from living a life with dignity and from fully participating in society, and is therefore, an infringement of basic human rights.

The establishment of dedicated structures within the HSE to address and combat elder abuse in Ireland has seen progress in our understanding of the risk, nature and extent of the abuse of older persons in our country. These advances have only been achieved by acknowledging and embracing elder abuse as an issue that cannot be addressed by any one organisation, but is one that requires a multifaceted response obtained through collaborative working with individual older people, families, communities, statutory agencies, voluntary organisations, business institutions and the legal profession.

Research conducted by the National Centre for the Protection of Older People (NCPOP), such as the study on the prevalence of elder abuse in Ireland and the study of older people's experiences of suffering abuse, have enhanced our ability to put in place appropriate responses and support structures to minimise risk and ensure the safety of the older person while, at the same time, offering therapeutic interventions for the perpetrators.

Indeed, since the HSE commenced capturing elder abuse data, the service has recorded an increase in referrals each year; from 927 referrals in 2007 to 2,302 referrals in 2011. While on the face of it this might seem a worrying trend, the increase may be attributed to a number of factors, namely an increasing public awareness of the issue, greater appreciation of how and to whom to report abuse and a confidence in the HSE's responses. All referrals of abuse to the HSE are treated seriously and the main objectives in dealing with cases of abuse are to stop unwanted behaviour, restore and/or support relationships and provide assistance for both the victim and the person causing the concern.

In 2011, the HSE undertook its third media and public awareness campaign. This campaign included a conference to coincide with World Elder Abuse Awareness Day on June 15th as well as exhibiting at events such as the National Ploughing Championships and the Senior Times Over 50s Show. The HSE also continued its collaboration with the Equality Authority and the Department of Health by participating in the eighth annual Say No to Ageism Week which addresses the issue of elder abuse in a societal context and provides a unique opportunity to turn the spotlight on the language, behaviours, policies and practices that devalue people simply because of their age. In addition, the campaign promotes a more inclusive society for older people.

Training and education for healthcare professionals and those working and interacting with older people has also greatly assisted in the recognition and response to the issue of elder abuse and enabled older people to discuss concerns and avail of various supports ranging from home support, monitoring, respite, meal on wheels, etc.

In addition, the development of policies, procedures, protocols and guidelines will aid healthcare professionals, and those in statutory agencies, to work together to assist detection and to offer comprehensive, timely and appropriate responses that people can have confidence in.

This year, 2012, has been designated European Year of Active Ageing and Solidarity between Generations. This provides all of us with an opportunity to raise awareness about our ageing population, promote an age-friendly environment and promote quality of life as people get older. The focus of the year will be on maintaining vitality, respecting dignity and enhancing involvement in volunteering and society, while, at the same time, removing barriers and fostering respect and understanding between generations.

Despite advances in addressing ageism and elder abuse in Ireland, significant challenges still remain. The NCPOP prevalence study indicates that more older people are experiencing abuse than are reporting it. In 2010 they estimated that 10,201 older people experienced abuse in the previous year. The study suggests several reasons for this under-reporting and includes not recognising the behaviour as abusive, a reluctance to inform on perpetrators, lack of knowledge on how to report abuse, feelings of guilt or shame as well as a lack of confidence in the professionals to detect or respond to elder abuse. This under-reporting of elder abuse is not unique to Ireland – it is widely recognised internationally.

Although much remains to be achieved, much has been accomplished. Combating elder abuse is a journey of awareness and education for older people themselves and for healthcare professionals, voluntary agencies, businesses and community groups, and the general public. It is only through consultation, collaboration and joint working that progress can be made to combat elder abuse in society and create a culture that respects, values and includes all people, regardless of age.

In our efforts to combat abuse, I would like to thank all HSE staff, voluntary organisations, community groups, statutory agencies and the business community for their efforts and support.

Frank Murphy, Chair, National Elder Abuse Steering Committee

Elder abuse is defined as –

“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 or violates their human and civil rights.”

Protecting our Future, Report of the Working Group on Elder Abuse, (2002)¹.

The HSE recognises a number of different types of abuse, which may result from deliberate intent, neglect, thoughtlessness or ignorance. The different types of abuse may be categorised as follows:-

- **Physical abuse**, including slapping, pushing, hitting, kicking, misuse of medication, inappropriate restraint (including physical and chemical restraint) or sanctions.
- **Sexual abuse**, including rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent.
- **Psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
- **Financial or material abuse**, including theft; fraud; exploitation; pressure in connection with wills, property or inheritance, or financial transactions; or the misuse or misappropriation of property, possessions or benefits.
- **Neglect and acts of omission**, including ignoring medical or physical care needs, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Discriminatory abuse**, including ageism, racism, sexism, that based on a person’s disability, and other forms of harassment, slurs or similar treatment.

It should be noted that the definition of elder abuse as set out in *Protecting Our Future*¹ does not include self-neglect as this was not set out in the terms of reference for the Working Group.

However, in recognising that self-neglect does occur and is in fact the second most reported reason for referral to the HSE elder abuse service since 2008 (approx. 20% of all referrals), the HSE developed a policy, *HSE Policy and Procedures for Responding to Allegations of Extreme Self-Neglect*² to guide responses to cases of self-neglect. In the policy, self-neglect is defined as *“the inability or unwillingness to provide for oneself the goods and services needed to live safely and independently”*.

1.1 Elder Abuse Service Structure

The structure of the HSE’s elder abuse service is largely based on the recommendations contained within *Protecting our Future, Report of the Working Group on Elder Abuse (2002)*.¹

1.1.1 National Elder Abuse Steering Committee

The HSE National Elder Abuse Steering Committee, established in 2007, oversees the HSE’s elder abuse service nationally and works to ensure that the recommendations contained within *Protecting our Future*, as well as those contained within the review of that report in 2009 - *Protecting our Future, Review of the Recommendations of the Report of the Working Group on Elder Abuse*³ - are implemented. In addition, the HSE National Elder Abuse Steering Committee considers issues as they arise that may require a consistent approach.

The membership of the National Elder Abuse Steering Committee is multi-agency and multi-disciplinary to enable it to address specific and emerging issues. The wide cross section of membership enables the Committee to address complex issues sometimes outside the scope of the HSE. See Appendix 1.

The work of the Committee is supported at regional level by four Area Elder Abuse Steering Groups. These are based in the four HSE administrative areas, i.e. HSE West, HSE South, HSE Dublin Mid Leinster and HSE Dublin North East.

1.1.2 Area Elder Abuse Steering Groups

Area Elder Abuse Steering Groups operate in each of the HSE's four administrative areas. They ensure local implementation of nationally agreed approaches to elder abuse and resolve any significant issues arising in their own areas or bring these to the attention of the appropriate forum. They act as a conduit for communication between local agencies, advocacy groups and the National Committee.

1.1.3 Dedicated Officers for the Protection of Older People

The workings of the National Elder Abuse Steering Committee and the Area Elder Abuse Steering Groups are supported by Dedicated Officers for the Protection of Older People. These Officers (previously Dedicated Officers for Elder Abuse, whose title was amended in 2011 to more accurately reflect their role) are largely responsible for policy and protocol development, training, advice and consistency in application of elder abuse policies, procedures and guidelines. Dedicated Officers for the Protection of Older People are currently in post in HSE Dublin North East, HSE Dublin Mid Leinster and HSE West. The position in HSE South is currently vacant.

1.1.4 Senior Case Workers for Protection of Older People

Senior Case Workers for the Protection of Older People (SCWs) assess all referrals of alleged elder abuse reported to them and work in a sensitive and respectful manner in trying to resolve elder abuse issues. This may involve complex interactions with family, neighbours, friends, other healthcare staff, businesses and the legal profession.

Currently, there are 31 SCWs in post. A vacancy exists in the Local Health Office of Kildare/West Wicklow. However, despite this there is a system in place to manage referrals of elder abuse. Referrals are managed by the General Manager with onward referral to the appropriate service for follow up.

1.2 Responding to Elder Abuse Concerns

Senior Case Workers (SCWs) receive an increasing number of referrals each year. However, much more abuse goes unreported and many older people are suffering without support that could help alleviate the problem.

Cases of elder abuse can be very intricate and may involve dealing with complex interactions between family, neighbours, friends or businesses. SCWs start every case with the presumption that the older people they work with have mental capacity and, as such, have a right to self determination. This means that they have the right to make decisions for themselves even though others may not necessarily agree with the decisions made. It must be borne in mind that upholding this right to self determination can, in itself, be an important protection for older people. However, it can involve risk for the older person and very often the role of the SCW is to work with the older person to minimise this risk while respecting his or her wishes.

Generally, in an abusive situation, the SCWs find that older people want three things:-

- They want to remain in their own homes.
- They want the relationship with the person causing concern to continue. This may particularly be the case when the abuser is a family member or friend.
- They want the abuse to be minimised / stopped.

Older people, like many other victims of abuse, may be reluctant to disclose their fears and concerns about a situation. There are many barriers that may contribute to this reluctance. Primary among them is the fear of losing or harming their relationship with their abuser – especially where family members are involved. This can centre not just on the fear of losing the support that they depend on, but also on the love for their relatives and not wanting them to suffer any repercussions.

Many health professionals have expressed an apprehension and reluctance in communicating with older persons about their abuse concerns. It can be difficult to raise the subject of abuse. In talking to an older person about abuse, we must be respectful, empathetic and we must not appear judgemental. Listening, not only to what the older

person says but to how he/she is saying it, including body language and gestures, will give a fuller understanding and appreciation of their concerns. The SCWs' own language and how questions are asked can make it easier for an older person to open up and share concerns.

The following are examples of how professionals can initiate/prompt some of these difficult conversations:-

- Is there anything you'd like to talk about?
- Do you ever feel taken advantage of / mistreated? How?
- Tell me about your living situation; are you happy with it?
- Is there anyone who you don't feel comfortable around? What is the reason for this?
- Are you comfortable with how your finances are being managed?
- Are you getting all the help that you need?

Health care workers' hesitation to discuss abuse concerns can be compounded where they have a lack of knowledge about what is likely to happen after an elder abuse concern is brought to light. In training staff to recognise possible abuse, attention needs to be focused on how concerns are assessed and what some of the likely responses to these are. Though each case is different and each is responded to based on the particulars of that situation, concerns must be dealt with sensitively and the older person, and where appropriate, their family and supportive others should be involved in the assessment process.

Generally speaking, intervention by the HSE is not about righting a wrong done or establishing guilt but rather on responding to the needs and wishes of the older people and working with them and their families to resolve the issue. In the vast majority of cases, the older person wants the abuse to stop but wishes their relationship with the abuser to continue.

When a SCW receives a referral (this may be by way of phone call, direct discussion or receipt of referral form), he or she would usually start the assessment process by having an informal discussion with the person bringing the concern to light. They will confirm the details already received and the referrer is asked to put their concerns in writing. Even at this very early stage, an assessment of risk is made as in some of the more serious cases, protection measures may be required to be put in place immediately.

The next person the SCW would usually speak to is the older person who is the subject of the alleged abuse. The SCW may make direct contact with the older person and follow this up with a home visit or an alternative location chosen by the older person. On other occasions, the SCW may visit the older person with a Public Health Nurse, the person raising the concern or a member of the older person's family. At this stage, depending on the nature of the concern and the older person's wishes, family members may be involved. The SCW, and others involved in the case, must be sensitive in how they introduce themselves and how they address the issues. Usually, the SCW will explain that their role is related to protection of older people and that they wish to discuss in confidence the particular concern which has been raised. In the majority of cases, the referrer has already addressed their concerns to the older person and discussed the possibility of seeking HSE support.

During the assessment and intervention process, the focus is on:-

- Ensuring the safety of the older person.
- Restoring the rights, dignity and wellbeing of the older person.
- Creating or re-building support systems for the older person.

Many cases of elder abuse take some time to resolve and there is no one set of actions that will work in every instance. Each case is unique and many are complex requiring a multifaceted response involving many health care professionals, the older person, their family and other agencies. Helping an older person move past the harm caused and towards a safer and better quality life requires time, support and cooperation.

2.0 Elder Abuse Working Groups

The 2010 study by the NCPOP entitled *Abuse and Neglect of Older People in Ireland, Report on the National Study of Elder Abuse and Neglect*⁴, found that elder abuse and neglect are the potential outcomes of complex interactions between a multiplicity of social, economic, health, social isolation, education, environmental and individual characteristics. The study further indicated that a multi-agency approach is needed to produce a multifaceted response to target prevention with a focus on resolving the mistreatment. The responsibility for responding to elder abuse is therefore shared across the whole of society.

A review of the recommendations of *Protecting our Future, Report of the Working Group on Elder Abuse*¹, was commissioned by the National Council for Ageing and Older People and was conducted in 2009 by PA Consulting. In that report, *Protecting our Future, Review of Recommendations of the Report of the Working Group on Elder Abuse*, it was acknowledged that although considerable efforts and resources were invested in providing information on elder abuse, continued investment would be needed to ensure sufficient awareness and understanding of elder abuse among the general public.

The Review also identified a number of areas of emerging concern and recommended that policies, procedures, protocols and guidelines be developed to enable inter-agency collaboration and joint working to address these concerns.

In order to progress work in specific areas of elder abuse and to act on the recommendations outlined in the above reports and the NCPOP study, the National Elder Abuse Steering Committee established a number of working groups. These groups, some with multi-agency memberships to provide a wealth of experience, knowledge and ideas, are addressing the following areas:

- Media and Public Awareness
- Policies, Procedures, Protocols, and Guidelines
- Staff Awareness and Curricula
- National Financial Abuse of Older Persons

2.1 Media and Public Awareness Working Group

One of the recommendations contained in *Protecting Our Future (2002)*¹ was that “a public awareness programme... be undertaken to raise awareness of elder abuse among the general public in Ireland”.

The review of *Protecting our Future (2009)*³ acknowledged that significant progress has been made in implementing recommendations in *Protecting Our Future*¹. Areas where progress was most evident included roll out of initiatives to raise awareness of elder abuse and acknowledged the scale of the challenge in building awareness on elder abuse.

The Review also identified a number of areas that need to be strengthened in the current implementation framework to prevent and address elder abuse. These included, among others, “extending current prevention and awareness programmes”. Close liaison with the NCPOP to enable its research to inform future awareness programmes by the HSE, The National Office for the Prevention of Domestic, Sexual and Gender-based Violence (COSC), the Equality Authority and community and voluntary organisations was also recommended. In addition, the Review recommended “a three-year public awareness programme, building on the existing awareness campaign, and incorporating an evaluation process as appropriate”.

The Department of Health and Children, in supporting recommendations for public awareness, provided funding for elder abuse public awareness campaigns in 2008 and 2010. These campaigns have greatly aided the understanding of elder abuse and the acceptance that it exists in society as well as encouraging those experiencing abuse to speak out. Referrals to the HSE have been increasing each year. 2010 saw a 10% increase in the number of cases being reported to the HSE with 2,110 referrals being received. However, the NCPOP study *Abuse and Neglect of Older People in Ireland, Report on the National Study of Elder Abuse and Neglect (2010)*⁴ estimated that over 10,000 older people experienced abuse in the previous year, highlighting the under-reporting of elder-abuse. The World Health Organisation in their publication, *A Global Response to Elder Abuse and Neglect (2008)*⁵, estimated that elder abuse is underreported by as

much as 80%. There are many other reports that suggest that public awareness is a vital element in combating elder abuse. Giles et al. (2010)⁶ highlighted the importance of public awareness, “Over the next ten years, the field of elder abuse must take steps to increase public awareness of elder abuse and take action to shift public attitudes”. In the US, the Government Accountability Office (1991)⁷ found that “80 percent of state officials ranked public and professional awareness as the most effective factor for identifying elder abuse victims”.

This supports the strongly held view that more work is needed to highlight elder abuse, educate on preventative measures and publicise the supports available to older people who access the elder abuse service in an effort to address and remove barriers to reporting.

In 2011, the HSE embarked upon a third Elder Abuse Media and Public Awareness Campaign and focused on elder abuse in the community; raising awareness of potential risk factors, how to minimize these, improve prevention and encourage reporting where abuse is suspected.

2.1.1 Media and Public Awareness Working Group Membership

The Media and Public Awareness Working Group was chaired by Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West. In order to review the previous *Open Your Eyes* campaigns and to formulate a campaign for 2011, representatives from the HSE and other agencies were sought in order to provide a range of experience, ideas and thinking that would add a richness and relevance to the proposed campaign.

Representatives from the following organisations were invited to participate:

- Age Action
- Active Retirement Ireland
- Alzheimer Society of Ireland
- An Garda Síochána
- Department of Health and Children
- Health Service Executive
- National Centre for the Protection of Older People (UCD)
- The Carers Association
- The Equality Authority
- The International Network for the Prevention of Elder Abuse (Irish representative)

Please see Appendix 2 for a full listing of the membership.

2.1.2 Campaign Focus

The Group agreed that the thrust of the 2011 campaign should again be focused on abuse in the community, targeting older people themselves as well as the community groups, businesses and professionals that interact with older people on a daily basis. The Working Group recognised that these people are in a unique position to identify signs of elder abuse, to offer support and advice if needed and to report concerns where necessary. The campaign also sought to expand its messages to include a younger population as creating an awareness of elder abuse and the impact of ageism on older people at a young age helps foster a culture of respect and value.

The Working Group considered that an evaluation of the 2010 campaign materials, specifically the community awareness DVD, *Open Your Eyes to Elder Abuse in Your Community* and the elder abuse information leaflet would help inform future campaign strategy in relation to maximising the effectiveness of these educational and publicity materials.

The Working Group proposed several key elements designed to attract media attention, assist professional recognition and response, and inform and educate the general public as well as specific community groups and are outlined below.

- i. Independent evaluation of the 2010 campaign materials, specifically the community awareness DVD, *Open Your Eyes to Elder Abuse in Your Community* and the information booklet.

- ii. Say No to Ageism Week, May 30th – June 3rd.
- iii. A national conference to mark World Elder Abuse Awareness Day on June 15th in University College Dublin, in collaboration with the National Centre for the Protection of Older People (NCPOP), and the International Network for the Prevention of Elder Abuse (INPEA).
- iv. Launch of *Open Your Eyes, HSE Elder Abuse Services* (2010)⁸ publication at the National Conference.
- v. Launch of newly redeveloped and expanded elder abuse web section on the HSE website.
- vi. Publicity and promotional activities - National Ploughing Championships and the Senior Times Over 50s Show

2.1.3 Evaluation of 2010 Campaign Materials

In 2011, the HSE undertook an evaluation of the core materials used in its 2010 elder abuse awareness campaign, namely the community DVD, *Open Your Eyes to Elder Abuse in Your Community*, and the information booklet. A leading Irish research company, Millward Brown Lansdowne, was commissioned to conduct the qualitative research. The key objectives were:

- To evaluate in detail the understanding of elder abuse among a mix of carers and older people exposed to the DVD.
- To understand the impact, relevance and credibility of the DVD and the booklet.
- To understand what factors would influence people in deciding whether or not to report abuse.
- Ultimately, to help the HSE understand what worked and what did not, with a view to informing future campaign strategies for elder abuse awareness.

Millward Brown Lansdowne conducted four focus group interviews from June to August 2011. The groups comprised of carers and non-carers from both rural and urban areas.

The evaluation concluded that:

- *"The research has validated the Open Your Eyes Awareness campaign as an important and highly effective campaign and recommended continuing the Open Your Eyes Campaign in its broadest possible remit as a means of gradually improving awareness of older people's needs, rights and place in society".*
- *"There was consensus that elder abuse is an important topic for public debate and that building awareness of the topic should continue within the broadest possible framework to ensure maximum reach"*
- *"There was unanimity that the campaign was relevant; that it had an important role to play in educating people about how to identify elder abuse and that it can impact a person's thinking and behaviour positively when interacting with older people"*
- In its conclusions Millward Brown Lansdowne stated that *"three factors were identified that create an environment in which elder abuse can thrive and each of these should be addressed as part of future campaign development:*
 - *A culture which does not cherish older people.*
 - *Carers who are inexperienced, stressed and who have insufficient support.*
 - *An inherent vulnerability of older people due to age, illness, lack of confidence."*

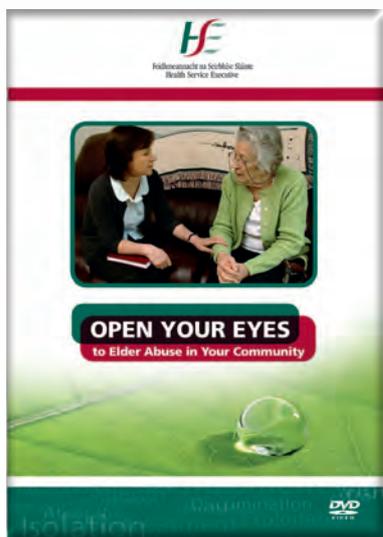
In particular, evaluation participants felt

- *"Adults in middle age should be encouraged to plan for the future early and make important decisions about their financial situation and about their care while they are well enough to do so. A "reality check" is needed."*
- *"Empowering older people by providing them with accessible information on their rights should be an important part of continuing with the "Open Your Eyes" campaign."*
- *"Older people should be encouraged to maintain regular contact with friends so they are not isolated and overly dependent on family, which can be unhealthy."*

Open Your Eyes to Elder Abuse in Your Community DVD

In recognition of the success of the elder abuse training DVD for residential care settings, the Elder Abuse Media and Public Awareness Working Group proposed the development of a DVD to promote awareness and understanding of elder abuse in the community as the majority of referrals originate in the community.

Animo Communications were contracted to script, film and edit the DVD in consultation with HSE professionals and representatives from national voluntary and older persons' organisations. THE DVD was launched at the national elder abuse conference on June 15th, 2010 and was widely distributed throughout the HSE and to the various national voluntary and older person organisations. The DVD was designed as a stand alone awareness raising tool so that it could be used without the need for a trainer.



HSE Open Your Eyes to Elder Abuse in Your Community Awareness DVD

The evaluation by Millward Brown Landsdowne of the DVD highlighted a number of key points.

- The DVD is an excellent learning tool with the key message of *early intervention* coming across strongly
- All facets of society, not just older people or carers, should view the DVD. *“Education should begin at a younger age. This DVD should be made more widely available to reach all segments of society including young people so as to begin education from a young age”*. Indeed, participants in the evaluation felt that *“elder abuse awareness should start at an early age (i.e. in schools) to encourage respect for older people and to heighten awareness of how older people can be abused. Awareness programmes should extend to all parts of the community – not just to older people and carers”*.
- The requirement for a one page *how to use the DVD* to be part of future dissemination.
- Need to include a dissemination plan as part of the overall project
- Need to track usage rather than just dissemination.

Following presentation of the findings of the evaluation in early September it was decided that the recommendations for the DVD would be included in the planning for the 2012 campaign. As part of the new campaign further viewings of the DVD will be promoted, a younger audience will be targeted, guidance notes to assist facilitators showing the DVD will be developed, and efforts will be made to track usage and gain feedback from viewings.

Elder Abuse Information Booklet

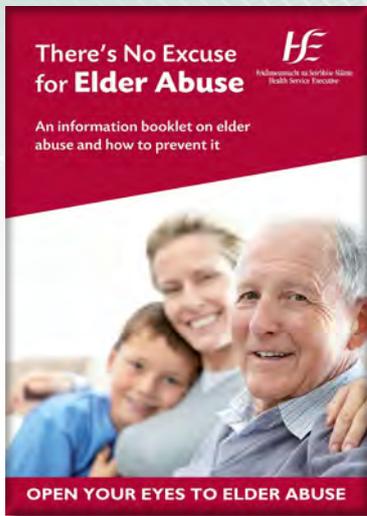
For the 2009 elder abuse awareness campaign, a leaflet on elder abuse was developed. In 2010, the Elder Abuse Media and Public Awareness Working Group decided to expand on the information provided in the leaflet and produced an A5 information booklet. The NCPOP undertook testing of the booklet by holding cognitive interviewing with a focus group representing the target audience. Feedback from the sessions allowed the booklet to be published in a user friendly and easy to understand format.

The evaluation by Millward Brown Landsdowne made the following recommendations in relation to the booklet:

- A more eye catching cover with a clearer title, i.e., a need for the booklet to be more explicit in what it is addressing.
- More positive / empowering messages regarding prevention should be included.
- The booklet should be a stand alone document and should not rely on references to the awareness campaign.
- Wider distribution of the booklet to include families and younger people.



HSE Elder Abuse Awareness Campaign Material Open Your Eyes - An Information Booklet on Elder Abuse



HSE Elder Abuse Awareness Campaign
Material: *There's No Excuse for Elder Abuses – open Your Eyes to Elder Abuse Information Booklet.*

As supplies of the booklet were low it was decided immediately following the evaluation findings to proceed with the redesign and redevelopment of the booklet to incorporate the evaluation recommendations.

The newly revised booklet *There's No Excuse for Elder Abuse – Open Your Eyes to Elder Abuse* was available for the National Ploughing Championships in Athy in September and was also used in the Senior Times Over 50s Show in the RDS in Dublin in October.

The booklet was widely distributed to the SCWs and will be used in awareness and training sessions. Wider distribution of the booklet will be considered for the 2012 campaign in line with the evaluation findings.

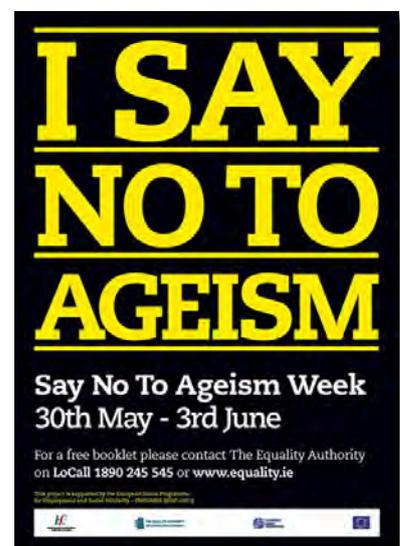
2.1.4 Say No to Ageism Week

According to the World Health Organisation (WHO) and the International Network for the Prevention of Elder Abuse (INPEA), (*Missing Voices: View of Older Persons on Elder Abuse, (2002)*⁹), elder abuse is one of the most extreme forms of ageism and remains one of the least recognised forms of oppression.

The *Say No to Ageism* campaign is one measure developed to tackle ageism in Irish society. It is a collaborative initiative between the Equality Authority, the HSE and the Department of Health. The campaign entered its eighth year in 2011. It is designed to promote and increase awareness and understanding of ageism, and of how it excludes older people from participating in, and contributing to, society. It promotes positive attitudes to ageing and older people and challenges negative stereotypes and discriminatory practices that can exclude older people from society. It is a very important campaign, as unchallenged, ageism can lead to a culture where abuse is tolerated.

In 2011, *Say No to Ageism Week* took place from May 30th to June 3rd and featured a public awareness campaign to encourage people to *Say No To Ageism*. An international information seminar, *Older People and Insurance in Ireland and the EU* was organised to discuss age related barriers in accessing the products promoted by the insurance sector, with a particular focus on health and travel insurance. The conference featured international speakers who outlined EU initiatives that explore the treatment of older people in the provision and pricing of insurance protection. Leading Irish experts examined these developments through an Irish lens and discussed and explored the consequences of accessing insurance when one gets older.

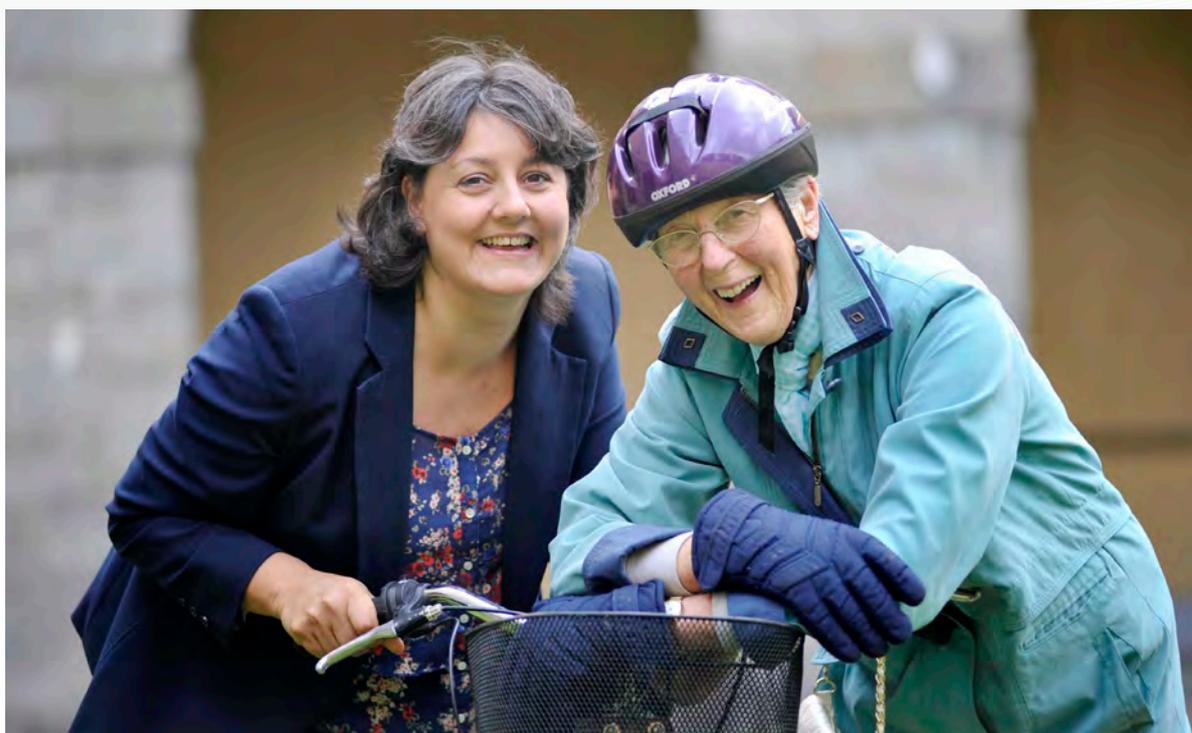
Health care and travel are key services for older people and contribute to the maintenance of independence and full participation in society. Insurance premia can soar when a person reaches a particular age, regardless of the risk of the activities or lifestyle of the individual. The *Say No to Ageism* ethos directed the discourse of the open discussion and was designed to inform these key sectors of the evidence, policies and practices that influence decisions and market rates in the provision of insurance to older people in Ireland.



I Say No to Ageism poster for the 2011 Campaign.

Say No to Ageism Week was scheduled to complement the publication of the HSE's elder abuse report for 2010 and World Elder Abuse Awareness Day on June 15th.

The campaign was supported with press releases, posters, flyers, badges and advertising on billboards. The HSE took delivery of 24,000 posters and 16,000 badges. These were distributed widely throughout LHO offices. Free advertising sites (96 in total) were donated by Veolia for the campaign. A total of 48 additional publicity sites were also negotiated with Dublin Bus, Bus Eireann and Iarnrod Eireann.



Pictured celebrating Say No to Ageism Week, which takes place from 30th May to 4th June 2011 are (L to R) Ms. Bernadette Casey, Senior Case Worker for the Protection of Older People, HSE Dublin South City and Ms. Maud White, Rathgar, Dublin.

Ageism has been described as the last great “ism” to be challenged. Like racism and sexism, ageism has no place in a modern and civilised society and it should be challenged at every turn. Ageism is a form of discrimination and manifests itself in behaviours that exclude or restrict older people as participating members of society and from opportunities that are available to others. Left unchecked, society will no longer be required to consider whether actions or behaviours are ageist and will cultivate the attitude that older people have less rights and are less valuable, making them vulnerable to being abused.

2.1.5 'Open Your Eyes' Elder Abuse National Conference marking World Elder Abuse Awareness Day

World Elder Abuse Awareness Day is held annually on June 15th in support of the United Nations International Plan of Action which recognises the significance of elder abuse as a public health and human rights concern. The day serves as a call for all individuals, organisations and communities to raise awareness about abuse, neglect and exploitation of older people.

In 2011, the day was marked with a national conference organised by the HSE in collaboration with the NCPOP, UCD and the International Network for the Prevention of Elder Abuse (INPEA). The conference, which was streamed live via the NCPOP website, was opened by the Minister for Disability, Equality, Mental Health and Older People, Ms. Kathleen Lynch, TD. The conference provided an overview of the HSE elder abuse service, profiled the elder abuse referrals received into the service, detailed the research undertaken by the NCPOP and outlined the work of INPEA. See Appendix 3 for the conference programme.



Pictured at the national conference to mark World Elder Abuse Awareness Day, June 15th 2011, are (L to R) Ms. Marguerite Clancy, Senior Research and Information Officer, Services for Older People, HSE West; Ms. Pauline Ducray, Senior Case Worker for the Protection of Older People, HSE Dublin North West; Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West; Ms. Sarah Mahon, Dedicated Officer for the Protection of Older People, HSE Dublin Mid Leinster; Ms. Marcella Pokorna, Senior Case Worker for the Protection of Older People, HSE North Dublin; Mr. Frank Murphy, Chair, National Elder Abuse Steering Committee; Ms Brenda Hannon, Specialist, Services for Older People, Dublin Mid Leinster; and Councillor Gerry Breen (seated), Lord Mayor of Dublin.

The keynote speaker at the conference was Professor Mary Gilhooly, Executive Director at Brunel Institute for Ageing Studies, London. She presented her recent research into *Detecting and Preventing Financial Abuse of Older Adults*. Professor John Horgan, Press Ombudsman for Ireland, presented his reflections on the conference and its presentations and emphasised the need for continued vigilance and action to effectively address elder abuse.

The event was attended by over 300 delegates from a large cross-section of society, including representatives from the HSE, private nursing homes, An Garda Síochána, the Law Reform Commission, the Law Society, the Department of Health, the Department of Social Protection, financial institutions such as the Irish Banking Federation and the Irish League of Credit Unions, the Insurance Industry Federation, An Post and older persons' voluntary and community groups.



Delegates attending the national conference to mark World Elder Abuse Awareness Day, June 15th 2011.

Dr. Amanda Phelan, the Irish representative of the International Network for the Prevention of Elder Abuse, presented an account of INPEA's work at the conference. She also arranged for the *INPEA Declaration Against Elder Abuse* to be signed by key dignitaries at the conference including the Minister for Disability, Equality, Mental Health and Older People, Ms. Kathleen Lynch, TD; the Deputy Garda Commissioner Nacie Rice; Dr Martin McNamara, Dean and Head of UCD School of Nursing, Midwifery and Health Systems; and the Lord Mayor of Dublin, Councillor Gerry Breen. Mayors from other counties also signed the *INPEA Declaration Against Elder Abuse* prior to the national conference.



Pictured at the national conference to mark World Elder Abuse Awareness Day, June 15th 2011, are (L to R) Dr. Attracta Lafferty, Centre Director, National Centre for the Protection of Older People; Professor Mary Gilhooly, Executive Director, Brunel Institute for Ageing Studies; Professor John Horgan, Press ombudsman for Ireland; Professor Pearl Treacy, Programme Director, National Centre for the Protection of Older People; Dr. Amanda Phelan, Programme Director, UCD and Irish Representative for the International Network for the Prevention of Elder Abuse; and Professor Gerard Fealy, Programme Co-Director, National Centre for the Protection of Older People.

A number of information and advisory stands were available at the conference and provided participants the opportunity to discuss in more detail the services provided by the various exhibiting organisations.

Press releases were issued and media interviews given to further promote the conference, World Elder Abuse Awareness Day and generally raise public awareness of elder abuse.

The attendance at the conference represented an almost 50% increase on audience figures from the previous year. The feedback from the conference was very positive, with 93% of delegates who submitted evaluation forms rating

the topic of great importance to them. 80% rated the presentations very good to excellent, and 80% also commented that the event greatly enhanced their understanding and knowledge of elder abuse. Suggestions for improvements centred mainly on the duration of the conference with a longer day being preferred to give time for more questions and discussion. This has been proposed for 2012.

2.1.6 Open Your Eyes, HSE Elder Abuse Services 2010



Open Your Eyes – HSE Elder Abuse Services 2010 document.

The conference also marked the launch of *Open Your Eyes, HSE Elder Abuse Services (2010)*⁸ document.

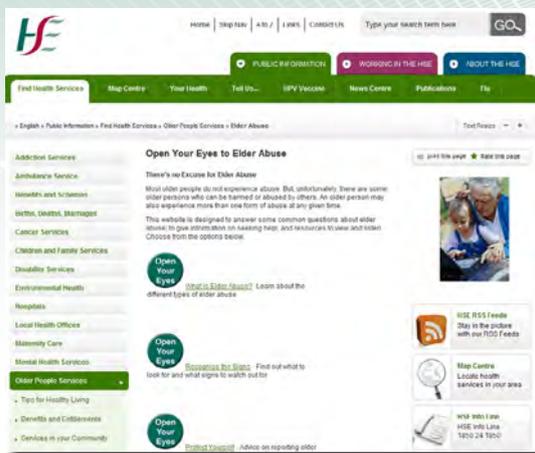
This document, which has been produced annually since 2008, highlights many of the elements involved in delivering the HSE elder abuse service and provides a snapshot of the achievements of the service as well as outlining areas for future direction and development. The statistical section provides a greater insight into the types of abuse being alleged, where abuse is happening and the perpetrators involved. The statistics also show the outcomes of cases and the type of supports offered. Issues identified for the alleged perpetrators are also presented. This data is integral to the provision of information on referral patterns and management of cases within the HSE. It contributes to the development of policy, service provision and public awareness.

The 2010 report also gave details on the body of research work carried out by the NCPOP. The Centre's programme of research examines elder abuse in Ireland and contributes to the knowledge and understanding of elder abuse, as well as the development of policy and practice.

2.1.7 HSE Website – Elder Abuse Section

The HSE internet and intranet sites host information on elder abuse. However, given the growing volume of information and the many resources available for elder abuse, it was decided that the section on the websites should be expanded, updated and redesigned.

In 2011, a redevelopment of the elder abuse section on the HSE website was undertaken. This included a new look, the branding of *Open your Eyes* and more accessible navigation. The information available on elder abuse was also expanded to include preventative measures in line with the feedback from the Milward Brown Landsdowne evaluation exercise, as well as providing access to publications, online viewing



HSE Elder Abuse Section on www.hse.ie

of the community awareness DVD, online viewing of the winning short film competition clips from 2010 and a more comprehensive resource section. Contact details for SCWs, the HSE Information Line and contact details for the ordering of materials and general queries are also available.

The newly revised and updated elder abuse section on the HSE website went live during the conference. Visit www.hse.ie/go/elderabuse

In 2011, information on elder abuse on the HSE website was accessed 23,979 times.

2.1.8 Advertising & Publicity

The National Conference was supported by press releases and media interviews, as well as publicity kindly offered by COSC - The National Office for the Prevention of Domestic, Sexual and Gender Based Violence, and Caring for Carers on their websites.

National Ploughing Championships

The National Ploughing Championships is one of Ireland's largest public events and usually attracts 180,000 - 200,000 visitors over three days. The Championships feature, apart from ploughing, an extensive public information and commercial exhibition space. This year, the event was held on September 20th - 22nd in Cardenton, Athy, Co. Kildare.



The HSE had a marquee at the event designed to capture the attention of the varied and sizeable audience that attended. The aim was to inform them of services on offer and the health advice and education that can be provided. Over the three days, an estimated 5,000 adults and children visited the HSE area for either information or health screening, an increase from the 3,000 who visited in 2010.

Pictured at the HSE Elder Abuse Service Information Stand at the National Ploughing Championships in Athy in September 2011 were Ms. Marcella Pokorna, Senior Case Worker for the Protection of Older People, HSE North Dublin; Ms. Pauline Ducray, Senior Case Worker for the Protection of Older People, HSE Dublin North West; and students from schools in the locality.

The Elder Abuse Service was in attendance at a stand in the HSE marquee. During the three day event, the SCWs engaged with a large number of people. In addition, they also targeted school groups with an interactive quiz and materials such as stickers and pencils, developed specifically for schools/youth groups.

The Senior Times Over 50's Show

The Senior Times Over 50s Show held in Dublin, Cork and Spain annually is a lifestyle event for older people and features a number of exhibits, displays, presentations and demonstrations. Topics covered include health and well being, personal finance, holidays, hobbies, fashion and beauty, genealogy, security, senior care and government and statutory information.

Over 22,000 people attended the Dublin show in 2011, with over 250 information stands.

The HSE Elder Abuse Service reserved an information stand at the exhibition in Dublin in the RDS from 21st to 23rd October, 2011 with specialist staff in attendance over the three days. Great interest was shown by the public. Icebreakers such as quizzes were completed by visitors to the stand. People were keen to test their knowledge and there were lively discussions between married couples, parents and adult children. On the whole, people appear to be more aware of elder abuse and were far more engaged than previous years. The majority were 'young' seniors who were involved in active retirement groups or who visited older neighbours.

Sligo Institute of Technology Science Week - Fair Day

Sligo Institute of Technology hosted its 12th annual Science Fair from Sunday, 13th November to Saturday, 20th November. The event marked the official launch of Science Week Ireland 2011 and was opened by Mayor of Sligo, Councillor Rosaleen O'Grady.



What's on @ IT Sligo?
Sunday 13th November
Monday 14th – Friday 18th

12th Annual Science Fair Day
Series of Evening Lectures

12th Annual Science Fair
Sunday 13th November 2011
12noon - 6pm
Suitable for all ages - All welcome - Free!

Sligo Institute of Technology Science Fair Day as part of
Sligo IT Science Week.

Up to 5,000 visitors attended one of the largest, free events for families in the North West. The week consists of a Science Fair day and then a series of speakers throughout the week. The theme of the week was *The Chemistry of Life*.

The Science Fair day took place on Sunday, 13th November and ran from 12 midday to 6pm. There was a large selection of science shows and performers, as well as a number of exhibits by science companies and businesses. Among them were An Garda Síochána, the Fire Brigade, Sligo Life Boat and the Army.

The HSE elder abuse service hosted a stand at the event with a SCW available to discuss any concerns in relation to elder abuse, as well as to provide information on the issue. The stand reported a steady stream of attendees who were very interested in the service. The publicity material, such as the pencils and stickers, were well received by younger visitors. A number of older primary school children took part in the quiz and the standard of understanding and genuine interest was high.

2.1.9 The HSE Information Line

All publicity, information and education material featured the HSE Information Line contact number - 1850 24 1850 - and the HSE website address (www.hse.ie). The HSE Information Line received a total of 334 calls relating to elder abuse in 2011.

2.1.10 International Conferences

IAHSA Leading Age Global Ageing Conference, Washington, D.C.



The IAHSA Leading Age Global Ageing Conference was organised by Leading Age and the International Association for Homes and Services for the Elderly. Leading Age was formally known as the American Association for Homes for the Ageing. The Conference was held in the Washington Convention Centre in Washington D.C. in October.

Poster advertising the IAHSA leading Age Global Ageing Conference.

Mr. Paschal Moynihan, Specialist, Services for Older People and Chair of the HSE Media and Public Awareness Working Group, was invited to present a paper at one of the sessions at the Conference. The title of the session was *Elder Abuse Prevention/Global Models*. During this session, there were presentations from representatives from New York City, Canada and Israel. Delegates at this session seemed impressed with Ireland's progress in combating elder abuse, particularly its media and public awareness campaigns, the establishment of the NCPOP and independent inspection and registration of nursing homes.

ANBO 'Ageing in Dignity' Conference, Brussels

A conference in Brussels entitled '*Ageing in Dignity*' was hosted by ANBO, the largest organization for seniors in the Netherlands, representing their interests and rights. ANBO is a member of AGE Platform Europe and the AARP Global Network. The conference was addressed by various speakers, including representatives from the OECD, the WHO, Germany, Italy, Sweden and Ireland.

At the request of the Department of Health, Mr. Paschal Moynihan, Specialist, Services for Older People and Chair of the HSE Media and Public Awareness Working Group attended and presented at the conference.

Many of the presentations focused on the need for national programmes to combat elder abuse, including the need for ensuring high quality long term residential care and outlining good practice on elder abuse. One of the common themes was the need to make efforts to increase public awareness of the issue and to combat ageism as it is recognised as a source of elder abuse.

It emerged that The Netherlands, Austria and Ireland had made significant progress. In reviewing the ANBO report, which contains a checklist of forty suggested good practices from various countries, 10 of these were taken from Ireland, the highest representation of any country. The Netherlands was next with 9. The next highest was 4. Indeed, some of the suggestions associated with other countries have already been progressed in Ireland, such as "National Campaign to End Elder Abuse" (Italy) and "Train the Trainer in Elder Abuse" (The Netherlands).

These conferences allowed the HSE elder abuse service to assess its progress in addressing elder abuse while also offering excellent opportunities for learning from other countries. It also provides feedback from other countries on the Irish position in addressing elder abuse and enables us to benchmark our service.

2.2 Policies, Procedures, Protocols and Guidelines Working Group

The Policies, Procedures, Protocols and Guidelines (PPPG) Working Group is a sub group of the National Elder Abuse Steering Committee. The sub group was established in 2008 in order to develop PPPGs to help guide and assist those in assessing and dealing with elder abuse concerns. Because the elder abuse dedicated service is relatively new within the HSE, the development of such PPPGs was seen as a very important aspect in dealing with elder abuse referrals. See Appendix 4 for the membership of the PPG Working Group.

The HSE has an overall policy in relation to elder abuse concerns. This policy – *Responding to Allegations of Elder Abuse* (2008)¹⁰ gives clear guidance to staff and managers in responding to allegations of elder abuse.

In the development of further PPPGs, the sub group has consulted with a wide range of staff and disciplines in order to ensure that the PPPGs are of wide relevance.

The sub group has developed a policy in relation to self-neglect. It is hoped that this policy will be formally adopted as HSE policy in 2012.

In 2011, under the chair of Ms. Oonagh McAteer, Dedicated Officer for the Protection of Older People, Dublin North East, the sub group finalised drafts of a number of documents:-

- Will Making by Older People in Residential and Day Services Guidelines
- HSE Protocol for the Transfer of Elder Abuse Cases between Local Health Offices.
- Prevention of Elder Abuse: Best Practice Guidelines for Voluntary, Not for Profit Organisations and Private Service Providers.
- Review of the HSE Elder Abuse Policy, *Responding to Allegations of Elder Abuse*.

2.2.1 HSE Staff Guidelines for Assisting Older People in Residential and Day Services with making a Will

Guidelines have been drawn up in conjunction with the Law Reform Commission, to inform staff on their roles and responsibilities when an older person in residential care wishes to make a will. The guidelines will also form the basis of a protocol for solicitors drawn up by the Law Society. The final draft of the guidelines has been completed.

The purpose of these guidelines is to facilitate older people in the care of the HSE and/or their agents, who wish to make a will and to obtain legal advice to do so.

Staff have a duty of care to older people availing of its services and must therefore be alert to the possibility that, in certain circumstances, some older people may be vulnerable to financial abuse. There is also an obligation on services to have in place a policy on the prevention, detection and response to abuse within residential care settings. (National Quality Standards for Older People in Residential Care HIQA 2008)¹¹

These guidelines aim to support staff and promote best practice in this area in order to protect older people and prevent possible abuse.

2.2.2 The Transfer of Elder Abuse Cases between Local Health Offices

The purpose of this protocol is to provide a standardised method for the transfer of open elder abuse cases between Local Health Office (LHO) Areas / Integrated Service Areas (ISAs), when clients move permanently outside the LHO / ISA. Its aim is to standardise practice and service delivery, to promote best practice and to ensure effective communication and collaboration between staff within the HSE.

This protocol applies to all HSE Senior Case Workers or other nominated staff.

The protocol has been finalised and is expected to be adopted by the HSE in 2012.

2.2.3 Prevention of Elder Abuse: Best Practice Guidelines for Voluntary, Not for Profit Organisations and Private Service Providers

These guidelines were prepared to assist voluntary and private organisations that provide health and social care for older people in their efforts to minimise opportunities for elder abuse. The main purpose of these guidelines is to assist non-statutory organisations in developing best practice policies and procedures on elder abuse. These may include the development of an elder abuse policy, values of the organisation, principles, rights, reporting procedure, safe recruitment practices, management practices, training policy and links to other networks/services.

A specific sub group was established to progress these guidelines. Membership included representation from the HSE, Age Action, the Carers Association, the Alzheimer Society of Ireland, Nursing Homes Ireland, the National Centre for the Protection of Older People, Mental Health Ireland, the Professional Institute of Care Providers and Home Instead Senior Care.

Best Practice Guidelines have been drafted and it is anticipated that they will be adopted in early 2012.

2.2.4 Review of the HSE Elder Abuse Policy, Responding to Allegations of Elder Abuse

In line with one of the recommendations contained in *Protecting Our Future – The Report of the Working Group on Elder Abuse* (2002)¹, the HSE developed a written policy on elder abuse – *Responding to Allegations of Elder Abuse*¹⁰ – in 2008. Since then, there have been a number of changes in HSE structures and it is timely that this policy be reviewed to take account of those changes. The PPPG Group has completed a revision of this policy and it will be presented to the National Elder Abuse Steering Committee in early 2012.

2.3 HSE Staff Awareness and Curricula Working Group

Elder abuse, like other forms of abuse, is never an acceptable response to any problem or situation, however stressful. Effective interventions can help prevent or stop elder abuse. By increasing awareness and education efforts, health professionals and others who provide services to, or interact with, older people will have the skills, knowledge and expertise to understand the prevalence and consequences of elder abuse. In addition, it will assist staff in identifying early indicators and in recognising the symptoms of abuse, provide them with the confidence to respond to suspected abuse sensitively and be aware of the avenues for assistance and advice. It will also enable staff to report concerns, thereby breaking patterns of abuse and neglect and enabling the abused and the abuser, where appropriate, to get the help needed to stop the abuse.

Protecting Our Future (2002)¹, recommended training and education for health and social care workers and suggested that it was "particularly important for those groups involved in primary care (for example, General Practitioners and Public Health Nurses); there is considerable evidence to show that identification of elder abuse by the primary care team is critical in reducing the incidence of abuse". This observation is reinforced by data on elder abuse referrals in Ireland which show the Public Health Nursing service as a very significant source of elder abuse referrals. Moreover, the recent prevalence study on elder abuse in Ireland (Naughton et al 2010)⁴ cited the potentially significant role that General Practitioners have in detecting abuse and supporting the victims. The prevalence research found that all study participants who had experienced mistreatment had accessed some kind of formal health or social service within the previous six months. By far the most likely contact was the older person's General Practitioner (GP), with all but one participant who disclosed mistreatment visiting their GP practice in the six months prior to the survey.

In the 2009 review of *Protecting Our Future*, PA Consulting made the following recommendation:-

- "The key areas requiring further progress are education and training, and prevention."
- "The Office for Older People, with the HSE National Elder Abuse Steering Committee, should actively engage with professional bodies to ensure that the protection of older people is included in their undergraduate, post graduate and continuing professional development curricula."

The HSE elder abuse service continues to be the main provider of elder abuse training for all agencies providing services for older people. Currently, health care staff involved in the delivery of care to older people can avail of this

training in the workplace. In addition, some also receive elder abuse training through a professional body or Third Level College.

Efforts have also been made to have elder abuse included in professional curricula. A number of academic institutions and professional bodies were contacted to ascertain what modules, if any, were in place. The majority of institutions involved in providing health care courses were providing modules on elder abuse and the content consistently covered key areas. For those institutions where elder abuse was not covered, they adopted the HSE module after engaging in the review.

The Royal College of Physicians in Ireland invited the HSE elder abuse service to design and develop a training module for 2011. This was predominately aimed at hospital doctors, but invitations were extended to the multi-disciplinary teams. An afternoon seminar was conducted in October, 2011 and a number of nurses and social workers attended, alongside consultants and junior doctors. The feedback from this seminar was positive and a second date is planned for 2012.

2.3.1 Training for the Financial Sector

Following recommendations from The National Financial Abuse of Older Persons Working Group, the Dublin Mid Leinster Elder Abuse Steering Committee piloted a training programme for the financial sector. This pilot was conducted in September, 2010 and an evaluation was undertaken in December, 2010, recommending its use as a module for financial institutions through a *“Train the Trainer”* approach. The module addressed the following topics:

- What is financial abuse?
- HSE elder abuse service
- The law and capacity
- Financial abuse case studies

Subsequent to recommendations made following the pilot and amendments to the course, a *“Train the Trainer”* session was delivered by the HSE to the Irish Banking Federation in November, 2011. Nine trainers attended and plan to roll out training within their institutions. To assist them in this regard, the trainers will seek out further specialist training from other experts, such as the legal sector, to add to their knowledge.

2.3.2 Training for the Legal Sector

A one hour seminar was provided by the HSE elder abuse service to 40 solicitors from South County Dublin in April, 2011. Following this, a request was received by the organisation *Solicitors for the Elderly* to hold further seminars in conjunction with the Law Reform Commission in 2012. The first of these has been scheduled for February 2012. This training focuses on the definitions of elder abuse and landmark legal cases.

2.3.3 An Garda Síochána

A workshop on elder abuse was designed by the Dublin Mid Leinster Area Elder Abuse Steering Group in 2008. This was delivered by training staff in Templemore. A follow up review of this training has been planned for 2012.

2.3.4 HSE Awareness Raising Training

A standardised awareness raising training programme was developed in 2007 and approved by the **HSE National Steering Committee on Elder Abuse**, in 2008. This programme highlights the signs, symptoms and definitions of abuse and outlines the legal and policy context for staff. This training is largely provided by the Dedicated Officers and the SCWs. A review of the data in 2011 shows that 79% of this training is delivered by HSE staff, and in the majority by SCWs and Dedicated Officers. The training is delivered to HSE staff and other agencies, both public and private, that provide services for older people. This has now been enhanced by the provision of a DVD on elder abuse in community settings, *Open Your Eyes to Elder Abuse in Your Community*.

In addition, a *Train the Trainer* programme has been established for use in residential care units. A three hour training programme provides information to trainers from public, private and voluntary nursing homes on

the use of the training DVD - *Recognising and Responding to Elder Abuse in Residential Care Settings* and its associated workbook. Having completed this training, the trainers roll out the training in their units and provide data on numbers and grades of staff attending this training to the Dedicated Officers. The *Train the Trainer* programme is largely delivered by the Dedicated Officers for the Protection of Older People and there have been five sessions in 2011. The Dedicated Officers and SCWs also use the DVD to provide training in residential units where a trainer has not been identified. This training complements the Health Information and Quality Authority (HIQA) standards in relation to the protection of older adults in residential care settings.

The table below outlines the numbers of HSE staff and staff working outside the HSE, including staff of voluntary agencies, external service providers and nursing homes, that have attended awareness raising sessions by HSE area.

HSE AREA	2007	2008	2009	2010	2011
SOUTH	2358	2264	1896	1456	634
WEST	847	1618	2039	2945	2735
DML	779	1,352	2662	2039	2311
DNE	200	828	718	1686	2597
Total	4184	6062	7315	8126	8277

HSE Elder Abuse Community Awareness DVD

The *Open Your Eyes to Elder Abuse in Your Community* DVD, which was developed as part of the 2010 elder abuse media and public awareness campaign, was distributed to voluntary organisations, older persons' groups and throughout the HSE via General Manager Offices. The evaluation of the DVD conducted by Millward Brown Landsdowne suggests that more effort is needed to increase its usage among the voluntary organisations and older persons' community groups. This will be a key objective in the 2012 media and public awareness campaign.

Whilst the provision of elder abuse awareness as described in this report is continuous and will be ongoing throughout 2012, a number of key areas will be targeted as follows:

- **An Garda Síochána.** A review of training will be conducted and areas for further development highlighted
- **Training for Solicitors.** Following evaluation of the training scheduled in February further training will be targeted for 2012.
- **Financial Sector.** Continued delivery of elder abuse programme throughout 2012.
- **Managers/Risk Assessment training.** A pilot is currently being evaluated in HSE Dublin Mid Leinster. It is envisaged that this be ready for delivery across the HSE in 2012.
- **The College of Psychiatry** will be contacted in 2012 with a view to providing a module similar to that in the Royal College of Physicians Ireland. An online version of the community DVD, *Open Your Eyes to Elder Abuse in Your Community* is available to students on the college's intranet.

In addition to the training provided through professional bodies and third level colleges, the NCPOP has further supported awareness raising and training through initiatives such as their own conferences and presentations.

2.4 National Financial Abuse of Older Persons Working Group

Protecting Our Future (2002)¹ highlighted both the disturbing and complex nature of financial abuse. The Report stated that "Financial abuse is a widespread concern. Like many other forms of abuse, it is difficult to identify; in particular, it is difficult to distinguish between acceptable exchange and exploitative conduct, between misconduct and mismanagement".

The Review of *Protecting our Future* (2009)³, further outlined the complexities of financial abuse stating that financial abuse is a particularly intricate area of abuse to detect and suggested that financial institutions have an important role to play in detecting abuse. The Review suggested that consideration should be given to the establishment of a working group, with multi-agency membership, on financial abuse.

A National Financial Abuse of Older Persons Working Group was established in 2010. This Working Group provides a multi-agency forum through which it is hoped the challenges posed by the financial abuse of older people can be responded to in an effective manner.

2.4.1 Members of the National Financial Abuse of Older Persons Working Group

Members of the Working Group comprise nominees from the HSE, Irish Banking Federation, Insurance Industry Federation, An Post, Department of Health and Children, Irish League of Credit Unions, Money Advice and Budgeting Service, Law Reform Commission, Law Society and An Garda Síochána.

2.4.2 Review of the Financial Regulator's Consumer Protection Code

One significant area of work undertaken by the Group related to the Financial Regulator's review of the Consumer Protection Code.

A sub group was formed in late 2010 to make a submission to the Financial Regulator as part of its review of the Consumer Protection Code. The sub group consisted of representatives of the HSE; Irish Banking Federation; An Post; the Irish League of Credit Unions; Money, Advice and Budgeting Service (MABS); the Law Society; and the Law Reform Commission.

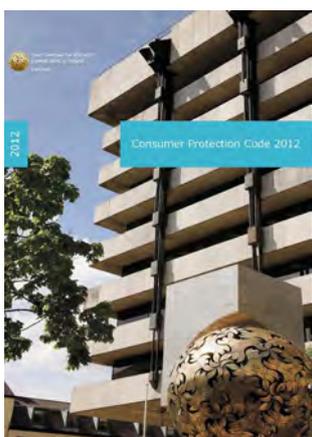
The first Consumer Protection Code was introduced in August 2006 and set out the requirements that regulated entities must comply with when dealing with consumers. The purpose of the Code was to ensure the same level of protection for consumers, regardless of the type of financial services provider they chose.

After reviewing the existing Code, a number of comments/suggestions were forwarded to the Financial Regulator in August, 2010 in relation to minimising opportunities for financial abuse and making provisions for vulnerable consumers.

The Financial Regulator then issued a *Consultation Paper on Review of the Consumer Protection Code* for final comments and amendments.

The sub group was reconvened in late November, 2010 to consider this Consultation Paper and to make any final suggestions. The final submission of the sub group was issued to the Financial Regulator in January 2011.

The Insurance Industry Federation and the Irish Banking Federation did not participate in the sub group's final submission proposals as they made separate submissions. The Department of Health also made its own submissions.



The 2012 Consumer Protection Code

The newly revised Consumer Protection Code 2012 was published in mid-October, 2011 and builds on the protections of the previous version, but includes more detailed requirements. Some provisions include the need for financial firms to be more careful in assessing whether a product or service is suitable for a particular consumer. They must also give more details on their investment products to brokers. Financial institutions must also consider whether there is any evidence that a consumer is vulnerable and make arrangements to help such people.

The overriding objective for the revision of the Code was to continue to strengthen the consumer protection framework and to introduce new measures which will benefit consumers in their dealings with regulated firms. To this end, the 2012 Code, once implemented, will provide a number of additional protections for consumers of financial services, along with enhancements to existing protections.

The revised Consumer Protection Code came into effect on 1st January 2012 and is binding on regulated entities and must, at all times, be complied with when providing financial services.

2.4.3 Report of the National Financial Abuse of Older Persons Working Group

The HSE National Financial Abuse of Older Persons Working Group, is currently compiling a report on its work for the Department of Health. It is expected that this report will be finalised in the first half of 2012.

3.0 NATIONAL CENTRE FOR THE PROTECTION OF OLDER PEOPLE

3.1 Introduction

The National Centre for the Protection of Older People was formally opened by the Minister for Health and Children, Ms. Mary Harney TD, in November, 2009. The principal objective of the National Centre is to place elder abuse in the wider social context as opposed to within the context of the HSE only.

Financial abuse, ageism and discrimination are key issues which cannot be resolved within the HSE and the opportunity to inform policy across a wide range of departments and agencies will be strengthened by a centre that has an interagency mandate.



The Centre has undertaken a number of research projects over the past three years with the most notable being its study on abuse and neglect of older people in Ireland, the first ever elder abuse prevalence study undertaken in Ireland. The study, *Abuse and Neglect of Older People in Ireland, Report on the National Study of Elder Abuse and Neglect*⁴, suggests that over 10,000 older people had experienced abuse in Ireland in the previous year.

This section outlines the Centre's constitution and governance and presents an overview of the research projects and dissemination activities which the Centre engaged in year three (year ending 30th September, 2011).

3.2 Constitution and Governance

3.2.1 NCPOP Governance Structures

The programme directors, team members and the Centre staff continued to meet regularly throughout year three of the Centre. These meetings discussed and planned the various research projects and the dissemination and public engagement work of the Centre.

3.2.2 HSE/UCD Governance Structures

Throughout year three, the NCPOP programme directors met with the HSE Steering Group for the purposes of reporting and consultation in relation to Centre activities. Meetings took place during October, 2010 and May and September, 2011. Management meetings involving the NCPOP research team and the HSE also took place in December, 2010 and September, 2011. These meetings discussed the dissemination work of the Centre and the progress of the research projects undertaken by the Centre. A number of meetings also took place to discuss the work of the Centre for the period 2011 to 2014.

3.2.3 International Advisory Group

The International Advisory Group is made up of experts in the field of ageing and elder abuse. One of the group members, Professor Karl Pillemer, Cornell University, New York, met with the UCD research team in November, 2010 to advise on the work programme of the Centre.

3.2.4 User Group

The Centre User Group includes representatives of older people and organisations representing older people and/or with an interest in elder abuse. Meetings were held in October, 2010 and February, 2011.

3.3 Research Projects Year Three (October 2010 – September 2011)

The research work of the Centre in year three focused primarily on three research studies and two literature reviews. The three research studies built on the literature reviews and feasibility studies completed in year two. Work in year three included a study of *Senior Case Workers (SCWs) experiences of managing cases of elder abuse in Ireland*, a study of *Older people's experiences of mistreatment and abuse*, and a study entitled *Staff-resident interactions and conflicts in residential care settings for older people*. Two literature reviews were conducted: *A review of elder abuse screening tools for use in the Irish context*, and *A review of national and international responses to elder financial abuse*. Further details on these projects are presented in Appendix 7.

3.4 Related Activities Year Three.

The Centre engaged in a number of dissemination activities throughout the year. In particular, NCPOP hosted a number of dissemination events, including the launch of the report *Abuse and neglect of older people in Ireland, report of the national study of elder abuse and neglect*. Two NCPOP seminars were also held as well as the World Elder Abuse Awareness Day 2011 conference. Presentations were delivered at various national and international conferences on the research of the Centre and the dedicated NCPOP website was redesigned and updated.

3.4.1 Dissemination

Launch of the Report on the National Study of Elder Abuse and Neglect

The report on the National Study of Elder Abuse and Neglect was launched by the Minister for Older People and Health Promotion, Ms. Áine Brady T.D. in UCD on Monday, 8th November, 2010. Speakers included Dr. Corina Naughton from the National Centre for the Protection of Older People at UCD and Prof Karl Pillemer from Cornell University, New York. The launch was well attended by representatives from health, social care, financial and legal sectors.

The full report, summary report, auxiliary documents and recordings of presentations are available to download from www.ncpop.ie. Hard copies of the report can be provided on request.

3.4.2 NCPOP Seminar Series 2010/2011

Two seminars were held at the UCD Health Sciences Centre during year three of the Centre. The seminar dates, titles and speakers were as follows:

Date	Title	Speaker
Wednesday 13 th October, 2010	Understanding financial abuse of older people	Dr. Attracta Lafferty, NCPOP
	Complaints by older people against financial institutions	Mr. Conor Cashman, Senior Investigator, Financial Services Ombudsman
Tuesday 22 nd February, 2011	The legal implications of ambivalence in caregiver relationships	Prof. Katherine Pearson, Pennsylvania State University, US
	Financial abuse: The legal and regulatory gaps.	Commissioner Patricia Rickard-Clarke, The Law Reform Commission

All seminars were well attended and received positively by attendees from a range of organisations including advocacy charity organisations for older people, researchers, academics, social workers, nurses, legal and financial professionals and older people themselves.

Video recordings and powerpoint presentations from these seminars are available to download from www.ncpop.ie.

3.4.3 World Elder Abuse Awareness Day 2011 Conference

To mark World Elder Abuse Awareness Day (WEAAD), the National Centre for the Protection of Older People at UCD, in collaboration with the Health Service Executive (HSE) and the International Network for the Prevention of Elder Abuse (INPEA), hosted a conference entitled *Open Your Eyes* on Wednesday, 15th June, 2011 in the Health Sciences Centre, UCD. See section 2.1.5 for further details.

Video recordings and powerpoint presentations from the event are available to download from www.ncpop.ie

3.4.4 Conferences and Presentations

The work of the Centre continued to be disseminated throughout the year. Presentations were delivered at: Our Lady's Hospice, Harold's Cross in January, 2011; the Royal College of Surgeons Ireland (RCSI) in February, 2011; and St Vincent's University Hospital in February, 2011.

Dr. Amanda Phelan delivered a paper on *Examining newspaper reports of care in an Irish nursing home: A discursive analysis* and Dr. Corina Naughton delivered a paper on *Designing a national prevalence survey of elder abuse in Ireland* at the 6th Congress of the European Union Geriatric Medicine Society at the Convention Centre, Dublin in October, 2010.

Research from the Centre was also presented at a number of international conferences. The paper *Public perceptions and attitudes towards elder abuse in society* was presented by Dr. Attracta Lafferty at the Fourth European Nursing Congress: Older Persons: The Future of Care, Rotterdam, The Netherlands in October, 2010. Dr. Corina Naughton presented *Findings from the national prevalence study of elder abuse and neglect* at the International Network for the Prevention of Elder Abuse (INPEA) symposium held concurrently with the International Association of Gerontology and Geriatrics 7th European Congress, Bologna, Italy in April, 2011.

In September, 2011, two presentations on the research of the Centre were also delivered at the 59th Annual Irish Gerontology Society Conference in Croke Park, Dublin. Dr. Corina Naughton presented *Findings from the national prevalence study of elder abuse and neglect* and Dr. Attracta Lafferty presented *Researching elder abuse in Irish residential care settings for older people*. Three papers were accepted for the CARDI Ageing Globally, Ageing Locally Conference held in Dublin in November, 2011.

3.4.5 NCPOP Publications in Peer-review Journals

During year three, one peer-reviewed paper was published and a second peer-reviewed paper was in press at the time of reporting, as follows:

1. Fealy GM, McNamara M, Treacy MP, Lyons I (2011). Constructing ageing and age identities: A case study of newspaper discourses *Ageing & Society* Doi: 10.1017/S0144686X11000092 (Published online 4 March 2011)
2. Naughton C, Drennan J, Lyons I, Lafferty A, Treacy M, Phelan A, O'Loughlin A, Delaney L. (in press) Elder abuse and neglect in Ireland: results from a national prevalence survey. *Age and Ageing*.

3.4.6 NCPOP Newsletter

The NCPOP newsletter was distributed to a wide range of individuals and organisations and is available to download from the NCPOP website. The newsletters provide information on the work of the Centre, on NCPOP research projects, on resources (presentations, books, reports and publications) available to download from the NCPOP website and any recent developments in the field of elder abuse.

3.4.7 Website Development

The NCPOP website was redesigned and redeveloped in the summer of 2011 to improve user interaction, enhance user ability and to better highlight the activities of the Centre. Attention was given to ensure the redesigned website maintained the user friendly layout of the original NCPOP website while allowing for the addition of a number of new features including animated photos, a video gallery and a news and events feed on the home page.

The dedicated NCPOP website continued to be updated with national and international reports, seminar presentations, journal articles, elder abuse reports in the news, etc. During year three, the NCPOP website had over 11,000 unique visitors with an average of almost 1,700 visits a month to the website.

3.4.8 Activities

In collaboration with the HSE, NCPOP co-hosted three discussion groups to scope suggestions for future research priority areas. The first group comprised of eight representatives from organisations who support and advocate for older people and was held in UCD. The second group involved three older people, also held at UCD. The third group consisted of approximately 17 family carers of older people and this took place in Tullamore, Co. Offaly. The outcomes from the discussions will be used to help inform and direct future research priorities in this field.

3.5 Research Projects Proposed (2011-2014)

- Study 1: Screening and risk assessment for elder abuse
 - Study 2: Carer stress
 - Study 3: Empowerment of older people
 - Study 4: Evaluation of the HSE national training programme for the prevention of elder abuse
-
- Review 1: Older people with dementia
 - Review 2: Abuse in residential care settings: best practice
 - Review 3: Elder abuse services and interventions

4.0 ELDER ABUSE NATIONAL STATISTICS

In the analysis presented in the following sections, emphasis will be placed on outlining the position in relation to elder abuse referrals in 2011. This will look at the total group followed by subcategory analysis of those cases with an alleged perpetrator and, finally, self-neglect cases will be addressed independently. Tables are also provided under each subheading which provide the difference in each measure relative to 2010 and also the trend across time reflecting the full data recording years 2008-2011. (On review measures, i.e., data which is recorded within a Form 6 - tables will outline the relative yearly position for 2010 and 2011 to provide more comprehensive review data for 2010)

4.1 Methodology of Data Collection

All referrals of alleged or suspected elder abuse made to the Senior Case Workers for the Protection of Older People are recorded on a 'Record of Initial Referral - Form 5' (see appendix 5). A unique identifying number is assigned to each referral to allow it to be tracked through the service while ensuring anonymity. All Forms 5 are forwarded to the Dedicated Officers for the Protection of Older People for validation, coding and inputting into MS Excel. In addition, a reassessment is completed, either on case closure or at six-monthly intervals, and recorded on a 'Follow-up on Record of Initial Referral - Form 6' (see appendix 6).

Summary tables are automatically generated which provide key statistics both at local health office, administrative area and national level. These tables include number of referrals, gender of alleged abused, types of alleged abuses, status of referrals, outcome of the referrals, places of residence of the alleged victims and location of abuse. In addition, on a quarterly basis, the following performance indicators are returned to the Department of Health:

- Total number of referrals.
- Percentage breakdown on the four main alleged abuse categories (physical, psychological, financial and neglect).
- Percentage of cases that receive a first response within four weeks.
- Total number of active cases.

In the following sections, the full sample size is reflected as an N value. This value varies depending on the availability of data. The HSE administrative areas are summarised as DNE (HSE Dublin North East), DML (HSE Dublin Mid Leinster), South (HSE South) and West (HSE West). As the database is constantly updating it is vital that, within reports such as this, the most up-to-date position is reflected.

4.2 Summary of Total Referrals

In 2011, the cut off point for this report was set at March 9th, 2012. The later cut-off date was necessary as there was a knock on effect on data collection due to the absence of Dedicated Officers in two HSE Areas. Every effort was made to include all referrals with reminders issued to SCWs on a monthly basis of cases due for review. However, as has been the case in previous years, a small number were received after this date and are included in the database but not considered in this analysis.

In total, there were 2,302 referrals made to the service in 2011, an increase of 9% from 2010. Of these 1,867 had an alleged person causing concern, 429 were self-neglect cases and 6 represented organisational abuse (where no one individual/group of individuals is causing concern). The HSE area breakdown indicated an increase in referrals from three areas - DML, DNE and HSE West with a marginal decline in HSE South. There were 582 cases in DNE (↑35%, representing 25% of total national referrals); 447 referrals from DML (↑10%, representing 19% of total national referrals); 475 from the West (↑3% representing 21% of total national referrals); and 798 from the South (↓2% representing 35% of total national referrals). The relative increase from 2010 was greatest in DNE.

Table 1: All Referrals by HSE Area for Each Year 2008-2011

	2008	2009	2010	2011	% Cases	Change 2010-2011	Change 2008-2011
DNE	433	431	430	582	25	35%	34%
DML	254	278	407	447	19	10%	76%
South	877	805	811	798	35	-2%	-9%
West	323	402	463	475	21	3%	47%
Total	1887	1916	2111	2302	100	9%	22%

Since 2008, as outlined in Table 1, there has been a national increase of 22% in the rate of referrals. There has been an increase in all areas except in HSE South. The decline in HSE South may be explained by the standardisation in recording of re-referrals.

Figure 1 provides a graphical representation of the cumulative referrals by month in 2011. There is clearly a narrowing of the divide between the regions, particularly when comparisons are made to previous years.

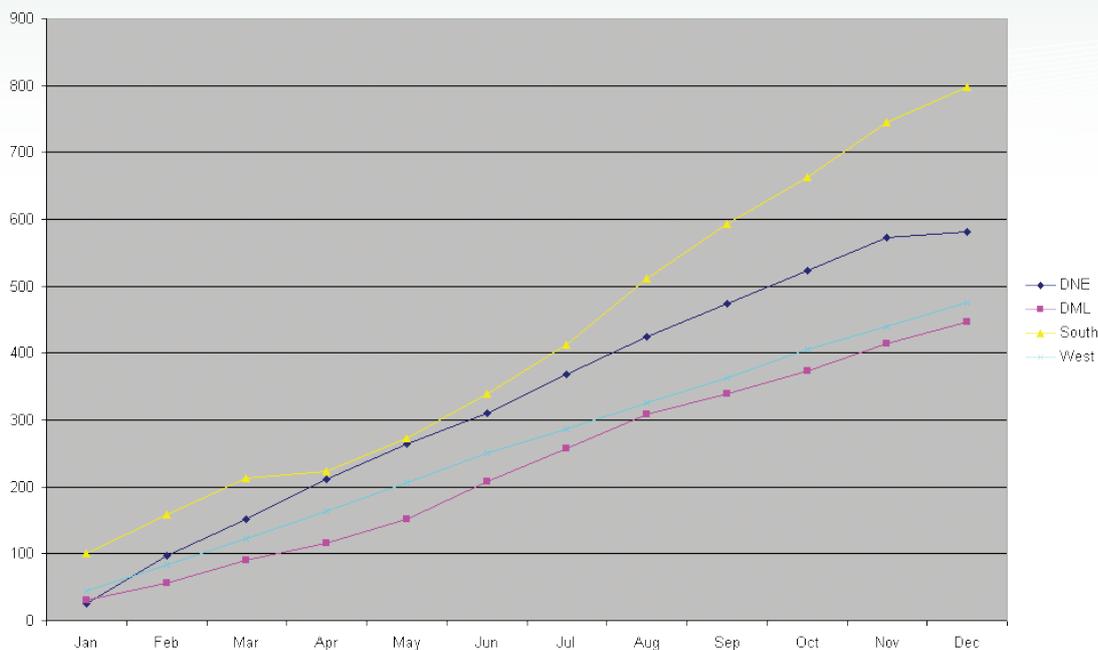


Figure 1: Cumulative Profile of Referred Cases by HSE Area in 2011

4.2.1 Gender/Age Classification

As was evident in previous years, the gender breakdown is consistent in all areas, with more females referred (63%). The national referral rate/1,000 of the over 65 years population is 4.46 (Table 2). Both DNE and HSE South exceed the national average in terms of overall referrals which is carried through in the subcategories (65-79 years and 80+ years). Consistent with 2010, 51% of all referrals relate to clients over 80 years. The over 80 year referral rate/1,000 population increased from 8.54 in 2010 to 9.47 in 2011 and was over three times the referral rate in the 65-79 year olds. This pattern is further confirmed in the cumulative analysis presented in Table 3. Additionally, it is interesting to note that, although in a general sense more referrals relate to females than males, in the over 80 category this is much less evident. This is apparent, both in the analysis of 2011, and also in cumulative analysis of the last four years (46% males over 80 versus 52% females).

Table 2: 2011 Data Age Categorisation of Referral Rate /1,000 Population by HSE Area

	Total Over 65 Years			65-79 Years			80+ Years		
	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 population
DNE	92266	556	6.03	70990	253	3.56	21276	303	14.24
DML	122369	415	3.39	93271	208	2.23	29098	207	7.11
South	128545	660	5.13	97960	334	3.41	30585	326	10.66
West	124746	455	3.65	92793	222	2.39	31953	233	7.29
National	467926	2086	4.46	355014	1017	2.86	112912	1069	9.47

Of 2,302 referrals-missing data=124 cases revising total to 2,178 of which 2,086 cases were for those aged 65+ years.

Table 3: Age Categorisation of Referral Rate /1,000 Population by HSE Area Total Data 2008-2011

	Total Over 65 Years			65-79 Years			80+ Years		
	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 population
DNE	92266	1745	4.73	70990	846	2.98	21276	899	10.56
DML	122369	1306	2.67	93271	686	1.84	29098	620	5.33
South	128545	2775	5.40	97960	1409	3.60	30585	1366	11.17
West	124746	1569	3.14	92793	794	2.14	31953	775	6.06
National	467926	7395	3.95	355014	3735	2.63	112912	3660	8.10

Of 8,216 referrals missing data=453 cases revising total to 7,763 of which 7,395 cases were for those aged 65+ years.

4.2.2 Reason for Referral

The majority of cases (68%) alleged only one type of abuse, with a further 24% identifying two. There were 2,607 abuse categories identified in relation to the 2,302 clients referred. In contrast to 2010, there has been a decline in self-neglect referrals. Consequently, financial abuse is now second to the growing rate of alleged psychological abuse.(Figure 2). Table 4 provides a summary of alleged abuse categories from 2008 to 2011.

Analysis of alleged abuse category by HSE area shows that physical and financial abuse were reported most in DML, psychological abuse in the West and self-neglect highest in the South (Figure 3). There has, however, been a reduction in the HSE South in the proportion of cases relating to self-neglect from 29% of total referrals in 2010 to 23% in 2011.

In section 4.3, more in-depth analysis of all cases with an alleged perpetrator will be discussed with exclusive self-neglect cases examined independently in section 4.5. The rationale for this is that self-neglect is not included in the HSE definition of elder abuse, and also not included in policy documents, except in exceptional circumstances.

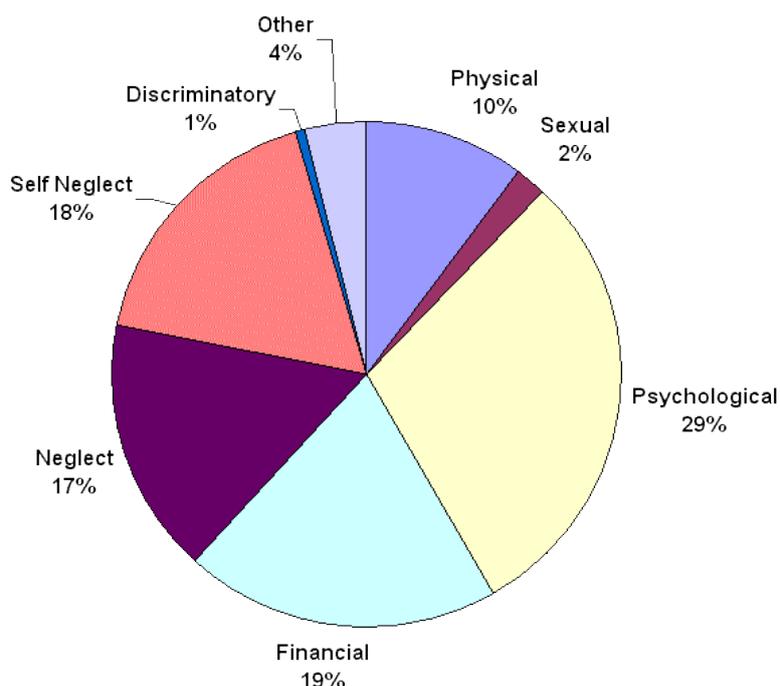


Figure 2: Multiple Response Analysis of Reason for Referral Abuse Categories - All Cases 2011.

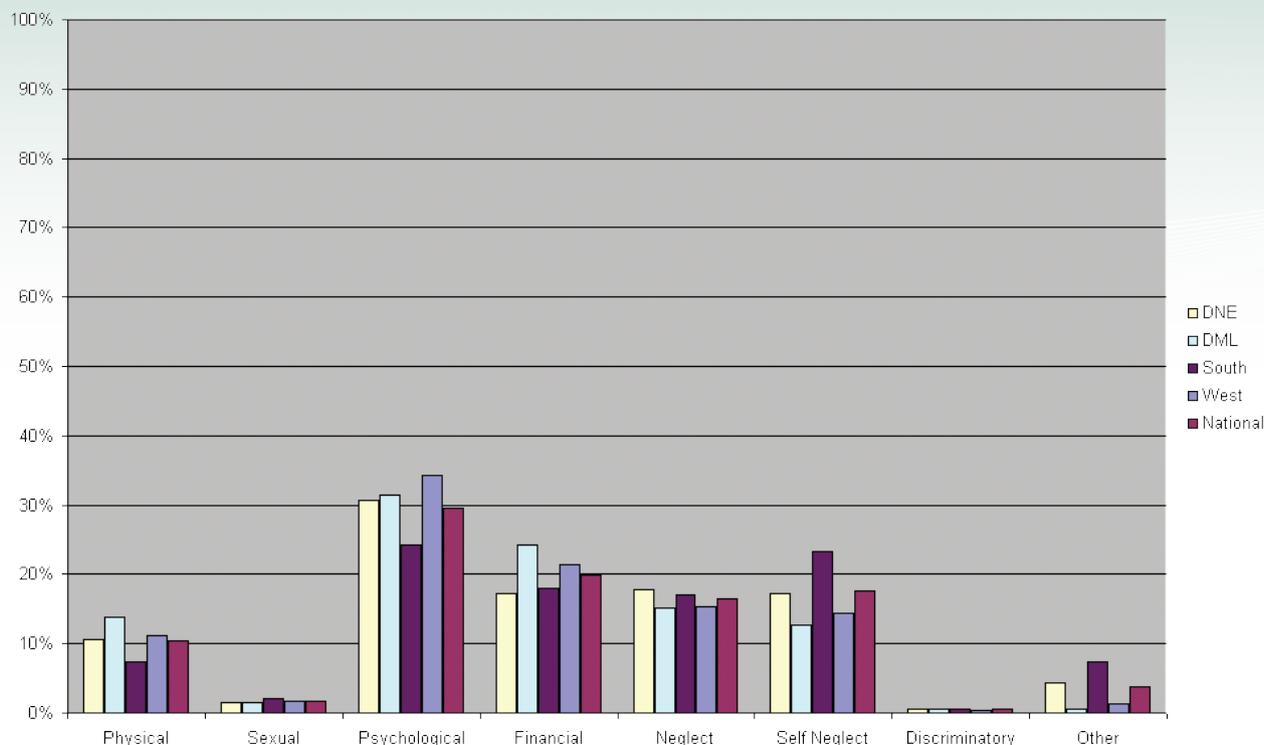


Figure 3: Profile of Abuse Categories Nationally and by HSE area

Table 4: All Referrals Classified by Alleged Abuse Category for each year 2008-2011

	2008	%	2009	%	2010	%	2011	%	
Total Referrals	N=1840		N=1870		N=2110		N=2302		
Rank Alleged Abuse Category	1	Psychological	26	Psychological.	28	Psychological	26	Psychological	29
	2	Self-neglect	20	Self-neglect	21	Self-neglect	21	Financial	19
	3	Neglect	19	Financial	18	Financial	19	Self-neglect	18
	4	Financial	16	Neglect	17	Neglect	19	Neglect	17
	5	Physical	12	Physical	12	Physical	14	Physical	10

4.3 Analysis of Total Referrals 2011 Excluding Absolute Self-Neglect

4.3.1 Age & Gender

In total, 1,867 cases were referred in 2011 that had an alleged person causing concern. Referrals that had a self-neglect component, but also involved another type of abuse, thus an alleged person causing concern, are included in the analysis. In total, there were 104 such cases.

The majority of referrals relate to females (66%) and the spike in referrals in the over 80 years population recorded in 2010 (increase from 45% in 2009 to 61% in 2010) has levelled, and is now at 48%. Although the rate/1,000 population has increased from 6.85 in 2010 to 7.94 in 2011, this is more a reflection on the increased number of referrals (Table 5). There are, however, particularly high referrals in the over 80 years age group in DNE relative to both the area's population and in comparison to the other HSE areas.

Table 5: 2011 Age Categorisation of Referral Rate /1000 Population by HSE Area

	Total Over 65 Years			65-79 Years			80+ Years		
	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 population
DNE	92266	445	4.82	70990	193	2.72	21276	252	11.84
DML	122369	356	2.91	93271	173	1.85	29098	183	6.29
South	128545	513	3.99	97960	247	2.52	30585	266	8.70
West	124746	377	3.02	92793	181	1.95	31953	196	6.13
National	467926	1691	3.61	355014	794	2.24	112912	897	7.94

Of 1,867 referrals missing data=104 cases revising total to 1,763 of which 1,691 cases were for those aged 65+ years.

Table 6: Cumulative Age Categorisation of Referral Rate /1000 Population by HSE Area 2008-2011

	Total Over 65 Years			65-79 Years			80+ Years		
	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 Population	Pop.	No of Referrals	Rate/1,000 population
DNE	92266	1373	3.72	70990	661	2.33	21276	712	8.37
DML	122369	1123	2.29	93271	578	1.55	29098	545	4.68
South	128545	2059	4.00	97960	1017	2.60	30585	1042	8.52
West	124746	1277	2.56	92793	613	1.65	31953	664	5.20
National	467926	5832	3.12	355014	2869	2.02	112912	2963	6.56

Of 6,466 referrals missing data=614 cases revising total to 5,852 of which 5,832 cases were for those aged 65+ years.

4.3.2 Referral Characteristics

The Public Health Nursing service (PHN) is the main source of referrals, with HSE staff, hospital and family being the other major sources. The strong linkages with the PHN service are particularly evident in HSE South where almost 40% of referrals come from this source (Figure 4). Hospital, "Other HSE Staff" and family referrals are the other common sources of referrals. In DNE and DML, the average national rate of referrals from 'Other HSE Staff' was exceeded. There has been a high level of training in the large teaching hospitals and wider community teams in Dublin, which due to the population and specialities, would have a far greater throughput. This may explain the higher level of referrals from this source. Also, family and self referrals were above the national average in HSE West. Note that where "other referral source" was documented the main sources were friend/ neighbour, private nursing home and solicitor.

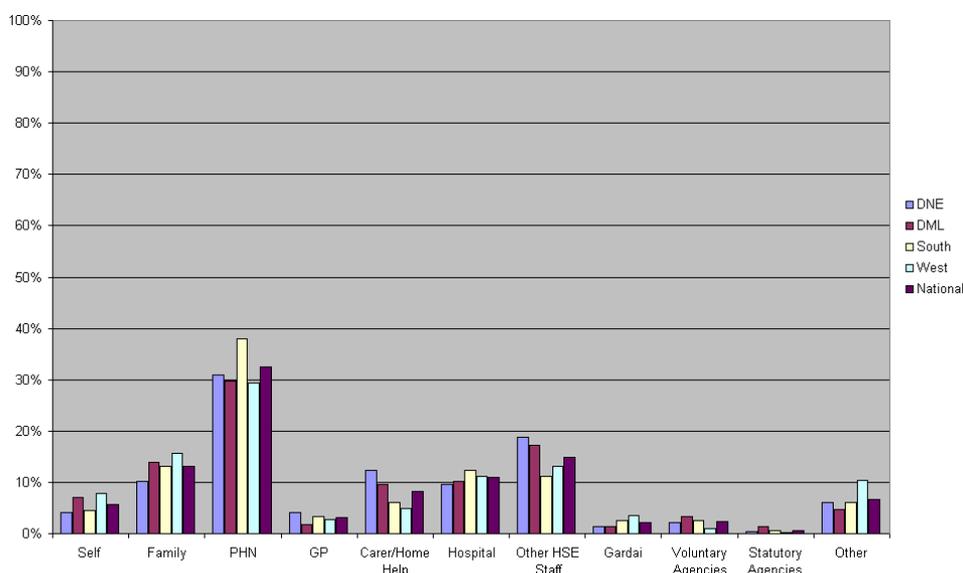


Figure 4: Profile of Referral Source Nationally and by HSE Area 2011

There were 2,607 alleged abuse categories identified in 2011. Figure 5 illustrates the breakdown by category which shows psychological, financial; neglect and physical abuse remain the most common alleged abuse types reported. Table 8 provides a summary of the categorisation of alleged abuse types for the past four years with consistent trends evident.

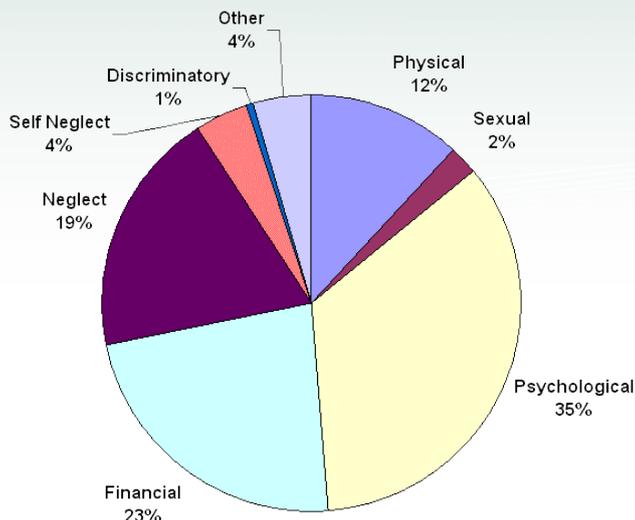


Figure 5: Multiple Response Analysis of Reason for Referral- Inclusive Partial Self-Neglect

Table 7: Summary of Alleged Abuse Categories with removal of self-neglect 2008-2011

		2008	%	2009	%	2010	%	2011	%
Total Referrals		N=1481		N=1435		N=1629		N=1867	
Rank Alleged Abuse Category	1	Psychological	29	Psychological	34	Psychological	31	Psychological	35
	2	Neglect	22	Financial	22	Financial	23	Financial	23
	3	Financial	19	Neglect	20	Neglect	22	Neglect	19
	4	Physical	15	Physical	14	Physical	13	Physical	12

The majority of referrals relate to individuals who live at home (81%), 8% reside in private nursing homes with 3% in public continuing care (Figure 6). Consistent with statistics since 2008, in 95% of cases in 2011, the abuse was alleged to have occurred in the person's primary place of residence.

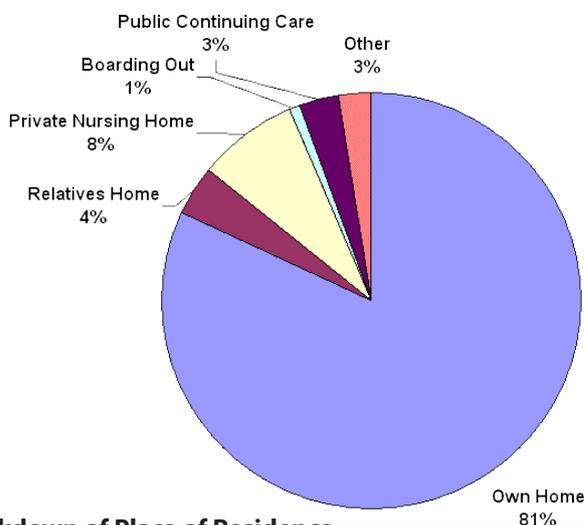


Figure 6: National Breakdown of Place of Residence

4.3.3 Characteristics of Person Causing Concern

In 2011, 75% of cases suggest just one person causing concern which rises to 87% when considering all cases with one or two alleged perpetrators. In total, in 48% of cases, the alleged abuser and alleged victim are living together. The association between abuse type and living status will be further explored in the section dealing with the substantiated cases.

In 2011, the main alleged perpetrators are son/daughter (44%), other relative (18%) and partner/husband/spouse (16%) (Figure 7). In total, 9% of referrals cited "other". These include friends, landlord, general acquaintances and, in many cases, people that could be included in a broad definition of family, e.g. partner's son. The consistency in this measure over time is evident in Table 8 which illustrates very little, if any, change in the profile of this measure over the past four years.

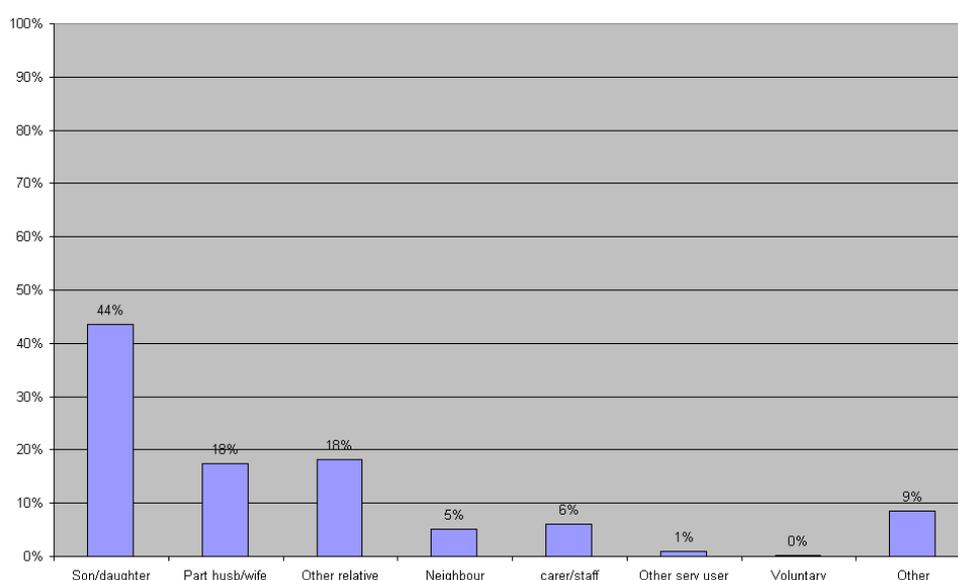


Figure 7: National Profile of Alleged Person Causing Concern 2011 (n=1729)

Table 8: Cumulative Profile of Alleged Person Causing Concern 2008-2011

	2008	2009	2010	2011	Change 2010-2011	Change 2008-2011
Son/daughter	44%	43%	44%	44%	0%	0%
Partner/husband/wife	17%	18%	16%	18%	1%	1%
Other relative	19%	19%	18%	18%	0%	-1%
Neighbour	4%	6%	5%	5%	0%	1%
Carer/staff	7%	4%	6%	6%	0%	-1%
Other service user	2%	1%	2%	1%	-1%	-1%
Voluntary	0%	0%	0%	0%	0%	0%
Other	8%	8%	8%	9%	1%	1%

4.3.4 Status & Outcome of Cases

Of a total of 1,867 cases in 2011 894 remain open at year end (48%) ranging from 44% in DNE to a high of 56% in HSE West (Table 9). In total, there were 1,143 cases reviewed, equating to 62% of referrals. This is consistent with the review rate in 2010. The cumulative position regarding active cases with a person causing concern is presented in Table 10 illustrating the difference at HSE area level. Only a very small percentage of cases remain open from 2008 and 2009.

Table 9: Cumulative Active Cases by HSE Area 2008-2011 (with a Person Causing Concern)

	DNE		DML		South		West		National	
	No. of Open Cases	%								
2008	5	1	7	3	7	1	1	.4	20	1
2009	5	2	19	8	50	9	8	2	82	6
2010	19	6	42	12	120	21	50	13	231	14
2011	204	44	191	49	277	45	222	56	894	48

The national substantiation rate has increased from 23% in 2008 to 28% in 2011. In the same time period, the level of confirmed non abuse has stayed relatively stable while the level of inconclusive outcomes has decreased from 44% to 37% (Table 10). Specifically in 2011, the highest rate of substantiation was in DNE. However, with 44% of the cases reviewed being “confirmed non abuse” one would question the appropriateness of some of the referrals. Cumulative analysis further confirms this trend (Table 11). Additionally, there continues to be a high rate of inconclusive outcomes in the HSE South. This is likely to be addressed through the planned appointment of a Dedicated Officer to this region in the near future.

Table 10: 2011 National and HSE Area Breakdown on Referrals by Case Outcome

	DNE		DML		South		West		National	
	No. of Referrals	%								
Substantiated	112	38	97	36	97	28	79	34	385	34
Confirmed Non Abuse	130	44	66	25	121	35	78	34	395	35
Inconclusive	56	19	104	39	129	37	74	32	363	32

Table 11: National and Area Summary of Outcome of Cases 2008-2011

	DNE		DML		South		West		National	
	No. of Referrals	%								
Substantiated	371	30	396	37	408	21	380	33	1555	28
Confirmed Non Abuse	529	42	280	26	687	35	377	32	1873	34
Inconclusive	349	28	397	37	893	45	409	35	2048	37

Allegation substantiated: Where substantial evidence exists that the client has been abused.

Not substantiated: Where a professional assessment has concluded that the abuse has not taken place.

Inconclusive: Where it has not been possible to either prove or disprove the allegation.

4.3.5 An Garda Síochána & Legal Involvement

In 2011, there was consultation with An Garda Síochána in 15% of cases, with 23% of cases resulting in Garda notification. Note that these figures cannot be aggregated as there is a level of cross over between the two measures. Table 12 provides a summary for all data indicating that, relative to baseline, there has been a significant increase in the level of Garda notification. In terms of legal action ensuing, there has only been a marginal increase over the same time period. Where actions have been taken, consistent with previous years, these related to domestic violence, ward of court and powers of attorney.

Table 12: Interaction with An Garda Síochána on Elder Abuse Cases 2008-2011

	2008 (n=1493)	2009(n=1412)	2010(n=1503)	2011(n=1094)
Garda Consultation	12%	16%	18%	15%
Garda Notification	10%	20%	23%	23%

4.3.6 Issues and Interventions for Client

In 2011, 637 clients were identified as having some health issue. This represents 34% of the total group. The majority (n=521) had just one recorded health issue. Consistent with findings in previous years, physical ill health remains the dominant health issue followed by dementia and mental health.

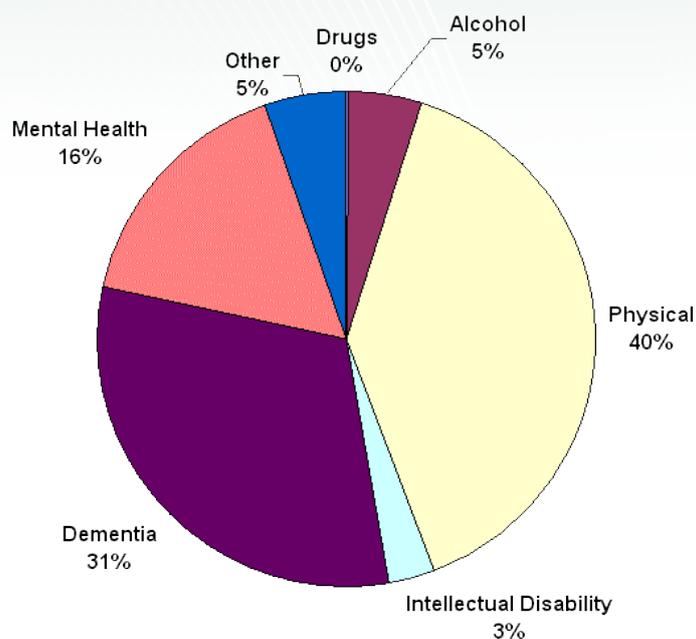


Figure 8: National Breakdown of Issues for Client (n=766)

Table 13: National Breakdown on Issues for the Client 2008-2011

	2008 n=1098	2009 n=1037	2010 n=1124	2011 n=766
Drugs	0.27%	0.48%	0.18%	0.20%
Alcohol	8%	7%	5%	5%
Physical	41%	36%	39%	40%
Intellectual Disability	2%	3%	3%	3%
Dementia	12%	26%	26%	31%
Mental Health	27%	20%	20%	16%
Other	10%	7%	7%	7%
Total	100%	100%	100%	100%

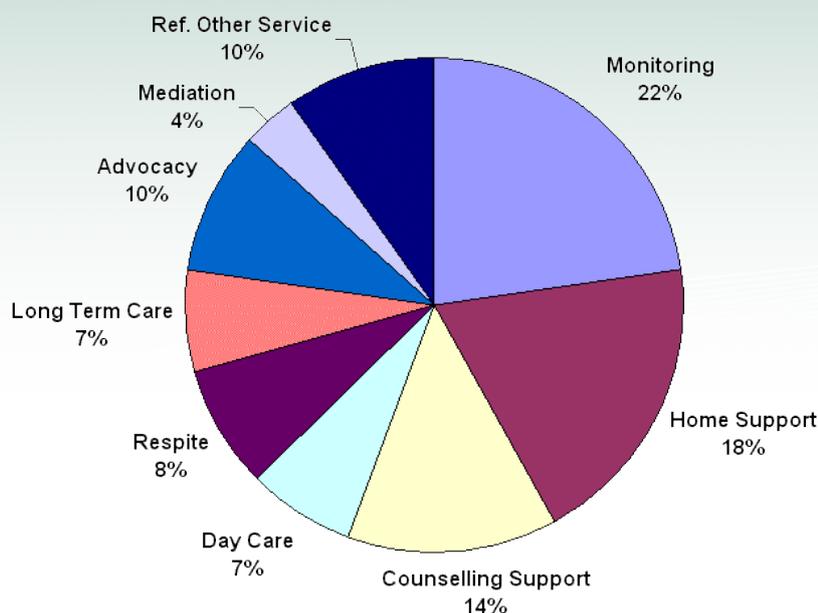


Figure 9: National Profile of Services Offered to Clients (n=1871)

Table 14: Summary of Interventions Provided to Clients 2008-2011

	2008 %	2009 %	2010 %	2011 %
Monitoring	21	21	21	22
Home Support	19	17	21	18
Counselling Support	18	15	13	14
Day Care	4	8	9	7
Respite	10	9	9	8
Long Term Care	12	8	9	7
Advocacy	4	7	7	10
Mediation	2	5	3	4
Referral Other Services	11	9	8	10

Clients continue to be receptive to receiving interventions with a 75% uptake from a total of 87% of individuals offered services. Monitoring, home support and counselling/support are the most availed of services. Advocacy and referral to other services accounted for a further 10% each; the latter being primarily mental health, old age psychiatry, geriatrician and housing/local authority services.

4.3.7 Issues and Interventions for the Person Causing Concern

Of the 1,143 cases in which a review was conducted, only 332 (29%) alleged perpetrators were listed by the Senior Case Worker as having at least one possible health issue. Consistent with findings over the past four years, alcohol and mental health were the main issues documented. "Other" factors represent a large proportion of issues with stress cited most often followed by family dynamics and financial issues.

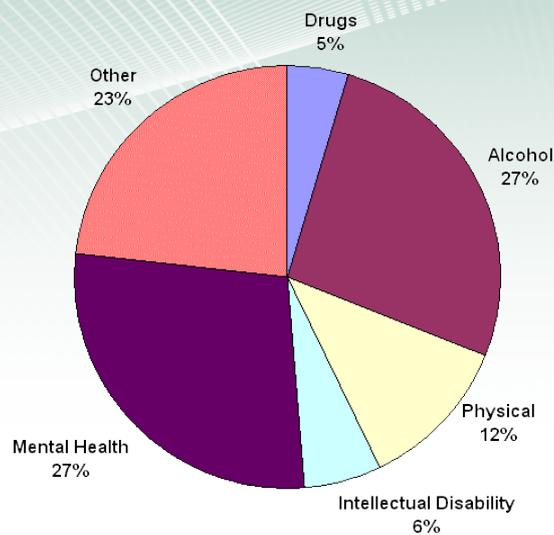


Figure 10: National Profile on Issues for the Person Causing Concern (n=389)

Support offered and referral to another service, mainly mental health and addiction services, were the most common interventions for the person causing concern.

Table 15: Interventions Provided to the Alleged Person Causing Concern 2008-2011

	2008	2009	2010	2011
Garda Action	12%	17%	17%	13%
Support Offered	51%	50%	49%	46%
Disciplinary Action	4%	2%	4%	6%
Service Refused	15%	10%	9%	14%
Referral Other Service	18%	21%	20%	20%

4.4 Substantiated Cases

In total since 2008, there have been 1,555 cases of substantiated abuse. This includes revised data from 2008-2010 and also outcome data for cases that have been reviewed in 2011. Specifically in 2011, in 283 cases it was concluded that abuse did take place with the majority recording just one abuse type (n=186).

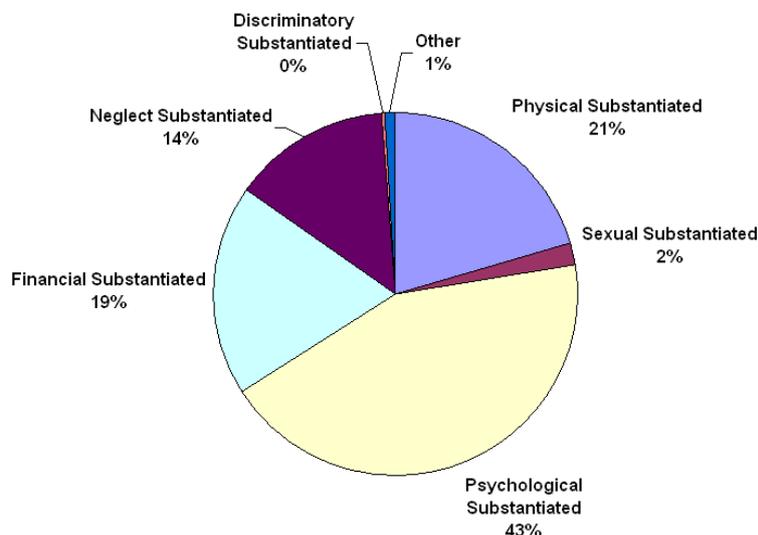


Figure 11: Profile of Substantiated Cases 2008-2011 by Confirmed Abuse Type

4.4.1 Physical Abuse Profile

There have been 395 cases with a physical dimension substantiated in the past four years thereby making it the second most common abuse type to be confirmed. Physical abuse, in comparison to some other abuse types, may be more easily identifiable (Figure 11). In the majority of cases, the abuse was perpetrated independently with a small proportion combined with psychological abuse. Most physical abuse is perpetrated by males. However, in 2011, there was a significant increase in females perpetrating this type of abuse (increase from 31%-33% to 43%). Across all years, in over two thirds of cases, the client is residing with the perpetrator. Son/Daughter (49%), partner/husband/wife (27%) and other relative (12%) are the main perpetrators. As with all abuse reported, there is a higher proportion of females that are victims of physical abuse. However, there is an increase in incidence in men over 80 years.

Having a health issue, most notably a physical or mental impairment, was found to be a significant risk factor in physical abuse. There has been a greater involvement with An Garda Síochána on these cases with 43% consulted on and 49% notified. There was legal action in a total of 60 cases.

4.4.2 Psychological Abuse Profile

The trend which has seen psychological abuse being the most common alleged abuse category is followed through in the rate of cases substantiated. Four year analysis indicates that 925 of total cases have a psychological dimension. Psychological abuse is most likely to be perpetrated against females in the 65-79 years age category. When combined with another abuse type, it is most likely to be physical (169/925) or financial (112/925). Son/daughter (51%), partner/husband/wife (21%) and other relative (14%) are the main perpetrators of this type of abuse. In the majority of cases, this is perpetrated by one individual who is most likely to be male. Where there are two perpetrators, this is most likely to be a male/female combination.

On average, in 60% of cases, the perpetrator is residing with the victim. There was Garda consultation in 31% of cases and notification in 37%. Only 12% involved legal action. Two thirds of the victims had an identified health issue and in almost half of these cases it was a physical issue with dementia and mental health not as significant.

4.4.3 Financial Abuse Profile

This type of abuse presents in many different manifestations such as stealing money or misappropriation of assets. In the four year data analysis, 19% of all cases substantiated had a financial component representing 367 cases. The gender breakdown was consistent to that reported for all cases received - 68% Female: 32% Male. The age profile of the victims were spread evenly between the under and over 80 years category and this was consistent for both genders. There was notification to An Garda Síochána in 40% of cases and referral in 49%. In total, 110 resulted in legal consultation with a final legal action taken against 70. This was in the form of barring orders, wardship, criminal justice and domestic violence legislation.

In only 31% of cases, the client was residing with the perpetrator. The perpetrator was most likely male, acting alone, and a close family member son/daughter 41% or "other relative" (19%). Neighbour continues to be a significant group in perpetrating this type of abuse. In total, 75% of these victims had identified health issues. Consistent with the overall trend these were physical, dementia and mental health issues.

4.4.4 Neglect Profile

There have been 269 cases with a confirmed substantiated neglect component, making it the fourth most common type of abuse in terms of its four year substantiation rate. Exposure to neglect is consistent with overall reporting levels. However, when age is considered, the over 80's are at increased risk. One in three cases referred also confirmed another abuse type with the main combinations being psychological/neglect and financial/neglect. Neglect has been found to be most often perpetrated by family members (son/daughter, partner/husband/wife, other relative), generally living with the victim. In 55% of cases, the perpetrator was male; 32% female; with the balance almost exclusively comprising of one male one female. The level of both Garda referral and notification was consistent with that reported for the total group with a low level of legal action. A high proportion (85%) had an identified health issue with physical and dementia being the main factors identified.

4.4.5 Self-Neglect

In 2011, there was a total of 429 self-neglect referrals made to the elder abuse service. This represents a reduction of 12% from 2010 referrals. The breakdown by HSE area is as follows:- South n=177 (41%); DNE n=111 (26%); West n=80 (19%); and DML n=61 (14%).

Cumulative figures from 2008 to 2011 illustrate that there is a consistent trend across the HSE areas in their proportionate contribution on referring cases of this nature to the elder abuse service. Of a total of 1,739 referrals, 48% came from the HSE South, 23% DNE 18% West and 11% DNE.

When compared to referrals involving an alleged perpetrator there is a reversal of the gender profile with more males referred; M:52% : F:48%. This breakdown has been evident year on year and is replicated when assessing the cumulative position for 2008-2011.

Table 16: Gender Breakdown by HSE Area 2011 Referrals

	DNE		DML		South		West		National	
Male	54	49%	23	38%	98	56%	47	59%	222	52%
Female	57	51%	38	62%	78	44%	33	41%	206	48%
Total	111	100%	61	100%	176	100%	80	100%	428	100%

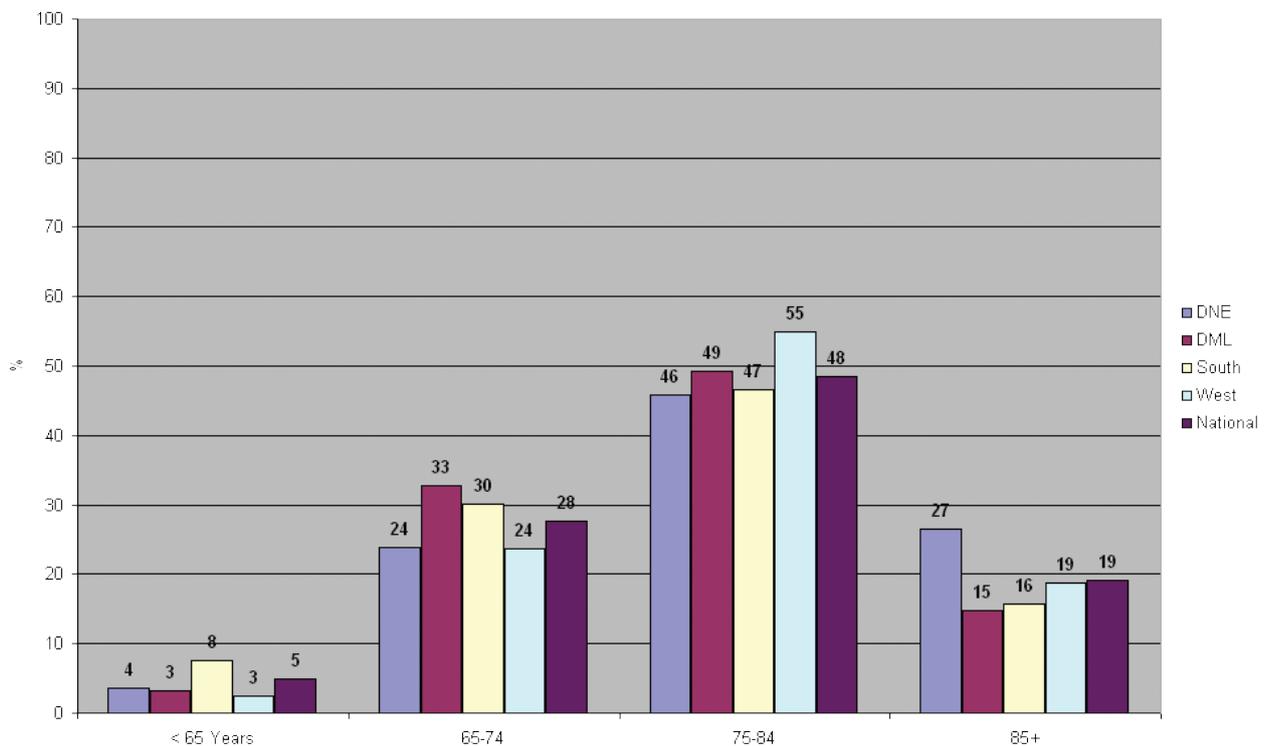


Figure 12: National and Area Profile of Self-Neglect by Age Category

In 2011, most referrals of self-neglect related to those in the 75-84 years age category. There was significantly more over 85 year olds referred in DNE compared to all other HSE areas (Figure 12). The highest proportion of under 65s was in HSE South. These trends are replicated when the cumulative position over the past 4 years is considered. (Figure 13)

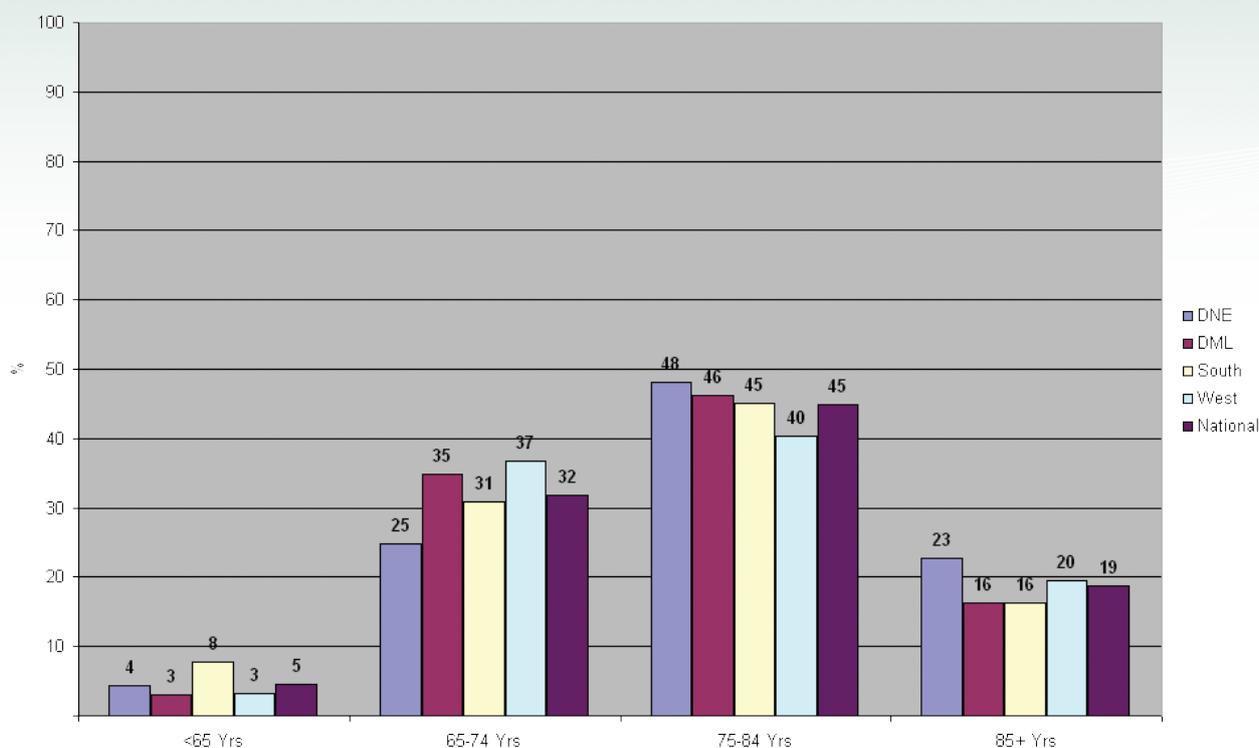


Figure 13: Cumulative 2008-2011 Profile of Age of Self-neglect Referrals by HSE Area.

In total, 60% of referrals came from the PHN service with the balance comprising of hospital and other HSE Staff. It is important to note that referrals from General Practitioners (6%) are higher in relation to these type of cases relative to other elder abuse types where there is an alleged person causing concern. HSE DML has a significant proportion of referrals from the home help service (12%) in contrast to the other three HSE areas which average at 3%.

Table 17: Active Self-neglect Cases Nationally and by HSE Area

	DNE		DML		South		West		National	
	No. of Open Cases	%								
2008	2	2	1	3	1	1	0	0	4	1
2009	1	1	1	3	16	7	5	7	23	5
2010	6	6	7	5	33	14	14	17	60	13
2011	44	40	29	48	85	48	49	61	207	48
Total	53		38		135		68		294	

As was the case in 2010, the majority of individuals referred lived at home (93%). A further 3% were classified as "other" which consisted of sheltered housing and homeless situations. The balance were residing in nursing homes.

At year end 2011, 207 cases remain open (48%) which is in addition to the active cases from previous years illustrated in Table 17. The total active cases are 294.

Last year data indicated that case length was influenced by case type with self-neglect cases more likely to close within 12 months. Cumulative data now suggests that there is no difference in the rate of case closure between the self-neglect cases and those cases where there is a person causing concern. (Figure 14)

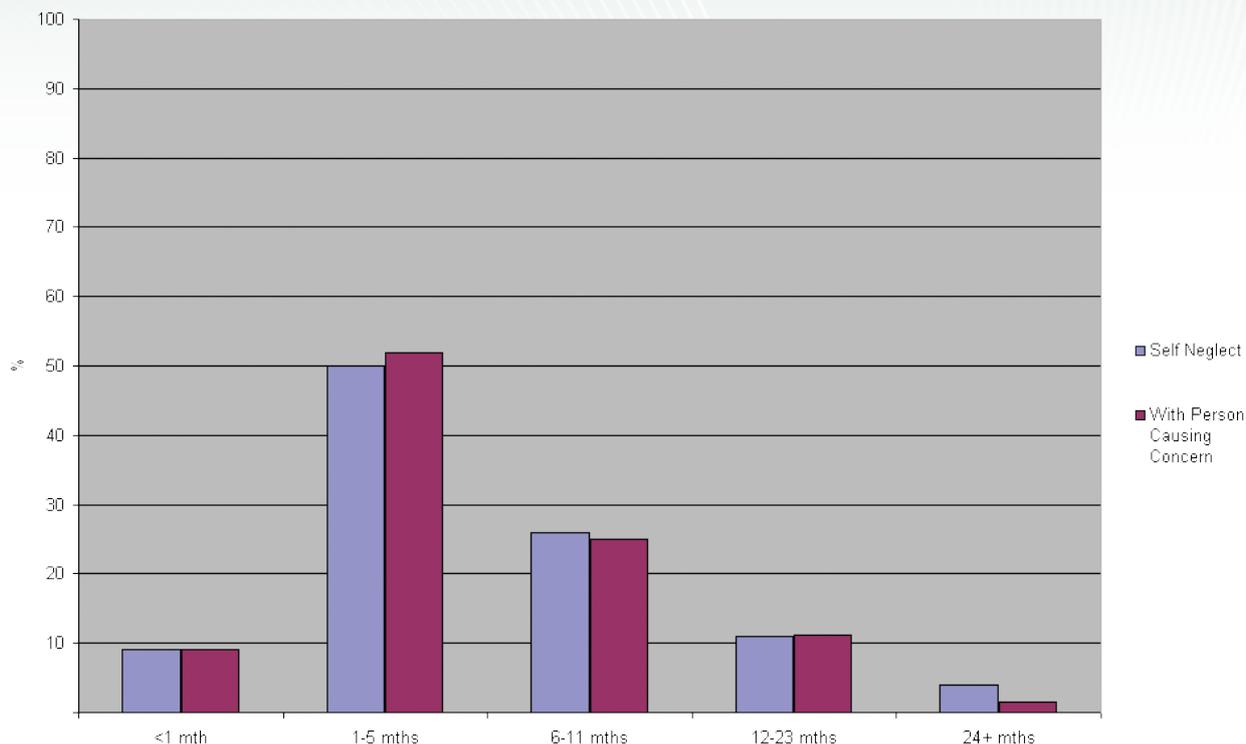


Figure 14: Cumulative Case Length 2008-2011 Self-neglect and Cases with Person Causing Concern

In total, 236 of this year’s cases have been reviewed. 11% resulted in both a Garda consultation and Garda notification. There is an insignificant level of legal action in relation to these cases.

The majority of clients, 66%, have taken up services offered with monitoring, home support and counselling continuing to be the most utilised. In total, 15% were referred to “other” services, e.g., housing and mental health/old age psychiatry. The trend, illustrated in previous reports, to decline services offered was again evident in 2011 (22% self-neglect cases declined services in contrast to 13% in the cases with an alleged perpetrator).

Analysis of service provision over time shows a year on year increase in home support and monitoring in self-neglect cases with a reduction in the use of counselling, respite and long term care.

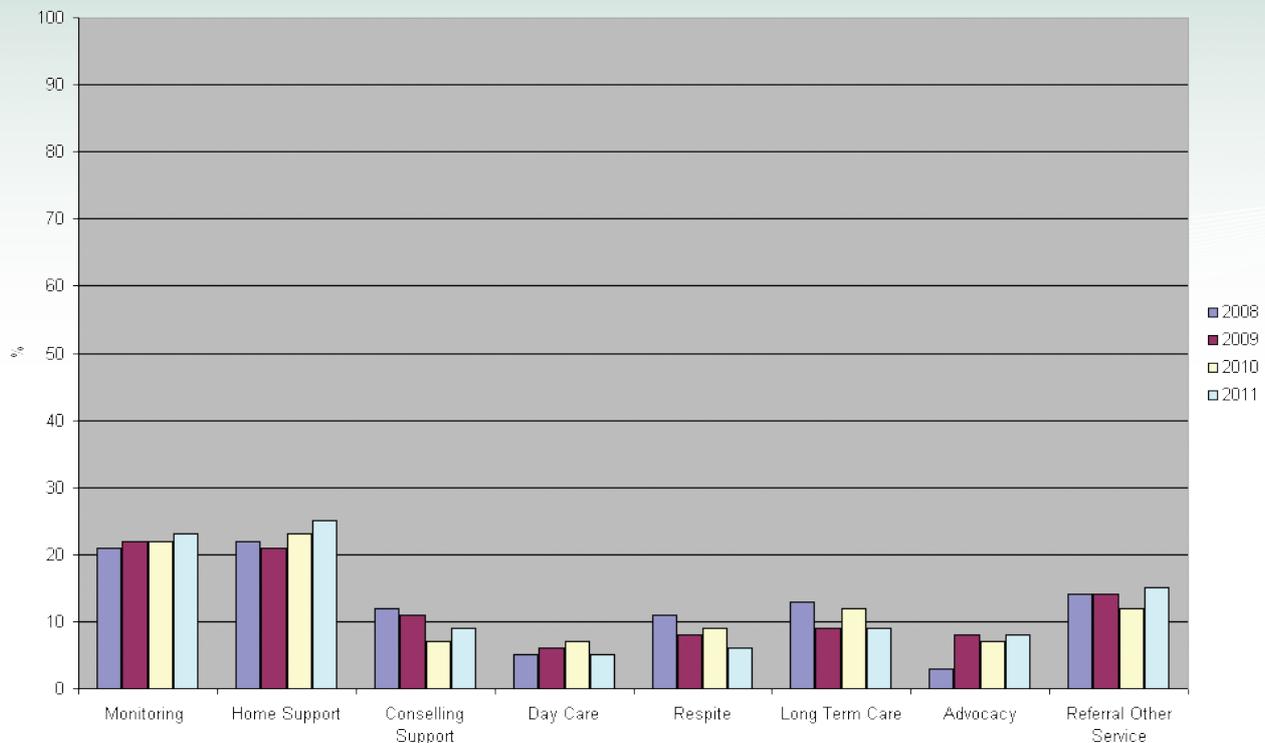


Figure 15: National Profile of Services Offered to Self-neglect Clients 2008-2011

While almost two thirds of the referrals in 2010 had an identified health issue, this has declined to only 30% of the group in 2011. Of those that had a health issue, this related, for the most part, to just one issue with mental health, physical, alcohol and dementia the most documented.

In total, there have been 1,739 self-neglect referrals made to the service across four HSE Areas in the past four data collection years. Just under half of these referrals came from the HSE South. The gender profile is more balanced with marginally more males referred - 52% males and 48% females. There were marginally more clients in the over 80 years age category.

4.5 Discussion

The key factors that emerge from the data presented above are that there are well established trends emerging that we can draw on for service developments into the future. This pertains most evidently to the abuse types most likely to be reported and substantiated, characteristics of the perpetrator specific to each abuse type, referral sources, intervention mechanisms and engagement with An Garda Síochána and the legal system.

The consistently higher level of female victims subject to abuse being perpetrated by a close family member, evident in the four year data, is replicated both in national and international research^{4,12,13,14}. While the publication in Age and Ageing on the National profile of referrals (Appendix 8) provided a valuable and necessary insight into referral characteristics in an Irish context, more conclusive findings on substantiated cases within this report serve to enhance that information.

As has been reiterated in all our publications, the rate of reporting, while increasing year on year will never reach a stage where it is on a par with the levels of elder abuse that are estimated within the population based on the national prevalence study (2.2% estimated to be 10,201 cases annually) . Many incidents of elder abuse will never come to the

attention of a dedicated service. In a recent study conducted in New York State ¹⁵(2011), it concluded that there were 24 times more self reported cases of elder abuse than reports registered with official agencies (social services, police). This confirms that many elder abuse cases are, and continue to be, managed within the dynamic of the extended family. Therefore, it is important to note that while family members are most likely to perpetrate elder abuse they also serve as a strong source of support in managing and dealing with its manifestations. In fact the national prevalence study confirmed that where there is poor family and community support, elder abuse was 3-4 times more likely to be reported.

The importance of accurate and consistent data continues to be an integral part in the success of tracking trends in elder abuse. We need to make every effort to further develop the information collated to enhance both service development and ongoing engagement with those at highest risk.

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Appendices

Appendix 1

Membership of the National Elder Abuse Steering Committee

Mr. Frank Murphy, Integrated Services Manager, Mayo, Lead Older Persons Services, HSE West (*Chairperson*)
Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West
Ms. Brenda Hannon, Specialist, Services for Older People, HSE Dublin Mid Leinster
Ms. Bridget McDaid, Dedicated Officer for the Protection of Older People, HSE West
Ms. Oonagh McAteer, Dedicated Officer for the Protection of Older People, HSE Dublin North East
Ms. Sarah Marsh, Dedicated Officer for the Protection of Older People, HSE Dublin Mid Leinster
Mr. Brian Carey, Consultant Geriatrician, HSE South
Mr. Donal Hurley, Senior Case Worker for the Protection of Older People, HSE West
Ms. Margaret Costello, Domestic Violence, HSE
Mr. John Lenihan, Specialist, Services for Older People, HSE South
Mr. John Brennan, Social Worker, Mater Hospital
Ms. Geraldine McCarthy, Consultant in Psychiatry of Old Age, HSE
Ms. Maria Moran, Consultant in Psychiatry of Old Age, HSE
Ms. Hilary Scanlon, Services for Older People, HSE South
Ms. Anne Boland, Director of Public Health Nursing, HSE West
Ms. Marcella Pokorná, Senior Case Worker for the Protection of Older People, HSE Dublin North East
Ms. Maura Seabrooke, Senior Case Worker for the Protection of Older People, HSE Dublin Mid Leinster
Ms Marguerite Clancy, Senior Research & Information Officer, HSE West
Ms. Margaret Kerlin, Team Coordinator, A/Director of Nursing, HSE West
Ms. Madeline Halpin, General Manager, HSE Dublin Mid Leinster
Mr. Pat Doherty, Alzheimer Society of Ireland
Ms. Suzanne Kiely, Senior Occupational Therapist, HSE Dublin North East
Mr. Tony Flynn, COSC, The National Office for the Prevention of Domestic, Sexual and Gender-based Violence
Inspector Declan Daly, An Garda Síochána
Ms. Mo Flynn, CEO, Our Lady's Hospice Ltd., Harold's Cross & Blackrock
Ms. Miriam McGuinness, Area Manager, Older Person Services, HSE West
Ms. Louise O'Mahony, Irish Banking Federation

Appendix 2

Membership of the HSE Elder Abuse Media and Public Awareness Working Group

Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West (Chair)
Ms. Suzanne Moloney, Services for Older People, HSE West
Ms. Mary Gleeson, HSE Communications
Ms. Audrey Lambourn, HSE Communications
Ms. Enda Saul, HSE Communications
Ms. Pauline Ducray, Senior Case Worker for the Protection of Older People, HSE Dublin North East
Ms. Maria Stanley, Office for Older People, Department of Health
Ms. Sarah O'Callaghan, Head of Public Affairs and Communications, The Alzheimer Society of Ireland
Ms. Catherine Cox, Communications Manager, The Carer's Association
Ms. Cathy White, The Carers Association
Mr. Eamon Timmins, Team Leader Advocacy & Communication, Age Action Ireland
Ms. Susan Shaw, National Development Officer, Active Retirement Ireland
Dr. Corina Naughton, UCD School of Nursing, Midwifery & Health Sciences, National Centre for the Protection of Older People
Sergeant John Crosse, Community Relations and Community Policing, An Garda Síochána
Mr. Brian Merriman, The Equality Authority
Ms. Amanda Phelan, Irish Representative, International Network for the Prevention of Elder Abuse (INPEA)

Appendix 3

Open Your Eyes Elder Abuse National Conference Programme



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



NCPOP
National Centre for the Protection of Older People



People in Ireland are living longer, healthier and more active lives than ever before. However, some older people experience mistreatment, neglect or abuse. The issue of elder abuse has only been highlighted relatively recently. Elder abuse can be a hidden issue. It is important that an increased awareness of this issue, along with a better understanding of the types and signs of abuse, and how to seek help and advice, is promoted among our communities, healthcare workers and anyone interacting with older people.

The Health Service Executive and the National Centre for the Protection of Older People - University College Dublin, in collaboration with the International Network for the Prevention of Elder Abuse, are hosting a conference on elder abuse entitled 'Open Your Eyes'. The conference will take place on



World Elder Abuse Awareness Day 2011
My World... Your World... Our World... Free of Elder Abuse

World Elder Abuse Awareness Day, Wednesday, June 15th

Health Science Centre, UCD, Belfield, Dublin 4



International Network
for the
Prevention of Elder Abuse
INPEA
Founded 1997

OPEN YOUR EYES

SESSION ONE: Chair: Professor Pearl Treacy, Programme Director, National Centre for the Protection of Older People

- 9.00 - 10.30 Registration / Refreshments
- 10.30 Welcome
- 10.30 - 10.45 Opening Address and Launch of the Review of the HSE Elder Abuse Services 2010
Ms. Kathleen Lynch, T.D., Minister for Disability, Equality, Mental, Health and Older People
- 10.45 - 10.55 Overview of the HSE Elder Abuse Service
Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West
- 10.55 - 11.10 Report from the National Centre for the Protection of Older People
Dr. Attracta Lafferty, Centre Director
- 11.10 - 11.25 HSE Elder Abuse Referrals 2010
Ms. Marguerite Clancy, Senior Research and Information Officer, HSE West
- 11.25 - 11.45 Refreshments

SESSION TWO: Chair: Professor Gerard Fealy, Programme Co-Director, National Centre for the Protection of Older People

- 11.45 - 12.40 Keynote Speaker – Detecting and Preventing Financial Abuse of Older Adults
Professor Mary Gilhooly, Executive Director, Brunel Institute for Ageing Studies, London
- 12.40 – 12.45 International Network for the Prevention of Elder Abuse (INPEA)
Dr. Amanda Phelan, UCD, Programme Director, NCPOP and Irish Representative for INPEA
- 12.45 – 1.00 Conference Reflections
Professor John Horgan, Press Ombudsman for Ireland
- 1.00 - 1.10 Closing Remarks
Ms. Sarah Marsh, Dedicated Officer for Elder Abuse, HSE Dublin Mid Leinster
- 1.10 Refreshments

A number of information and advisory stands will be available at the seminar.
The Conference will be streamed live via the NCPOP website (www.ncpop.ie).
Conference presentations will also be available to view or download from this website.

R.S.V.P. karen.malone@hse.ie or telephone 061 461165 by Wednesday, June 8th

Appendix 4

Membership of the Policies, Procedures, Protocols and Guidelines Working Group

Ms. Oonagh Mc Ateer, Dedicated Officer for the Protection of Older People, HSE Dublin North East (Chair 2011)

Ms Bridget McDaid, Dedicated officer the Protection of Older People, HSE West (Chair 2008 – 2010, 2012)

Ms. Sarah Mahon, Dedicated Officer for the Protection of Older People, HSE Dublin Mid Leinster

Ms. Maggie McNally, Senior Case Worker for the Protection of Older People, North Tipperary

Mr. Gordon Barrett, Social Work Team Leader, Sligo

Ms. Anne Nixon, Assistant Director of Public Health Nursing, Roscommon

Ms Maura McCrudden, Senior Case Worker for the Protection of Older People, Dun Laoghaire (2009-2010)

Ms. Maura Seabrooke, Senior Case Worker for the Protection of Older People, Meath (joined 2011)

Mr. Donal Hurley, Senior Case Worker for the Protection of Older People, Clare (joined 2011)

Ms. Aisling Coffey, Senior Case Worker for the Protection of Older People, Dublin South West (joined 2011)

Mr. Seamus Mc Garvey, Senior Case Worker for the Protection of Older People, Donegal (joined 2011)

The Group would like to acknowledge Ms. Patricia Rickard-Clarke, Law Reform Commissioner for her invaluable support and advice.

Appendix 5
Elder Abuse Record of Initial Referral - Form 5

Form 5: Senior Case Worker-Elder Abuse, Record of Initial Referral



Local Health Office: _____ **Date Referred:** _____
Client Referral No.: _____ **Any previous Client Referral No.:** _____
Date of 1st Response _____

1. Gender Male Female

2. Age: Under 65 65-69 70-74 75-79 80-84 85-89 90+
 Unknown

3. Who referred

Self Family
 PHN/Comm RGN GP
 Carer: Residential
 Non residential
 Home Help: HSE
 Contracted
 Hospital Other HSE Staff
 Gardai Voluntary agencies
 Statutory agencies
 Other *please specify* _____

4. Reason for referral (*tick as many as apply*)

Alleged Physical abuse
 Alleged Sexual abuse
 Alleged Psychological abuse
 Alleged Financial / material abuse
 Alleged Neglect /acts of omission
 Alleged Self Neglect
 Alleged Discrimination
 Other *please specify* _____

5. Primary place of residence (*tick 1 option*)

Own Home Relatives Home Private Nursing Home Boarding Out
 Public continuing care (e.g. HSE CNU/ welfare home) Other *Please specify:* _____

6. Location where alleged abuse took place (*tick 1 option*)

Place of residence as above Day Care Unknown
 Other *please specify:* _____

Note on Qs 7 - 10

If the allegation of abuse relates to the environment, practices or systems of work within an organisation where there is no one individual / group of individuals causing concern - please tick here and skip Qs 7 – 10.

Qs 7 -10 should also be skipped in cases where self neglect is the only reason for referral

7. Number of persons allegedly causing concern _____

8. Gender of person(s) allegedly causing concern (*tick 1 option*)

1 Male 1 Female 1 Male & 1 Female 2 Males 2 Females
 If 3 or more persons causing concern – Mostly Male Mostly Female Even no. of males & females

9. Person allegedly causing concern (*tick as many as apply*)

Son/Daughter Partner/husband/wife Other relative
 Neighbour Carer/Staff Other service user
 Volunteer Other *please specify* _____

10. Is person(s) allegedly causing concern living with the older person? (*tick 1 option*)

Yes No Sometimes Don't know

11. Have you consulted with the Gardai? Yes No

12. Have the Gardai been notified? Yes No **If yes, by whom:** _____

Signed: SCW Protection of Older People: _____ **Date:** _____

Appendix 6

Elder Abuse Follow Up on Record of Initial Referral - Form 6



Form 6: Follow-up on Record of Initial Referral

Local Health Office: _____ Date referred: _____
 Client referral No. _____ Any previous client referral No. _____

1. Status of case (a) Ongoing Closed Client RIP Person allegedly causing concern RIP
2. Status of case (b) Allegation substantiated Confirmed non abuse Inconclusive

If allegation has been substantiated please complete the details in the box provided below

Use one row for each type of abuse and / or perpetrator						
Type of abuse substantiated *State 1 per row*	Relationship to client of person against whom abuse has been substantiated *State 1 per row*			Gender of perpetrator	Is perpetrator living with client	
Physical	Financial/material	Son/Daughter	Husband/Wife/Partner	Male or Female	Yes	No
Sexual	Neglect/Act of omission	Other relative	Neighbour		Sometimes	Don't know
Psychological	Discrim	Other Service User	Volunteer...			
e.g Physical	Other		Other	Male	Yes	

Note on Qs 3 – 14

- For first form 6 on each client please answer all questions
 - For 2nd and subsequent form 6s on each client please update Qs 3-14 with any new information / changes since the previous form 6 was completed. If no changes please leave blank

3. Have YOU consulted with the Gardai in relation to this referral Yes No
4. Have the Gardai been notified? Yes No If yes, by whom: _____
5. Legal consultation? Yes No
6. Legal action taken? Yes No If 'yes' -
 Ward of Court Domes Viol Act Nursing Home Reg/Act Other :please specify: _____
7. Service offered to client referred: Yes No Service offered but declined
8. Indicate client interventions that have been put in place *not restricted to SCW interventions* (tick as many as apply):
 Monitoring Home support services Counselling / support Day Care
 Respite care Long term care Advocacy Mediation/Conflict resolution
 Referred to other service please specify: _____
9. Any actions taken re: person allegedly causing concern (tick as many as apply):
 Garda action Support offered Disciplinary action Service offered but declined
 Referred to other services please specify: _____
10. Suspected / possible issues for person allegedly causing concern (tick as many as apply):
 Drugs Alcohol Physical Intellectual disability
 Mental Health Other please specify: _____
11. Suspected / possible issues for Client (tick as many as apply):
 Drugs Alcohol Physical Intellectual disability
 Dementia Mental Health Other please specify: _____
12. Case Meetings held? Yes No If 'yes please state total number since case was opened: _____
13. Case Conference held? Yes No If 'yes please state total number since case was opened: _____
14. Family Meetings held? Yes No If 'yes please state total number since case was opened: _____
15. Medical consultation? Yes No

Signed: SCW Protection of Older People: _____ Date: _____
 Date case closed (if applicable): _____

Appendix 7

National Centre for the Protection of Older People: Studies and Reviews

STUDY 4: MANAGING CASES OF ELDER ABUSE IN IRELAND: THE SENIOR CASE WORKERS' EXPERIENCES

Background

Elder abuse is becoming increasingly recognised as a significant problem worldwide. A wide variety of methods have been developed and implemented to tackle the problem. To date, there is limited evidence to support these various approaches and there remains little consensus on best practice in response to elder abuse. In Ireland, since 2007, the Health Service Executive (HSE) provided a dedicated elder abuse service for those who have experienced abuse. This specialist service is delivered by qualified social workers, as acting as Senior Case Workers (SCWs), who deal with referrals of suspected cases of abuse involving people aged 65 years and over. The SCWs encounter older people who have experienced abuse on a daily basis and are therefore considered key stakeholders in the provision of services for older people in Ireland who experience abuse, possessing a wealth of experiential knowledge and skills in the management of cases of elder abuse.

Aim and Objectives

The overall aim of the study was to explore the experience of managing elder abuse cases from the perspective of senior case workers.

The objectives of this study were to:

1. Explore Senior Case Workers' experiences in managing cases of elder abuse.
2. Examine current practices adopted by Senior Case Workers.
3. Examine the challenges and dilemmas faced by Senior Case Workers in managing cases of elder abuse and how these are overcome.
4. Identify good practice in the management of elder abuse cases, as perceived by the Senior Case Workers.
5. Identify priorities for future service development and provision for elder abuse.

Method

This study involved one-to-one depth interviews with a sample of 18 Senior Case Workers. The study was approved by the UCD Human Research Ethics Committee and all Senior Case Workers provided written informed consent to participate. The interviews focused on SCWs' self-reported current practices in assessing and managing cases of elder abuse, issues and challenges faced in the management of cases, experiences of collaboration and interagency working, supervision, management and training and priorities for the future of elder abuse services in Ireland. The majority of interviews were held in each SCW's place of work. With the exception of one interview where comprehensive notes were taken, all interviews were audio-recorded. Interviews were between one to three hours duration.

Study Outcomes

This study:

- Provides a detailed qualitative description of Senior Case Workers' perspectives and experiences in dealing with cases of elder abuse.
- Provides a greater understanding of Senior Case Workers' current practices in the management of cases of elder abuse.
- Identifies the challenges and issues faced by the Senior Case Workers in dealing with cases of elder abuse.
- Identifies Senior Case Workers' views of best practice in the management of cases of elder abuse.

The report of this study will be launched in 2012 and will be available to download from www.ncpop.ie.

STUDY 5: OLDER PEOPLE'S EXPERIENCES OF MISTREATMENT AND ABUSE

Background

Despite increasing attention on elder abuse in recent years, the voice of older people about their experiences of mistreatment is rarely heard (Hightower *et al.* 2006). Moreover, a recognised limitation of information available about elder abuse is that it is not grounded in older people's understandings and experiences of abuse (Nandlal & Wood 1997). Hence, in order to better understand the experience of abuse, it is important to obtain the views of older people who have experienced abuse and not to make assumptions about the abusive experiences based solely on the views and experiences of professionals (Pritchard 2000).

Aim

The aim of this study was to increase knowledge and understanding of older people's experiences of abuse.

Objectives

The objectives of this study were to:

- 1 Describe older people's self-reported experiences of elder abuse.
- 2 Examine the impact of abusive experiences on older people.
- 3 Examine the decision-making pathways and forms of action taken by older people in response to abuse.
- 4 Explore coping strategies that older people adopt to help them deal with abuse.
- 5 Identify the support needs of older people who have experienced abuse.

Method

The research involved interviews with older people who had been referred to the HSE and who were already engaged with the health services regarding their abusive experience. A sample of older people who had experienced abuse was recruited through Senior Case Workers. The SCWs were asked to examine their caseload and identify older people who had experienced elder abuse and who fulfilled the study's inclusion criteria, and if appropriate, to invite them to indicate their interest in participating in the study. Older people's participation in the study was entirely voluntary and their confidentiality was assured.

Nine older people (7 females, 2 males), aged between 67 years and 83 years were recruited to the study. Face-to-face, in-depth semi-structured interviews were undertaken to collect data about their experiences of being abused. Participants were interviewed about their abuse experiences, its impact on them, their experiences of coping, and their perceived support needs in relation to the abuse. Interviews took approximately one to two hours and were mainly conducted in participants' homes. All interviews were audio-recorded and transcribed verbatim.

Inclusion criteria

Those identified for inclusion in the study were older people who(se):

1. Experienced abuse since turning 65 years of age.
2. Were victims of substantiated abuse.
3. Were victims of physical, psychological, sexual, financial abuse and/or neglect (involving someone with whom the older person had a trust relationship).
4. Had the capacity to consent to partake in the study.
5. Were considered emotionally and mentally stable to speak about their experiences of abuse as determined by the Senior Case Worker.
6. Would not be at serious risk from the perpetrator as a result of their participation in this study.
7. Case of abuse was closed or was considered to be at least 'informally resolved' by the Senior Case Worker.

Study Outcomes

This study afforded abused older people the opportunity to tell their story of the experience of being abused in their own words and from their own perspective. It provided a detailed qualitative description of older people's experiences of elder abuse and highlighted the impact that being abused can have on older people. The findings will support the ongoing development of intervention strategies for the prevention of elder abuse and will highlight the support needs of older people who have experienced abuse.

The report of this study will be launched in 2012 and will be available to download from www.ncpop.ie.

STUDY 6: A SURVEY OF STAFF-RESIDENT INTERACTIONS AND CONFLICTS IN RESIDENTIAL CARE SETTINGS FOR OLDER PEOPLE

Background

The quality of care provided to older people in nursing homes and care settings has received increasing attention over recent years. However, there is limited empirical data on the extent of mistreatment experienced by older people in residential care settings. The limited available research suggests that such maltreatment does occur (Pillemer & Moore 1989; Goergen 2004). The report *Protecting Our Future* highlighted that problem of impoverished care environments and the fact that older people were 'being treated and cared for by over-worked, stressed, burnt-out staff who are too small in number to be able to cater for their needs properly' (p17). A recent review of *Protecting Our Future* also highlighted the abuse of older people in institutional settings as a priority area for research (NCAOP 2009). Although there has been a body of work on elder abuse in community settings, it is only within the last decade that a concerted effort has been made to examine mistreatment and conflict in residential care settings for older people.

Aim

The aim of this study is to measure observed and perpetrated abuse as reported by nursing home care staff and to identify associated risk factors.

Objectives

The objectives of the study are:

1. To measure the extent to which nursing and care staff working in residential care settings for older people experience conflict with residents.
2. To measure the extent to which nursing and care staff working in residential care settings for older people observe potentially neglectful or abusive behaviours towards residents.
3. To measure the extent to which nursing and care staff working in residential care settings for older people engage in potentially neglectful or abusive behaviours towards residents.
4. To identify the factors associated with the mistreatment of residents in residential care settings.

Methods

Research Design

The research design was a cross-sectional survey of nursing and care staff working in public, private and voluntary residential care homes in Ireland.

Sampling

Sample Design

In order to obtain a representative sample of public, private and voluntary residential care settings for older people, 16 geographical regions nationwide were randomly selected based on weights determined by the number of beds in each regional cluster. Subsequently four nursing homes were randomly selected in each cluster, also weighted by number of beds in each residential home, thereby ensuring a representative sample of 64 residential care settings.

Sample

All public, private and voluntary residential care homes across Ireland were included in the sampling frame and each had the same statistical chance of being selected. The study sample consisted of 19 public nursing homes, 44 private nursing homes and 1 voluntary nursing home. Of the original 64 randomly-selected homes, 7 declined participation and were replaced by alternatives. The primary sampling unit was the residential care home and the secondary sampling unit was the nursing and care staff working in these settings.

Procedure

Each of the 64 randomly-selected residential care homes received an invitation letter to participate in the survey. This was followed up with a telephone call(s) to secure agreement and permission to distribute questionnaires to the nursing and care staff. A meeting then took place with the proprietor or director of nursing to arrange distribution

of questionnaires to staff and subsequent visits to the nursing home. Participants had the option of returning the completed questionnaire either directly using a stamped addressed envelope or by placing it in a sealed collection box supplied to each residential home. A follow-up reminder letter was sent within two weeks of the first visit. Each residential setting was visited on average between 3 to 4 times over the course of the survey.

Measuring Instruments

This study was undertaken using a self-completed questionnaire which was distributed to all nursing and care staff working in the randomly-selected residential care homes. The advantages of this approach included the relatively low cost, the lack of time pressure on the respondent to complete the questionnaire, the potential to recruit large numbers of respondents to the survey and to assure anonymity.

The questionnaire measured respondents' perceptions of their working environment, interactions with residents and conflicts that had occurred. The questionnaire also measured stress, burnout, job satisfaction, general health and level of education of the study respondents as a way of examining correlates of conflict and abuse of older people in residential care settings (Pillemer & Moore 1989; Goergen 2004).

Data collection is taking place at the time of reporting.

Outcomes

This study will provide a baseline measurement of the problem of mistreatment and neglect in residential care settings, as reported by nursing and care staff. The study will also identify the factors that are associated with the mistreatment of older people in the residential care sector. From this evidence, appropriate interventions to improve staff-patient interactions and reduce conflicts that may arise in residential care settings can be identified, developed, implemented and evaluated.

The report of this study will be launched in 2012 and will be available to download from www.ncpop.ie.

REVIEW 5: CRITICAL REVIEW OF ELDER ABUSE SCREENING TOOLS FOR USE IN THE IRISH CONTEXT

Background

Within the Irish policy document *Protecting Our Future* (DOHC 2002), the recommended basic reporting assessment involves the detection of elder abuse, and screening tools have been suggested as a method of assisting practitioners in establishing the risk of elder abuse (Fulmer *et al.* 2005). Screening tools in elder abuse have great practical potential, particularly as the literature suggests that many professionals struggle to recognise the issue (Heath *et al.* 2005; Kennedy 2005; Newton 2005; Killick & Taylor 2009).

Aim

The overall aim of this review was to examine elder abuse screenings tools and consider a tool(s) of particular merit in the Irish context.

Objectives

The objectives of this review were to:

1. Examine elder abuse screening tools.
2. Identify a tool(s) of particular merit.
3. Identify issues related to the use of elder abuse screening tools.
4. Make recommendations regarding the use of elder abuse screening tools in Ireland.

Methods

A literature search was undertaken using CINAHL and PUBMED using the terms 'elder abuse and screening tools' and 'elder abuse detection' for the years 1980-2010. Grey literature was also searched through a review of internet websites using the same search terms. In addition a number of personal consultations were held with the authors of published screening tools which demonstrated particular merit in terms of reliability and validity.

Findings

Screening tools are not diagnostic, but do highlight cases which have a higher statistical probability of a disease or disorder (Stampfer *et al.* 2004; Kettles *et al.* 2004) and therefore warrant further investigation by a practitioner (Yaffe *et al.* in press). In relation to screening tools for elder abuse, there are a number of tools available; however, these vary in their approach to screening, including the use of qualitative or quantitative measures, the focus on universal or targeted screening, the timing (prospective or retrospective), the target (older person or caregiver), the population (mental capacity or mental incapacity), the data collection method (face to face, non-face to face) and user of the data collection instrument (older person or health care professional).

Tools reviewed included:

1. The Hwalek-Sengstock Elder Abuse Screening Test (Hwalek & Sengstock 1986)
2. Vulnerability Abuse Screening Scale (VAST) (Schofield & Mishra 2003)
3. The Elder Assessment Instrument (EAI) (Fulmer *et al.* 2003)
4. The Indicators of Abuse Screen (IOA) (Reiss & Nahmaish 1998)
5. The Caregiver Abuse Screen (Reis & Nahmiash 1995)
6. The Elder Abuse Suspicion Index (EASI) (Yaffe *et al.* 2008)
7. Psychological Elder Abuse Scale (PEAS) (Wang 2005)
8. Caregivers Psychological Elder Abuse Behaviour Scale (Wang *et al.* 2006)

Conclusion

Screening tools for elder abuse may have the ability to provide a systematic, standardised, multi-disciplinary objective assessment for potential elder abuse. However, further testing of screening instruments is fundamental to refining the validity and reliability of such tools. Although some screening tools have shown some promise, particular categories of abuse may have been omitted, particularly the area of sexual abuse. Within the context of the screening tools reviewed, the EASI has the ability to screen for all abuse manifestations. The EASI has and continues to be used in differing cultures and has been subject to WHO (2008) review and support. It is a relatively rapid screening instrument to use, is easy to complete and has the capacity to be practitioner administered or self-administered. Most importantly, it addresses all categories of elder abuse and measures abuse within the preceding twelve month period.

The report of this review will be launched in 2012 and will be available to download from www.ncpop.ie.

REVIEW 6: NATIONAL AND INTERNATIONAL RESPONSES TO FINANCIAL ELDER ABUSE

Background

There is concern internationally among health service providers, social workers, advocacy groups, legislators and others that elder financial abuse is a growing problem. The purpose of this review of literature was to identify the scale and scope of elder financial abuse internationally and to identify policy and practice responses to the problem. Based on an estimated prevalence of 1.3 per cent for financial abuse experienced by older Irish people (Naughton *et al.* 2010), it may be extrapolated that in excess of 6,000 older people in Ireland had experienced financial abuse in the twelve months prior to the study. Financial abuse was the third most common form of abuse among substantiated cases in 2008 and 2009 (HSE 2011). However in 2010 it was found that there was an increase in the reporting of financial abuse, to such an extent that it was the second most common form of abuse among substantiated cases (HSE 2011). Bearing in mind that the population of older people in Ireland is increasing it may be anticipated that the problem is set to grow accordingly.

Aim

The aim of the review was to collate, analyse and summarise published and unpublished literature on elder financial abuse, in order to inform national policy and to inform further research into elder financial abuse. The objective of the review was to examine the nature, incidence, prevalence, and impact of elder financial abuse and to identify strategies to manage and prevent its occurrence.

Methods

A systematic and comprehensive search of published works indexed in the databases CINAHL Plus, MEDLINE, British Nursing Index and EMBASE from 2000–2011 was conducted. The search keywords used were: incidence, prevalence, elder, elder financial, abuse, financial abuse, financial abuse, financial mistreatment, financial exploitation, perpetrator, and abuse risk factors. Bibliographies of retrieved articles were examined for the key search terms in their titles and ancestral searching of the reference lists of retrieved items was also conducted to identify further items not found in the keyword searches. Various terms such as 'Europe' and 'financial elder abuse' were combined in the search. Grey literature, including government and non-government agency reports and conference papers, was also reviewed. Text books that dedicated chapters to financial elder abuse were also reviewed.

Findings

Financial abuse is the most frequently-occurring form of elder abuse in Ireland (Naughton *et al.*, 2010). Financial abuse of older people is frequently perpetrated by relatives, including male and female offspring. Male offspring are more likely to be perpetrators of elder financial abuse (Metlife Mature Market Institute 2009; Choi & Mayer 2000; Wainer *et al.* 2010). Financial abuse by adult children is seldom simple and may be a manifestation of pre-existing intra-family abuse that emerges as parents grow older and more vulnerable, and in some cases it may be one manifestation of continuing abusive family dynamics (Wainer *et al.* 2010). Grandchildren perpetrators are less common (Wainer *et al.* 2010; NCEA 1998).

The mean age at which financial abuse occurs is a function of the age and social-economic circumstances of individuals and the source of data used in each study as well as the methods applied by researchers. As elder financial abuse is so complex, it is not possible to identify generic preventative strategies to overcome an older populations' risk to financial abuse. Individual circumstances will dictate the degree to which a person is at risk to financial abuse. As many as fifty-five separate risk factors were identified in this literature review, these include altered cognitive function and mental health; lower educational achievement of carers; home ownership and intellectual and physical disabilities.

The signs of elder financial abuse can be difficult to recognise especially if the victim cannot or will not complain or if the professional is not attuned to the signs (Reed, 2005). Police, judicial and health systems find financial abuse the most difficult type of abuse to deal with (Loddon Campaspe Community Legal Centre, 2008).

Few referrals of financial abuse come from financial institutions, despite the fact that disappearance of funds and/or valuables is the most common type of exploitation (Choi *et al.* 1999). The release of equity by an older person to a relative may be a less obvious form of elder financial abuse (Brennan & Ritch 2010). Financial abuse perpetrated by fraud and tele-marketing can seriously impact on older people (Darzins *et al.* 2009).

A distinction needs to be made between financial 'mismanagement' and financial 'abuse' (Choi *et al.* 1999). Agreement on an international definition of what is and what is not financial abuse has proved challenging (Lowndes *et al.* 2009) and hence comparing prevalence studies across countries is difficult. The diversity of methods used by researchers to study the phenomenon precludes reliable comparative analysis of results. There is no optimal single assessment method for the identification of elder financial abuse (Cooper *et al.* 2008).

Conclusion

Financial abuse is not system specific; it crosses social, physical, intellectual, economic and spiritual divides and resists the medical and legal models of case management with which it is more frequently addressed. It is important to provide on-going education of health professions and to establish protocols for the management of suspected cases of financial abuse (Hafemeister 2003). It is recommended that future research on financial abuse should be directed towards assessing mental and physical health conditions associated with mistreatment of older people (Acierno *et al.* 2010).

Preventative measures for elder financial abuse should include: greater involvement of families in the older person's life so as to prevent social isolation; preventing any one person getting too much control over an older person's assets; automatic electronic payment of bills; engaging legal advice when preparing or changing a will and educating professionals involved with older people on recognising and managing financial abuse. The focus on managing financial abuse needs to shift from concern with prevalence, to developing detection and management strategies. Recommended actions to address elder financial abuse include: raising awareness, education and outreach, general detection, legal interventions and establishing multi-disciplinary teams (Reeves & Wysong 2010).

The report of this study will be launched in 2012 and will be available to download from www.ncpop.ie.

Appendix 8 National Profiling of Elder Abuse Referrals

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National profiling of elder abuse referrals

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Abstract

Background: there is little consistent data on patterns of reporting of elder abuse in Europe. Between 2002 and 2007, the Irish Health Service Executive developed dedicated structures and staff to support the prevention, detection and management of elder abuse without mandatory reporting. Public awareness campaigns, staff training and management briefings heightened awareness regarding this new service. Central to this process is the development of a national database which could provide useful insights for developing coordinated responses to elder abuse in Europe.

Objective: to report the rate of referrals of elder abuse, patterns of elder abuse and outcomes of interventions related to a dedicated elder abuse service in the absence of mandatory reporting.

Methods: data on all referrals were recorded at baseline by a national network of Senior Case Workers dedicated to elder abuse, with follow-up conducted at 6 months and/or case closure. All cases were entered on a central database and tracked through the system. The study design was cross-sectional at two time points.

Results: of 1,889 referrals, 381 related to self-neglect. Of the remaining 1,508, 67% ($n = 1,016$) were women. In 40% ($n = 603$) of cases, there was more than one form of alleged abuse. Over 80% of cases referred related to people living at home. At review 86% ($n = 1,300$) cases were closed, in 101 client had died, 10% of these clients had declined an intervention. Cases are more likely to be open longer than 6 months if substantiated 36 versus 21% in the closed cases. Consultation with the police occurred in 12% ($n = 170$) of cases. The majority of clients (84% $n = 1,237$) had services offered with 74% ($n = 1,085$) availing of them. Monitoring, home support and counselling were the main interventions.

Conclusion: the number of reported cases of abuse in Ireland indicates an under-reporting of elder abuse. The classification of almost half of the cases as inconclusive is a stimulus to further analysis and research, as well as for revision of classification and follow-up procedures. The provision of services to a wide range of referrals demonstrated a therapeutic added benefit of specialist elder abuse services. The national database on elder abuse referrals provides valuable insight into patterns of elder abuse and the nature of classification and response. The pooling of such data between European states would allow for helpful comparison in building research and services in elder abuse.

Keywords: aged, elder abuse, elderly, neglect, reporting

Introduction

While there has been increasing international research on the prevalence and incidence of elder abuse, there has been little empirical research on referral and process patterns in Europe [1]. A better understanding of the presentation and outcome of referrals of suspected elder abuse on a national scale can be valuable in planning coordinated systems for the prevention, detection and management of elder abuse.

The development of a national elder abuse services in Ireland can provide insights into elder abuse referrals in a European country. Of 4 m inhabitants, 11% are aged over

65, and the number over 65s is set to treble by 2041. Elder abuse policy has been driven by key publications, including the first reports of elder abuse in the Irish medical and social literature in 1990 [2, 3] and a report from the government advisory group on ageing in 1998 [4] which recommended a government working group on elder abuse. This was established in 1999, and produced a policy document, Protecting our Future [5], in 2002. This recommended a framework and programme of work in relation to elder abuse in Ireland, and was adopted immediately by the Department of Health and Children (responsible for health and social services in Ireland), but not at wider governmental level. A unique feature of the

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recommendations from an international perspective was that these guidelines and policies were trialled in the field, re-evaluated, and then changed accordingly.

The 29 recommendations from *Protecting Our Future* [5] are grouped into 11 categories: context; policy; staffing of elder abuse services; legislation; awareness, education and training; financial abuse; advocacy; impaired capacity; research and education and reporting. An elder abuse implementation group was set up which strongly promoted a national database of referrals, and this was developed in 2007, with due regard to confidentiality and data protection. Central to the success of this service was increased awareness both in the general public and among staff which was targeted through media campaigns and dedicated training/awareness sessions.

The importance of accurate and uniform data is integral to the success of tracking trends in elder abuse [6]. Critical information includes characteristics of the victim and perpetrator (age and gender), type(s) of abuse and outcome data to determine the efficacy of interventions: this data can inform key stakeholders in the development of services focused on the prevention, intervention and advocacy for those at risk of elder abuse. The aim of this study was to catalogue the number of referrals of alleged elder abuse within a newly instituted national elder abuse network, the nature of the abuse, the linkages with other agencies and the outcomes of the assessments at 6 to 12 months after referral.

Methodology

In 2007 the health service in Ireland established a non-mandatory reporting system for elder abuse referrals, with 2008 representing the first full year of data collection. Dedicated staff at local (Senior Case Workers (SCWs)) and regional level (Dedicated Officers) are involved in the recording and collation of statistics.

All referrals of alleged/suspected elder abuse are recorded by the SCW employing unique identifiers to enable tracking of clients while maintaining anonymity. This records key characteristics on the client and alleged perpetrator. All forms are forwarded to the Dedicated Officers for validation, coding and inputting into MS Excel. A reassessment is completed, either on case closure or at 6-monthly intervals which records if cases are substantiated, documenting interventions along with the identification of any key health issues for the client and the alleged perpetrator (alcohol/drugs/dementia/intellectual disability etc). All cases were tracked through the system.

The only exclusion criterion for this study was referrals for self-neglect: these will be analysed in a subsequent paper. Subgroup analysis is provided on the cases that have been substantiated. Descriptive statistics were employed with multiple response and Chi-square analysis. National Census figures [7] were employed in the calculation of relative reporting rates.

Results

Of 1,889 referrals to the service in 2008, 381 cases related to concerns of self-neglect only and were excluded. Of the remaining 1,508, 67% ($n = 1,016$) were women. Public health nurses were the main source of referral (34% $n = 505$) followed by other health service staff (18% $n = 265$), family (13% $n = 201$) and hospital (12% $n = 174$) (Table 1).

There were 2,171 alleged abuse categories identified. Multiple response analysis indicated that psychological (29%), neglect (22%), financial (19%) and physical abuse (15%) were the most common alleged abuse types reported. In 36% of referrals more than one type of abuse was alleged underlying the complexity of elder abuse cases. Where two or more types of abuse were reported, the most frequent combinations were psychological and financial (20%) followed by neglect and self-neglect (19%).

Chi-square analysis using Cramer's V found a significant association between gender and alleged abuse type (Chi-square: 8.27, 4 df, $P < 0.05$). In the case of sexual and psychological abuse, the alleged victim was likely to be female by a larger margin: sexual abuse (female 75%: male 25%) and psychological (female 73%: male 27%).

The referral rate/1,000 population over 65 years indicated that there were three times as many referrals for the over 80 years (5.84/1,000 population +65 years) compared with those 65–79 years (2.09/1,000 population +65 years): 47% ($n = 660$) of investigated cases related to victims aged 80 years or older. The age profile was older for neglect (52% aged 80 or older) and younger for alleged sexual abuse (20%) and discriminatory abuse (14%).

The majority of cases relate to older people living in their own home (82%). In 94% of cases, the alleged abuse took place in the older person's place of residence. Most cases report just one alleged perpetrator, specifically son/daughter (43%), partner (17%) and other relative (19%). In 53% of cases the alleged perpetrator lives with the client.

Follow-up

Of 1,508 cases, 1,418 (94%) had been subject to a review either at 6 months or on case closure. A total of 86% ($n = 1,300$) of cases were closed, of which 23% ($n = 322$) were substantiated, in 32% ($n = 459$) abuse was found not to have taken place and 45% ($n = 673$) were deemed inconclusive. Interventions were provided regardless of case outcome. Excluding psychological abuse, physical abuse was more likely to be substantiated, neglect least likely to be substantiated and financial abuse most likely to be labelled inconclusive.

Issues and interventions for client

Consultation with the police took place in 12% ($n = 170$) of cases with 10% ($n = 150$) resulting in a formal referral to the police. Some level of legal consultation

National profiling of elder abuse referrals

took place in 130 cases (9%) with 60 (4%) proceeded to legal action, predominantly barring and safety orders. Services were offered to 84% of referrals ($n = 1,237$) with 74% ($n = 1,085$) availing of them. Monitoring, home support and counselling were the three commonest interventions (Table 2).

At least one possible/suspected health issue was identified by the SCW in 862 cases (57%), predominantly physical and mental health factors/dementia (Table 2). A health issues was identified in 30% ($n = 455$) of alleged perpetrators, most commonly mental health and alcohol issues, with (16%) reporting carer stress or intellectual disability.

Table 1. Referral characteristics

Variables	<i>n</i>	%
Gender ($n = 1,500$)		
Male	484	32
Female	1,016	67
Age ($n = 1,402$)		
<65 years	76	5
65–79	666	48
80–89	539	38
90+	121	9
Reasons for referral ($n = 2,171$)		
Alleged physical abuse	318	15
Alleged sexual abuse	36	2
Alleged psychological abuse	632	29
Alleged financial/material abuse	416	19
Alleged neglect/acts of omission	480	22
Alleged self-neglect	147	7
Alleged discrimination	28	1
Other	114	5
Place of Residence ($n = 1,503$)		
Own home	1,231	82
Relatives home	71	5
Private nursing home	86	6
Boarding out	24	1
Public continuing care	32	2
Other (ACUTE)	59	4
Who referred ($n = 1,500$)		
Self	69	5
Family	201	13
Public health nurse	505	34
GP	56	4
Carer/home help	94	6
Hospital	174	12
Other HSE staff	265	18
Gardaí	11	1
Voluntary/statutory agencies	50	2
Other	75	5
Location of alleged abuse ($n = 1,484$)		
Place of residence	1,396	94
Day care	6	0.4
Unknown	24	1.6
Other	58	4
Person allegedly causing concern ($n = 1,423$)		
Son/daughter	620	44
Partner/husband/wife	248	17
Other relative	170	12
Neighbour	53	4
Caret/Staff	49	3.4
Other service user	22	1.5
Volunteer	2	0.1
Other	111	8
Is person(s) allegedly causing concern living with the older person ($n = 1,358$)		
Yes	715	53
No	532	39
Sometimes	69	5
Do not know	42	3
Gender of person allegedly causing concern ($n = 1,254$)		
One male	627	50
One female	450	35.9
One male and one female	116	9.3
Two males	23	1.8
Two females	21	1.7
If three or more persons causing concern		
Mostly male	7	0.6
Mostly female	6	0.5
Even no. of males and females	4	0.3

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Substantiated cases

Of the 322 substantiated cases further information was available on 262 (81%). The majority of cases 65% ($n = 171$) involved just one abuse type with 29% ($n = 75$) involving two. In cases involving one abuse type, psychological ($n = 71$), physical ($n = 41$), neglect ($n = 31$) and financial ($n = 26$) abuse were documented. Where two abuse categories were confirmed, psychological abuse was a component of the two predominant categories: psychological/financial ($n = 36$) and psychological/physical ($n = 22$).

Table 3 illustrates the key characteristics in relation to these top four substantiated abuse categories. Adult children are most likely to be the perpetrators for all types, with spousal abuse least likely in relation to financial abuse.

Carers were a significant group in terms of financial abuse. Additionally, perpetrators were least likely to reside with the clients in cases of financial abuse or neglect.

Discussion

In a newly developed national framework for elder abuse assessment, the referral rate of elder abuse represents only a small proportion of the likely total number of cases. International research suggesting incidence rates between 1 and 5% [3] extrapolates to an incidence from 4,670 to 24,350 in an Irish context. This data needs to be contextualised in that it only represents

Table 2. Summary of findings at 6-month follow-up

	Variables	<i>n</i>	%
Status of case ($n = 1,506$)	Ongoing	206	14
	Closed (including client deaths)	1,300	86
Case outcome ($n = 1,454$)	Allegation substantiated	322	23
	Not substantiated	459	32
	Inconclusive	673	45
Police consultation ($n = 1,477$)	Yes	170	12
	No	1,307	88
Police notification ($n = 1,477$)	Yes	150	10
	No	1,327	90
Legal action ($n = 1,471$)	Yes	60	4
	No	1,411	96
Legal action defined ($n = 64$)	Ward of court	9	15
	Domestic violence act	20	33
	Nursing home act	8	13
	Other	27	45
Services offered ($n = 1,475$)	Yes	1,085	74
	No	238	16
	Offered but declined	152	10
Client interventions ($n = 2,391$)	Monitoring	494	20.7
	Home support	453	19
	Counselling/support	430	18
	Day care	97	4
	Respite care	250	10.5
	Long-term care	263	11
	Advocacy	92	3.8
	Mediation/conflict resolution	49	2
	Referred to other service	263	11
	Police action	70	12
	Support offered	306	51
Disciplinary action	Disciplinary action	24	4
	Service offered by declines	92	15
	Referred to other service	110	18
	Drugs	21	4
	Alcohol	181	31
Issues for person causing concern ($n = 586$)	Physical	76	13
	Intellectual disability	10	2
	Mental health	204	35
	Other	94	16
	Drugs	3	0.3
	Alcohol	85	8
	Physical	438	41
Issues for client ($n = 1,068$)	Intellectual disability	22	2.1
	Dementia	126	11.8
	Mental health	292	27.3
	Other	102	9.6

National profiling of elder abuse referrals

referrals to a specialist elder abuse service in the health service. It does not measure all elder abuse concerns in Ireland, for example, those that come to the attention of other professional services including the police. Additionally this service is in its infancy, it is anticipated that referrals will increase as awareness both within the health services and in the general public enhances.

The low rate of reporting may also be influenced by our system of non-mandatory reporting [5]. The National Incidence Study in the United States [8] determined that for every case reported and substantiated a further five are not, highlighting the under-reporting of elder abuse even with mandatory reporting.

Our findings are consistent with international evidence that elder abuse is most often perpetrated by a family member either an adult child, spouse or other relative with women more likely to be victims [9–11]. Although household surveys show that spouses are more likely to abuse [12, 13] by adult children is reported most often [8, 14]. Abuse is more likely to occur in a shared living situation [15–17], but this trend is reversed in financial abuse where victims are more likely to live alone [18] concurred in this study.

The profile of physical health of clients accords with research which has shown that older people in poor health and who have functional limitations are at heightened risk [19, 20]. Mental health/dementia emerged as the most consistently reported dimension of vulnerability. The

perpetrator profile is consistent with international research which has shown that perpetrators are likely to have mental health and substance abuse problems [12, 21–25].

The principal sources of referral within this study are public health nurses and other healthcare staff. This trend contrasts with US research [14, 26] where the most common reporters of elder abuse were family members, social services staff, friends and neighbours with medical staff (nurses, home health staff, doctors) constituting less than 5% of total reports. This reflects the positive outcome of targeted training provided to healthcare staff. Additionally, it is evidence of the central role public health nurses play in the interaction between the general public and the health service. While individuals may not be aware of the existence of SCWs, it is clear that they refer their concerns to the public health nurses.

The substantiation rate within this study of 23% is significantly lower than has been found in US studies—the 2000 [26] and 2004 surveys of Adult Protection Services reported a substantiation rate of 48 and 46%, respectively—but consistent with at least one European survey where the substantiation rate was 26% [27]. In the case of physical abuse, there is greater likelihood of substantiation than for other abuse types and it is more likely to be perpetrated by males. The high rate of inconclusive outcomes has been documented in another official report on elder abuse services [19] but does not seem to have figured as yet in the research literature. The introduction of classifications such as ‘Unlikely on balance of probability’ and ‘Likely on balance of probability’ may prove more a more flexible, and clinically useful form of defining categories of outcome. However, some reassurance can be gained from the high level of referral for services, regardless of classification of outcome. The SCW role is to ameliorate the situation and to improve factors affecting the client adversely and not exclusively focused on determining if abuse is substantiated.

Even at this initial stage these data are informing policy development and awareness campaigns. Specifically findings in relation to financial abuse have led to an awareness/media campaign. Evidence illustrating the extent of abuse occurring in the home and community settings has led to the development and national distribution of an elder abuse community awareness DVD.

Further development of this referral database will be required, and in particular inclusion of measures of quality-of-life and empowerment, and the establishment of clear criteria for measurement of take up of services. It is intended to agreed criteria for case outcome determination, a by-product of which would be a reduction in the number of inconclusive outcomes. It is also intended to establish more precise criteria for the closure of cases. This would inter alia contribute to more precise objective responses. It would also be appropriate to focus on the reliability and validity of our data collection tool to minimise subjectiveness of responses. The continued collection of consistent national data over time will provide invaluable trend

Table 3. Profile of characteristics of perpetrators and abuse type in substantiated cases 2008

	Abuse type			
	Psychological component	Physical component	Financial component	Neglect component
No. of cases substantiated ^a	161	106	73	82
Perpetrator (%)				
Son/daughter	49	48	47	42
Spouse	21	23	5	11
Other	16	18	21	12
Relative				
Carer			15	
Gender of perpetrator ^b (%)				
One male	57	59	51	42
One female	27	35	34	44
One male and one female		1	7	10
Living with client (victim) (%)				
Yes	65	66	51	45

^aThis documents all substantiated abuse types individually therefore the total exceeds the case number as there is a certain level of overlap where more than one abuse type was substantiated.

^bNote category does not add up to 100% as variations involving three or more perpetrators are documented on forms but not included in this table.

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information on elder abuse in a European context and ultimately guide us in tackling this problem.

Key points

- A national database of referrals of suspected elder abuse and neglect can provide valuable insights into elder abuse patterns and reporting and assess progress being made.
- Such prospectively collected data is informing policy development and awareness campaigns, specifically a media campaign focused on financial abuse is being developed along with a community awareness DVD.
- A significant number of cases are found to be inconclusive but appear to indicate concerns over vulnerability which prompt health and social care interventions.

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