Abuse and Neglect of Older People in Ireland

REPORT ON THE NATIONAL STUDY OF ELDER ABUSE AND NEGLECT




NOVEMBER 2010

C. Naughton, J. Drennan, M.P. Treacy, A. Lafferty, I. Lyons, A. Phelan, S. Quin, A. O'Loughlin, L. Delaney

UCD DUBLIN

NCPOP
National Centre for the Protection of Older People

HSE
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

This study was funded by the Health Service Executive as part of the work of the National Centre for the Protection of Older People (NCPOP) at University College Dublin.

This report should be cited as Naughton, C., Drennan, J., Treacy, M.P., Lafferty, A., Lyons, I., Phelan, A., Quin, S., O'Loughlin, A., Delaney, L. (2010) Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect. University College Dublin.

National Centre for the Protection of Older People
UCD School of Nursing, Midwifery and Heath Systems

Health Sciences Centre
University College Dublin
Belfield, Dublin 4, Ireland

Tel: +353 (0)1 716 6467 Fax: +353 (0)1 716 6498
Email: *ncpop@ucd.ie* Web: *www.ncpop.ie*

Acknowledgements

The research team would like to acknowledge and thank the following for their contribution to the study:

- The older people who participated in the pilot and main survey. Without their openness and engagement the work would not have been possible
- The NCPOP International Advisory Committee comprising Professor Simon Biggs, King's College London; Dr. Isabel Iborra Marmolejo, Queen Sofia Centre for Studies on Violence, Valencia, Spain; Professor Karl Pillemer, Cornell Institute for Translational Research on Aging, Cornell University. Their knowledge and expertise made this study possible within the timeframe
- The Health Service Executive (HSE) which funds the NCPOP and the programme of research of which the survey is part
- The support for this work provided through the NCPOP HSE Steering Committee and the NCPOP HSE Management Group
- Professor Hannah McGee, Royal College of Surgeons in Ireland and Dr. Dorothy Watson, Economic and Social Research Institute, Dublin for advice at the development stage of this survey
- Mr. Tim Grant, CSTAR for statistical advice at the planning and analysis stage of the study
- Participants from the Third Age Foundation, Summerhill Community Group who took part in a face-to-face cognitive interviewing process which contributed to the development of the questionnaire
- Members of the NCPOP User Group for their engagement with this survey and the work of the Centre. Membership includes Age Action Ireland, Care Alliance Ireland, COSC, Friends of the Elderly, Irish Banking Federation, Law Reform Commission, National Disability Authority, Office for Older People, Older and Bolder, The Health Information and Quality Authority, Third Age Foundation and a number of older people
- The Amárach team for assistance with data collection and the interviewers for their persistence and sensitivity in conducting the interviews
- Ms. Catherine Tormey, NCPOP Administrator for her untiring assistance

Table of Contents

Chapter 4: One Year Prevalence of Mistreatment

Chapter 5: Perpetrator Characteristics

Chapter 6: Impact of Mistreatment

Table of Contents

List of Tables

List of Figures

List of Abbreviations

ADL	Activities for Daily Living
CSO	Central Statistics Office
DoHC	Department of Health and Children
ED	Electoral Division
HSE	Health Service Executive
MCS	Mental Composite Score (SF-8)
NCAOP	National Council on Ageing and Older People
NCPOP	National Centre for the Protection of Older People
PCS	Physical Composite Score (SF-8)
SCW	Senior Case Worker
SF-8	Short Form 8
UCD	University College Dublin
UN	United Nations
WHO	World Health Organisation

Introduction

The abuse and mistreatment of older people has existed throughout the ages but its formal recognition as a societal problem requiring dedicated action has only occurred over the last 20 to 30 years. The mistreatment of older people is now viewed beyond isolated family violence and is identified as a human and civil rights issue in its own right (World Health Organisation 2002). In order to address elder abuse effectively as a societal problem within Ireland the extent to which older people are experiencing abuse and neglect needs to be identified. This study addresses that need and is the first to measure the prevalence of abuse and neglect of older people in Ireland.

The survey focused on community-dwelling older people's experiences of abuse or neglect, and provides information on the type, frequency and impact of mistreatment on older people. It also outlines a profile of demographic, socio-economic, health and social support characteristics of those who have experienced mistreatment compared to people who have not, and includes a profile of those who were identified as perpetrators of mistreatment.

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 (World Health Organisation 2002).*

The current study into the prevalence of elder abuse and neglect in Ireland broadly adopted the World Health Organisation (WHO) definition in identifying abuse in community-dwelling older people aged 65 years and older. Adopting the WHO definition of elder abuse facilitated comparison with previous international surveys completed in the United Kingdom, Spain, Israel and the United States. The study captured data on older people's experiences of physical, psychological, financial and sexual abuse, and neglect within interfamily relationships, by care workers or close friends, and also by those in the wider community (neighbours and people distantly known to the older person), and by strangers.

The estimated prevalence of elder abuse reported in international studies varies widely with the lowest reported prevalence rate in Spain (0.8%), for family abuse (Marmolejo 2008), and the highest rate in Israel, at over 18%, rising to 35% when neglect was included (Lowenstein et al. 2009). The majority of studies have measured four types of mistreatment (physical, psychological, financial abuse and neglect). Sexual abuse has only been explicitly examined in three studies and contributed less than 1% to the overall prevalence rate.

Previous research has identified a number of risk factors for elder abuse. Physical impairment and dependence on others for assistance with activities of daily living are the most consistently identified risk factors, followed by older people co-habiting with family and being socially isolated. There is also some evidence that being female, of advanced age and lower socio-economic status may be risk factors.

A number of adverse consequences of the abuse of older people have been identified in the literature including premature mortality (Lachs et al. 1998), increased experiences of fear and grief (Comijs et al. 1998), anger and upset, and isolation from family and friends (O'Keeffe et al. 2007). Furthermore, abuse resulted in older people experiencing emotional distress, and loss of self-confidence and self-esteem, while more significant psychological impact, such as depression and thoughts of suicide or self-harm were associated with longer-term and more severe abuse (Mowlam et al. 2007). A key theme emerging in the qualitative literature is the lasting effects of violence on older people. Some older people who have been abused described their experiences as 'devastating' with many feeling they would never fully recover (Mears 2003).

Aims and Objectives

With the support of the Health Service Executive, the National Centre for the Protection of Older People (NCPOP) undertook a national prevalence survey of elder abuse in Ireland to provide statistics on overall rates of abuse and individual types of abuse experienced by older people. The study focused on community-dwelling older people and excluded those living in residential settings.

The objectives of the study were to identify in community-dwelling people aged 65 years and older:

1) The prevalence of overall abuse and individual types of abuse in the previous twelve months, within the context of those in a 'position of trust' (family, care workers, close friends), the wider community (neighbours, people distantly known to the older person), and strangers.
2) The prevalence of overall and individual types of abuse since the age of 65 years, perpetrated by people in a 'position of trust' and the wider community.
3) The demographic, socio-economic, health and social support characteristics of people who have experienced abuse, compared with those who have not.
4) The profile of perpetrators of abuse as described by older people who have experienced abuse.
5) The impact of abuse and how older people responded to these experiences

Operational Definition

This study focused on five forms of elder abuse perpetrated by those in a 'position of trust' (e.g. a family member, close friend or care worker) in the previous 12 months. These included:

Physical abuse: One or more incidents of physical abuse (e.g. slapped, pushed, physically restrained).

Psychological abuse: Ten or more incidents of psychological abuse (e.g. insulted, threatened, excluded), or any incident that had a serious impact on the older person.

Financial abuse: One or more incidents of financial abuse (e.g. stolen money or possessions, forced to sign over property).

Sexual abuse: One or more incidents of sexual abuse (e.g. talked to or touched in a sexual way).

Neglect: Ten or more incidents of neglect (e.g. refusal or failure of carer to help with activities of daily living such as shopping, washing or dressing), or any incident that had a serious impact on the older person.

The findings in this report are primarily based on this operational definition of elder abuse and neglect. However, results based on broader definitions, examining mistreatment since age 65 years, and within the wider community are also presented.

In this report the term abuse is reserved for physical, sexual, financial and psychological experiences. Neglect is not included under this general term as in the majority of cases older people did not perceive the deficits in their care as acts of abuse. The term mistreatment is used to refer to all five types. Interpersonal abuse is the term used to collectively describe psychological, physical and sexual abuse.

Methods

This survey focused on community-dwelling older people's experiences of mistreatment. People aged 65 years and older were interviewed in their own home between April and May 2010 using face-to-face interviews. All the interviewers were older women and all interviews were conducted in private with the older person.

In order to obtain an accurate estimate of the level of elder abuse, it was calculated that 2,000 completed interviews were required. To ensure a nationally representative study population, a multi-stage cluster random probability sample was used, with quota controls for age and gender. The first stage was to stratify the population into seven regions. The number of clusters in each of the seven regions was calculated to be proportional to the number of persons aged 65 years and over in each region, based on 2006 census data (CSO 2007a). The cluster boundary was taken to be an Electoral Division (ED). A total of 150 EDs were selected with a target of 14 individual interviews in each ED. A random route finding methodology with a randomly selected starting address was used within each ED to identify households with an eligible older person. Quota sampling was used to obtain a representative sample of older people in relation to age and gender. The quota controls were stratified into male and female, and three age groups: 65-69 years, 70-79 years, and 80 years or older.

The questionnaire used in the survey examined the following areas:

- Socio-demographics
- Social support
- Health and functional status
- Incidents of financial, physical, psychological and sexual abuse, and neglect
- Impact and reporting of mistreatment
- Perpetrator characteristics

Findings

Completed interviews were conducted with 2,021 older people, giving a response rate of 83%. The characteristics of the survey population were compared to the 2006 census data (CSO 2007a) and the Survey of Lifestyle, Attitudes and Nutrition in Ireland, SLÁN 2007 (Morgan et al. 2008).

Thirty-seven percent of the study population lived in a rural location (population <1500), just over 20% lived in Dublin city or county, and the remaining respondents lived in a small, medium or large urban setting. The vast majority of the sample were identified as white Irish (98%). The remainder described themselves as Irish travellers (0.25%) or from other backgrounds (1.4%), mainly 'other white non-Irish'. The majority of the study population were women (55%) and 45% were men. The mean age of the study population was 74 years, with ages ranging from 65 to 98 years. The age and gender profile of the study population closely matched that of the national population (CSO 2007a). Over 40% of participants lived alone with slightly more women than men in this group. Approximately 36% lived with a spouse or partner and the remaining 20% lived in intergenerational households or with extended family.

Forty-five percent of participants described their general health as good or excellent and 5% described their health as poor or very poor. The level of reported poor health was similar to that in the SLÁN 2007 survey (Morgan et al. 2008). Eighteen percent of participants indicated that they needed regular help with activities of daily living such as shopping, preparing meals and transport. Four percent required regular help with personal care activities such as washing, using the toilet or mobilising. Four percent of people aged 65 years or older provided regular help and care for a dependent, and a further 3% of participants indicated that their primary carer was aged 65 years or older.

In this study population, 59% of people felt they received high levels of support within their communities and 91% felt well supported by their families. Five percent felt they had poor community support and 2.5% felt they had poor family support. Men tended to report lower levels of support than women.

Prevalence of Elder Abuse and Neglect

The overall prevalence of mistreatment in the previous 12 months was 2.2%. Applying these statistics to the general population of people aged 65 years or older (CSO 2007a), the number of older people who have experienced mistreatment is estimated at 10,201.

In the previous 12 months, financial abuse at 1.3% was the most frequent type of abuse reported, followed by psychological abuse (1.2%), physical abuse (0.5%), and neglect (0.3%). Sexual abuse at 0.05% was the least common type of reported abuse. In relation to financial abuse, the most frequently reported behaviour was being forced to give money or property to someone in a position of trust. The most frequent types of psychological abuse reported included verbal insults, followed by being excluded, undermined and threatened verbally. The majority of the physical abuse reported related to being pushed, followed by being threatened or hit with an object, kicked, and denied access to equipment such as a walking or hearing aid, or being restrained.

Clustering of Mistreatment

Twenty-five percent of the sample who reported that they had been mistreated in the last 12 months experienced more than one type of mistreatment and 14% experienced three or more types of mistreatment. In particular, psychological abuse was likely to accompany other forms of abuse such as physical abuse, financial abuse or neglect.

Demographic Characteristics of People who Reported Mistreatment

Women (2.4%) were more likely than men (1.9%) to report experiences of mistreatment in the previous 12 months, in particular financial and interpersonal abuse. People aged 70-79 years and aged 80 years or older experienced similar levels of overall mistreatment, double that of people aged 65-69 years. Those aged 70-79 years experienced more interpersonal abuse, while financial abuse was more common in the other two age groups. Financial abuse increased for both men and women in the 80 years and older age group.

Overall, the highest level of mistreatment occurred in people who were divorced or separated. People who were widowed had the second highest risk of mistreatment, while older people who were single (never married) reported the lowest level of mistreatment.

The highest levels of mistreatment (3.4%) occurred in intergenerational households or complex household structures where the older person(s) shared the house with an adult child and their family or other relatives, compared to 1.9% for older people living alone or with a spouse/partner.

Socio-economic Characteristics of People who Reported Mistreatment

There was an inverse relationship between level of mistreatment and level of education. Higher levels of mistreatment were reported by those who had lower levels of education, with the lowest level of mistreatment occurring in older people who had degrees or higher awards. This trend was particularly evident for women.

As with level of education there was an inverse relationship between level of overall mistreatment and weekly income. People living on less than €220 per week reported the highest level of mistreatment, followed by those living on €220-€438 per week. There was a significant decrease in the levels of mistreatment in the higher income groups.

Lower socio-economic status was also associated with higher levels of mistreatment. Older people in the skilled manual, or semi-skilled/unskilled/never worked social classification experienced higher levels of mistreatment compared to the professional/managerial or non-manual social groups.

Health and Service Use of People who Reported Mistreatment

There was a distinct trend in relation to self-reported health status and prevalence of mistreatment, with increased levels of mistreatment related to decreasing levels of health. Respondents in the 70-79 years age group who identified their health as poor or very poor reported the highest prevalence of mistreatment. Measures of physical and mental health using the Short Form 8 (Ware et al. 2001) showed a similar pattern. Older people with below average physical health scores were over three times more likely to report mistreatment, while those with below average mental health scores were nearly six times more likely to report mistreatment.

All participants who experienced mistreatment had accessed some kind of formal health or social service within the previous six months. By far the most likely point of 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. Over three quarters of older people who experienced mistreatment had high frequency contact with their GP (>two visits in six months). People who had disclosed mistreatment were also significantly more likely to contact additional health or social services compared to participants who had not experienced mistreatment

Social Support Characteristics of People who Reported Mistreatment

Older people with poor levels of community support were over four times more likely to report mistreatment compared to those with strong levels of community support. Women with poor community support were particularly vulnerable to interpersonal and financial abuse. People who reported poor or moderate levels of family support were over three times more likely to report mistreatment compared to those with strong family support.

Perpetrator Characteristics

Older people who reported acts of mistreatment most frequently identified adult children as perpetrators (50%), followed by other relatives (24%), and a spouse/partner (20%). Adult children were equally likely to be implicated in financial and interpersonal abuse, while spouse/partners were more frequently involved in interpersonal

abuse. Those identified as 'other relatives' were more likely to be involved in financial abuse. People aged between 30 years and 64 years were most frequently identified as perpetrators of abuse, however younger adults or teenagers and older adults (≥65 years) were also identified. Particular risk factors were living with the perpetrator (37%), the perpetrator being unemployed (51%) and the perpetrator abusing alcohol (19%).

Impact of Mistreatment

The vast majority of older people who reported mistreatment identified physical and financial abuse as having a serious impact on their lives. Between 50% and 58% of people who reported neglect or psychological abuse also described the impact as serious, with the remainder identifying the impact as moderate. When clustering of mistreatment is taken into account, 84% of this population felt their experiences of abuse or neglect in the last 12 months had a serious impact on them, with 14% describing the impact as moderate.

Over one third of participants did not report the abuse or neglect to anyone. In the case of people who did report mistreatment, other family members were the most likely people to be told about the abuse (41%), followed by a GP (11%). In 9% of cases the police were told about the abuse. A quarter of those who reported abuse stated that mistreatment was ongoing at the time of the survey.

Mistreatment Since 65 Years

Broadening the definition of mistreatment to include any episode of financial, physical, sexual, psychological abuse, or neglect since 65 years, perpetrated by a person in a position of trust, the reporting of mistreatment nearly doubled to 4%. This would indicate that since the age of 65 years up to as many as 18,764 older people have had experiences that were potentially abusive.

Examining the types of mistreatment using this broader definition, a different pattern emerged compared to the 12-month prevalence rate. Psychological abuse was the most prevalent type of mistreatment at 2.4%, with nearly double the number of people identified. Financial abuse was the second most common type of mistreatment at 1.4%, but there was only a marginal increase compared to the 12-month prevalence. Neglect was the third most common type of mistreatment at 1.2%, and had the largest increase in numbers of people identified compared to the 12-month prevalence. There was a slight increase in physical abuse (0.7%), and there remained a single episode of sexual abuse. The prevalence of interpersonal abuse was 2.6%, emphasising the clustering of these types of abuse.

Mistreatment Within the Wider Community

Including neighbours and acquaintances as perpetrators in a 12-month definition of elder mistreatment, the prevalence rate increased to 2.9%. Neighbours and acquaintances were implicated in 26% of the reported incidents, placing them second to adult children as the most frequent perpetrators of mistreatment. Psychological abuse (29%) was most commonly identified in relation to neighbours/acquaintances, followed by physical abuse (28%) and financial abuse (17%).

The inclusion of strangers increased the mistreatment prevalence rate to 3% in the previous 12 months. However, even allowing for mistreatment by neighbours/acquaintances or strangers the majority of older people experienced mistreatment by people close to them.

Conclusion

Using an international definition of elder abuse (WHO 2002), 2.2% of the study population experienced abuse or neglect in the previous 12 months. When extrapolated to the general population, this equates to 10,201 older people. Patterns of mistreatment varied between men and women and across the different age groups. Overall, women reported higher levels of mistreatment than men. With regard to age, men aged 80 years and older reported the highest levels of mistreatment, mainly financial abuse, while women in the 70-79 years age group reported the highest levels of mistreatment, mainly interpersonal abuse.

Socio-economic markers and health status were strongly correlated with prevalence of mistreatment, as was level of community and family support. Although there were identifiable risk factors, the mistreatment of older people was spread across all social groups and health status.

The 12-month prevalence rate of elder abuse and neglect identified in this study is relatively low but is similar to the prevalence estimates obtained in other studies, especially the UK study (2.6%) (O'Keeffe et al. 2007). The characteristics of the older people at higher risk of mistreatment, and the perpetrator characteristics identified in this study have also been reported in other studies.

This study, combined with international research and in-depth qualitative work on older people's and practitioners' experiences, can help to plan the way forward to address and manage elder abuse. Elder abuse and neglect are the potential outcomes of complex interactions between a multiplicity of social, economic, health, social isolation, education, environmental and possibly individual personality characteristics. Rarely is the mistreatment related to a single isolated factor. The interaction or mediating effects of multiple factors as identified in this study makes it clear that no single government department or social service will be effective in reducing the annual incidence of elder mistreatment. The response needs to be multifaceted, targeting early risk factors with an emphasis on prevention, and later risk factors with a focus on resolving the mistreatment. The responsibility is shared across the whole of society including individual older people, families, communities, health and legal professionals, voluntary organisations, the media, policy makers, legislators, education, health, social and housing services, financial organisations, employers, academic and social policy institutes.

1.1 Background

The abuse and mistreatment of older people has existed throughout the ages but its formal recognition as a societal problem requiring dedicated action has only occurred over the last 20 to 30 years. Internationally, societal and political responses to elder abuse are varied. Some developed world countries see it as a unique and distinct phenomenon and respond with dedicated policies, legislation and services. Others treat it as a dimension of family conflict and domestic violence, as primarily a health related problem, or within the broad framework of protection of vulnerable adults (Podnieks et al. 2010a). Moreover, many developing world countries do not actively recognise the phenomenon, resulting in a lack of policy and services to respond to cases of elder abuse (Podnieks et al. 2010b).

An initial first step for many countries is to define their view of what constitutes elder abuse and then to estimate the extent of the problem through conducting prevalence or sentinel studies. In order to address elder abuse effectively as a societal problem within Ireland the extent to which older people are experiencing abuse and neglect needs to be identified. This study addresses that need and is the first to measure the prevalence of abuse and neglect of older people in Ireland.

1.2 Report Layout

Chapter 1 provides an overview of elder abuse within Ireland in relation to population characteristics, policy, legislation and services. A definition of elder abuse is discussed and the results from recent international prevalence studies are presented. Finally the aims and objectives of this study are set out. Chapter 2 presents the operational definition of elder abuse used in this study and describes how the abuse and neglect constructs were operationalised. An overview of the methodology, sampling frame, fieldwork and study response rate is also included. Chapter 3 describes the study population and compares it to the general population 2006 census statistics from the Central Statistics Office (CSO 2007a) and data from a Survey of Lifestyle, Attitudes and Nutrition in Ireland (Morgan et al. 2008). Chapter 4 presents the data on one year prevalence of abuse or neglect perpetrated by people in a position of trust. Chapter 5 describes the characteristics of the perpetrators of abuse, while Chapter 6 examines the impact of the mistreatment on the older person and the outcomes in terms of actions to prevent the abuse recurring. Chapter 7 looks at alternative definitions of abuse including the prevalence of abuse since 65 years, and the prevalence of abuse when the definition is extended to include neighbours, people distantly known to the older person (acquaintances) and strangers. The final chapter discusses the implications of the results and suggests future developments in this field.

1.3 Elder Abuse in the Irish Context

1.3.1 Population

Ireland, similar to many developed world countries, has seen a rapid growth in its older population largely due to the success of public health campaigns, a rise in living standards and improvement in health and social care provision (Tussing and Wren 2006). In less than 100 years the average life expectancy in Ireland has increased from 57.6 years in 1926 to 79.2 years in 2006, a gain of approximately 22 years (CSO 2007a). In the latest Census carried out in 2006, 11% (467,926/4,239,848) of the population was aged 65 years or older and 2.7% were aged 80 years or older (CSO 2007a).

There is a tendency to presume a direct relationship between growth in the older population and a rise in the prevalence of elder mistreatment but there is no data to support this assumption (O'Loughlin and Duggan 1998, Perel-Levin 2008). The assumption is based on observations identifying an increase in the prevalence of risk factors associated with different types of abuse. The ageing process can result in an increase in frailty or dementia leading to a higher dependency and/or cohabiting with family members. Such changes in physical or mental health have been associated with neglect and psychological or physical abuse, while frailty, social isolation or living alone are linked to financial abuse (Pillemer and Finkelhor 1988, Lachs and Pillemer 2004, Biggs et al. 2009).

A report from the Central Statistics Office (CSO 2007b) on *Ageing in Ireland* suggests many of these characteristics may be increasing among the older population in Irish society. The level of overall disability among the 65 years and older age group was 30% in 2006, with a significant increase with increasing age, ranging from 19% in the 65-69 years age group to 59% among the 85 years and older age group (CSO 2007b).

This may be correlated with a 44% increase between 2000 (n=1839) and 2005 (n=2953) in the proportion of the population aged 65 years or older who received a 'carers' allowance as they took on the caring role for a debilitated spouse or parent (CSO 2007b). In terms of living arrangements, 20% of people aged 65-69 years lived alone but this steadily increased to 35% for those aged 80-84 years, dropping to 31% for those aged ≥85 years (CSO 2007b). These population trends are likely to continue but their relationship to the prevalence of elder abuse is unknown.

1.3.2 Irish Policy

There is no single cohesive policy or strategy in relation to welfare, protection and provision for older people in Ireland. Instead the older population are mentioned explicitly or implicitly in policies dealing with broad topic areas such as health, pensions, nursing home payment, nursing home regulation, and crime prevention. The primary focus of Irish policy related to the older person is health. The Department of Health and Children (DoHC) has issued various health strategies including the national strategy to promote healthy ageing, entitled *Adding Years to Life and Life to Years* (DoHC 1998), and general population health strategies, namely *Quality and Fairness – A Health System for You* (DoHC 2001a) and *Primary Care – A New Direction* (DoHC 2001b). The latter strategies do not single out older people for special consideration but rather 'describes the implications of the general health care system for older people' (O'Shea 2006: 95).

Similarly older people and elder abuse are not specifically identified in policies dealing with security and policing. Police statistics on crime do not recognise elder abuse as a distinct classification. Crimes against older people are reported under general categories such as burglary, theft or assaults. In the recent White Paper, *Crime Prevention and Community Safety* (Department of Justice, Equality and Law Reform 2009), elder abuse is not considered as a separate entity. Older people are mentioned in a single place in the document, in the context of vulnerable adults. At an operational level the Garda Síochána currently do not have specific policies, guidelines or training on elder abuse but there is ongoing collaboration between the Garda Síochána and the Health Service Executive (HSE) to develop such policies.

The first formal political recognition of elder abuse in Ireland came with the publication of the *Protecting Our Future* report in 2002 (Working Group on Elder Abuse 2002). The working group was established by the DoHC in response to the publication of an earlier report on the abuse and neglect of older people (O'Loughlin and Duggan 1998). *Protecting Our Future* has acted as a blueprint, directing the government response to elder abuse over the last decade. The Elder Abuse National Implementation Group was established in 2003 to advise on and monitor the implementation of the report's recommendations, and since 2007 the HSE has made progress in the implementation of the basic tenets of the report (HSE 2010).

A recent independent evaluation of the implementation of the recommendations of *Protecting Our Future* acknowledged the substantial contribution the report and the National Implementation Group have made to developing services to protect older people in Ireland (National Council on Ageing and Older People [NCAOP] 2009). However, the authors identify an urgent need for comprehensive and responsive strategies and policies to protect and meet the needs of an ageing population. The Department of Health and Children (DoHC) is currently engaged in consultation and development of a National Positive Ageing Strategy to support older people's participation in society, and their health and well-being. The policy aims to have far reaching implications for older people in terms of equity and equality but from the outset there is a reluctance to commit to any new service development or allocate specific funds for the implementation of the strategy (DoHC 2009).

1.3.3 Irish Legislation

Legislation relating to elder abuse in Ireland is dispersed across a number of legislative pieces and laws dealing with specific topics. A recent overview of Irish legislation with relevance or implications for elder abuse was compiled by the National Centre for the Protection of Older People (Lyons et al. 2009). In Ireland the overarching principles of protection are enacted through human rights legislation and were recently updated through the *Human Rights Commission Acts* (Department of Justice, Equality and Law Reform 2000, 2001) and the *European Convention on Human Rights Act* (Department of Justice, Equality and Law Reform 2003). These Acts support the basic framework for the legal

rights of people contained in the Irish Constitution (Bunreacht na hÉireann 1937). Other legislative areas with particular relevance to older people include mental capacity and mental health legislation, domestic violence, criminal law, civil law, protected disclosure, regulation of health and social care services and staff, financing for nursing home care, equality and age discrimination, financial regulation, and consumer protection legislation (Lyons et al. 2009).

This dispersion of legislation can create difficulties for personnel charged with the protection of older people. In 2003 the Law Reform Commission published a consultation paper entitled *Law and the Elderly* (Law Reform Commission 2003). The Commission recognised that older people 'constitute a significant and growing group who may need specific support and protection from the legal system' (Law Reform Commission 2003: 1). The specific deficits or ambiguities in the law recognised by the Commission related to legal capacity, substitute decision making, legal mechanisms to protect older people subject to financial or physical abuse, and protection of vulnerable older people who have legal capacity but are considered to be at risk. The Law Reform Commission acknowledged that the recommendations made in the consultation paper had relevance to 'other adults with decision making disabilities or who otherwise needed protection' (Law Reform Commission 2003: 2). In 2006 the Law Reform Commission published its report *Vulnerable Adults and the Law* (Law Reform Commission 2006). The principal recommendations concerned reform of the law on mental capacity and the establishment of a new guardianship structure. Many of the recommendations have been incorporated into a new *Mental Capacity and Guardianship Bill 2008* which is currently going through the legislative process (Department of Justice, Equality and Law Reform 2008).

The current bill dealing specifically with mental capacity will update the law in this regard but the wider protection of vulnerable adults, including older people, remains fragmented, with separate laws dealing with protection and decision making. There are also aspects of abuse which the legislative framework does not address, in particular, the areas of neglect and self-neglect. Within Irish legislation neglect is only considered within the context of a 'duty of care' and in practical terms is only enacted against professionally qualified practitioners. Thus, this excludes family members or unqualified care workers who may, by an intentioned or un-intentioned act or omission, cause harm or distress to an older person. A practical implication of this lack of legislation is that health care or social workers, or the police, cannot access a home in which they suspect an older person may be experiencing abuse or neglect. Another obvious omission from the legislative protection framework is the regulation and vetting of domiciliary care services and staff (private and public). The Law Reform Commission (2009) has made recommendations for the amendment to the current *Health Act 2007* to address this deficit.

1.3.4 Elder Abuse Structures and Services in Ireland

Since 2007 the HSE has spearheaded the development of an elder abuse structure and service provision, guided by the recommendations in *Protecting Our Future*. One of the most significant developments was the appointment of dedicated regional and local area personnel to manage elder abuse. The current structure comprises a National Elder Abuse Steering Committee within the HSE with a reporting relationship to the Department of Health and Children. This Steering Committee oversees the activity of four area elder abuse steering committees and five sub-groups which are charged with specific activities including national elder abuse awareness, communication, operational policies, procedures and guidelines, training and financial abuse.

Elder abuse service provision is managed through dedicated posts including four regional dedicated officers for elder abuse and thirty two senior case worker (SCW) posts for elder abuse that operate at Local Health Office level. The primary role of the SCW is to assess and manage suspected cases of elder abuse, while the dedicated officers are charged with the development, implementation and evaluation of the HSE response to elder abuse. These activities include a recent policy on reporting and responding to allegations of elder abuse, and the central collation of information on reported cases (HSE 2009). The HSE also funds the National Centre for the Protection of Older People (NCPOP) based in University College Dublin (UCD) to conduct original research in the field of elder abuse and protection in Ireland and to collate evidence on national and international practice on topics such as legislation, service provision, training and screening (see www.ncpop.ie). One of the functions of the centre is to disseminate these findings to HSE services.

As part of the ongoing developments in a national response to elder abuse, the National Council on Ageing and Older People commissioned a review of the implementation of the recommendations of *Protecting Our Future*. The review found that at an operational level the dedicated personnel model adopted by the HSE is working well (NCAOP 2009). The authors qualified this statement by identifying a number of areas for concern including a lack of integration between the dedicated elder protection service and wider social and health services for older people, poorly established inter-agency collaboration, lack of professional supervision for senior case workers and a lack of national policies and procedures for dealing with cases of abuse. The report also recommended strengthening and simplifying the governance structure to ensure accountability, responsibility and authority in the ongoing development of services for the protection of older people both within the HSE and across other agencies.

The services for the protection of older people in Ireland are at an early stage of development and while the current operational focus is on dealing with actual cases of elder mistreatment, the goal is the development of robust inter-agency structures to protect all vulnerable adults including older people.

1.4 Defining Elder Abuse

1.4.1 Definition

Defining elder abuse remains one of the most controversial and key challenges within this field of research and continues to be widely debated. The most recent prevalence studies into elder abuse have used the definition adopted by the World Health Organisation (WHO) in 2002:

> *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 (WHO 2002: 3).*

Separate to the WHO, the United Nations (UN) has been engaged in a Programme on Ageing since 1982. One of the outputs from the Programme was an International Plan of Action on Ageing, developed at the Second World Assembly on Ageing in Madrid, and subsequently endorsed by the United Nations (Resolution 57/167). This plan focused on the human rights of older people, and included neglect, abuse and violence as a priority area. The work of both these organisations have begun to place the mistreatment of older people beyond the framework of isolated family violence and identify it as a human and civil rights issue in its own right. The impact of this change in focus has been slow to penetrate national policies on elder abuse but increasingly elder abuse as a violation of human rights and dignity is being adopted and reflected at national policy and legislative level (Podnieks et al. 2010a, Teaster et al. 2010).

In the Irish context the Working Group on Elder Abuse in the report *Protecting Our Future* extended the original WHO definition as follows: *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* (Working Group on Elder Abuse 2002). This study adopted this expanded WHO definition and encompasses three elements: behaviour, relationship and impact. The precise measurement of elder abuse in prevalence surveys requires clear operational definitions. This has led researchers in the most recent studies to focus on five specific areas of mistreatment – financial abuse, physical abuse, psychological abuse, sexual abuse and neglect. The relationship element of the definition, 'expectation of trust', has focused attention on inter-family relationships, friends or care workers and excludes the wider community within which older people live. The third element 'impact', while measured, is often excluded from the prevalence calculation (O'Keeffe et al. 2007).

The research team acknowledge that many regard the current definition of elder abuse and how it is operationalised as too narrow because it fails to take account of self-neglect, abandonment, or state and societal discrimination and ageism. Even the WHO, in its report entitled *Missing Voices*, challenged the validity of this definition (WHO 2002). In the *Missing Voices* report older people from around the globe identified the categories of abuse that significantly impacted on their lives. These were classified as structural and societal abuse, neglect and abandonment, disrespect and ageist attitudes, psychological, verbal and emotional abuse, physical abuse, financial and legal abuse. The report suggests that research, through focusing exclusively on interpersonal abuse, ignores the 'vital importance of structural-societal factors underpinning all aspects of elder abuse' (WHO 2002: 8).

The current study into the prevalence of elder abuse in Ireland has focused on interpersonal abuse, financial abuse and neglect. This reflects current practice in the field and facilitated comparison with international studies from Europe, Israel, Canada and the US. The study measured the five types of mistreatment (financial, physical, psychological, sexual abuse and neglect) and captured data on elder abuse within inter-family relationships, by care workers or close friends, but also in the wider community (neighbours and people distantly known to the older person), and by strangers.

1.4.2 Data on Elder Abuse in Ireland

There is a dearth of research on elder abuse in Ireland. O'Loughlin and Duggan (1998) surveyed service providers regarding their perceptions and views on elder abuse in Ireland. The primary theme identified was that service providers were aware of a wide range of abuse, neglect and mistreatment of older people both in the community and elderly care institutions. Service providers also reported reluctance among victims, families and professionals to report abuse, and a lack of knowledge to enable the reporting of elder abuse.

The first official statistics on elder abuse were compiled with the establishment of the HSE dedicated elder abuse service in 2007 (HSE 2009). Senior case workers collect and submit data to a central register on all alleged or suspected cases of elder abuse. Data is categorised by the five types of abuse indicated above but also includes self-neglect and discrimination[1].

In 2008, the first year for which complete data is available, there were 1,840 individual reported cases of abuse, if self-neglect and discrimination are excluded there were 1,465 cases. This gives an estimated prevalence of 0.3%-0.4% (1,465-1,840/467,926) depending on the definition used. This implies that for every 1,000 older persons in the Irish population, three to four older people who experience abuse will come to the attention of the specialist elder abuse service.

The majority of cases reported were female (63%) and 49% were aged 80 years or older. The rate of referral based on the number of people aged 80 years or older in the population was 6.9/1,000 population compared to 2.3/1,000 in the 65-79 years age group. Many older people reported more than one type of abuse. Excluding isolated cases of self-neglect, there were 2,212 categories of abuse among 1,481 cases[2]. Psychological abuse was the most frequently reported form of abuse at 29%, followed by neglect (22%), financial abuse (19%), physical abuse (15%), self-neglect (7%) (only counted when accompanied by another type of abuse), sexual abuse (2%) and other/discrimination (6%). With regard to outcome there was data on 771 cases, 23% of cases were substantiated cases of abuse, 47% were inconclusive and 31% were not substantiated (HSE 2009).

In 2009, 1,870 cases of elder abuse were recorded by senior case workers with re-referrals accounting for 8% of cases. The age and gender profile remained the same as the previous year but there were slight differences in the frequency of abuse reported, psychological abuse (28%) remained the most common, but financial abuse (18%) became the second most frequently reported abuse followed by neglect (17%) (HSE 2010).

Reporting Elder Abuse

In Ireland there is no mandatory reporting of elder abuse as in many US states. There is, however, legislation on 'protected disclosure' which provides 'legal safeguards for people who want to report serious concerns they have about standards of safety or quality in Irish health and social care services' (Health Information and Quality Authority 2010). This effectively excludes community-dwelling older people who experience mistreatment at the hands of a non-health care worker.

Official statistics on abuse are known to under estimate the true prevalence and are generally regarded as the 'tip of the iceberg' (Pillemer and Finkelhor 1988, Acierno et al. 2010). The reasons for under reporting of elder abuse, especially to official services, are multifaceted but include feelings of shame or guilt by the older person, intimidation, fear of reprisals, not recognising the behaviour as abusive, lack of knowledge on how to report abuse, or little confidence in the structures and supports in place to protect or help older people who have been abused (Rovi et al. 2009).

[1] Including ageism, racism, sexism, and discrimination based on a person's disability, and other forms of harassment, slurs or similar treatment.

[2] Isolated self-neglect refers to cases where self-neglect was the only category of abuse reported. There were 2,479 separate categories of abuse identified among the total 1,840 cases.

In addition to the above factors the HSE data for 2008 and 2009 may be affected by organisational factors (HSE 2009, 2010). The central collation of data is relatively new. There is large variation in regional reports of abuse, which may reflect variation in the staffing levels and/or operational practices in the different regions rather than actual regional differences in the occurrence of abuse. Also it is possible that not all cases of suspected abuse reported to social services will come to the attention of senior case workers, especially in areas where such posts are vacant (HSE 2010).

1.4.3 International Data on Prevalence of Elder Abuse

Since the 1980s there have been ten large scale surveys of elder abuse among community-dwelling older people in developed countries (Table 1.1). Eight national prevalence studies of elder abuse using nationally representative samples of older people have been conducted in the UK (Ogg and Bennett 1992, O'Keeffe et al. 2007), Spain (Marmolejo 2008), Israel (Lowenstein et al. 2009), Germany (Wetzels and Greve 1996), Canada (Podnieks 1992a) and the US (Laumann et al. 2008, Acierno et al. 2010). Two remaining studies estimated prevalence in the large urban centres of Boston (Pillemer and Finkelhor 1988) and Amsterdam (Comijs et al. 1998) using representative samples of older people.

The estimates of prevalence vary widely with the lowest prevalence rate in Spain (0.8%) for family abuse and the highest in Israel (over 18%, rising to 35% when neglect was included). The majority of studies have measured four types of abuse (physical abuse, psychological abuse, financial abuse, and neglect). Sexual abuse has only been explicitly examined in three studies and contributed less than 1% to the overall prevalence. Excluding the Israeli study, six studies measured physical, psychological, financial abuse and neglect, in these studies the prevalence of disclosed abuse ranged between 0.8% and 11.4%.

There was no consistent pattern across the studies in terms of which type of abuse was the most prevalent. Neglect was ranked first in three studies (O'Keeffe et al. 2007, Marmolejo 2008, Lowenstein et al. 2009), and second in two studies (Wetzels and Greve 1996, Acierno et al. 2010). Psychological abuse was ranked first in three studies (Ogg and Bennett 1992, Comijs et al. 1998, Laumann et al. 2008) and second in three studies (Pillemer and Finkelhor 1988, Podnieks 1992a, Lowenstein et al. 2009). Financial abuse was ranked first in two studies (Podnieks 1992a, Acierno et al. 2010,) and second in three other studies (Comijs et al. 1998, O'Keeffe et al. 2007, Laumann et al. 2008), while physical abuse was ranked first or second in only two studies (Pillemer and Finkelhor 1988, Wetzels and Greve 1996). In the three studies that measured sexual abuse (O'Keeffe et al. 2007, Marmolejo 2008, Acierno et al. 2010) it was the item with the lowest prevalence, at less than 1%. Overall, neglect and psychological abuse tend to be more prevalent than financial, physical or sexual abuse, but differences in how the abuse types were measured make it difficult to draw conclusions.

There remains considerable methodological variation among these studies in terms of how the different types of abuse were operationalised. For example, a single question on the abusive behaviour as in the Spanish (Marmolejo 2008) and early UK study (Ogg and Bennett 1992) versus multiple questions or the use of validated instruments, the study period identifying prevalence versus incidence (since 65 years or previous 12 months), and the minimum age of participants (60 or 65 years). In particular, the definition of a 'position of trust' showed wide variation and ranged from the inclusion of close family members only, as in the Spanish study, and extending in other studies to all family, plus or minus care workers, plus or minus close friends, to plus or minus anyone. The definition of neglect and psychological abuse was also variable. Five studies used a criteria of ten or more episodes in the past 12 months before the behaviour was considered abuse, while the remaining studies considered any episode of psychological abuse or neglect.

Table 1.1 **Community based prevalence surveys of elder abuse in Western Countries**

Author Year Country	Target population	Sample size (Response rate)	Data collection method	Prevalence period	Position of trust	Overall prevalence of abuse	Neglect	Financial	Psychological/ verbal abuse	Physical	Sexual
Acierno et al. (2010) US	National random sample ≥60 years	5777 (69%)	Telephone	Preceding 12 months & since 60 years	Anyone	11.4% (12 months)	5.1% (12 months)	5.2% (12 months)	4.6% (12 months) 13.5% (60 yrs)	1.6% (12 months) 1.8% (60 yrs)	0.6% (12 months) 0.3% (60 yrs)
Laumann et al. (2008) US	National random sample 57-85 years	3005 (75.5%)	Face to face & self-completion	Preceding 12 months	Family	–	–	3.5%	9%	0.2%	–
Marmolejo (2008) Spain	National random sample ≥65 years	2401 (not reported)	Face to face	Since 65 years	Family	0.8%	0.3%	0.2%	0.3%	0.2%	0.1%
O'Keeffe et al. (2007) UK	National random sample ≥66 years	2111 (65%)	Face to face	Preceding 12 months & since 65 years	Family, care worker, close friend	2.6% (12 months) 3.4% (65 yrs)	1.1%*	0.7% (12 months) 1.2% (65 yrs)	0.4%*	0.4% (12 months) 0.8% (65 yrs)	0.2% (12 months) 0.3% (65 yrs)
Lowenstein et al. (2009) Israel	National random stratified sample (urban dwelling only) ≥65 years	1045 (75% approx)	Face to face	Preceding 12 months	Family & care workers	18.4% (excluding neglect) 35% (including neglect)	18%	6.4%	14.2%	2.7% 4% (freedom limitation)	–
Wetzels and Greve (1996) Germany	National random sample ≥60 years	5711 (84%)	Face to face	Last 4 years	Family, household resident	3.1%	2.7%	1.3%	0.8%	3.4%	–
Comijs et al. (1998) Netherlands	Urban (Amsterdam) No details ≥65 years	1797 (44%)	Not reported	Preceding 12 months	Family, people familiar	5.6%	0.2%*	1.4% 4.8% (65 yrs)	3.2%* 3.9% (65 yrs)	1.2%	–
Ogg and Bennett (1992) UK	National random sample ≥60 years	593 (not reported)	Face to face	Recently	Family	–	–	1.5%	5.4%	1.5%	–
Podnieks (1992a) Canada	National representative sample ≥65 years	2008 (not reported)	Telephone	Since 65 years	Anyone	4.0%	0.4%*	2.5%	1.4%*	0.5%	–
Pillemer and Finkelhor (1988) US	Urban (Boston) random sample ≥65 years	2020 (72%)	Telephone	Preceding 12 months & since 65 years	Anyone	2.6% (12 months) 3.2% (65 yrs)	0.4%*	–	1.1%* (12 months)	2.0%	–

– Not reported or not measured
* ≥10 incidents in one year

Despite these variations there are also strong similarities to suggest that comparable abuse constructs were measured. The majority of the studies operationalised abuse using multiple questions on each type of abuse. Six studies used similar definitions for neglect, based on the Activities of Daily Living (ADL) model. The study populations were generally large (>1,000 people), restricted to those living in the community, and used random or stratified random sampling to ensure a representative sample of the older population. Response rates, when reported, were 50% or more. The data collection method used was face-to-face interviews in six of the studies, telephone interviews in three other studies and one study did not report the data collection method. In these ten studies interviews were conducted directly with older people themselves and in private, with only a small number of proxies used in the Boston study (Pillemer and Finkelhor 1988).

Elder Abuse Prevelance Studies from Asia

There are four published population based surveys from Asia (Yan and Tang 2001, Yan and Tang 2004, Oh et al. 2006, Dong et al. 2007) and one from India (Chokkanathan and Lee 2006). All were based in large urban centres (Table 1.2). Only one study used random sampling (Chokkanathan and Lee 2006), but the Korean study (Oh et al. 2006) interviewed over 15,000 people. The overall prevalence rate ranged from 6.3% in Seoul (Oh et al. 2006) to 35% in Hong Kong (Dong et al. 2007).

Table 1.2 **Community based prevalence surveys of elder abuse in Asia**

Author & Year	Chokkanathan and Lee (2006)	Oh et al. (2006)	Yan and Tang (2001)	Yan and Tang (2004)	Dong et al. (2007)
Country	India	Korea	Hong Kong	Hong Kong	China
Target population	Urban (single residential district Chennai) random sample	Urban (single residential district Seoul) Sampling method not identified	Urban community centres Hong Kong Convenience Sample	Urban community centres Hong Kong Convenience Sample	Urban medical clinic Convenience Sample
	≥65 years Cognitively normal (formal test)	≥65 years	≥60 years	≥60 years	≥60 years
Sample size (Response rate)	400 (80%)	15,230 (53%)	355 (≤80%)	276 (≤80%)	412 (82%)
Data collection method	Face to face	Face to face	Face to face	Face to face	Self completion questionnaire
Prevalence period	Since 65 years	Month prior to the interview	12 months	12 months	Not specified
Position of trust	Family	Family	Family	Family	Family/caregiver
Overall prevalence of abuse	14%	6.3%	21.1%	27.5%	35%
Neglect	4%	2.4%	–	–	16.9% (abandonment 0.7%)
Financial	5%	4.1%	–	–	13.6%
Psychological/ verbal abuse	11%	4.2%	20.8%	26.8%	11.4%
Physical	4%	1.9%	2.0%	2.5%	5.8%
Sexual	–	–	–	–	1.2%
Violation of personal rights	–	–	3.9%	5.1%	–
Multiple	7%	–	–	–	36%

– Not reported or not measured

Psychological or verbal abuse ranked as the most prevalent types of abuse across all four studies (Yan and Tang 2001, Yan and Tang 2004, Oh et al. 2006, Dong et al. 2007).

There are definitional, operational, sampling and methodological differences between the studies conducted in the different countries or cities, making it unsafe to draw conclusions regarding cultural differences on the prevalence of elder abuse. However, these studies confirm that elder abuse has been identified in all communities and societies, either western or eastern, that have attempted to measure it.

There are also a small number of studies that focused on particular subgroups of the older population living in the community. The subgroup studies were mainly frail older people, with or without cognitive impairment, in receipt of care or attending emergency department services. Higher rates of abuse were reported (18%-25%) among these subgroups and key factors were physical and/or cognitive decline and dependence (Compton et al. 1997, Cooney et al. 2006, Cooper et al. 2009b).

A systematic review of the prevalence of elder abuse and neglect by Cooper et al. in 2008 excluded the most recent studies from the US, UK, Spain and Israel, but their conclusions remain relevant. They suggest that general population studies of elder abuse underestimate the prevalence of abuse among particular vulnerable sub-groups of older people. Studies also tend not to report the reliability or validity of the instruments they use and there remains a lack of consensus on 'what constitutes an adequate standard for validity of abuse measures' (Cooper et al. 2008b: 151).

Despite the heterogeneity in operational definition and methodologies between recent studies, each has contributed to the understanding of this topic within their own country and in the wider international context. As studies are conducted in different countries the cultural and inter-family dimensions are starting to emerge in more detail. The overall prevalence statistics are less important than the pattern of the abuse types and associated risk factors in order to set priorities, and develop policies and effective responses to protect older people. At an international level the commonalities in elder abuse need to be recognised to progress theory development in this field and to enable a better understanding of the phenomenon. Simultaneously the unique cultural or ethnic dimensions of elder abuse need to be understood in order to develop strategies and interventions that are effective but also acceptable to older people themselves.

1.4.4 Risk Factors for Elder Abuse

Large population based studies have increased our understanding of the risk factors associated with elder abuse and clearly highlight that this is a multifaceted complex phenomenon. It is likely that the different types of abuse are characterised by both unique factors and those common across the abuse types. It is also recognised that abuse is often clustered, with psychological abuse in particular occurring concurrently with other abuse types such as physical abuse or neglect.

Studies that identified independent risk factors using multiple regression models are summarised in Table 1.3. The majority of studies were underpowered to look at risk factors for individual types of abuse and treated all abuse types as similar. This is likely to be an over simplification of the phenomenon, but nonetheless common themes have emerged. In particular, physical impairment and dependency for ADLs are correlated with a higher incidence of abuse. Cohabiting with family and social isolation are frequently identified, while female gender, advanced age and lower socio-economic status are variably identified as risk factors.

The study by Acierno et al. (2010), with a sample of 5,777, is one of the few studies with sufficient statistical power to look at risk factors for individual abuse types. Financial abuse (5.2%), neglect (5.1%) and emotional abuse (4.6%) were the most prevalent types of abuse. The associated statistical models, based on 254 to 297 cases, identified associations between the individual abuse type and predictive risk factors. In the emotional abuse model being aged less than 70 years and having low social support increased the risk of abuse three-fold. A previous traumatic event doubled the risk, while unemployment, poor health and need for ADL assistance increased the risk by 40% to 80%. In the neglect model, low social support quadrupled the risk of abuse; poor health doubled the risk, while race and lower income were also significant factors. The financial abuse model identified an association with need for ADL assistance, non-use of social services and poor health. In the physical abuse model, with 86 cases, low social support nearly tripled the risk of abuse while being aged less than 70 years quadrupled the risk. Other factors did not reach statistical

significance but there was a trend towards increased risk with poor health and low socio-economic status. The sexual abuse model included only 34 cases and indicated that low social support and a previous traumatic event were very strongly associated with this type of abuse. However, female gender and low income did not reach significance but this is likely to be due to lack of statistical power. This study highlights the common risk factors across many abuse types, in particular, health, social support and economic factors. It also questions commonly held beliefs regarding age and gender, as advanced age (>70 years) and female gender in isolation were not identified as independent risk factors.

Cross-cultural comparisons of risk factors may be premature due to the methodological differences in the studies but some observations are possible. Firstly, higher levels of verbal abuse or psychological abuse were reported in surveys where there were higher levels of cohabitation with family members other than spouse. Secondly, common to all studies that explored risk factors for abuse was the association between poor health and increased dependence for activities of daily living and abuse. Thirdly, low social support was recognised as a risk factor in western type societies but not in eastern societies, perhaps due to higher levels of cohabitation. The role of gender, education, marital status and socio-economic status as risk factors was inconsistently identified. Based on existing studies it is difficult to safely determine whether observed differences in prevalence and risk factors are associated with cultural variation or are related to methodological differences.

Table 1.3 **Risk factors identified for overall abuse**

Author, Year and Country	Female	Male	Advanced age	Social support	Marital status	Poor physical health	Dependency for ADLs	Higher education	Lower socio-economic
Laumann et al. (2008) US	✔ (verbal)		Protective for financial & verbal		✔ (alone financial)		✔ (verbal)	✔ (verbal)	
Marmolejo (2008) Spain	✔		✔	✔ (low)		✔	✔		
O'Keeffe et al.(2007) UK	✔	✔ (financial)	✔	✔ (low)	✔	✔			✔
Lowenstein et al. (2009) Israel	✔	✔ (financial)		✔ (low)		✔			
Podnieks (1992a) Canada				✔ (low)	✔			✔	✔
Pillemer and Finkelhor (1988) US		✔		✔ (low)	✔	✔			
Chokkanathan and Lee (2006) India	✔			✔ (living with family)	✔ (widowed/ single)	✔		✔	✔
Oh et al. (2006) Korea		✔	✔	✔ (living with family)		✔	✔		
Yan and Tang (2001, 2004) Hong Kong			✔			✔	✔		
Dong et al. (2007) China	✔		Protective			✔	✔	✔ (lower)	✔

1.4.5 Outcomes from Elder Abuse

Few studies have attempted to measure the long-term outcomes of elder abuse from the perspective of people who have experienced abuse. Official statistics tend to classify cases as substantiated, inconclusive or unsubstantiated; and outcomes as 'case closed' or 'ongoing'. However, they do not collect information on outcomes such as mortality, satisfaction with services, the impact on physiological and psychological health and well-being, or ongoing effects of abuse on the older person. Lachs et al. (1998) reported on a cohort study of older people investigated by protective services (n=104) compared to older people not referred to protective services (n=1,303) over a thirteen year period. In a regression model adjusting for confounding variables such as age, health, depression and social factors, older people who experienced abuse were three times more likely to die within the study period (odds ratio (OR) 3.1; 95% CI 1.4, 6.7), while those who experienced self-neglect were 70% (OR 1.7; 95% CI 1.2, 2.5) more likely to die compared to older people who had not experienced abuse or self-neglect (Lachs et al. 1998).

Comijs et al. (1998), in the prevalence study of elder abuse in Amsterdam, examined the consequences of the abuse. Most of the victims reported feelings of anger, disappointment or grief. One quarter of participants who experienced verbal or physical aggression responded aggressively, while 35% reported feelings of fear (Comijs et al. 1998). In this study over 70% of respondents who experienced abuse tried to prevent recurrence, but in less than 50% of cases the actions taken were successful in preventing further abuse. Similarly in the UK prevalence study participants were asked questions regarding the impact of the abuse. Seventy-seven percent described emotional reactions such as being angry or upset; 52% ignored the abuse or walked away, but 49% reported a verbal, physical or a confrontational reaction. Seventy-six percent of respondents described the abuse as having a serious or very serious effect on their lives. These were mainly emotional effects but 61% felt they became isolated from family or friends, while 11% described physical discomfort or pain due to physical abuse or neglect (O'Keeffe et al. 2007).

Much of the insight we have into the consequences of elder abuse come from qualitative in-depth interviews with small numbers of older people who reported experiences of abuse. One of the most recent studies by Mowlam et al. (2007) was conducted with a sub-sample of participants in the UK prevalence study (O'Keeffe et al. 2007) and augmented by people from ethnic minority groups. The psychological impact of abuse was common across many of the different abuse types and included emotional distress, loss of self confidence and self-esteem, while more significant psychological impact such as depression, thoughts of suicide or self-harm were associated with longer-term and more severe abuse (Mowlam et al. 2007). Other consequences of abuse were social isolation, deterioration in physical health, loss of independence, financial loss and impact on family relations.

A number of studies by Band-Winterstein and Eisikovits (2005, 2009) explored how long-term intimate partner violence was experienced and how it evolved as both parties aged. This type of abuse was characterised by its severity in terms of behaviour and injury, the intensification in frequency, a movement from overt to covert abuse and change in types of violence. The authors identified four abuse clusters: a) violence is alive and active, b) violence in the air, c) more of the same but different d) violence through illness. The impact of sustained and long-term abuse on women was substantial, leading to erosion of self-esteem and worth, and inability to counteract or remove themselves from the situation as they become 'locked into certain trajectories created by life circumstances' (Band-Winterstein and Eisikovits 2009: 178). Psychologically, women experienced intense emotions which clouded their lives, for example, loneliness on all ecological levels (self, the family of origin, violent partner, children and extended family), betrayal, regret, anger, frustration and sorrow. These women often experienced deep social isolation, blame, and deterioration in health during their prolonged experience of abuse (Buchbinder and Winterstein 2004, Winterstein and Eisikovits 2005).

A key theme emerging in the qualitative literature is the lasting effects of violence, which participants described as 'devastating' with many feeling they would never fully recover (Mears 2003). An equally strong theme to emerge in this literature is the survival instinct of people who experience this behaviour and the strategies they develop to help them cope. Podnieks (1992b) described the adaptive strengths and 'hardiness' of older abuse victims and their inner strength when dealing with mistreatment.

In the last 10 years there has been an increase in the quantitative and qualitative literature on elder abuse. Such studies have contributed to the understanding of this complex issue within the communities and societies in which they were conducted. These studies provide detailed information on the unique characteristics and patterns of the phenomenon within individual countries and are reflective of the wider demographic, socio-economic and cultural dimensions of that society. The information obtained from prevalence studies often substantiates the suspicions of practitioners who work with older people and can help to focus political and societal attention on this significant societal problem.

1.5 Study Aims and Objectives

Currently there is minimal information available in Ireland on the level of elder abuse amongst community-dwelling older people, the circumstances which lead to abuse and how the abuse is managed from an individual and societal perspective. With the support of the HSE, the National Centre for the Protection of Older People (NCPOP) set out to conduct a national prevalence survey of elder abuse in Ireland to provide statistics on overall and individual types of abuse. This study focused on community-dwelling older people and excluded those living in residential settings. The operational definitions of abuse and the study design were informed by previous surveys and, in particular, closely replicated the recent UK study of abuse and neglect of older people (O'Keeffe et al. 2007). This approach allows for international comparison of data.

The objectives of the study were to identify in community-dwelling people aged 65 years and older:

1) The prevalence of overall abuse and individual types of abuse in the previous twelve months, within the context of those in a 'position of trust' (family, care workers, close friends) and the wider community (neighbours, people distantly known to the older person), and strangers.

2) The prevalence of overall and individual types of abuse since the age of 65 years perpetrated by people in a position of trust and the wider community.

3) The demographic, socio-economic, health and social support characteristics of people who experienced abuse compared to those who did not.

4) The profile of perpetrators of abuse as described by older people who experienced abuse.

5) The impact of abuse and how older people responded to these experiences.

2.1 Introduction

The last thirty years has seen an increase in knowledge and expertise in conducting research in the related areas of domestic violence, sexual abuse and abuse of older people. This wealth of knowledge and experience from national and international experts is summarised and informed the conduct of this study on the prevalence of elder abuse in Ireland.

2.2 Method of Data Collection

One of the primary considerations was the selection of an appropriate method of data collection to ensure that: 1) the study population was representative of the national population aged 65 years and older in terms of gender, age structure and geographical spread, 2) the research approach recognised the sensitivity of the topic and was acceptable to the target population to allow disclosure of experience of elder abuse, and 3) the approach would maximise the response rate while also building in protection measures for the older person.

Three methods of conducting prevalence surveys are reported in the literature. These are postal survey, telephone and face-to-face interview. Each has their advantages and limitations and these are briefly outlined here.

Postal Survey

Postal survey is the least used and perhaps least favoured approach. Its advantages are cost and convenience in conducting the study, but far outweighing these advantages are the low response rates, typically 30%-40%, associated with any general public survey. It is also likely that response rates on a sensitive topic such as elder abuse may be even lower. Other difficulties relating to the topic is that the questionnaire design involved 'skips' or omission of question not relevant to some participants. Such a layout may lead to confusion, and any misunderstanding or misinterpretation on the part of the participant cannot be clarified, potentially leading to inaccurate responses or incomplete questionnaires. Elements of participant safety are also difficult to build into a postal survey design as by its nature there is no direct contact with participants.

Telephone Survey

Telephone surveys have been used in the US and Canada to successfully conduct surveys on this topic. The primary advantage with a telephone approach is the anonymity it affords participants which may promote more open disclosure. The cost associated with telephone surveys is generally less than face-to-face and through random digit dialling a nationally representative cluster random sample can be more easily achieved. Older people may also feel less threatened by a telephone approach compared to a stranger calling to their home as may occur with face-to-face interviews.

The primary limitation of the telephone methodology is that it is more difficult to establish a rapport between the interviewer and the participant and therefore may lead to less disclosure of abuse or even participation in the interview. Telephone surveys depend on land line or mobile phone coverage and while in Ireland people aged 70 years or older are entitled to a free telephone land line, coverage is still estimated to be less than 80%. People who have speech or hearing impairment are also largely excluded by this approach. The practice of telephone 'Cold Calling' (calling without warning or invitation) results in many people hanging up the phone before they even hear about the survey which may affect response rates.

Some researchers believe it is more difficult to build in adequate safety strategies required for sensitive topics such as elder abuse because there is no visual assessment of the person and therefore it is difficult to judge how distressed participants may become while disclosing traumatic experiences. However two recent surveys in Ireland, *Sexual Abuse and Violence in Ireland* and *Domestic Abuse of Women and Men in Ireland*, were successfully carried out with appropriate safety and support frameworks (McGee et al. 2002, Watson and Parsons 2005).

Face-to-Face Interview

By far the most common approach in this area of research is face-to-face interview. The recent prevalence studies in the UK, Israel and Spain employed this approach. The primary advantage is the engagement with participants and the opportunity to build confidence and trust which may lead to more open disclosure and more accurate prevalence data. Also it may afford greater protection in the case of a person who lives with an abuser. The

researcher is in a position to judge the situation and may not proceed with the interview if they believe it may put an individual at increased risk. This approach allows the researcher to visually assess how distressed a participant may become during the course of an interview and take the appropriate action. Face-to-face interviews provide the opportunity to clarify any ambiguities a participant may have with the questions, ensuring more accurate and complete data collection. There is also the opportunity to delve deeper in some areas if the participant is willing to talk.

The primary disadvantage of face-to-face interviews is the cost, especially if a nationally representative sample is required. There is a counter argument related to safety in that face-to-face contact may actually increase the danger for a person who is living with an abuser as suspicion about the interview may trigger a violent reaction. There is also a concern regarding the safety of the interviewer. Another disadvantage of the face-to-face interview, especially in this population, is the justifiable concern regarding allowing strangers into one's home which may impact on response rates.

Method Comparison

There is limited research to recommend one approach over another and what evidence there is remains contradictory (Herzog and Rodgers 1988). Studies that used both methods of data collection tend to report no significant difference in response rate, interviewee fatigue or internal consistency of responses, and conclude that telephone interviews are as reliable as face-to-face (Aneshensel et al. 1982, McCormick et al. 1993, Worth and Tierney 1993). Research on mode of data collection related to sensitive topics or vulnerable populations suggests that non-face-to-face methods such as automated telephone interviews or self-completed questionnaires may promote disclosure (Reddy et al. 2006, Kim et al. 2008). However there is growing concern at decreasing response rates using telephone survey methods, and older people in particular may be less likely to respond to unsolicited telephone surveys or 'cold-calling' than younger people. These factors influenced the decision to use face-to-face rather than telephone interviews.

2.3 Context and Focus of Present Study

The variability between studies in the area of elder abuse meant that several decisions had to be taken with this study in terms of context and focus. Some of the key decisions are outlined below.

This study focused on five forms of elder abuse: physical, psychological, financial, sexual abuse and neglect. It is well recognised that these abuses rarely occur in isolation and many forms are clustered together to a greater or lesser extent. Examining these abuses collectively allowed the research team to explore unique and shared risk factors for different types of abuse, the impact of abuse on older people, their help-seeking behaviour, and the formal and informal response to reported abuse.

The age cut off to define elder abuse is debated in the literature, but increasingly a consensus has emerged around age 65 years, as this is the official retirement age in most developed countries. The age of 65 years was selected in this study as it allowed international comparison with other European studies. It is also recognised that older age may be a risk factor and focusing on age 65 years or older increased the potential for case identification.

This study focused on the prevalence of elder abuse in the community. Older people living in residential or community care were excluded. It is recognised that community-dwelling older people have distinctly different health and social profiles to those in residential settings where dementia or severe physical debility is often the key trigger for admission. Institutional elder abuse is inherently different from that occurring in the community and requires separate measurement approaches, often relying on proxy reporting by staff or relatives rather than direct interviews with the older person.

In the published literature there is variation in defining the timeframe within which abuse is measured. Some studies identify incidence i.e. new cases in the previous 12 months, other studies report prevalence of abuse since the age of 65, while other studies consider it in the wider context of life-time abuse. This variation in defining the timeframe of abuse makes comparison between studies difficult. The decision taken in this study was to examine both prevalence of abuse since age 65 and incidents of abuse in the previous 12 months. This format is similar to

that used in the UK study (O'Keeffe et al. 2007). Examining abuse in both timeframes allowed the research team to explore some of the assumptions underlying the operational definitions of abuse.

A final key decision concerned the definition of the perpetrator of abuse. The WHO (2002) identified abuse as that committed by a 'person in a position of trust'. Again there is considerable variation in the literature as to how this is operationalised and ranges from a focus on partner abuse to family abuse, or extends to include health care professionals, neighbours, acquaintances and strangers. In this study an inclusive approach was adopted which allowed the reporting of immediate family/carer abuse, as well as a wider circle including neighbours, friends and strangers.

2.4 Ethical Considerations

Ethical approval for the study was obtained from the Human Sciences Research Ethics Committee, University College Dublin (UCD). In contrast to similar studies in this area there was open disclosure as to the true purpose of this study. Once an eligible participant was identified and privacy secured potential participants were informed that *This survey deals with older peoples experiences of mistreatment, abuse or neglect* (Appendix 1). This open disclosure did not result in any participants withdrawing from the study at this stage.

As part of the ethical conduct of the study, participant distress and safety protocols were developed, and all interviewers were provided with specific training on the topic and the use of these protocols (see www.ncpop.ie). At the end of an interview, or if an interview was terminated prematurely, all participants were given an information letter detailing sources of help in the event a person had experienced mistreatment (Appendix 2).

2.5 Sample

The 2006 Census recorded that 11% (467,926) of the Irish population were aged 65 years or older, with a higher proportion of older females in the aged population compared to the general population. It is also estimated that 5% (23,396) of the older aged population live in residential homes (CSO 2007b).

Table 2.1 **Age and gender distribution of population aged ≥65 years**

	Male n (%)	Female n (%)	Total N
≥65 years (Total)	207,095 (44%)	260,831 (56%)	467,926
65-69 years	70,895 (34%)	72,501 (28%)	
70-79 years	96,661 (47%)	114,957 (44%)	
≥80 years	39,539 (19%)	73,373 (28%)	

The sampling considerations taken into account in this study were: 1) the need to obtain a nationally representative sample of the community-dwelling population aged 65 years or older in terms of age profile, gender and geographical distribution, 2) the low prevalence, typically 2%-4%, of elder abuse reported in other European and US studies, and 3) the need to identify a minimum number of cases to explore risk factors for abuse and the profile of perpetrators of abuse.

2.5.1 Sampling Methodology

In order to obtain an accurate estimate of the level of elder abuse in the community-dwelling older population, and based on experience from other studies, it was estimated that 2,000 completed interviews were required. Using an estimate of 3% prevalence of abuse, an expected 60 cases of abuse would be identified in a population of 2,000 older people.

Sample Selection

To ensure a nationally representative study population, a multi-stage cluster random probability sample with randomly selected starting points in each cluster and quota controls for age and gender was used. The first stage was to stratify the population into seven NUTS-3 regions[3]. The number of clusters in each of the seven NUTS-3 areas was calculated to be proportional to the number of persons aged 65 years or older in each region.

Electoral Divisions (ED, formerly District Electoral Divisions) were used as cluster boundaries within each NUTS-3 area and an algorithm was used which ascribes the probability of an ED being selected as proportional to the number of persons aged 65 years or older in that ED,

[3] Nomenclature of Units for Territorial Statistics is a geocode standard for referencing the subdivisions of countries for statistical purpose and is regulated by the European Union.

based on 2006 Census data. A total of 150 EDs formed the primary sampling units. EDs were selected across communities of different sizes to ensure large urban towns (population >10,000), medium urban towns (5000-10000), small urban (1500-5000) and rural populations (<1500) were represented.

In each ED a starting address was randomly selected. Addresses were obtained from the Geodirectory, a complete database of households in Ireland. These starting addresses represented the location or starting point for a cluster of interviews and within each ED 14 completed interviews were required.

Random Route

Based on the starting address a random route approach was used to identify eligible households in the cluster. The interviewer followed a predefined set of instructions based on the response from the household (successful interview/no response, refusal/ineligible). An example of the operating rules for a random route methodology is as follows: the interviewer calls at the starting address and they complete a successful interview, they come out of the house and with their back to the door, turn left and count five doors down and approach this house, if there is a refusal or ineligible at this house they then go to the next house on the left. This pattern (5th house or next door) is continued until the end of the road. The interviewer then alternates left and right turns at the end of each road, but always keeps within the boundary of the ED. All interviewers were supplied with maps outlining the boundary of the ED. In the event of a non-response interviewers called back to the house on 5 separate occasions before the house was excluded from the sample.

Random route is recognised as a legitimate means of obtaining a random probability sample in a more timely and cost-efficient manner than random sampling using predefined addresses. In Ireland there is no complete database of people aged 65 years and over thus all addresses from the Geodirectory would be eligible for inclusion in the sampling frame which would include business, vacant, derelict units and holiday homes. The primary limitation of the random route methodology is the reliance on the interviewers to adhere to the random route rules. In this study this issue was dealt with through training and rehearsing the random route methodology with interviewers, supplying maps of the ED with the starting address indicated, weekly contact between the field interviewers and the project supervisor, and validation of 10%-20% of the interviews in each cluster. The validation was achieved through telephone or face-to-face call back by interview supervisors.

Quota Sampling

Quota sampling was used to obtain a representative sample of older people in relation to age and gender. Previous research suggests that older females are likely to be over represented in general population surveys using simple random sampling.

The quota was stratified into male and female, and three age groups: 65-69 years, 70-79 years, and 80 years or older. The quotas within each age group were based on the proportion of older people in the general population. Within each cluster of 14 interviews, interviewers aimed to survey 2 males and 2 females in the 65-69 age group, 3 males and 4 females in the 70-79 age group, and 1 or 2 males and 2 females in the 80+ age group. Interviewers actively monitored the cluster quotas and were not allowed to substitute one age group for another without permission from the study supervisors. Quota priorities were identified, i.e. difficult to reach groups such as males ≥80 years, and guided the selection of participants in the event of more than one eligible participant in a household (see study protocol at www.ncpop.ie).

Inclusion and Exclusion Criteria

The inclusion criteria were people aged 65 years or older, living at a private permanent address (including sheltered accommodation). Only one adult per household was interviewed and the interview had to be conducted in private (i.e. no other member of the household was able to over-hear the conversation). Proxy interviews were not allowed in any circumstances. The principal exclusion criteria were living in residential care or significant cognitive dysfunction. Although there was no formal test of cognitive ability, the nature and length of the questionnaire meant that people with moderate to severe cognitive dysfunction were likely to be excluded from the survey. Temporary halting sites used by travellers were also excluded as research with this population presents particular challenges and requires alternative methodologies (UCD School of Public Health, Physiotherapy and Population Science 2010). Also validation of interviews would be very difficult due to the nomadic nature of this group.

2.6 Construct of Key Questions and Definitions

One of the biggest challenges in research into elder abuse is the variation in the definition of abuse and how it is operationalised for the purpose of data collection. Many prevalence studies of elder abuse have excluded sexual abuse or neglect, and have focused on physical, psychological/verbal and financial abuse. However, when neglect is included this was generally the most prevalent form of abuse and recent studies have included these five forms of abuse which collectively are considered to constitute elder abuse.

The operational definitions of the types of abuse also differ considerably between studies and can range from single broad questions, such as have you ever experienced financial abuse, to a breakdown of a number of specific actions that constitute financial abuse (Table 2.2). Among researchers active in this field it is generally agreed that the most accurate data is obtained by providing specific behavioural definitions rather than summary terms which have varied meanings for the general public (McGee et al. 2002).

The construct of the abuse questions used in this study built upon previous work by Professor Simon Biggs (Kings College London), involved in the UK study, and Dr Mark Lachs and Professor Karl Pillemer (Cornell University), involved in the Boston and recent New York study on elder abuse. In particular, permission was obtained from Dr Lachs to modify a telephone interview schedule which was developed for a prevalence survey of elder abuse in New York. Each of the five types of abuse were operationalised through multiple behaviourally specific questions (Table 2.2). The focus was on the action, i.e. 'has anyone stolen money or any of your possessions/property/land or documents from you', rather than the broader area of financial abuse. By constructing the abuse in this way people were asked to recollect specific experiences which may have more meaning for people and trigger better recall. Also by asking multiple questions on the same topic it allowed a greater opportunity for recall of experiences. The disadvantage of this approach was that some of the questions were quite explicit and some people may have found them offensive and/or upsetting. There was a balance struck between using explicit terms but not offending participants which may have prompted them to disengage from the interview. Experiences from researchers in the UK and the US suggested that the use of explicit terms were acceptable to people in their studies and although the topic may be distressing, older people were willing to report abuse and wanted these experiences highlighted (Cooper et al. 2008b).

Validity and Reliability

The above format for constructing questions on abuse was based on the current methods for measuring family violence using specific behavioural activities. This format has become standard in most surveys on elder abuse and many of the actual questions used in the Irish prevalence survey had previously been tested in recent elder abuse surveys, allowing for comparable international data. In particular the questions on physical, psychological and sexual abuse were derived from the well validated 'Conflict Tactics Scales'. Such specific behavioural measures have been shown to have a stable factor structure, moderate to high reliability, construct validity and participant acceptability across a range of domestic violence settings including elder abuse (Straus 2007, Cooper et al. 2008a, Cooper et al. 2009a).

2.6.1 Operational Definitions

The operational definition adopted was similar to that in the UK study (O'Keeffe et al. 2007) and defined abuse and neglect as:

> *Any episode of financial, physical or sexual abuse or ≥10 episodes of psychological abuse or neglect or episodes of psychological abuse or neglect that had a serious impact on the older person, occurring in the previous 12 months and perpetrated by a person in a position of trust (family, close friend or health care worker)*

Financial abuse was defined as the unauthorised and improper use of funds, property or any resources of an older person, and included theft, coercion, fraud, misuse of power of attorney, and also not contributing to household costs where this was previously agreed. Abuse was recorded if a person experienced one or more incidents in the previous 12 months.

Physical abuse was defined as the non-accidental infliction of physical force that resulted in a bodily injury, pain or impairment. The questions captured episodes of actual or threatened physical violence, such as slapping, hitting with an object or fist, use of a weapon or forced restriction through inappropriate use of medication or physical restraint. Physical abuse was recorded if a person experienced one or more incidents in the previous 12 months.

Sexual abuse was defined as direct or indirect involvement in sexual activity without consent. This included talking or touching a person in a sexual way that they considered inappropriate, or non-consensual intercourse. Again, one or more incidents in the previous 12 months were considered sexual abuse.

Psychological abuse was defined as the persistent use of threats, humiliation, bullying, swearing and other verbal conduct and/or any form of mental cruelty that resulted in mental or physical distress. The questions tried to capture experiences of verbal abuse such as swearing, insulting, threatening, and other kinds of emotional abuse such as undermining, belittling, preventing access to people the older person cares about, or preventing access to equipment such as walking aids. Psychological abuse was recorded if a person experienced 10 or more incidents in the previous 12 months or, if less than 10 incidents, if the abuse had a serious impact on the older person.

Neglect was defined as the repeated deprivation of assistance needed by the older person for important activities of daily living. The key concept here was that the older person was dependent on another person for help with one or more ADL. ADLs ranged from complex tasks such as shopping, preparing meals, doing routine jobs around the house, taking medicines, making routine journeys, to personal care activities such as dressing, getting in or out of bed, mobility, use of a toilet or eating. The older person was first asked if they needed help and who routinely or normally provided this help. Neglect was recorded if there were 10 or more incidents where help was not provided in the previous 12 months or, if less than 10 incidents, if it had a serious impact on the older person.

The individual questions asked are shown in Table 2.2.

In this report the term abuse is reserved for physical, sexual, financial and psychological experiences. Neglect is not included under this general term as in the majority of cases older people did not describe their carers as perpetrators of abuse. The term mistreatment is used to collectively refer to the five types of abuse. In addition, the term interpersonal abuse is used to describe psychological, physical and sexual abuse.

2.6.2 Questionnaire Development and Fieldwork

Once the key constructs and operational definitions were established the first phase in the development of the questionnaire involved the organisation of the questions into 7 discrete sections (Appendix 1). Section 1 collected information on marital status, health status, and service use. Section 2 introduced the concept of elder abuse and asked for older peoples' opinion on what elder abuse was and what behaviours they regarded as abusive (not included in this report). Section 3 established the person's functional ability using activities of daily living and if they had experienced neglect based on the operational definition (Table 2.2). Sections 4 and 5 dealt with experiences of financial, physical, psychological and sexual abuse. At the end of this section there was one final catchall question:
This survey is about elder abuse and neglect. We have asked a number of questions on this topic but I would like to ask one final question: have you ever experienced abuse or neglect since turning 65 years of age which we have not covered?
This allowed the person a final opportunity to disclose abuse. Section 6 aimed to establish outcomes from the abuse and provide information on perpetrators, and section 7 concentrated on demographics, social support and socio-economic data.

The second phase of questionnaire development involved a process of cognitive interviewing with a group of 10 older people. A real interview situation was simulated, the researcher noted questions that the participant found difficult to answer, or needed to be repeated or explained. Following the interview the participants identified areas they found difficult and discussed sections noted by the interviewer in order to identify lexical problems, inclusion/exclusion (skipped question), temporal problems, logical or computational problems (Drennan 2003).

Table 2.2 **Operational definition of elder abuse and neglect for Irish prevalence study**

Financial	One or more incidents in the past 12 months by family member, close friend, care worker 1. Stolen money or any of your possessions/property/land or documents 2. Deliberately prevented you access to your money/possessions/property/land or documents 3. Forced or misled you into giving them money/possessions/property/land or your pension book against your will 4. Forced or misled you to sign over ownership of your home or property or pension book against your will 5. Forced or misled you to change your will (Last Will/Testament) or any other financial documents against your will 6. Signed your name on cheque/pension book or other financial documents without your knowledge or permission 7. Misused the power of attorney you gave them or have been forced or misled into signing a power of attorney 8. Tried/pressured you (but not succeeded) in doing any of the previous (to steal money, property, change legal documents) 9. Stopped contributing to household expenses such as rent or food where this had been previously agreed
Physical	One or more incidents of physical abuse in the past 12 months by family member, close friend, care worker 1. Tried to slap or hit you 2. Pushed, grabbed, shoved or slapped you 3. Kicked, bit or hit you with a fist 4. Hit or tried to hit you with an object 5. Burned or scalded you 6. Given you drugs or too much medicine in order to control you or make you sleepy 7. Restrained you in any way e.g. locked you in your room, tied you in a chair 8. Threatened you with a knife, gun or other weapon 9. Injured you with a knife, gun or other weapon
Sexual	One or more incidents in the past 12 months by family member, close friend, care worker 1. Talked to you in a sexual way that you did not like 2. Touched you or tried to touch you in a sexual way you did not like/against your will 3. Forced you or tried to force you to have sexual intercourse against your will
Psychological	Ten or more incidents of psychological abuse in the past 12 months by family member, close friend, care worker, and/or if <10 the abuse had a serious impact 1. Insulted you, called you names or swore at you 2. Threatened you verbally 3. Undermined or belittled what you do 4. Excluded you or repeatedly ignored you 5. Threatened to harm others that you care about 6. Prevented you from seeing others that you care about or your doctor or nurse 7. Removed or prevented you access to equipment such as hearing or walking aids
Neglect	Neglect is based on an assessment of a person's ability to independently perform basic and complex activities of daily living. Neglect was identified if a person: (i) Stated they were unable to perform an activity independently. (ii) Had experienced refusal by a carer to supply help more than 10 times in past 12 months OR (iii) Not receiving the help was perceived by the older person as having a serious impact on them Complex activities of daily living are listed as: Shopping for food clothes, preparing food, housework, taking medication, using public transport or driving Basic activities of daily living are defined as cutting up and eating own food, moving around the house, going to the toilet, dressing, washing

All the participants found the questionnaire acceptable in terms of content and length and none of the abuse-related questions were described as too sensitive. The main problem encountered was temporal when participants were asked to think of abuse since 65 years, and then switching to the number of times the abuse occurred in the previous 12 months. The wording of the question was altered to emphasise the change in time frame.

The next step was to pilot the instrument with field interviewers. Sixty pilot interviews were conducted in five selected EDs in the Dublin area in order to test the questionnaire, response rate, interviewer adherence to random route, participant information leaflets and the safety protocols. Minor changes were made to the questionnaire following this pilot phase.

Instruments Used

The Short Form 8 (SF-8) is an 8 item health evaluation instrument based on the larger SF-36 and SF-12. It uses a 4 week recall period and 5 or 6 point Likert response scales. The SF-8 measures the same 8 health concepts as the larger instruments: perceived overall health, physical function, pain, vitality, social functioning, mental health, physical and emotional ability. It also measures two summary constructs for overall physical and mental health, physical composite score (PCS) and mental composite score (MCS). Unlike the other instruments the SF-8 uses one question for each health concept making it simpler and less burdensome to complete. This was borne out in the early stages of questionnaire testing in this survey, older respondents preferred the SF-8 to the SF-12. They found it easier to answer the questions resulting in fewer items being skipped. In the SF-8 the aggregated physical and mental health scores are transformed to achieve norm based scores (mean 50, SD 10) based on the general US population. Higher scores indicate better health, while PCS and MCS scores above and below 50 are considered above or below the average in the US population (Ware et al. 2001). The usability, reliability and validity of the SF-8 is increasingly recognised, especially in vulnerable populations (Turner-Bowker et al. 2003, Lefante et al. 2005, Roberts et al. 2008).

The Oslo-3 Social Support Scale is a three item instrument using 4 or 5 point Likert response scales. The questions relate to: 1) the number of people that the older person is close to (can rely on for help), 2) number of people who take a friendly interest, and 3) ease of obtaining help from neighbours. The items can be used individually or combined additively to give three categories. A score ranging between 3 and 8 is classified as poor support, a score between 9 and 11 as intermediate support, and a score between 12 and 14 represents strong support. The developer reported a Cronbach's alpha of 0.60, indicating relatively low reliability (Dalgard 2006). However the instrument was used in the SLÁN 2007 survey and it was decided to include it in this survey for comparison purposes. The Cronbach's alpha of the instrument was 0.61 in this population.

An additional question specifically related to family support was included, and asked about the ease of obtaining help from family. Including this item increased the Cronbach's alpha of the instrument to 0.71, however this item was reported separately.

Fieldwork

Data collection was completed between April and May 2010. All interviews were face-to-face, using paper questionnaire, and only took place during daylight hours. If a participant did not disclose mistreatment interviews lasted between 25-30 minutes. If a participant disclosed mistreatment interviews lasted between 40-60 minutes.

All interviewers were female and aged between 40 and 70 years, with a minimum of 2 years experience of face-to-face interviewing. They were not living in the EDs selected for data collection but lived in the same general region and shared a common regional accent. Experience from other researchers in this area indicated this interviewer profile would be less threatening for older people and more likely to achieve higher levels of participation and disclosure of abuse. All interviewers received training on elder abuse, how to screen and select potential participants, questionnaire layout, random route, recording response rate and safety protocols. This was backed up with an interviewer manual covering the study procedures and protocols, including a comprehensive list of organisations that an interviewer could direct an older person to if they disclosed abuse.

Participant Safety

One of the primary concerns regarding a sensitive topic such as elder abuse is participant safety and well-being. It was feasible that in some situations the abuse may be ongoing and the older person could be living with an abuser. For these reasons only one person per household was interviewed; the interview had to be in private and only the interviewee knew the true nature of the survey. Households did not receive advanced notice of the survey, nor was there national advertising of the survey prior to the start of the study. This decision was primarily a safety issue; if someone was living with an abuser then prior warning using postal information would alert the abuser to the survey and potentially prevent the older person's participation. The second concern was that bogus interviewers could use the study as a guise to gain access to an older person's home.

Local Garda (police) stations were informed of the survey prior to data collection in the ED and interviewers carried information which allowed a potential participant to verify the legitimacy of the survey with either the police station or the research office. At the end of completed or part completed interviews an information leaflet was left with participants. The purpose of the leaflet was to leave information on where to obtain help and advice regarding elder abuse (Appendix 2).

2.7 Sample Response

The sample response rate was 83% and was calculated as outlined below. In the course of the survey interviewers called to 5,658 households. There was no prior sampling frame of older people available so interviewers had to screen each household to identify eligible participants. The outcome from each visit was logged by the interviewers and categorised into three broad categories 'ineligible', 'eligibility could not be determined' (unknown eligibility) and 'eligible' (see Appendix 3 for a detailed outline of visit outcomes). Figure 2.1 outlines response outcomes. The eligible number of households was based on the total number of eligible households identified by interviewers (n=2,326) plus 11% (prevalence of ≥65 years in the population) of households where eligibility could not be established. Therefore, the total number of households assumed to be eligible was 2,447. Complete interviews were conducted with 2,021 people giving a response rate of 83%. The total number of refusals and incomplete interviews was 305 and consisted of 197 direct refusals from people aged 65 years or older, 26 incompletes and 82 people who were unavailable or declined to participate due to physical or mental ill health.

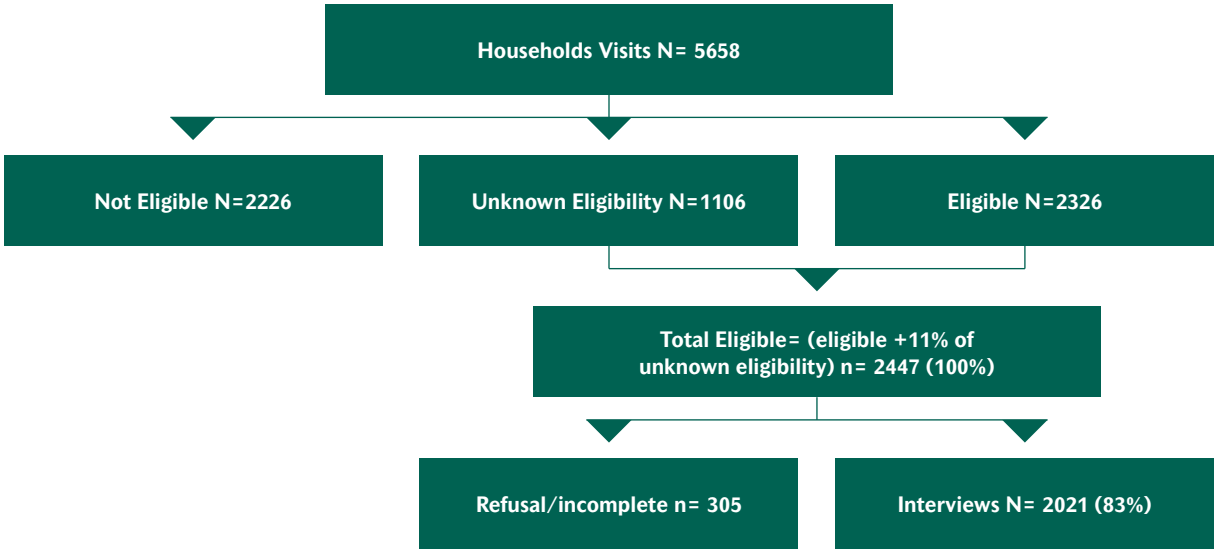

Figure 2.1 **Profile of household visits and interviews conducted**

2.8 Data Analysis

The survey estimated the prevalence of elder abuse and neglect in a population of community-dwelling people aged 65 years or older and characterised the profile of people who experienced mistreatment and those who perpetrated mistreatment.

Statistical Methods

In the preliminary analysis sample weighting was used to compensate for any biases in the distribution of characteristics in the completed survey sample compared to the general population of people aged 65 years or older. The distribution characteristics of the sample was adjusted in terms of age (65-69 years, 70-79 years, and ≥80 years), gender and marital status. The general population estimates for these factors were based on the 2006 Census (CSO 2007a). The weighting resulted in less than a 0.05% difference to the prevalence estimates and it was decided to present the unweighted data. The weighted data for the prevalence estimates are presented in Appendix 4. The analysis was adjusted for the cluster sample design.

Descriptive statistics were used, with the prevalence presented as a percentage (%) and number of cases (n), alongside the associated 95% confidence interval (CI) adjusted for the cluster design. Tests of significant differences between the mistreated group and the non-mistreated group were calculated using Fisher's exact test (small sample sizes) and an associated trend between variables was tested using the Cochrane-Armitage test for trend. Caution must be observed when examining the associations between variables due to the small number of abuse or neglect cases identified. Statistical analysis was performed using SAS 9.1 (CA).

3.1 Introduction

The survey collected information on 2,021 people aged 65 years or older living in private households. This equated to 0.4% of the national population of people aged 65 years or older. Population weighting for age, gender and marital status was applied to the study data but the sampling method, using quota sampling, ensured the data closely matched the distribution of these characteristics in the national population resulting in very minor changes. The proportions are therefore based on unweighted data but the weighted and unweighted bases are presented.

This chapter describes the survey population in terms of demographics, socio-economic characteristics, education, health status, service use and social support. The characteristics of the study population are compared to the national older population using the 2006 Census data from the Central Statistic Office of Ireland (CSO 2007a) and a recent national Survey of Lifestyle, Attitudes and Nutrition in Ireland, SLÁN 2007 (Morgan et al. 2008).

3.2 Socio-demographics

Location

Thirty-seven percent of the study population lived in a rural location (open countryside). The remainder lived in small, medium or large urban settings, with just over 20% living in Dublin city or county (Table 3.1). The population distribution differs slightly from the SLÁN 2007 survey which was based on a wider population, aged 18 years and older. There was a higher distribution of older people in rural or small villages in the sample with a corresponding lower proportion living in Dublin compared to the SLÁN 2007 survey (Morgan et al. 2008).

Ethnicity

In this population, 98% described themselves as white Irish, 0.25% were Irish Travellers and 1.4% were from other backgrounds, mainly 'other white non-Irish' (Table 3.2). The ethnic composition of the national older population is relatively homogenous, 93% are white Irish, compared to many other European countries (CSO 2007a). Less than 1% of the older Irish population are from countries such as Africa, Asia or China, reflecting the very low levels of emigration into the country before the early 1990s (CSO 2007a). Irish Travellers comprise just over 0.1% of the older national population (CSO 2007a), however a recent report suggests this may be a substantial underestimate (UCD School of Public Health, Physiotherapy and Population Science 2010).

Age and Gender

Fifty-five percent (1,109/2,021) of the study population were women and 45% (912/2,021) were men reflecting the current national distribution of 56% and 44% respectively for the 65 years and older age group. The mean age of the study population was 74 years (SD 6.6, min 65 years, max 98 years). The age profile of the study population closely matched that of the national population due to quota sampling across three age groups (Table 3.2).

Table 3.1 **Location: Comparison of prevalence survey and SLÁN 2007 survey**

	%	n 2021	Study total	SLÁN 2007 (≥18 years)
Open countryside	37	754	44%	41%
Village	7	134		
Town (1500+)	27	544	35%	35%
City (other than Dublin)	8	157		
Dublin City	19	386	21%	24%
Dublin County	2	45		

Table 3.2 **Socio-demographic profile: Comparison of prevalence survey and Irish population data (Census 2006)**

	Total number	Male	Female	Study total	Irish population (≥65 years)
	n	%	%	%	%
Age (years)					
65-69	573	31	26	28	31
70-79	972	46	49	48	45
≥80	476	23	24	24	24
Ethnicity					
White Irish	1987	98	98	98	93
Irish Traveller	5	0.3	0.2	0.3	0.1
Other	29	1.5	1.3	1.4	3
Marital status					
Ever-married[1]	1009	60	42	50	52
Widowed	705	20	47	35	31
Single	302	20	11	15	16
Bases unweighted	2021	912	1109		
Bases weighted	2021	893	1128		

[1] includes separated or divorced, but excludes widowed.

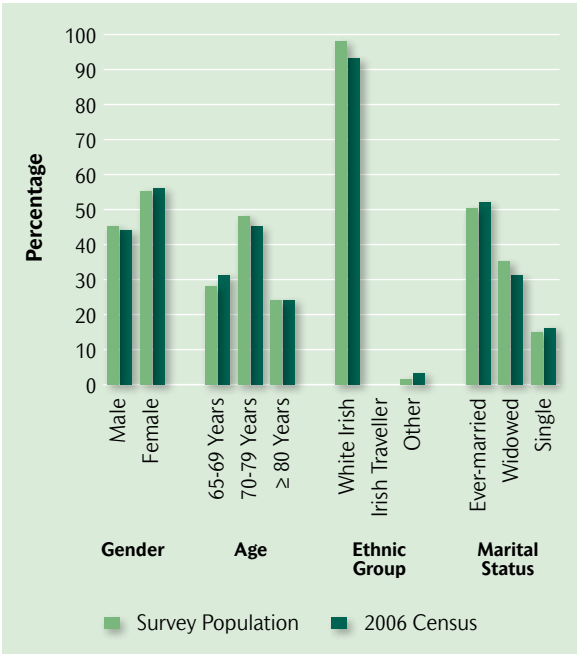

Figure 3.1 **Prevalence survey and Irish population (Census 2006) characteristics**

Relationships

The majority of participants were married and 4% of people were divorced or separated. Over one third of participants were widowed with slightly more women than men in this group, while men were more likely to be single. Compared to the 2006 Census data there was a slightly higher proportion of widowed participants in this study compared to the national population but the categories 'ever-married' and single were similar (Figure 3.1).

Just under half of the group (47%, 941/2,021) had a spouse or significant partner relationship while 53% (1,075/2,021) did not. Men (54%) were significantly more likely to be in a relationship compared to women (45%) ($p<0.001$). The proportion of people in partner relationships showed a significant decline with age, 58% (329/573) were married or partnered in the 65-69 years age group, 49% (475/972) in the 70-79 years age group, dropping to just 29% (137/476) in the 80 years or older age group (Cochran-Armitage test for trend $p<0.001$).

The survey population was comparable to the 2006 Census data for this age population (≥65 years) on important demographic characteristics (Figure 3.1). The number of participants in the different ethnic groups was too small to allow for further meaningful comparison.

Living Arrangements

Just over 40% of participants lived alone, with slightly more women than men in this group (Table 3.3). The most common shared living arrangement was with a spouse or partner (36%), 9% lived with a spouse and an adult child, and a further 8% lived with an adult child only. In total 20% (408/2,021) of participants were living in intergenerational households (adult children plus or minus their families) or in complex family arrangements involving extended family such as in-laws, siblings or grandchildren. Women were more likely to live in a complex household structure than men.

Table 3.3 **Living arrangements**

	Total n	Male %	Female %	Total %
Alone	873	39	46	43
Spouse/partner	730	42	31	36
Spouse & children +/-others	179	11	7	8.8
Adult children+/-others	169	4	12	8.3
Other relative or non-relatives	65	3	3	3.2
Refused	5	0.2	0.3	0.2
Bases unweighted	*2021*	*912*	*1109*	
Bases weighted	*2021*	*893*	*1128*	

3.3 Socio-economic Indicators

Education

The majority (68%) reported lower levels of education. Slightly more women completed secondary education but more men proceeded to third level education. The distribution is similar to the national population (Table 3.4); any variation could be explained by the 10% coded as unknown/other education category in the census data (CSO 2007a).

Social Class

The social class was based on the full-time or main occupation of the older person. In the case of a couple, social class was based on the main or full-time earner. This partly explained why there was an equal gender distribution in the professional and managerial categories. The largest occupational group was skilled manual, followed by non-manual and semi-skilled groups. There was considerable discrepancy between the 2006 Census and the survey data. This may in part be explained by the high level of 'unknown' or 'gainful employed but unidentified' category in the census data (33%) for this aged population (Table 3.4) (CSO 2007a).

Income

Just over 20% of the study population lived on the basic state pension for a single person (€219) and a further 51% lived on the minimum state pension for a couple (€438). In the higher income category there were slightly more men than women.

House Tenure

There was a high level of house ownership among both men and women (91%). One percent lived in a relative's home and 6% in rented accommodation, usually county council housing (social housing). A small number lived in housing for older people or a house provided by the church.

Table 3.4 **Education and socio-economic status: Comparison of prevalence survey and Irish population data (Census 2006)**

		Total number	Male	Female	Study total	Irish population (≥65 years)
		n	%	%	%	%
Education	Lower[1]	1384	71	66	68	62
	Intermediary[2]	429	17	25	21	21
	Higher[3]	208	12	9	10	7
Social class[4]	Professional/managerial	467	23	23	23	28
	Non-manual	488	21	27	24	11
	Skilled manual	527	30	23	26	12
	Semi/unskilled	481	24	25	24	14
	Other not classified	58	2	3	3	33
Income € **(per week)**	<€220	424	19	23	21	–
	€220-€438	1049	51	53	51	–
	>€438	548	30	25	27	–
House tenure	Own home	1835	91	91	91	–
	Live with relatives	26	1.1	1.4	1	–
	Rented	127	7	6	6	–
	Other	10	0.3	0.6	0.5	–
	Unknown	23	1	1	1	–
	Bases unweighted	2021	912	1109		
	Bases weighted	2021	893	1128		

[1] No formal education, primary, group or intermediate, basic skills.

[2] Leaving certificate, vocational/technical certificates.

[3] Degree or higher.

[4] The social class of the primary or full time worker was used, CSO social class classification see http://www.cso.ie/census/census2006_volume8.htm (appendix 3)

3.4 Health and Service Use

In this survey 45% of participants described their health as good or excellent. This was a little higher than a similar age group in the SLÁN 2007 national survey (Morgan et al. 2008). Levels of self-reported poor health were similar in both surveys at 5%-6%. Thirty-six percent (724/2,021) described themselves as having a long term illness or disability (>6 months) compared to 25% in the SLÁN Survey (Table 3.5). There is an apparent inconsistency in the two data sets, the survey population reported higher levels of excellent or very good health compared to people in the SLÁN 2007 survey, but also higher levels of long term illness. These differences may be due to how the question was asked or interpreted, e.g. long term illness as in this study or a long term illness that limits activities in SLÁN 2007 (Morgan et al. 2008).

The SF-8 health questionnaire was used to assess levels of physical and mental health in the survey population. Using norm based scores from a general population, 45% of this group had a physical health profile (physical health composite score (PCS)) below the US population average, while 26% had a mental health profile (mental health composite score (MCS)) below the US population average, of which 6% identified significant emotional problems.

Table 3.5 **Self-reported health status and measured health status using the SF-8**

	Total number	Male	Female	Study total	SLÁN 2007 (≥65 years)
	n	%	%	%	%
General health[1] excellent/very good	914	46	44	45	34
General health[1] poor	110	6	5	5	6
Long term illness	724	36	36	36	25
Physical Health Composite Score (SF-8) <50	900	42	46	45	–
Mental Health Composite Score (SF-8) <50	530	25	27	26	–
Bases unweighted	2021	912	1109		
Bases weighted	2021	893	1128		

[1] Self-reported general health.

Figure 3.2 shows the slightly higher levels of self-reported excellent or very good health in this survey population compared to the same age group in the SLÁN 2007 survey. Using the SF-8 health questionnaire there was a slightly higher proportion of women who recorded below average physical health scores (<50) compared to men, but there was no gender difference noted for mental health (Figure 3.2).

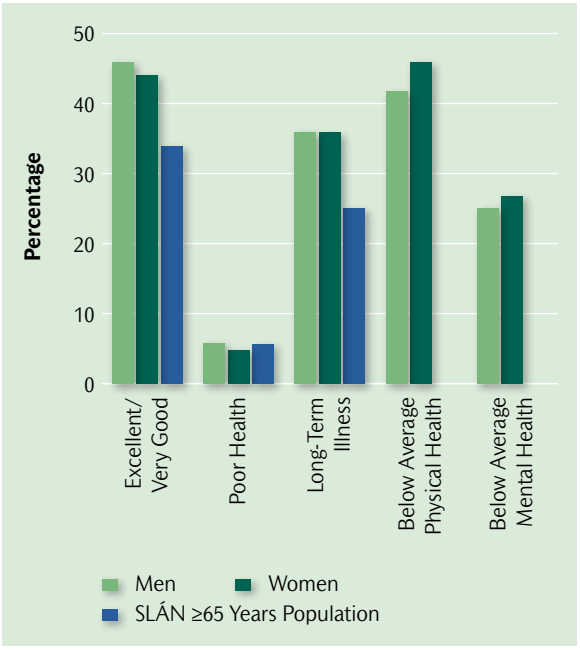

Figure 3.2 **Perceived and measured health status for men and women**

Informal Care

Eighteen percent of participants indicated they needed regular help with activities of daily living such as shopping, preparing meals and transport. Four percent required regular help with personal care activities such as washing, using the toilet or mobilising. In terms of formal support at home 13% of participants were in receipt of paid home help in the past six months.

Four percent of people aged 65 years or older in this sample provided regular help and care for a dependent, and a further 3% of participants indicated they had a primary carer who was aged 65 years or older. The census data indicated that nearly 4% of older people were engaged in informal care activities (CSO 2007a). This is lower than the 7% of households in this survey who indicated an older person was an informal carer.

Service Use

Over 90% (1,820/2,021) of participants had contact with some formal health or social service in the past six months, for the majority of people this was their GP practice (Table 3.6). The second most frequent point of contact was a hospital consultant (28%), followed by public health or community nursing (15%). Just over 1% had contact with a social worker and 13% of participants had regular contact with social or voluntary groups for older people.

Table 3.6 **Service use in the past six months**

Service	%	n 2021
GP	87	1765
GP Practice Nurse	33	661
Public Health Nurse	15	296
Social Worker	1.3	26
Meals-on-Wheels	2.9	60
Paid Home Help	13	265
Elderly Care Day Hospital	1.7	34
Community Psychiatric Nurse	0.8	16
Physiotherapist/Occupational Therapist	5	106
Hospital Consultant	28	569
Hospital admission	12	238
Emergency Department	7	144
Visits from voluntary groups	2	50
Involved in community groups	13	258
Other	3	67

3.5 Social Support

The Oslo-3 Social Support Scale was used to assess perceived levels of support based on the aggregate scores from 3 questions: 1) number of people that the older person is close to (can rely on for help), 2) number of people who take a friendly interest, and 3) ease of obtaining help from neighbours. An additional question related to ease of obtaining help from family was also included (Table 3.7). In this survey population, 59% of people felt well supported within their communities and 91% felt well supported by their families. Five percent felt they had poor community support and 2.5% felt they had poor family support. Men tended to report lower levels of support than women.

Table 3.7 **Social and family support: Comparison of prevalence survey with SLÁN 2007 survey**

	Total number	Male	Female	Study total	SLÁN 2007 (≥65 years)
	n	%	%	%	%
Community Social Support (Oslo-3 Social Support Scale)					
High	1185	55	62	59	–
Intermediate	728	39	34	36	–
Poor	108	6	5	5	–
Family support					
Easy/very easy to get help	1838	89	93	91	–
Possible	127	8	5	6	–
Difficult/very difficult	50	3	2	2.5	–
Individual questions from Oslo-3 Social Support Scale					
>3 people close	1386	65	72	69	79
Easy/very easy to get neighbours help	1754	86	87	87	81
Some or a lot of friendly interest	1802	87	91	89	80
Bases unweighted	2021	912	1109		
Bases weighted	2021	893	1128		

The SLÁN 2007 study reported the three questions from the Oslo-3 Social Support Scale separately. The comparable survey data is shown in Figure 3.3. In this survey, nearly 90% of participants reported high levels of 'neighbour help' and 'friendly interest' compared to 80% in the SLÁN data, but fewer participants in the survey population reported having three or more people close to them (Figure 3.3).

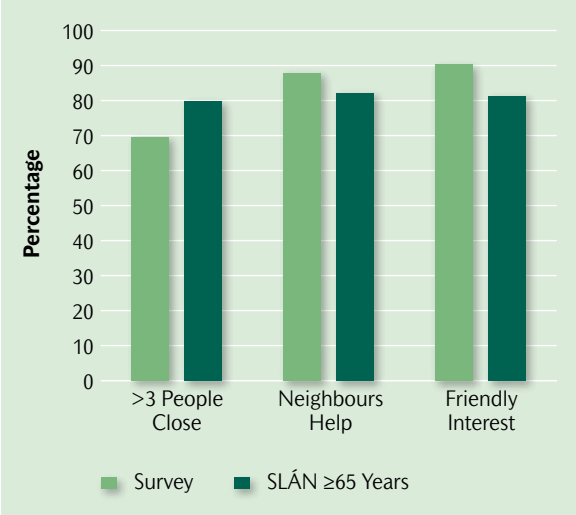

Figure 3.3 **Oslo-3 Social Support Scale: Comparison between prevalence survey and SLÁN 2007 survey**

3.6 Summary

The population in this survey was representative of the older national population. The majority of participants experienced good levels of health and social support. Nearly 20% of participants needed regular help with activities of daily living, 5% perceived their health to be poor or very poor, and between 2% and 5% of this group experienced low levels of support from families or within their community.

Key points

- In this study population 2.2% of people aged 65 years or older living in the community experienced abuse or neglect by a family member, close friend or care worker over the previous 12 months.
- In the general population this equates to 10,201 older people who experienced abuse or neglect.
- The most prevalent type of mistreatment reported was financial abuse at 1.3% (13 people per 1,000), followed by psychological abuse at 1.2% (12 people per 1,000), physical abuse at 0.5% (5 people per 1,000), neglect at 0.3% (3 people per 1,000), and sexual abuse at 0.05% (1 person per 1,000).
- Interpersonal abuse (psychological, physical and sexual abuse), at 1.3% (13 people per 1,000), accounted for 50% of the mistreatment reported. Mistreatment tended to occur in clusters, in particular psychological abuse was likely to accompany other types of mistreatment.
- Women reported higher levels of mistreatment than men (2.4% vs 1.9%), and this was mainly financial abuse followed by interpersonal abuse.
- People aged ≥80 years reported the highest level of mistreatment (2.5%) followed by the 70-79 years age group (2.4%), with the lowest level reported by the 65-69 years age group (1.6%).
- Those living in complex household structures were more likely to report mistreatment compared to those living on their own or with a spouse/partner.
- People with lower levels of education, on lower incomes and in a manual social class were more likely to have experienced mistreatment compared to those with higher levels of education, on higher incomes, and professional and non-manual social classes.
- People with perceived poor or very poor general health, or physical and mental health scores below the population average, were 3-6 times more likely to report mistreatment.
- People with poor levels of community or family support reported a higher prevalence of abuse or neglect.

4.1 Introduction

This chapter presents the one year prevalence of mistreatment that occurred within a relationship of trust, defined as family, relative, close friend or health care worker, in the previous 12 months. This is the most widely used international definition of elder abuse and neglect and asks people to recall experiences within a shorter time frame compared to 'since aged 65 years' and is less reliant on respondant recall. The overall prevalence and the individual types of mistreatment, and the characteristics of those who have experienced mistreatment are presented.

4.2 Overall Prevalence

The overall prevalence of elder abuse and neglect was 2.2% (44/2,021). Given a population of 467,926 people aged 65 years or older in the general population (CSO 2007a), the number of older people who reported experiences of mistreatment in the previous 12 months was estimated at 10,201, or just over one in forty-five of the older population (Table 4.1).

Table 4.1 **One year prevalence of mistreatment and population estimates**

Types of mistreatment	Prevalence[1]		General population estimates	
	% (n=2021)	95% Confidence Interval (CI)	n	95% CI
Financial	1.3 (27)	0.76-1.91	6,270	3,556-8,937
Psychological	1.2 (25)	0.66-1.82	5,802	3,088-8,516
Physical	0.5 (10)	0.14-0.85	2,293	655-3,977
Sexual	0.05 (1)	0.00-0.13	234	0-608
Neglect	0.3 (6)	0.02-0.57	1,404	94-2,667
Interpersonal (physical, psychological, sexual)	1.3 (26)	0.69-1.89	6,036	3,229-8,843
Any mistreatment in previous 12 months	**2.2 (44)**	**1.41-2.94**	**10,201**	**6,598-13,757**
Any mistreatment in previous 12 months (excluding neglect)	2.0 (41)	1.31-2.75	9,499	6,130-12,867

[1] Based on unweighted data, weighted data presented in Appendix 4.

4.3 Types of Mistreatment

Financial abuse at 1.3% was the most frequent type of mistreatment reported in the previous 12 months, followed by psychological abuse (1.2%), physical abuse (0.5%) and neglect (0.3%). Sexual abuse at 0.05% was the least common type of reported mistreatment (Figure 4.1).

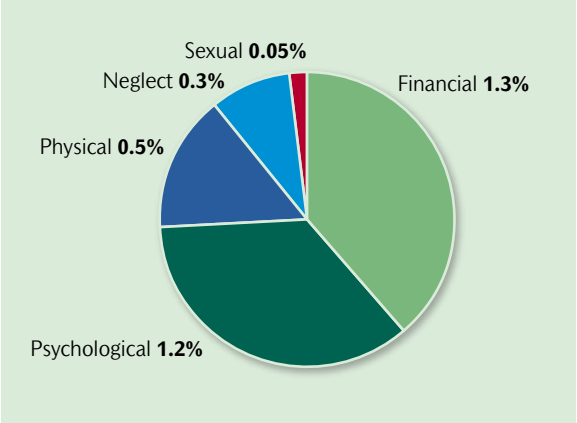

Figure 4.1 **Frequency of mistreatment types**

Previous studies have combined psychological, physical and sexual abuse because of the low number of cases, describing it as interpersonal abuse. In this study the prevalence of interpersonal abuse was 1.3% and was similar to the level of financial abuse.

4.3.1 Financial Abuse

There were 27 cases of financial abuse. Table 4.2 identifies the nine behaviours older people were asked about. The most frequently reported behaviour was being forced to give money or property to someone in a position of trust.

Table 4.2 **Behaviours related to financial abuse**

Types of financial abuse (n=27)	%[1]
Forced to give money or property	44
Denied access to money or property	40
Stolen money or possessions	33
Forced/misled to sign over ownership of home or property	26
Not contributing to household expenses	26
Pressured (but did not succeed) into signing over home ownership or giving money	22
Forged signature	11
Forced to change will	7
Misuse of power of attorney	4

[1] Percentages add to more than 100% because people experienced more than one kind of behaviour.

4.3.2 Psychological Abuse

Psychological abuse was defined as 10 or more episodes in the previous 12 months, or any episode that had a serious impact on the respondent. Twenty-five respondents reported the following behaviours: verbal insults at 76% was the most common type of psychological abuse reported, followed by being excluded (68%), or undermined (64%), verbal threats (56%), being prevented from seeing people the older person cares about (40%), this generally referred to grandchildren, and threatening to harm others they care about (12%). Respondents often identified more than one such behaviour.

4.3.3 Physical and Sexual Abuse

Ten respondents reported incidents of physical abuse, one of whom additionally reported sexual abuse. The majority of the abuse in this area related to being pushed (70%), threatened or hit with an object (40%), kicked (30%), denied access to equipment such as a walking or hearing aid (30%), or restrained (20%). One person also reported being threatened with a knife. Two of these incidents related to caring for a person with dementia or special needs.

4.3.4 Neglect

Neglect was defined as 10 or more incidents of an unmet need for help, or an incident of unmet need which had a serious impact on the participant. Eighteen percent of the study population (371/2,021) reported needing regular help with activities of daily living and 4% required additional help with personal care activities. The assessment of neglect was confined to this population. Six respondents were identified as having experienced neglect based on the study definition. All required help with activities of daily living such as shopping, transport and doing household tasks. Three respondents also needed help with personal care such as washing, dressing or mobilising.

4.3.5 Clustering of Mistreatment

Although five distinct types of mistreatment are recognised, they frequently occur in clusters. In this study population, one quarter (25%, 11/44) experienced more than one type of mistreatment, and 14% experienced three or more types of mistreatment. In particular, psychological abuse was likely to accompany other forms of abuse. For example, in nearly 100% of reported physical abuse cases there was accompanying psychological abuse, in over 40% of financial abuse cases there was corresponding psychological abuse, while in 50% of neglect cases there was financial abuse and psychological abuse (Table 4.3).

Table 4.3 **Number of people experiencing clusters of mistreatment**

Types of mistreatment	Financial	Neglect	Psycho-logical	Physical/ Sexual
	n	n	n	n
Financial	–	3	12	4
Neglect	3	–	3	1
Psychological	12	3	–	9
Physical/Sexual	4	1	9	–

4.4 Socio-demographic Characteristics of People who Reported Mistreatment

4.4.1 Age and Gender

Overall, women (2.4%) were more likely than men (1.9%) to report experiences of mistreatment, in particular financial and interpersonal abuse. People aged 70-79 years and aged 80 years or older experienced similar levels of overall mistreatment, double that of people aged 65-69 years. Those aged 70-79 years experienced more interpersonal abuse, while financial abuse was more common in the other two age groups. Financial abuse increased for both men and women in the ≥80 years age group (Table 4.4).

Table 4.4 **Mistreatment type stratified by age and gender**

	65-69 years	70-79 years	≥80 years
	% (n)	% (n)	% (n)
Men	*n=281*	*n=424*	*n=207*
Financial	0.3 (2)	0.3 (3)	1.1 (5)
Interpersonal	– (0)	1.7 (7)	1.5 (3)
Neglect	– (0)	0.2 (1)	0.5 (1)
Any mistreatment	0.7 (2)	2.1 (9)	2.9 (6)
Women	*n=292*	*n=548*	*n=269*
Financial	1.7 (5)	1.3 (7)	1.9 (5)
Interpersonal	1.0 (3)	1.6 (9)	1.5 (4)
Neglect	– (0)	0.7 (4)	– (0)
Any mistreatment	2.4 (7)	2.6 (14)	2.2 (6)
All	*n=573*	*n=972*	*n=476*
Financial	1.2 (7)	1.0 (10)	2.1 (10)
Interpersonal	0.5 (3)	1.7 (16)	1.5 (7)
Neglect	– (0)	0.5 (5)	0.2 (1)
Any mistreatment	1.6 (9)	2.4 (23)	2.5 (12)

Across the age groups women remained at higher risk of mistreatment than men. However by 80 years there was a merging of the risk; the risk for women slightly decreased compared to the 70-79 years age group, but it increased for men, especially for financial abuse (Figure 4.2).

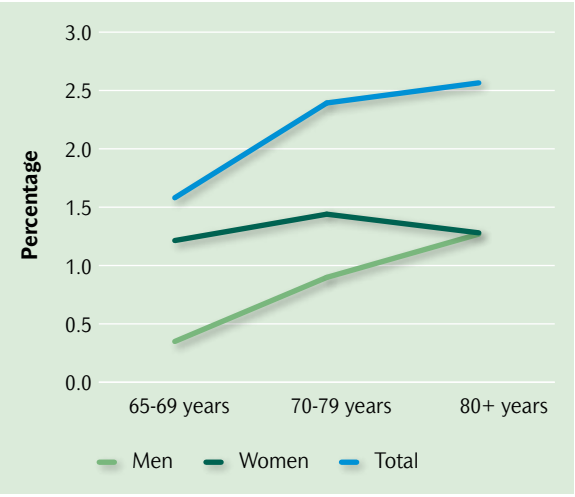

Figure 4.2 **Any mistreatment stratified by age and gender**

4.4.2 Age Mistreatment Started

Participants were asked the age they were when the mistreatment they described first started. The mean age was 62 years (SD 15). The age at which mistreatment began ranged from 10 years of age to 80 years. Over a third (34%, 15/44) indicated the mistreatment started before aged 65 years. In these cases the mistreatment was clustered around financial abuse and interpersonal abuse.

4.4.3 Marital Status

Overall the highest level of mistreatment occurred in people who were divorced or separated, however the number of people in this category was quite small (Table 4.5). People who were widowed had the second highest mistreatment levels, while being single carried the lowest risk. Interpersonal abuse was most frequently reported by both married men and women, while financial abuse was most frequently reported by widowed men, and for widowed women this was the second most frequently reported type of mistreatment after interpersonal abuse. In both single men and women financial abuse was the most common type of mistreatment.

Table 4.5 **Mistreatment type stratified by marital status and gender**

	Currently married	Widowed	Single	Divorced/ separated
	% (n)	% (n)	% (n)	% (n)
Men	*n=495*	*n=184*	*n=184*	*n=48*
Financial	0.8 (4)	2.2 (4)	1.1 (2)	– (0)
Neglect	0.2 (1)	0.5 (1)	– (0)	– (0)
Interpersonal	1.0 (5)	1.1 (2)	0.5 (1)	4.2 (2)
Any mistreatment	1.4 (7)	3.3 (6)	1.1 (2)	4.2 (2)
Women	*n=433*	*n=521*	*n=118*	*n=33*
Financial	1.4 (6)	1.5 (8)	1.7 (2)	3.0 (1)
Neglect	0.2 (1)	0.6 (3)	– (0)	– (0)
Interpersonal	1.6 (7)	1.7 (9)	– (0)	– (0)
Any mistreatment	2.3 (10)	2.7 (14)	1.7 (2)	3.0 (1)
All	*n=928*	*n=705*	*n=302*	*n=81*
Financial	1.1 (10)	1.7 (12)	1.3 (4)	1.2 (1)
Neglect	0.2 (2)	0.6 (4)	– (0)	– (0)
Interpersonal	1.3 (12)	1.6 (11)	0.3 (1)	2.5 (2)
Any mistreatment	1.8 (17)	2.8 (20)	1.3 (4)	3.7 (3)

4.4.4 Living Arrangements

The highest levels of mistreatment occurred in complex households, in particular where one older person lived in an intergenerational household, usually comprising an adult child and their family or other relatives such as grandchildren (Table 4.6). The second highest risk group was an older couple living in an intergenerational household, or with other older relatives. Overall 3.4% (14/413) of the participants who lived in complex household structures experienced mistreatment, compared to 1.9% (30/1,613) of those who lived alone or with their spouse or partner. Older men and women were equally likely to experience interpersonal and financial abuse when living in complex households. People who lived alone had higher levels of mistreatment compared to married couples living on their own.

Table 4.6 **Mistreatment type stratified by living arrangements and gender**

	Alone	Spouse/ partner	Spouse plus other	Adult child or others
	% (n)	% (n)	% (n)	% (n)
Men	*n=360*	*n=377*	*n=100*	*n=63*
Financial	1.1 (4)	0.8 (3)	1.0 (1)	3.0 (2)
Neglect	0.3 (1)	0.3 (1)	– (0)	– (0)
Interpersonal	0.6 (2)	1.3 (5)	– (0)	4.6 (3)
Any mistreatment	1.9 (7)	1.6 (6)	1.0 (1)	4.6 (3)
Women	*n=513*	*n=347*	*n=78*	*n=168*
Financial	1.2 (6)	1.4 (5)	1.3 (1)	3.0 (5)
Neglect	0.2 (1)	– (0)	1.3 (1)	1.2 (2)
Interpersonal	1.0 (5)	1.2 (4)	3.9 (3)	2.4 (4)
Any mistreatment	2.0 (10)	2.0 (7)	3.9 (3)	4.2 (7)
All	*n=873*	*n=730*	*n=179*	*n=234*
Financial	1.2 (10)	1.1 (8)	1.1 (2)	2.9 (7)
Neglect	0.2 (2)	0.1 (1)	0.6 (1)	0.9 (2)
Interpersonal	0.8 (7)	1.2 (9)	1.7 (3)	3.0 (7)
Any mistreatment	2.0 (17)	1.8 (13)	2.2 (4)	4.3 (10)

Figure 4.3 shows that interpersonal abuse tended to be more prevalent in complex households and where a couple lived together. Financial abuse was also a prominent feature in complex households. Financial abuse was the dominant type of mistreatment identified for older people who lived alone.

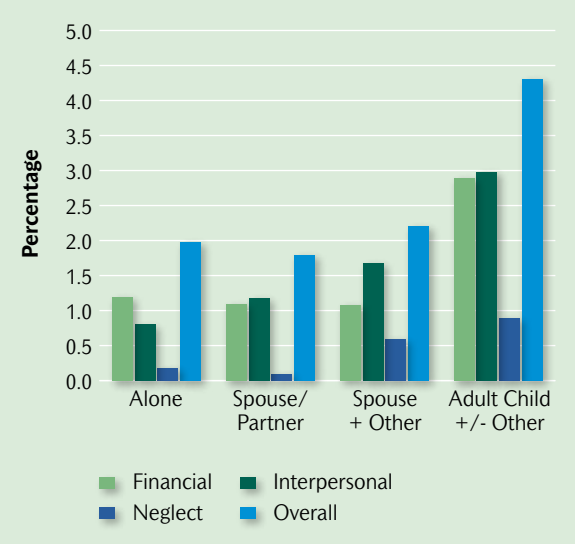

Figure 4.3 **Living arrangements and prevalence of mistreatment**

4.4.5 Home Location

Older people living in villages or towns reported the highest levels of mistreatment (2.5%), followed by people living in the open countryside (2.3%) while people living in cities had the lowest levels of mistreatment (1.7%) (Table 4.7). Women living in rural locations reported the highest levels of financial and interpersonal abuse and neglect. Men in rural locations reported the highest levels of financial abuse but those living in urban locations reported higher levels of interpersonal abuse.

Table 4.7 **Mistreatment type stratified by home location**

	Open country-side	Village/ town	City
	% (n)	% (n)	% (n)
Men	*n=364*	*n=310*	*n=238*
Financial	1.7 (6)	1.0 (3)	0.4 (1)
Neglect	0.3 (1)	0.3 (1)	– (0)
Interpersonal	0.8 (3)	1.3 (4)	1.3 (3)
Any mistreatment	1.6 (6)	2.3 (7)	1.7 (4)
Women	*n=390*	*n=413*	*n=305*
Financial	1.8 (7)	1.5 (6)	1.3 (4)
Neglect	0.8 (3)	0.2 (1)	– (0)
Interpersonal	1.8 (7)	1.9 (8)	0.3 (1)
Any mistreatment	2.8(11)	2.7 (11)	1.6 (5)
All	*n=754*	*n=723*	*n=543*
Financial	1.7 (13)	1.2 (9)	0.9 (5)
Neglect	0.5 (4)	0.2 (2)	– (0)
Interpersonal	1.3 (10)	1.7 (12)	0.7 (4)
Any mistreatment	2.3 (17)	2.5 (18)	1.7 (9)

4.4.6 Education

There was an inverse relationship between level of mistreatment and level of education. Higher levels of mistreatment were reported by those who had lower levels of education, with the lowest level of mistreatment occurring in those who held degrees or higher awards (Table 4.8). This trend was particularly evident for women.

Table 4.8 **Mistreatment type stratified by education and gender**

	Lower[1]	Inter-mediary[2]	Higher[3]
	% (n)	% (n)	% (n)
Men	*n=648*	*n=154*	*n=110*
Financial	1.4 (9)	0.7 (1)	– (0)
Neglect	0.3 (2)	– (0)	– (0)
Interpersonal	1.4(9)	– (0)	0.9 (1)
Any mistreatment	2.3 (15)	0.7 (1)	0.9 (1)
Women	*n=736*	*n=275*	*n=98*
Financial	1.6 (12)	1.8 (5)	– (0)
Neglect	0.5 (4)	– (0)	– (0)
Interpersonal	1.6 (12)	1.1 (3)	1.0 (1)
Any mistreatment	2.6 (19)	2.6 (7)	1.0 (1)
All	*n=1384*	*n=429*	*n=208*
Financial	1.5 (21)	1.4 (6)	– (0)
Neglect	0.4 (6)	– (0)	– (0)
Interpersonal	1.5 (21)	0.7 (3)	1.0 (2)
Any mistreatment	2.5 (34)	1.9 (8)	1.0 (2)

[1] No formal education, primary, group or intermediate, basic skills.
[2] Leaving certificate, vocational/technical certificates.
[3] Degree or higher.

4.4.7 Socio-economic Group

The highest levels of mistreatment were reported by people in the skilled manual or semi-skilled/unskilled/ never worked social classification. Similar levels of mistreatment were reported by those in professional/ managerial and the non-manual social classification (Table 4.9). Both men and women in the semi-skilled/ unskilled category reported higher levels of interpersonal abuse than other groups, while men in the non-manual classification were more likely to report financial abuse. In contrast, women in the skilled or semi-skilled/unskilled category reported higher levels of financial abuse.

Table 4.9 **Mistreatment type stratified by social classification and gender**

	Managerial/ professional	Non-manual	Skilled manual	Semi-skilled/ unskilled/ other[1]
	% (n)	% (n)	% (n)	% (n)
Men	*n=212*	*n=208*	*n=269*	*n=223*
Financial	– (0)	1.9 (4)	1.5 (4)	0.9 (2)
Neglect	– (0)	– (0)	0.7 (2)	– (0)
Interpersonal	0.9 (2)	– (0)	1.1 (3)	2.2 (5)
Any mistreatment	0.9 (2)	1.9 (4)	2.2 (6)	2.2 (5)
Women	*n=255*	*n=323*	*n=258*	*n=273*
Financial	0.8 (2)	1.2 (4)	1.9 (5)	2.2 (6)
Neglect	– (0)	0.3 (1)	0.4 (1)	0.7 (2)
Interpersonal	1.6 (4)	0.6 (2)	1.2 (3)	2.6 (7)
Any mistreatment	2.4 (6)	1.6 (5)	3.1 (8)	2.9 (8)
All	*n=467*	*n=531*	*n=527*	*n=496*
Financial	0.4 (2)	1.5 (8)	1.7 (9)	1.6 (8)
Neglect	– (0)	0.2 (1)	0.6 (3)	0.4 (2)
Interpersonal	1.3 (6)	0.4 (2)	1.1 (6)	2.4 (12)
Any mistreatment	1.7 (8)	1.7 (9)	2.7 (14)	2.6 (13)

[1] Never worked, work not classified.

4.4.8 Income

As with level of education there was an inverse relationship between level of overall mistreatment and weekly income (Table 4.10). People living on less than €220 per week, the minimum state pension for a single person, reported the highest level of mistreatment, followed by those living on €220-€438 per week, the minimum state pension for a married couple. There was a significant decrease in the levels of mistreatment in the higher income groups. Interpersonal abuse was highest for both men and women in the lower income group, and decreased with increased levels of income, while financial abuse was highest for people living on €220-€438 per week.

Table 4.10 **Mistreatment type stratified by income and gender**

Income per week	<€220	€220-€438	€439-€648	>€648
	% (n)	% (n)	% (n)	% (n)
Men	*n=173*	*n=466*	*n=161*	*n=102*
Financial	1.2 (2)	1.3 (6)	1.2 (2)	– (0)
Neglect	0.6 (1)	0.2 (1)	– (0)	– (0)
Interpersonal	1.7 (3)	1.3 (6)	0.6 (1)	– (0)
Any mistreatment	2.3 (4)	2.2 (10)	1.9 (3)	– (0)
Women	*n=251*	*n=583*	*n=182*	*n=90*
Financial	1.2 (3)	2.2 (13)	0.6 (1)	– (0)
Neglect	0.4 (1)	0.5 (3)	– (0)	– (0)
Interpersonal	2.4 (6)	1.4 (8)	0.6 (1)	1.11(1)
Any mistreatment	3.2 (8)	2.8 (16)	1.1 (2)	1.11 (1)
All	*n=424*	*n=1049*	*n=343*	*n=192*
Financial	1.2 (5)	1.8 (19)	0.9 (3)	– (0)
Neglect	0.5 (2)	0.4 (4)	– (0)	– (0)
Interpersonal	2.1 (9)	1.3 (14)	0.6 (2)	0.5 (1)
Any mistreatment	2.8 (12)	2.5 (26)	1.5 (5)	0.5 (1)

Figure 4.4 depicts the strong association between overall mistreatment and socio-economic markers, with lower weekly income, in particular, showing a linear trend, in that the lower the income the higher the level of mistreatment reported. The graph also highlights the higher levels of mistreatment experienced by women in all socio-economic groups compared to men, and the stronger association with economic indicators.

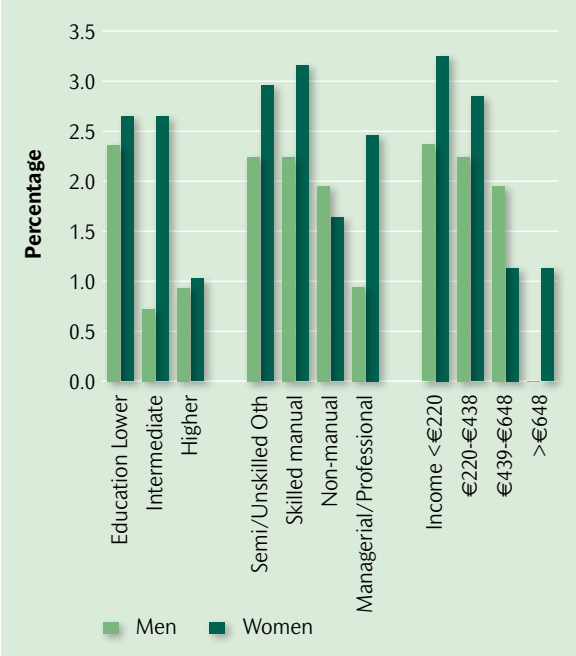

Figure 4.4 **Any mistreatment stratified by gender and socio-economic indicators**

4.5 Health and Service Use of People who Reported Mistreatment

This section describes the pattern of mistreatment in relation to participants perceived health status and their general physical and mental health, as measured using the SF-8 questionnaire. Mistreatment and contact with formal and informal services was also examined.

4.5.1 Self-reported General Health

There was a distinct trend in relation to perceived health status and prevalence of mistreatment, with increased levels of mistreatment correlated with decreasing levels of health (Cochran-Armitage trend test $p<0.001$) (Table 4.11). Financial abuse and interpersonal abuse increased in both men and women who perceived their health to be poor, or very poor. This association was also seen in people with a long term illness. This group reported nearly three times higher levels of mistreatment compared to the rest of the study population, 3.6% (26/724) and 1.4% (18/1,297) respectively ($p=0.004$).

Table 4.11 **Mistreatment type stratified by self-reported health and gender**

Self-reported health	Excellent/ very good	Good/ fair	Poor/very poor
	% (n)	% (n)	% (n)
Men	*n=423*	*n=314*	*n=175*
Financial	0.2 (1)	1.6 (5)	2.3 (4)
Neglect	– (0)	0.3 (1)	0.6 (1)
Interpersonal	0.7 (3)	1.3 (4)	1.7 (3)
Any mistreatment	0.7 (3)	2.2 (7)	4.0 (7)
Women	*n=491*	*n=359*	*n=259*
Financial	0.8 (4)	2.0 (7)	2.3 (6)
Neglect	– (0)	0.6 (2)	0.8 (2)
Interpersonal	0.6 (3)	1.7 (6)	2.7 (7)
Any mistreatment	1.0 (5)	3.3 (12)	3.9 (10)
All	*n=914*	*n=673*	*n=434*
Financial	0.6 (5)	1.8 (12)	2.3 (10)
Neglect	– (0)	0.5 (3)	0.7 (3)
Interpersonal	0.7 (6)	1.5 (10)	2.3 (10)
Any mistreatment	0.9 (8)	2.8 (19)	3.9 (17)

Self-reported General Health and Age

The three age groups (65-69 years, 70-79 years, ≥80 years) showed a similar increase in the prevalence of mistreatment with decreasing perceived levels of health. In each age group the highest prevalence of mistreatment was reported by those who felt their health was poor or very poor, and was highest in the 70-79 years age group (Table 4.12).

Table 4.12 **Mistreatment type stratified by self-reported health and age**

Self-reported health	Excellent/ very good	Good/ fair	Poor/very poor
	% (n)	% (n)	% (n)
65-69 years	*n=335*	*n=161*	*n=77*
Financial	0.3 (1)	1.9 (3)	3.9 (3)
Neglect	– (0)	– (0)	– (0)
Interpersonal	– (0)	1.2 (2)	1.3 (1)
Any mistreatment	0.3 (1)	3.1 (5)	3.9 (3)
70-79 years	*n=414*	*n=342*	*n=216*
Financial	0.5 (2)	1.5 (5)	1.4 (3)
Neglect	– (0)	0.6 (2)	1.4 (3)
Interpersonal	1.2 (5)	1.5 (5)	2.8 (6)
Any mistreatment	1.2 (5)	2.6 (9)	4.17 (9)
≥80 years	*n=165*	*n=170*	*n=141*
Financial	1.2 (2)	2.4 (4)	2.8 (4)
Neglect	– (0)	0.6 (1)	– (0)
Interpersonal	0.6 (1)	1.8 (3)	2.1 (3)
Any mistreatment	1.2 (2)	2.9 (5)	3.6 (5)

4.5.2 Physical and Mental Health Status

The SF-8 was used to calculate summary measures of physical health (physical health composite score) and mental health (mental health composite score). The survey population was stratified into people who had below population average scores, and people with average and above average physical and mental health scores.

Physical and Mental Health by Gender

In relation to the physical health scale, people who scored below average had levels of mistreatment over three times that of people who recorded average or higher scores (Table 4.13). This was true for both men and women. Similarly, people with below average mental health scores had over six times higher levels of mistreatment compared to people with average or higher scores. Both interpersonal and financial abuse were more commonly reported by men and women with below average mental health scores compared to those with below average physical health scores, while neglect was similar across both groups.

Table 4.13 **Mistreatment type stratified by physical and mental health (SF-8) and gender**

	Physical Health Composite Score		Mental Health Composite Score	
	Below average (<50) % (n)	Average or above (≥50) % (n)	Below average (<50) % (n)	Average or above (≥50) % (n)
Men	*n=384*	*n=528*	*n=228*	*n=684*
Financial	1.8 (7)	0.6 (3)	2.6 (6)	0.6 (4)
Neglect	0.5 (2)	– (0)	0.4 (1)	0.2 (1)
Interpersonal	1.8 (7)	0.6 (3)	3.5 (8)	0.3 (2)
Any mistreatment	3.1 (12)	1.0 (5)	5.3 (12)	0.7 (5)
Women	*n=516*	*n=593*	*n=302*	*n=807*
Financial	2.3 (12)	0.8 (5)	3.6 (11)	0.7 (6)
Neglect	0.8 (4)	– (0)	1.0 (3)	0.1 (1)
Interpersonal	2.3 (12)	0.7 (4)	4.3 (13)	0.4 (3)
Any mistreatment	3.9 (20)	1.2 (7)	6.0 (18)	1.1 (9)
All	*n=900*	*n=1121*	*n=530*	*n=1491*
Financial	2.1 (19)	0.7 (8)*	3.2 (17)	0.7(10)*
Neglect	0.7 (6)	– (0)	0.8 (4)	0.1 (2)
Interpersonal	2.1 (19)	0.6 (7)*	4.0 (21)	0.3 (5)*
Any mistreatment	3.6 (32)	1.1 (12)*	5.7 (30)	0.9 (14)*

* Fishers-exact test for significant difference between groups $p<0.001$.

Figure 4.5 shows the strong relationship between both perceived and measured poor health and the different types of abuse and neglect. People with below average physical health reported similar levels of financial and interpersonal abuse. People with below average mental health reported higher levels of interpersonal abuse.

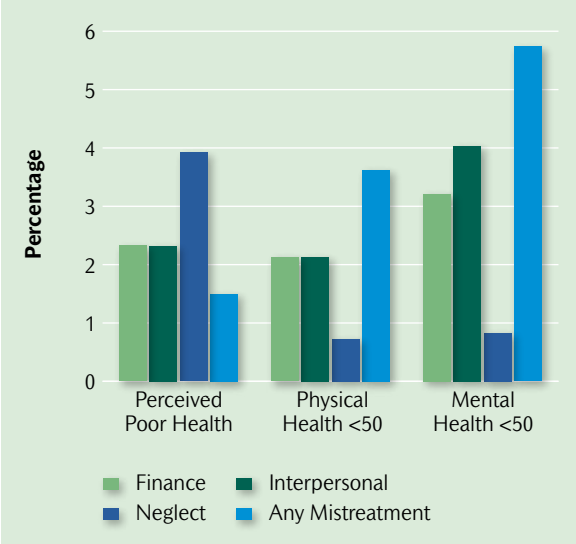

Figure 4.5 **Health status and prevalence of mistreatment**

Physical and Mental Health by Age

Stratifying the physical and mental health scores by age, the prevalence of mistreatment was highest among the 65-69 years age group with below average scores on physical health. This was nearly 5% compared to approximately 3% in the other age groups. This was mainly due to a greater number of financial abuse cases (Table 4.13). In relation to mental health scores, the highest level of mistreatment occurred in the 70-79 years age group with below average mental health scores, 7% compared to 4% in the other two groups. Interpersonal abuse was particularly common in this age group (Table 4.14).

Table 4.14 **Mistreatment type stratified by physical and mental health (SF-8) and age**

	Physical Health Composite Score		Mental Health Composite Score	
	Below average (<50) % (n)	Average or above (≥50) % (n)	Below average (<50) % (n)	Average or above (≥50) % (n)
65-69 years	*n=166*	*n=407*	*n=118*	*n=455*
Financial	3.6 (6)	0.3 (1)	3.4 (4)	0.7 (3)
Neglect	– (0)	– (0)	– (0)	– (0)
Interpersonal	1.8 (3)	– (0)	1.7 (2)	0.2 (1)
Any mistreatment	4.8 (8)	0.3 (1)	4.2 (5)	0.9 (4)
70-79 years	*n=427*	*n=545*	*n=252*	*n=720*
Financial	1.4 (6)	0.7 (4)	3.2 (8)	0.3 (2)
Neglect	1.2 (5)	– (0)	1.6 (4)	0.1 (1)
Interpersonal	2.3 (10)	1.1 (6)	5.6 (14)	0.3 (2)
Any mistreatment	3.5 (15)	1.5 (8)	7.1 (18)	0.7 (5)
≥80 years	*n=307*	*n=169*	*n=160*	*n=316*
Financial	2.3 (7)	1.8 (3)	3.1 (5)	1.6 (5)
Neglect	0.3 (1)	– (0)	– (0)	0.3 (1)
Interpersonal	2.0 (6)	0.6 (1)	3.1 (5)	0.6 (2)
Any mistreatment	3.0 (9)	1. 8 (3)	4.4 (7)	1.6 (5)

4.5.3 Contact with Services

All participants who experienced mistreatment had accessed some kind of formal health or social service within the last six months. By far the most likely point of contact was a GP practice, with all but one participant who disclosed mistreatment visiting a GP practice in the last six months (Table 4.15). Over three quarters of this group (77%, 34/44) had high frequency contact, defined as two or more visits in the past six months.

Excluding GP practices, 61% (27/44) of those who disclosed mistreatment had contact with other health carers or professionals, and 20% (9/44) had contact with voluntary or social support organisations (Table 4.15). In addition to the GP practice, people who disclosed mistreatment were significantly more likely to contact other formal health or social services compared to non-mistreatment participants ($p=0.02$). There was no significant difference between the groups in terms of contact with social support groups ($p=0.40$).

Table 4.15 **Mistreatment type by formal and informal service contact in past six months**

	GP/Practice nurse	Community nurse	Social worker	Hospital services	Community health supports[1]	Social supports[2]
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
All	*n=1776*	*n=303*	*n=26*	*n=663*	*n=378*	*n=322*
Financial	1.5 (26)	3.6 (11)	7.7 (2)	1.5 (10)	3.2 (12)	1.9 (6)
Neglect	0.3 (6)	1.0 (3)	– (0)	0.5 (3)	0.8 (3)	0.3 (1)
Interpersonal	1.5 (26)	3.6 (11)	– (0)	1.7 (11)	2.4 (9)	0.9 (3)
Any mistreatment	2.4 (43)	5.8 (16)	7.7 (2)	2.4 (16)	4.8 (18)	2.8 (9)
Men	*n=782*	*n=131*	*n=11*	*n=315*	*n=150*	*n=122*
Any mistreatment	2.2 (17)	6.1 (8)	18 (2)	2.9 (9)	6.7 (10)	2.5 (3)
Women	*n=994*	*n=172*	*n=15*	*n=348*	*n=228*	*n=200*
Any mistreatment	2.6 (26)	4.7 (8)	– (0)	2.0 (7)	3.5 (8)	3.0 (6)

[1] Meals on wheels, paid home help, community physiotherapist/occupational therapist, community psychiatric nurse.
[2] Voluntary or social/leisure community groups.

4.6 Social Support Characteristics of People who Reported Mistreatment

The Oslo-3 Social Support Scale was used to identify levels of social support within the community, with an additional question asked relating to family support.

Community Support

Mistreatment was present across all levels of support but there was an association between the level of social support and the prevalence of mistreatment in the previous 12 months (Table 4.16). People with poor levels of community support were three to four times more likely to report mistreatment compared to those with strong or moderate levels of community support ($p=0.02$). Interpersonal abuse was most likely to be reported by those with poor community support. Women with poor support were particularly vulnerable to interpersonal and financial abuse.

Table 4.16 **Mistreatment type by levels of community social support**

	Strong support	Moderate support	Poor support
	% (n)	% (n)	% (n)
Men	*n=500*	*n=356*	*n=56*
Financial	1.0 (5)	1.4 (5)	– (0)
Neglect	0.2 (1)	0.3 (1)	– (0)
Interpersonal	1.2 (6)	0.6 (2)	3.6 (2)
Any mistreatment	1.6 (8)	2.0 (7)	3.6 (2)
Women	*n=685*	*n=372*	*n=52*
Financial	0.9 (6)	2.2 (8)	5.8 (3)
Neglect	0.3 (2)	0.3 (1)	1.9 (1)
Interpersonal	0.7 (5)	1.6 (6)	9.6 (5)
Any mistreatment	1.6 (11)	2.69 (10)	11.5 (6)
All	*n=1185*	*n=728*	*n=108*
Financial	0.9 (11)	1.8 (13)	2.8 (3)
Neglect	0.3 (3)	0.3 (2)	0.9 (1)
Interpersonal	0.9 (11)	1.1 (8)	6.5 (7)
Any mistreatment*	1.6 (19)	2.3 (17)	7.4 (8)

Family Support

Strong family support appeared to offer protection against mistreatment but did not eliminate the risk (Table 4.17). People who perceived they had moderate or poor family support shared a similar risk of mistreatment. The level of mistreatment was over three times higher in these groups compared to people with strong family support ($p<0.01$).

Table 4.17 **Mistreatment type by levels of family support**

	Strong support	Moderate support	Poor support
	% (n)	% (n)	% (n)
All	*n=1838*	*n=127*	*n=50*
Financial	1.0 (19)	3.9 (5)	6.0 (3)
Neglect	0.2 (4)	0.8 (1)	2.0 (1)
Interpersonal	0.9 (17)	6.3 (8)	2.0 (1)
Any mistreatment	1.7 (32)	7.1 (9)	6.0 (3)

4.7 Summary

Using an internationally recognised definition of elder abuse, 2.2% of the study population experienced abuse or neglect. When extrapolated to the general population this equates to 10,201 older people. Patterns of mistreatment varied between men and women, and across the different age groups. Overall women reported higher levels of mistreatment than men. With regard to age, men aged ≥80 years reported the highest levels of mistreatment, mainly financial abuse, while women in the 70-79 years age group reported the highest levels of mistreatment, mainly interpersonal abuse. Socio-economic markers and health status were strongly correlated with prevalence of mistreatment, as was level of community and family support.

Key points

- The most frequently identified group of perpetrators of abuse or neglect in the past 12 months and within a relationship of trust were adult children (50%), followed by other relatives (24%) and spouse/partner (20%).
- Adult children were equally likely to be implicated in financial and interpersonal abuse, while spouse/partners were more frequently involved in interpersonal abuse, and 'other relatives' were more likely to be involved in financial abuse.
- People aged 31-64 years were most frequently identified as perpetrators but younger adults or teenagers and older adults were also identified.
- In 37% of cases the perpetrator lived with the older person at the time of the abuse.
- Other risk factors associated with the perpetrator were unemployment (51%) and alcohol problems (19%).

5.1 Introduction

Respondents were asked to provide information on up to two people who were principally involved in the incidents previously described. Forty-four people described episodes of mistreatment in the previous 12 months involving 47 individuals. Three participants reported mistreatment by two people in a position of trust.

Perpetrator characteristics of people in a position of trust (spouse, adult child, other relation, and friend or healthcare worker) for the 12-month prevalence of mistreatment were examined. Survey participants were asked questions about the perpetrators' demographics, occupation, current living arrangements and physical and mental health. A number of participants declined to provide details of the perpetrator other than relationship.

5.2 Demographics

The majority of people implicated in the mistreatment were aged between 31 and 64 years. Males were slightly more likely to be identified as perpetrators than females. The majority of perpetrators had intermediate level education and were married or partnered. Over 50% of perpetrators were not employed at the time the abuse occurred. Only a small number identified the perpetrator's occupation; semi-skilled or unskilled occupations predominated (18%), followed by professional occupations (6%) and non-manual or skilled manual (4%).

Table 5.1 **Demographic and socio-economic characteristics of perpetrators**

	%	n=47
Age		
≤30 years	11	5
31-64 years	60	28
≥65 years	13	6
Missing[1]	17	8
Gender		
Male	48	23
Female	38	18
Missing	13	6
Education		
Lower	22	10
Intermediary	51	24
Higher	6	3
Missing	28	10
Marital status		
Married/partnered	55	26
Single	22	10
Separated/divorced	11	5
Missing	13	6
Employment status		
Working	33	16
Unemployed	51	24
Missing	13	7

[1] Respondents declined to provide details.

5.3 Relationship

Adult children accounted for half of those identified as perpetrators, other relatives (24%) was the next most frequent group, followed by spouses/partners at 20% (Figure 5.1). There was a single episode identifying a paid home-help.

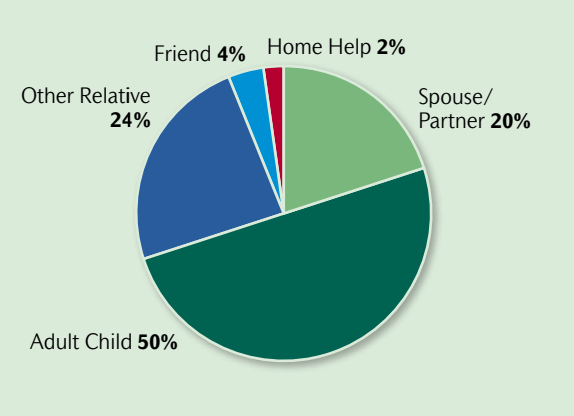

Figure 5.1 **Relationship between perpetrator and older person**

5.3.1 Perpetrator Relationship by Type of Mistreatment

There was not a distinctive pattern between the type of abuse and relationship of the perpetrator to the older person (Table 5.2). Neglect was excluded because of the small number of cases. Interpersonal abuse tended to be more common for a spouse/partner perpetrator, while adult children were equally likely to be implicated in both financial and interpersonal abuse (Table 5.2). This pattern reflects the clustering of abuse, especially among families.

Table 5.2 **Abuse type and relationship with older person**

All perpetrators of abuse excluding neglect[1]	Financial abuse	Interpersonal abuse
	% (n=30)	% (n=28)
Spouse/partner	20 (6)	25 (7)
Adult child	47 (14)	50 (14)
Other relative	27 (8)	21 (6)
Friend	3 (1)	4 (1)
Paid home help	3 (1)	– (0)

[1] Perpetrators are represented separately for both types of abuse, thus if a perpetrator was alleged to have committed financial abuse and interpersonal abuse the perpetrator is counted twice.

5.4 Living Arrangements

In 37% of cases the perpetrator lived with the older person at the time of the abuse and this continued to be the case for 30% of people at the time of the survey. In over three quarter of cases the abuse took place in the person's own home, 4% in a relative's home and a single episode in a day care centre (Table 5.3).

Table 5.3 **Living arrangements and location of abuse**

	%[1]	n=47
Living with perpetrator at time of abuse		
Yes	37	17
No	49	23
Currently living with perpetrator		
Yes	30	14
No	54	25
Sometimes	2	1
Where abuse occurred		
Own home	77	36
Relatives home	4	2
Respite/day care	2	1
Other (phone, social events)	4	2

[1] Percentages do not add to 100% due to missing data.

5.5 Health and Addiction

In a small number of cases the older person identified the perpetrator as having physical health problems. Four percent of perpetrators were identified as having mental health problems and/or intellectual disabilities. Alcohol addiction was a factor for 19% of perpetrators identified by the older person and in one case there was drug addiction. Furthermore, 6% of perpetrators had criminal records.

Table 5.4 **Health and addiction characteristics of perpetrators**

	%	n=47
Physical health problem	11	5
Mental health problem	4	2
Intellectual disability	4	2
Alcohol addiction	19	9
Drug addiction	2	1
Gambling addiction	–	0
Criminal record	6	3

The profile of the reported perpetrators supports the socio-economic dimension to elder abuse, with a high level of unemployment and alcohol addiction identified among perpetrators. In a small number of cases the mistreatment of the older person was related to their role caring for a person with physical, mental health problems or an intellectual disability. However, there were no clear risk factors identified for half of the perpetrators.

Key points

- Overall, 84% of participants identified that their experiences of mistreatment had a serious impact on them.
- Physical and financial abuses were nearly universally identified as having a serious impact.
- Over a third (34%) of the mistreatment went unreported, 41% was reported to a family member, 11% to a GP and 9% to the police.
- One quarter (25%) of the mistreatment was ongoing at the time of the survey.

6.1 Introduction

Participants were asked about the impact of each individual action (e.g. the impact of being insulted or the impact of having money stolen) with three possible response options (not serious, somewhat/moderate, very serious). Within each of the five categories of mistreatment the highest level of impact was recorded if more than one abusive action was identified. Similarly in the event of clusters of mistreatment the highest level of impact was selected from the five types. Participants were also asked to identify if they had reported the abusive behaviour, to whom, and to indicate the consequences of reporting the mistreatment.

6.2 Psychological Impact

Within the five types of mistreatment, physical abuse was universally identified as having a serious impact on the person. Nearly 90% of participants also identified financial abuse as having a serious impact. Between 50%-58% of people who reported neglect or psychological abuse also described the impact as very serious, with the remainder identifying the impact as moderate. When clustering of mistreatment is taken into account 84% of this population felt their experiences of abuse or neglect in the previous 12 months had a serious impact on them, with 14% describing the impact as moderate (Table 6.1).

Some participants described feelings of 'shock' and being 'shaken' by the experience. In the case of three participants (7%) physical injuries were sustained, mainly bruising, with one person consulting their GP regarding their injuries. There were no associated emergency department attendances or hospital admissions reported.

Table 6.1 **Impact of mistreatment over previous 12 months**

	Number	Not serious	Somewhat/ moderate	Very serious	Missing
		%[1] (n)	%[1] (n)	%[1] (n)	n
Neglect	**6**	– (0)	33 (2)	50 (3)	1
Financial	**27**	4 (1)	– (0)	89 (24)	2
Psychological	**25**	– (0)	32 (8)	68 (17)	0
Physical	**10**	– (0)	– (0)	100 (10)	0
Sexual	**1**	– (0)	– (0)	100 (1)	0
Any mistreatment	**44**	2 (1)	11 (5)	84 (37)	1

[1] Percentages are calculated as row percentages.

6.3 Reporting of Mistreatment

Over one third of participants did not report the mistreatment to anyone. In the case of people who did report abuse or neglect other family members were the most likely to be told about the mistreatment, followed by their GP (11%), the police (9%) and friends (9%). None of the participants, including those experiencing physical abuse, reported their experiences to a social worker, community or public health nurse, hospital-based doctor or nurse (Table 6.2).

Table 6.2 **Person to whom mistreatment was reported**

	%	n=44
Not reported	34	15
Family	41	18
Friend	9	4
Neighbour	5	2
Home Help	2	1
GP/Practice Nurse	11	5
Police	9	4
Other	4	2
Community Nurse	–	0
Social Worker/ Senior Case Worker	–	0
Hospital Doctor/Nurse	–	0

6.4 Outcomes and Interventions

In 31% (14/44) of cases the incident occurred once and in 16% of cases no action was required to stop the mistreatment. In 25% (11/44) of cases the abuse or neglect was ongoing at the time of the survey and in 17% (7/44) of cases the incidents had decreased following some kind of intervention. The most frequent type of intervention was a family member speaking to the perpetrator. In only one case did an older person speak directly to the perpetrator; instead older people were more likely to break contact with the perpetrator. In only two cases did the intervention include a professional, one of which resulted in a barring order being issued (Table 6.3).

Table 6.3 **Type of outcomes and interventions**

	%	n=44
No action mistreatment stopped	16	7
Mistreatment ongoing	25	11
You spoke to perpetrator	2	1
Family spoke with perpetrator	23	10
Professional spoke with perpetrator	5	2
Broke contact with perpetrator	9	4
Withdrew socially	2	1
Barring order	2	1
Other action	4	2

6.5 Summary

For the vast majority of older people in this survey the experiences they described over the previous 12 months had a serious impact on them. One third of participants did not report their experiences to anyone and in a quarter of cases the mistreatment was ongoing at the time of the survey. By and large, health or social care professionals or the police were not involved in interventions to resolve the mistreatment.

Key points

- The use of alternative definitions of elder abuse or neglect had a considerable impact on the estimated prevalence.
- Mistreatment since 65 years, including any episodes of neglect or psychological abuse perpetrated by people in a position of trust, increased the prevalence rate to 4%.
- Considering any episode of abuse or neglect in the previous 12 months perpetrated by those in a position of trust resulted in a prevalence rate of 3.3%.
- Using these broader definitions the differences in the estimated prevalence was mainly due to an increase in the number of psychological abuse and neglect incidents identified.
- Mistreatment within the wider community to include neighbours or people distantly known to the older person (acquaintances) in the past 12 months, with a definition of 10 or more episodes of psychological abuse or neglect, resulted in a prevalence rate of 2.9% compared to 2.2% when considering only people in a position of trust.
- Applying the above statistics to the general population the implications are that between 10,000 and 13,000 older people experienced mistreatment within their communities in the previous 12 months.
- Over the life course of older age (since 65 years) between 18,000 and 25,000 older people may have experienced abusive behaviour by people in a position of trust or the wider community.

7.1 Introduction

The definition of abuse used has an impact on the estimated prevalence rate. In particular the timeframe over which mistreatment is calculated and who is considered as a perpetrator can result in significant difference to the prevalence estimates. In this chapter the prevalence rates based on some of these alternative definitions is explored.

One of the most frequently used alternative definitions is elder abuse since 65 years of age. Mistreatment of older people also occurs outside the context of a relationship of trust and includes the wider community, defined as neighbours and people known to the older person but not in a position of trust (acquaintances), and finally mistreatment that includes incidents perpetrated by strangers.

7.2 Mistreatment Since 65 Years

A broader definition of elder abuse explored in this study was any mistreatment since 65 years perpetrated by people in a position of trust and included any episode of financial, physical, sexual, psychological abuse, or neglect. Using this definition the overall prevalence rate of abuse and neglect since 65 years was 4%, or one in twenty-five of the older population. This is nearly double the one year prevalence rate of 2.2% based on the stricter definition of 10 or more episodes of neglect or psychological abuse or any episode of financial, physical or sexual abuse used in Chapter 4.

When any episode of mistreatment since the age of 65 years was compared to any episode in the previous 12 months then there was less than a 1% difference (3.3% versus 4.0%). The increase in prevalence was mainly driven by episodes of psychological abuse and neglect and showed the effect of using ten episodes of psychological abuse or neglect as a cut off to define these concepts. Using a cut off of ten or more incidents may reduce the number of isolated or non-significant events identified, but asking people to recall the number of events over a prolonged time period such as since 65 years is likely to be affected by unreliable recall.

Table 7.1 **Alternative definitions of mistreatment and population estimates**

	Prevalence		Population estimates	
	% (n=2021)	95% CI	n	95% CI
Any mistreatment since 65 years	4.0 (81)	(2.91-5.11)	18,764	(13,617-23,911)
Any mistreatment in previous 12 months[1] (unrestricted definition)	3.3 (66)	(2.30-4.23)	15,301	(10,762-19,793)
Any mistreatment in previous 12 months (chapter 4, restricted definition)[2]	2.2 (44)	(1.41-2.94)	10,201	(6,598-13,757)

[1] Any episode of financial, physical, sexual, psychological abuse or neglect in the previous 12 months (unrestricted definition).

[2] Any episode of financial, physical, sexual abuse and ≥10 episodes of psychological abuse or neglect or causing a serious impact, in the previous 12 months (restricted definition used in chapter 4).

Table 7.1 illustrates the effect of the different definitions on the prevalence estimates and highlights the complexity of measuring human experiences especially over long time periods. However given that there is likely to be under reporting of abuse and neglect these broader definitions give an indication of the potential population at risk.

The implications of these statistics are that over 10,000 older people are likely to have experienced episodes of mistreatment in the previous 12 months and since the age of 65 years over 18,000 older people may have had experiences that were potentially abusive.

7.2.1 Types of Mistreatment

Examining the types of mistreatment using the broader definition (any mistreatment since 65 years) a different pattern emerged compared to the one year prevalence (Table 7.2). Psychological abuse was the most prevalent type of mistreatment at 2.4% with nearly a doubling of the number of cases identified. Financial abuse was the second most common type of mistreatment at 1.4%, but there was only a marginal increase compared to the one year prevalence.

Neglect was the third most common type of mistreatment at 1.2%, and had the largest increase in numbers of people identified compared to the one year prevalence. Caution must be exercised when applying this broad definition to neglect. The survey identified episodes of periodic unmet needs but in 64% (15/24) of cases the older person did not perceive this as having a serious impact on them and did not describe their carer as a perpetrator of abuse.

There was a slight increase in physical abuse (0.7%) and there remained a single episode of sexual abuse. The prevalence of interpersonal abuse was 2.6%, emphasising the clustering of these types of abuse.

Table 7.2 **Prevalence of different types of mistreatment**

	% (n)	95% CI
Psychological abuse		
Psychological abuse since 65 years	2.4 (48)	(1.50-3.25)
Any Psychological abuse in previous 12 months	2.1 (43)	(1.33-2.93)
Psychological abuse in previous 12 months (≥10 episodes or serious impact)	1.2 (25)	(0.66-1.82)
Financial abuse		
Financial abuse since 65 years	1.4 (28)	(0.81-1.97)
Financial abuse in previous 12 months	1.3 (27)	(0.76-1.91)
Neglect		
Neglect since 65	1.2 (24)	(0.63-1.74)
Any neglect in previous 12 months	0.8 (16)	(0.37-1.21)
Neglect in previous 12 months (≥10 episode or serious impact)	0.3 (6)	(0.02-0.57)
Physical abuse		
Physical abuse since 65 years	0.7 (15)	(0.28-1.20)
Any physical abuse in previous 12 months	0.5 (10)	(0.14-0.85)
Sexual abuse (same since 65, previous 12 months)	0.05 (1)	(0.00-0.28)

7.2.2 Age and Gender

Overall, women (4.7%) were more likely than men (3.2%) to have experienced mistreatment since the age of 65 years (Table 7.3). People currently aged 80 years or older reported the highest levels of mistreatment (6.9%), followed by the 70-79 years age group (3.5%), while those aged 65-69 years reported the lowest level of mistreatment (2.4%).

Among both men and women the most prevalent type of mistreatment since 65 years was psychological abuse and for men it increased with age; men aged 80 years or older experienced the highest prevalence. Financial abuse was the second most common type of mistreatment reported. Overall, women were more likely than men to report financial abuse. However, men aged eighty years or older were the highest risk group.

Levels of neglect experienced since turning 65 years were similar for men and women, and the highest risk groups were men and women aged eighty years or older. Physical abuse was slightly more common among women, with the 65-69 years and ≥80 years age groups more likely to report this type of abuse.

Table 7.3 **Types of mistreatment since 65 years stratified by age and gender**

	65-69 years	70-79 years	≥80 years	Total
	% (n)	% (n)	% (n)	% (n)
Male	*n=281*	*n=424*	*n=207*	*n=912*
Financial	0.7 (2)	0.7 (3)	2.9 (6)	1.2 (11)
Neglect	– (0)	0.7 (3)	2.9 (6)	1.0 (9)
Psychological	0.7 (2)	1.9 (8)	4.4 (9)	2.1 (19)
Physical/Sexual	0.4 (1)	0.7 (3)	0.5 (1)	0.5 (5)
Any mistreatment	1.4 (4)	2.8 (12)	6.3 (13)	3.1 (29)
Female	*n=292*	*n=548*	*n=269*	*n=1109*
Financial	1.7 (5)	1.3 (7)	1.9 (5)	1.5 (17)
Neglect	– (0)	1.3 (7)	3.0 (8)	1.4 (15)
Psychological	1.7 (5)	2.7 (17)	1.9 (9)	2.6 (29)
Physical/Sexual	1.0 (3)	0.7 (4)	1.1 (3)	0.9 (10)
Any mistreatment	3.0 (10)	4.0 (22)	7.4 (20)	4.7 (52)

7.2.3 Perpetrators of Mistreatment (since 65 years)

In the context of a position of trust 'other relative' was identified as the group most likely to perpetrate mistreatment, mainly related to psychological or physical abuse (Table 7.4). Adult children were the second most frequently identified group, and were particularly linked to financial, and to a lesser extent psychological abuse. Spouse or partners were the third largest group and were associated with physical, financial and psychological abuse. Describing neglect in the context of perpetrators is less clear cut, as many did not view their carers as abusers and this will be discussed more fully in Chapter 8.

Table 7.4 **Perpetrators of mistreatment since 65 years**

	Psychological	Financial	Neglect[1]	Physical/Sexual	Any mistreatment
	% (n=48)	% (n=28)	% (n=24)	% (n=15)	% (n=81)
Spouse/partner	20 (10)	21 (6)	12 (3)	33 (5)	17 (14)
Adult child	35 (17)	46 (13)	17 (4)	27 (4)	31 (25)
Other relative	44 (21)	43 (12)	12 (3)	47 (7)	33 (27)
Close friend	8 (4)	4 (1)	– (0)	– (0)	6 (5)
Health care worker	2 (1)	– (0)	– (0)	– (0)	1 (1)

Percentages add to greater than 100, except neglect, as people experienced more than one type of behaviour by different perpetrators.

[1] Although 24 people described episodes of unmet need, over 60% of people perceived these episodes had a minor impact and carers were not identified as 'perpetrators'.

7.3 Wider Community Prevalence of Mistreatment

Based on the international definition of mistreatment used in Chapter 4[4] but extending it beyond a relationship of trust to include neighbours and people known to the older person (acquaintances), this context can be considered the wider community in which the older person lives. In this wider context the prevalence of overall mistreatment in the previous 12 months increased from 2.2% to 2.9%. If extrapolated to the national population, this equated to 13,429 older people who experienced mistreatment in their communities.

The prevalence of individual mistreatment types perpetrated by people in a position of trust and the wider community are shown in Table 7.5. The biggest increase occurred in financial and psychological abuse. There were also four additional incidents of physical abuse, but no additional incidents of sexual abuse identified. Neglect, encompassing a definition of dependency and a position of trust, is not affected by people in this context as care was only provided by people close to the older person (family, home help or friends).

The prevalence of any mistreatment since 65 years including neighbours or acquaintances increased the prevalence from 4.0% to 5.5%, with a corresponding population estimate of 25,735 older people.

7.3.1 Perpetrators of Wider Community Mistreatment

Neighbours or acquaintances were implicated in just over a quarter of the reported mistreatment in the previous 12 months (Table 7.6). Psychological abuse was most commonly identified in relation to neighbours/acquaintances, followed by physical abuse and financial abuse. However, inter-family relationships remained the primary source of the mistreatment (Figure 7.1).

Table 7.5 **Prevalence of individual types of mistreatment within the community**

	Prevalence		Population estimates	
	% (n=2021)	95% CI	n	95% CI
Psychological	1.7 (34)	(1.02-2.35)	7,861	(4,773-10,996)
Financial	1.8 (36)	(1.08-2.48)	8,329	(5,054-11,604)
Neglect	0.3 (6)	(0.02-0.56)	144	(94-2,667)
Physical/Sexual	0.7 (14)	(0.29-1.09)	3,275	(1,357-5,100)
Any mistreatment in previous 12 months[1] (unrestricted definition)	2.9 (58)	(1.99-3.75)	13,429	(9,312-17,547)
Any mistreatment in previous 12 months (chapter 4, restricted definition)[2]	4.5 (91)	(3.30-5.70)	21,057	(15,441-26,671)
Any mistreatment since 65 years	5.5 (112)	(4.20-6.90)	25,735	(19,653-32,287)

[1] Any episode of financial, physical, sexual, psychological abuse or neglect in the previous 12 months (unrestricted definition).

[2] Any episode of financial, physical, sexual abuse and ≥10 episodes of psychological abuse or neglect or causing a serious impact, in the previous 12 months (restricted definition used in chapter 4).

[4] Mistreatment: any episode of physical, sexual, or financial abuse, ≥10 episodes or serious impact for neglect or psychological abuse.

Table 7.6 **Perpetrators of wider community mistreatment in previous 12 months**

	Psychological	Financial	Neglect	Physical/Sexual	Any mistreatment
	% (n=34)	% (n=36)	% (n=6)	% (n=14)	% (n=58)
Spouse/partner	21 (7)	19 (7)	33 (2)	21 (3)	16 (9)
Adult child	41 (14)	36 (13)	33 (2)	21 (3)	40 (23)
Other relative	21 (7)	25 (9)	33 (2)	28 (4)	19 (11)
Close friend	3 (1)	3 (1)	– (0)	– (0)	2 (1)
Health care worker	– (0)	3 (1)	– (0)	– (0)	2 (1)
Neighbour/acquaintance	29 (10)	17 (6)	– (0)	28 (4)	26 (15)

Percentages may add to greater than 100.

7.3.2 Stranger Mistreatment in Previous 12 Months

If the definition, any episode of physical, sexual, or financial abuse, ≥10 episodes or serious impact for neglect or psychological abuse, is extended to include strangers then the overall prevalence in the previous 12 months increases to 3.0% (61/2,021) or 14,038 older people.

Figure 7.1 emphasises that the majority of mistreatment experienced by older people was committed by people close to the older person, but neighbours/acquaintances and strangers also contributed significantly to the experiences older people reported.

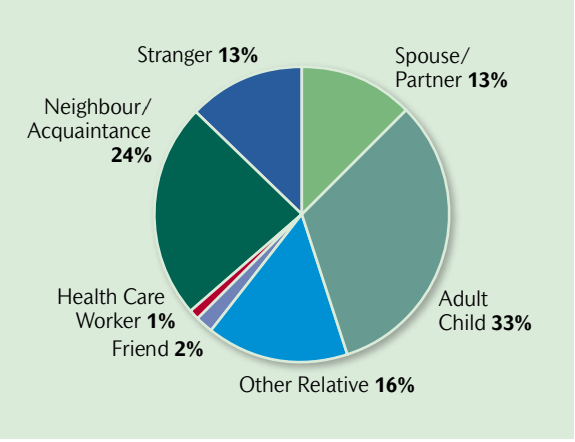

Figure 7.1 **Perpetrators of mistreatment including neighbours and strangers**

7.4 Summary

Considering a definition of any mistreatment since 65 years nearly doubles the prevalence estimates from 2.2% to 4.0%, but there was more variation in the types of experiences recounted. Including neighbours and acquaintances in a 12-month definition of elder abuse increased the prevalence to 2.9%. Allowing for mistreatment by neighbours/acquaintances or strangers the majority of older people experienced mistreatment by people close to them.

8.1 Introduction

This survey focused on community-dwelling older people's experiences of abuse and neglect. It was the first survey of its kind in Ireland and provided information on the type, frequency and impact of these experiences on older people. It also outlined a profile of demographic, socio-economic, health and social support characteristics of those who experienced mistreatment, and a profile of those who were identified as perpetrators of mistreatment.

The study sample of over 2,000 people aged 65 years or older was representative of the national population of older people and included people from rural, urban and large urban areas, from all regions in Ireland. The corresponding prevalence estimates are robust and can be generalised within the limits of statistical confidence to the general population of older people. The information presented reflects the direct experiences of older people themselves and on a national level allows them a voice on this important and significant societal problem. Finally the study adopted an operational definition of abuse and neglect that has been used in other recent international studies. Elder abuse and neglect is defined as *any episode of financial, physical or sexual abuse or ≥10 episodes of psychological abuse or neglect or episodes of psychological abuse or neglect that had a serious impact on the older person, occurring in the previous 12 months and perpetrated by a person in a position of trust (family, close friend or health care worker)*. This allows for comparison with recent elder abuse prevalence research and adds to the body of knowledge in this area.

8.2 The Prevalence of Elder Abuse and Neglect in Ireland

This study identified a prevalence rate of 2.2% for elder abuse and neglect, or 1 in 45 of the older population. This corresponds to 10,201 older adults a year or in other words a busy GP with 500 registered older patients could expect to see approximately 11 patients per year who experienced some kind of mistreatment by people in a position of trust.

The definition used restricts the number of incidents related to psychological abuse or neglect to 10 or more, or any incidents that had a serious impact, and only considers people in a position of trust (family, close friends, care workers). This is likely to be a conservative interpretation and identifies abuse at the more extreme or persistent end of the scale. Thus a prevalence of 2.2% could be regarded as the lower limit of mistreatment within Irish society or the 'tip of the iceberg'.

Allowing for measurement error or a conservative definition it is easy to overlook that the majority of older people were well supported and protected by people they trusted. This point must be particularly emphasised with regard to carers, 18% of the study population indicated they regularly relied on help from other people and less than 2% of this group identified persistent care deficits.

8.2.1 Comparison with International Studies

The advantage of using the international definition of elder abuse and neglect adopted in this study is that it allows Ireland to benchmark prevalence rates against other countries. A prevalence rate of 2.2% for overall abuse and neglect places the Irish study second lowest among similar European, US and Canadian studies. A summary of the prevalence rates in these studies was presented in Chapter 1 (Table 1.1). Spain had the lowest rate at 0.8% (Marmolejo 2008), while the highest rate in Europe was 5.6% but this was restricted to a single urban centre (Comijs et al. 1998). A recent national study from the US reported a rate of 11.4% but used a more inclusive definition for neglect and psychological abuse (Acierno et al. 2010).

The study most comparable to the Irish survey is the UK survey conducted in 2007. The Irish rate of mistreatment, at 2.2% (95% CI 1.4-2.9), is slightly lower than the overall UK prevalence rate of 2.6% (95% CI 1.9-3.8) which combines rates from England (2.6%), Scotland (3.1%), Wales (3.0%) and Northern Ireland (2.0%) (O'Keeffe et al. 2007). Interestingly mistreatment rates for Ireland and Northern Ireland are very similar. Although the absolute prevalence rates in the Irish and UK study differ the 95% confidence intervals overlap suggesting that there is not a statistically significant difference between these values.

8.2.2 Abuse and Neglect within the Wider Community

Many commentators and older people themselves do not make a distinction between abuse by a person in a position of trust and the wider community (neighbours and acquaintances) in which they live (WHO 2002, Dixon et al. 2010). Using the same definition as above but extending the definition of 'position of trust' to include neighbours and acquaintances increased the prevalence rate by 0.7% to 2.9% in the previous 12 months and was mainly driven by episodes of psychological and financial abuse. However, the incidents reported became less clear cut and often the disputes identified related to land boundaries. In the UK study including neighbours and acquaintances increased the prevalence of abuse and neglect (in the past year) from 2.6% to 4.0%, an increase of 1.4% (O'Keeffe et al. 2007), double that identified in this study.

8.2.3 Abuse and Neglect since 65 Years

Considering mistreatment over a longer time span identifies more cases of abuse and gives a broader indication of how pervasive this problem is within society, but it is less reliable in terms of recall and ability to examine risk factors. In the Irish study, when any episode of abuse or neglect since 65 years and within a relationship of trust or the wider community is considered, the prevalence rate increased to 4.0% and 5.5% respectively. Compared to the one year prevalence of any abuse or neglect within a relationship of trust or the wider community (3.3% and 4.5%), the prevalence rate increase was very modest. This suggests that some of the mistreatment was ongoing year after year, certainly over 30% of people who experienced mistreatment indicated the abuse had started before the age of 65 years and 25% indicated that the abuse or neglect was ongoing at the time of the survey. It is also likely that some isolated incidents of mistreatment were forgotten over time. The results, using a definition of mistreatment 'since 65 years' are in line with other studies that measured abuse and neglect over this time span and ranged between 3%-4% (Pillemer and Finkelhor 1988, Podnieks 1992a, O'Keeffe et al. 2007).

8.2.4 Alternative Definitions

Chapter seven explored the alternative definitions of abuse and the impact on prevalence estimates. These alternative definitions reflect the reality of measuring this complex phenomenon and dispel the concept of elder mistreatment as a dichotomous outcome (abuse present or abuse absent). It is more realistic to think of mistreatment along a continuum

Figure 8.1 **Alternative definitions and prevalence estimates**

rather than a single absolute value. The alternative definitions allow a stress test of the different assumptions underpinning the measurement of elder abuse and neglect. These alternative definitions produce an estimate of the best case scenario, using a conservative definition, and a worse case scenario using broader and more inclusive definitions.

Figure 8.1 presents a visual display of how the context (position of trust or wider community) and the measurement of psychological abuse or neglect impact on the prevalence and the number of people who may be affected. Between 10,000 and nearly 15,000 people may experience mistreatment every year by people in a position of trust or within the wider community. Extending the time period, over the course of older adulthood (since 65 years) then between 18,000 and 25,000 older people may experience some kind of mistreatment in later life.

Dixon et al. (2010), reflecting on experiences from qualitative interviews with participants in the UK prevalence study, confirmed the difficulties with using rigid definitions of abuse and noted that there is a trade off between using consistent definitions for the 'epidemiological and aetiology research of the syndrome' and a definition which captures the complexity of elder abuse within family and community relations. They suggest that any definition needs to be 'provisional, flexible and pragmatic' (Dixon et al. 2010: 418). The debate on a theoretical and operational definition of elder abuse and neglect is likely to continue until there is a more robust conceptual and theoretical understanding of this phenomenon (Biggs et al. 2009, Mixson 2010).

8.3 Pattern of Mistreatment

Financial Abuse

In this study financial abuse (1.3%) was the most commonly reported type of mistreatment followed by psychological abuse (1.2%), physical abuse (0.5%), neglect (0.3%) and sexual abuse (0.05%). Only one other national prevalence study that measured financial abuse over 12 months reported it as the most frequent type of mistreatment and this was the recent US study (5.2%) (Acierno et al. 2010). This may reflect the current financial crisis during this period in both countries. In the Irish study the majority of the financial abuses reported occurred within the previous 12 months rather than since 65 years.

Psychological Abuse

Psychological abuse was the second most prevalent type of mistreatment and often accompanied other mistreatment, especially physical abuse. The significance of psychological abuse is recognised in most other studies and is often the most or second most prevalent type of abuse (Podnieks 1992a, Marmolejo 2008, Lowenstein et al. 2009). Psychological abuse covers a broad range of constructs and can range from open insults and verbal aggression to more subtle forms such as denying access to grandchildren, undermining someone's confidence or exclusion from financial decisions. This study used a definition of 10 or more episodes or serious impact, the definition reduced the number of cases and if this restriction was not imposed psychological abuse would be the leading type of mistreatment identified.

Physical and Sexual Abuse

Physical abuse in this study, as in many other studies, was less likely to occur than other forms of mistreatment (Table 1.1). The incidents reported were mainly related to pushing/shoving or restraint (physical or denying access to walking/hearing aids). There was one episode of sexual abuse which was ongoing before the age of 65 years. Physical abuse is often perceived by the general public to be the most common form of abuse (HSE 2010). There is a risk that in the absence of overt physical abuse the older person or the perpetrator may not recognise the behaviour as abusive or inappropriate, thus some episodes of financial or psychological abuse and neglect may go unrecognised as elder abuse (Bonnie and Wallace 2003).

Neglect

The low level of neglect identified in this study may be surprising, in similar studies neglect was the primary or second most common type of mistreatment identified (O'Keeffe et al. 2007, Marmolejo 2008, Lowenstein et al. 2009, Acierno et al. 2010). In the UK study, neglect, using the same definition, was the most common type of mistreatment identified in all four regions (O'Keeffe et al. 2007). It is difficult to say whether the difference reflects variation in sampling methods or real population differences, for example 1.8% of the UK general population are aged 85 years or older compared to 1.1% of the Irish general population. In the UK 8% of participants described their health as poor compared to 5% in the

Irish study. Similarly 25% of participants in the UK study versus 18% in the Irish study were reliant on help with ADLs, also formal service provision was higher in the UK (21%) compared to the Irish study (15%).

Although there are demographic and health differences between the Irish and UK study populations the difference in the neglect rates detected is likely, in part, to be due to non-participation of this group in the Irish study. Nearly a third of refusals (27%) were due to ill health or mental incapacity. Also research studies that measured abuse and neglect rates among people with poor physical health or cognitive impairment identified substantially higher elder abuse prevalence rates (18%-25%) compared to general population studies (Cooney et al. 2006, Cooper et al. 2009b).

Neglect compared to the other mistreatment constructs is less straight forward. People's perception of neglect is likely to be influenced by expectations of help, relationship with carer and the degree of dependence on formal services. In the UK study some of the neglect reported was related to service provision deficits rather than carer omissions. As already alluded to in this study even when persistent omissions in care were identified very few older people considered their carers as 'perpetrators of mistreatment'. Also credit must be paid to the formal and informal services and carers that support older people in their homes. This area in particular needs to be more fully understood, and as the older population, including informal carers, age, reliance on formal services is likely to increase (McGee et al. 2008a).

8.3.1 Comparison with Official Statistics and Under-Reporting

Currently the Garda Síochána (Irish police force) do not provide a breakdown of investigations or allegations received based on victim age, though in the future it is possible that this information will be available. The only source of information on elder abuse and neglect in Ireland is the HSE data submitted by elder abuse senior case workers. In 2009 there were 1,870 cases identified giving a prevalence of 0.4% (HSE 2010) compared to 2.2% identified in this survey.

Comparing the pattern of referrals there are significant differences between the databases (Figure 8.2). The national prevalence survey identified more incidents of psychological and financial abuse compared to the HSE data. Financial abuse was the most prevalent type of abuse identified in the national prevalence survey but it was the third most prominent type of mistreatment in the HSE statistics, though the number of incidents reported had increased since 2008. Substantially more neglect cases were identified in the HSE statistics and this is largely due to community nurse referral rather than self-reporting as used in the national survey. Incidents of physical abuse and sexual abuse were similar in both databases.

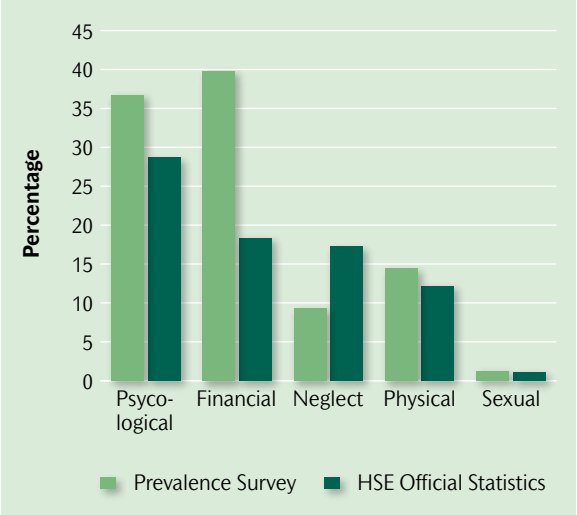

Figure 8.2 **Comparison of pattern of mistreatment types between the prevalence survey and HSE statistics 2009**

Under-Reporting

The under-reporting of elder abuse is widely recognised and even after 20 years of concentrated attention by national and international organisations it remains a hidden phenomenon (WHO 2008). It is estimated as many as 1 in 14 cases go undetected and some reasons for this have already been identified (Lachs and Pillemer 2004). It is suggested that this is a result of a combination of older people being reluctant to inform on the perpetrators, not recognising the behaviour as abuse, and the failure of service and professionals to detect abuse or neglect (O'Brien 2010).

A study of the experiences of social workers and other professionals involved in elder abuse protection in seven European countries highlighted the conceptual differences between intentioned and un-intentioned abuse and in particular the difficulties in detecting un-intentioned abuse (van Bavel et al. 2010). In un-intentioned abuse the older person or their family do not recognise the behaviour as mistreatment. Neglect, persistent low level psychological abuse and financial abuse often fall into this category. In part this may explain some of the difference between the prevalence survey and the HSE statistics. Asking people questions based on behavioural experiences, which is a form of screening used in the national prevalence study, compared to self-referral or referral by a third party will increase case identification for some types of abuse.

As already identified people in poor health were likely to be under represented in the national prevalence survey. This is confirmed by the HSE statistics (HSE 2010) where reported incidents of neglect were nearly three times greater than in the this survey. Other prevalence studies also reported difficulties in accurately capturing information on this group of older people (Comijs et al. 1998, O'Keeffe et al. 2007).

8.4 Risk Factors

The low number of cases identified in this survey made it difficult to examine distinct risk factors especially for the individual types of abuse. However, based on the results and data from other studies a clearer picture is emerging of population sub-groups and individual characteristics that make people more vulnerable to abuse or neglect.

Although some groups within Irish society experienced higher levels of mistreatment than others, it must be emphasised that people in all social classes, income levels, health, and social support categories experienced mistreatment to a greater or lesser extent. This phenomenon is not restricted to one or two groups within society.

The most significant risk factors to emerge in this study were related to both perceived and measured poor or below average health. Below average physical health increased a person's risk of mistreatment three-fold while below average mental health resulted in a six-fold increase in risk. A survey at a single point in time cannot determine whether health had deteriorated prior to the mistreatment or how the mistreatment contributed to health deterioration. It is likely, particularly in relation to mental health that there is a feedback mechanism as interpersonal abuse (physical, sexual and psychological abuse) was the most prominent abuse type identified by people in this group. It is also noteworthy that the relationship between poor health and mistreatment was not just due to neglect, in this study people in poorer health also experienced higher levels of financial and interpersonal abuse.

Social class, education and income are interrelated variables with a similar relationship to mistreatment. Lower income, manual type occupations and lower levels of education saw an increase in levels of mistreatment among both men and women. The relationship was inverse, increased levels of income, education or non-manual occupations were protective against abuse but did not eliminate the risk altogether.

Living arrangements rather than marital status showed the strongest relationship with mistreatment. People living on their own or with a spouse/partner experienced the lowest risk. The most significant risk was in complex households where an older person lived with an adult child with or without other family. Intergenerational cohabitation in some families is also likely to be a marker of socio-economic status.

An important factor that also emerged was social support and networks. People who identified poor levels of community support or poor to moderate levels of family support were three to four times more likely to report mistreatment compared to people who identified strong community and family support. Poor community support was associated with higher levels of interpersonal abuse, while people who identified poor family support were more likely to report financial abuse.

Many of the risk factors identified were present across the different types of mistreatment. This is partly explained by the tendency for abuse types to cluster with a quarter of participants reporting more than one type of mistreatment. The study by Acierno et al. (2010) highlighted the complexity of attributing unique characteristics to individual types of abuse or neglect. Undoubtedly poor health and increased dependency are risk factors for most types of mistreatment, and

socio-economic factors are also frequently identified (Pillemer and Finkelhor 1988, Podnieks 1992a, O'Keeffe et al. 2007, Marmolejo 2008, Lowenstein et al. 2009, Acierno et al. 2010).

The significant impact of social isolation has also emerged in the above studies. In the study by Acierno et al. (2010) a low level of social support was identified as an independent risk factor for emotional (psychological), physical, sexual abuse and neglect. In this recent national US study, low social support resulted in a three to six fold increase in the odds of an older person experiencing mistreatment.

In gaining an understanding of elder abuse the risk profile of the older person is only part of the picture and should be considered in conjunction with the perpetrator characteristics and the older person's response to mistreatment.

8.5 Perpetrators of Mistreatment

There was a broad spread of people implicated in the mistreatment reported. The majority of people were aged between 31 and 64 years, but a small number of teenagers, people in their 20s and over 65 years were also identified. Across all mistreatment types adult children were the most frequently identified group of perpetrators, followed by other relatives and spouses/partners. In the context of mistreatment in the wider community, neighbours and acquaintances were accountable for 26% of the mistreatment and were ranked second after adult children.

The characteristics described related mainly to people identified as perpetrating financial or interpersonal abuse. Unemployment was a particular feature of this group and in 19% of cases alcohol addiction was identified as a factor, while 6% had previous criminal records. Eleven percent of perpetrators were identified as having a physical health problem and 4% were identified as have cognitive impairment or an intellectual disability. The majority of incidents occurred in the person's home, in 37% of cases the perpetrator lived with the older adult and in 30% of cases cohabitation was ongoing at the time of the survey.

The profile of perpetrators in this study differed from the UK study. The majority of perpetrators (83%) in the Irish study were aged less than 65 years, while in the UK study 60% were aged 65 years or older, 10% more males than females were alleged to have perpetrated abuse in the Irish study while males accounted for over 50% of the mistreatment in the UK study. Unemployment (51%) and alcohol addiction (19%) were significant perpetrator characteristics in the Irish study but much less significant in the UK study (2% and 4% respectively). There were also higher levels of perpetrators cohabiting with the older person in the UK study (53%) (O'Keeffe et al. 2007) compared to 37% in the Irish survey.

In this study an examination of the perpetrators' profiles underlines the wider societal problems that contribute to the conditions in which elder mistreatment can occur, in particular unemployment and alcohol addiction, and the impact both factors can have on family welfare is widely recognised. However it would be too simplistic to view this as a problem affecting lower-socio-economic groups. The majority of perpetrators were married, had no health problems, were not cohabiting with the older person, and at least 10% worked in non-manual or professional occupations.

8.6 Impact of and Response to Mistreatment

Prevalence surveys of this nature can capture the number of incidents or people affected reasonably well but are limited when trying to evaluate the real impact of these incidents on individuals, and rely largely on crude categories (low, moderate or serious impact) to capture this. However given this limitation it is worthwhile considering how older people viewed the overall impact of the mistreatment. In this survey 84% of participants viewed the individual or clustered incidents of abuse and neglect as having had a serious impact, in particular physical (100%) and financial abuse (89%), while 58% of psychological abuse was viewed as having a serious impact. This is similar to the reported impact in the UK study, 76% of respondents described the mistreatment as having a serious or very serious impact on them (O'Keeffe et al. 2007).

Reporting of Mistreatment and Interventions

Despite the fact that 98% of these incidents were viewed as moderate or very serious, 34% went completely unreported. In the event that the mistreatment was reported, the older person was most likely to turn to

other family members (41%) followed by neighbours/ friends (14%) or their GP (11%), the police were involved in 9% of cases. It is interesting to note that although there are dedicated elder abuse social workers and that the majority of referrals to this service come from public health/community nurses neither of these professions was identified by participants in the survey, even when the police were involved.

Nearly one third of incidents involved a single episode and did not recur, but for 25% of participants the abuse was ongoing at the time of the survey. The most frequent type of intervention was family members talking to the perpetrator, in only one case did the older person confront the perpetrator directly, instead the more common response was to break contact with the person. In this study while most mistreatment of older people occurred within the family the most likely source of resolution and support for the older person was also the family unit. Currently there is a lack of research examining the resolution of conflict within the elder abuse context.

Understanding how older people cope with and respond to experiences of mistreatment is essential in order to develop strategies and services that they will access. Despite widespread advertising of the HSE protection services for older people there seemed to be a low level of awareness among the population surveyed. They either did not know about the service at all or may not have viewed it as appropriate to their situation.

8.7 Understanding Elder Abuse

The complexity of elder abuse is underlined by the diversity of theories used to explain and clarify it. No single theory successfully explains all dimensions of abuse observed in this age group (Bonnie and Wallace 2003). Pillemer and Wolf (1989) identify elements from five different theories: intra-individual and inter-generational transmission of violence, quality of family systems, care dependency relationships, external stress and social isolation in an effort to explain the diversity of factors involved.

Görgen et al. (2006, cited in van Bavel et al. 2010) identifies three typologies of abuse. In type 1 there is no intention to harm the older person, reasons include lack of knowledge or trying to do the best for the older person (e.g. restricting movement to reduce risk of falls). In type 2 there is situational intention to harm the older person; examples include physical or psychological abuse during family arguments or physical abuse due to the restraint of a person with dementia. In type 3 there is an overall intention to harm the older person arising out of long-term conflicts, perpetrator control and dominance. Broader theories allude to the dignity of older people in society and how modern societies have exalted youthfulness and individualisation at the expense of older people and a sense of community (WHO 2002, van Bavel et al. 2010).

In this study many of the cases of mistreatment identified reflected elements of the above theories or typologies. In particular, the quality of family systems and relationships, care dependency relationships, and in a small number of cases behaviour related to addiction or mental illness may have been a factor. This study did not explore the wider societal influences on elder abuse. A deeper understanding of this phenomenon in Irish society will require different research approaches.

8.8 Implications for Older People, Communities and Society

This study, combined with international research and in-depth qualitative work on older people's and practitioners' experiences, can help to plan the way forward to address and manage elder abuse. Elder abuse and neglect are the potential outcomes of complex interactions between a multiplicity of social, economic, health, social isolation, education, environmental and possibly individual personality characteristics (Bonnie and Wallace 2003). Rarely is the mistreatment related to a single isolated factor. The interaction or mediating effects of multiple factors as identified in this study, makes it clear that no single government department or social service will be effective in reducing the annual incidence of elder mistreatment. The response needs to be multifaceted targeting early risk factors with an emphasis on prevention and later risk factors with a focus on resolving the mistreatment (Mixson 2010). The responsibility is shared across the whole of society including individual older people, families, communities, health and legal professionals, voluntary organisations, the media, policy makers, legislators, education, health, social and housing systems, financial organisations, employers, academic and social policy institutes.

There is a lack of high quality research or service evaluation to guide the development and implementation of strategies to prevent or reduce elder abuse (Ploeg et al. 2009). International approaches focus on early prevention through education and awareness building and protection through policies, legislation and development of elder protection services with an emphasis on inter-agency cooperation (Filinson 2006, Mixson 2010, Teaster et al. 2010).

Awareness and Training

At an individual and family level protection is derived from understanding what is acceptable and unacceptable behaviour, being informed on the topic, involving the wider family, and availability of independent advice on important, especially financial, decisions. Carers or voluntary groups working with older people require specific training to recognise mistreatment and know what to do to prevent it. Professional groups and institutions that have contact with older people are encouraged to actively recognise this problem and provide training and guidelines for their members or employees. For example in this survey although 97% of people who experienced abuse or neglect attended their GP regularly, only 11% disclosed their experiences to a GP. This low level of disclosure to physicians has been reported in other studies (O'Brien 2010).

In Ireland, the HSE over the last two to three years has undertaken activities to raise awareness of elder abuse and neglect through national public awareness campaigns using local radio, national media, information leaflets, promotion of elder abuse awareness day and a short film competition. It has also produced education videos targeting care workers in acute and residential settings and the general public. The overall impact of this activity in terms of raising awareness of elder abuse among older people and the general public has not been evaluated.

Ageism and Social Isolation

Overt and covert ageism in society needs to be recognised challenged and actively addressed (WHO 2008). Ageist attitudes and structures can be subtle but pervasive. These include the portrayal of older people in the media as vulnerable and frail or as an economic burden, forced redundancy or retirement of older workers, segregation rather than inclusion of older people in communities and lack of education especially for younger people. Changing public attitudes, commercial and public sector ethos towards ageing and promoting contact between older and younger generations requires dedicated action (WHO 2002, Podnieks et al. 2010b).

Combating social isolation is a particular challenge that requires a societal and community response. This includes the provision of adequate income, reconnection with community resources, housing design to maximise communal interaction, and affordable and available community transport especially in rural areas (Acierno et al. 2010, Podnieks et al. 2010b). Voluntary groups with a focus on older people, but also organisations that include older members such as golf clubs, the Irish Country Women's Association (ICA), the Irish Farmers Association (IFA), and church groups also have an important role to play in keeping people connected to their communities, and providing education and information.

Vulnerability and Frailty

Central to reducing vulnerability is the maintenance of optimum mental and physical health and remaining socially active. Risk modification is the same as that for any chronic disease and includes diet, exercise, avoidance of smoking or excess alcohol, regular health checks and remaining socially engaged in the community. However at some point poorer health, increased dependency and advanced age are largely inevitable. The necessity of supporting the older person and their carers in order to avoid adverse outcomes such as carer depression and isolation, ill health, neglect or abuse is well documented (Greenberger and Litwin 2003, Beach et al. 2005, Fulmer et al. 2005). This requires detailed individual and family assessment with tailored health care and social service support such as multi-disciplinary case management teams for older people (McCann et al. 2005, Kumamoto et al. 2006). The standards of care and training of personnel involved in providing home care services should also be monitored. Ireland over the next decade can expect to see a significant increase in the older old population, the majority of care is likely to continue to be provided through the family network when available but there is likely to be increased demands on formal services (McGee et al. 2008b). The pivotal role primary health care needs to play in recognising and managing elder

abuse is well publicised but it relies on building capacity within the service (WHO 2008, Mixson 2010).

Policy and Legislation

Currently Ireland does not have a unified policy on age and aging, instead there are fragmented and isolated policies developed to address specific issues mainly related to the financing of care. These include recent policy changes on pensions and the financing of nursing home care. The broader implications of these policies should be actively monitored and evaluated with regard to the welfare of older people and their families.

There are suggestions that the existing legislative framework is not strong enough to adequately protect older people from abuse or neglect (Working Group on Elder Abuse 2002, National Council on Ageing and Older People 2009). A lack of legislation or conflicting legislation was recognised by the Law Reform Commission but the forthcoming Mental Capacity and Guardianship Bill may not address many of the areas that inhibit professionals in their current role and expose vulnerable adults to abuse. Noteworthy examples include lack of regulation of non-professional care providers and often cited by health and social care professionals, financial institutions and the police is data protection legislation which impedes the sharing of information between agencies. Inadequate regulatory frameworks and barriers to effective inter-agency working need to be addressed.

Societal Context

Elder abuse and neglect is not a static isolated phenomenon but is intimately linked to other societal problems such as unemployment, domestic abuse, alcoholism, drug addiction and external stresses such as the current financial crisis. The HSE Elder Abuse Service is managing the most extreme episodes of elder mistreatment but with approximately 29 front line posts and an annual case load of nearly 2,000 people this service may be nearing saturation. To significantly impact on and prevent the prevalence of elder abuse and neglect escalating, as associated risk factors increase in the population, will require dynamic, diverse and collaborative solutions (Connolly 2010).

Ireland is not alone in coming to terms with the breadth, depth and complexity of this problem (Filinson 2006, Mixson 2010, van Bavel et al. 2010). Recent collaborative work across Europe has emphasised the commonality in terms of the experiences, the under-reporting and the lack of effective response options to tackle elder abuse (van Bavel et al. 2010). The report concluded that:

> *There is a link between elder abuse and the denial of a senior's fundamental rights, with the lack of understanding of the social value of older people and with the lack of services that can support dignified ageing (van Bavel et al. 2010: 9).*

In response to this and earlier work the European Commission has recently sponsored the development and implementation of a European Charter on the rights and responsibilities of older people in need of long-term care and assistance (AGE 2010). Ireland's experiences in terms of service development, public awareness campaigns, development of practice guidelines, education and research will help to work towards addressing the deficits within Ireland and should also inform pan-European practices.

8.9 Study Limitations and Future Research

The starting point for this or any survey on a sensitive topic such as elder abuse is the belief that there is an under-reporting of incidents as exemplified by the 2.2% prevalence rate indentified in this study compared to the 0.4% reported to official HSE services (HSE 2010). Research also indicates that people in poor health and with cognitive impairment are less likely to participate in studies yet this group are at higher risk of mistreatment (O'Keeffe et al. 2007). Older people in nursing homes or other institutions were excluded from this survey, thus the prevalence of elder abuse in the whole of Irish society is not yet known.

A sample size of 2,021 was adequate to allow reliable calculation of prevalence rates but it was not sufficient for detailed examination of risk factors especially for individual types of abuse. The survey captured quite superficial categorical data and provided limited insight into the deeper relations and conflicts behind the abuse or neglect reported. It also relied on prior knowledge and questions on specific risk factors thus previously unknown factors may not be identified.

Future research needs to focus on filling in the missing pieces. Particular priorities include:

1) Examining the prevalence and context of elder abuse or neglect in care homes or institutions.
2) A deeper understanding of the relationship between the impact of abuse, reporting and coping with abuse, and the service and support needs of this group of people. Also research should involve the perpetrators and wider family to enable a better understanding of how family dynamics contribute to elder abuse and neglect.
3) The experiences of specific community sub-groups largely missing from this survey need to be explored e.g. older people with intellectual disabilities, physical or cognitive impairment and their carers, ethnic groups such as Irish Travellers, and the immigrant population as they age.
4) Evaluation of the response of specific and wider services for older people and the response from financial, legal, health, police, etc in recognising and managing elder abuse. Such activity should lead to the development of codes of practice and practice guidelines for prevention of elder abuse.
5) High-quality research in the area of elder abuse interventions using experimental or quasi-experimental designs (Ploeg et al. 2009).

Elder abuse research should not be seen in isolation from other research involving older people as many of the risk factors are generic and impact on global quality of life. Researchers need to consider this dimension and not be afraid to ask older people about their experiences (Cooper et al. 2008b). Information gained through longitudinal cohort studies, and knowledge and development of technologies for older people are likely to play an important part in empowering older people to protect themselves.

8.10 Summary and Conclusion

Using an international definition this survey estimated that the prevalence of elder abuse and neglect among community-dwelling older people in Ireland was 2.2%. This is in keeping with estimated rates in other western societies in particular the UK, including Northern Ireland. This figure implies that over 10,000 older people, or one in forty-five of the older population, experienced significant mistreatment in the previous year.

Given the stigma and reluctance to report all forms of family violence or abuse this figure is likely to be an underestimate of prevalence, and the definition used detected incidents at the more persistent and extreme end of the mistreatment spectrum. The use of alternative definitions suggests the figure may be significantly higher.

Financial abuse and psychological abuse were the most prevalent types of mistreatment identified; many of the international studies have not found financial abuse to be so prominent. Reported neglect was lower than in many other studies and may reflect lack of participation by this group in the survey or the demographics of the older Irish population, which has a smaller proportion of older old than many western societies.

There is significant commonality between the older person risk factors identified here and those reported in other studies, these include poor health, especially mental health, lower income, education and social isolation. Other important factors were unemployment and alcohol abuse among perpetrators. Incidents of mistreatment had a serious impact on older people but the information in the survey indicates many cases may go unreported and unresolved.

Elder abuse is complex and multidimensional involving personal characteristics, family stress, community and societal apathy towards ageism, and is compounded by wider societal problems such as unemployment, domestic violence and financial difficulties. Many of the risk factors associated with elder abuse and neglect will increase in Irish society over the coming decades. To effectively combat and prevent an escalation in the prevalence of elder abuse and neglect there needs to be strong leadership and dynamism from government, state agencies, academic institutes, financial and legal organisations, and older people themselves and the organisations that represent them.

The emphasis needs to be on empowering older people through appropriate technologies, education, income and community infrastructure underpinned by appropriate policy and legislation, and to clearly outline the boundaries in society regarding acceptable and unacceptable behaviour.

Acierno, R., Hernandez, M.A., Amstadter, A.B., Resnick, H.S., Steve, K., Muzzy, W. & Kilpatrick, D.G. (2010) Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), 292-297.

AGE (2010) *A European Charter of the rights and responsibilities of older people in need of long-term care and assistance*. AGE Platform Europe Available from http://www.age-platform.eu. (Accessed October 2010)

Aneshensel, C.S., Frerichs, R.R., Clark, V.A. & Yokopenic, P.A. (1982) Telephone versus in-person surveys of community health status. *American Journal of Public Health*, 72(9), 1017-1021.

Band-Winterstein, T. & Eisikovits, Z. (2005) The experience of loneliness of battered old women. *Journal of Women and Ageing*, 17(4), 3-19.

Band-Winterstein, T. & Eisikovits, Z. (2009) 'Aging Out' of Violence: the multiple faces of intimate violence over the life span. *Qualitative Health Research*, 19(2), 164-180.

Beach, S.R., Schulz, R., Williamson, G.M., Miller, L.S., Weiner, M.F. & Lance, C.E. (2005) Risk factors for potentially harmful informal caregiver behavior. *Journal of the American Geriatrics Society*, 53(2), 255-261.

Biggs, S., Manthorpe, J., Tinker, A., Doyle, M. & Erens, B. (2009) Mistreatment of Older People in the United Kingdom: Findings from the First National Prevalence Study. *Journal of Elder Abuse & Neglect*, 21(1), 1-14.

Bonnie R.J. & Wallace, R.B. (2003) *Elder mistreatment: abuse, neglect, and exploitation in an ageing America*, The National Academies Press, Washington DC.

Buchbinder, E. & Winterstein, T. (2004) "Like a Wounded Bird": Older Battered Women's Life Experiences with Intimate Violence *Journal of Elder Abuse & Neglect*, 15(2), 23-44.

Bunreacht na hÉireann (1937) *Constitution of Ireland*. The Stationery Office, Dublin.

Central Statistics Office Ireland (CSO) (2007a) *2006 Census Reports*. Central Statistics Office, Dublin, Available from http://www.cso.ie/census/Census2006Results.htm (Accessed October 2010).

Central Statistics Office Ireland (CSO) (2007b) *Ageing in Ireland*. Central Statistics Office, Dublin, Available from http://www.cso.ie/releasespublications/documents/other_releases/2007/ageinginireland.pdf (Accessed October 2010).

Chokkanathan, S. & Lee, A.E.Y. (2006) Elder Mistreatment in Urban India: A Community Based Study. *Journal of Elder Abuse & Neglect*, 17(2), 45-61.

Comijs, H.C., Pot, A.M., Bouter, L.M. & Jonker, C. (1998) Elder Abuse in the Community: Prevalence and Consequences. *Journal of the American Geriatrics Society*, 46(7), 885-888.

Compton, S.A., Flanagan, P. & Gregg, W. (1997) Elder Abuse in People with Dementia in Northern Ireland: Prevalence and predictors in cases referred to a psychiatry of old age service. *International Journal of Geriatric Psychiatry*, 12(6), 632-635.

Connolly, M.T. (2010) Where elder abuse and the justice system collide: police power, parens patriae, and 12 recommendations. *Journal of Elder Abuse & Neglect*, 22(1-2), 37-93.

Cooney, C., Howard, R. & Lawlor, B. (2006) Abuse of vulnerable people with dementia by their carers: can we identify those most at risk? *International Journal of Geriatric Psychiatry*, 21(6), 564-571.

Cooper, C., Manela, M., Katona, C. & Livingston, G. (2008a) Screening for elder abuse in dementia in the LASER-AD study: prevalence, correlates and validation of instruments. *International Journal of Geriatric Psychiatry*, 23(3), 283-288.

Cooper, C., Selwood, A. & Livingston, G. (2008b) The prevalence of elder abuse and neglect: a systematic review. *Age and Ageing*, 37(2), 151-160.

Cooper, C., Maxmin, K., Selwood, A., Blanchard, M. & Livingston, G. (2009a) The sensitivity and specificity of the Modified Conflict Tactics Scale for detecting clinically significant elder abuse. *International Psychogeriatrics*, 21(4), 774-778.

Cooper, C., Selwood, A., Blanchard, M., Walker, Z., Blizard, R. & Livingston, G. (2009b) Abuse of people with dementia by family carers: representative cross sectional survey. *British Medical Journal*, 338(2), b155.

References

Dalgard, O.S. (2006) *Explanation of the Oslo-3 Social Support Scale (OSS-3)*. Available from http://www.euphix.org/object_document/o5563n27411.html (Accessed 22 October 2010).

Department of Health and Children (DoHC) (1998) *Adding Years to Life and Life to Years: a health promotion strategy for older people in Ireland*. National Council on Ageing and Older People, Dublin.

Department of Health and Children (DoHC) (2001a) *Quality and Fairness: A Health System for You - Health Strategy*. The Stationery Office, Dublin.

Department of Health and Children (DoHC) (2001b) *Primary Care - A New Direction*. The Stationery Office, Dublin.

Department of Health and Children (DoHC) (2009) *Consultation on the National Positive Ageing Strategy*. Department of Health and Children, Dublin.

Department of Justice, Equality and Law Reform (2000) *Human Rights Commission Act*. The Stationery Office, Dublin.

Department of Justice, Equality and Law Reform (2001) *Human Rights Commission (Amendment) Act*. The Stationery Office, Dublin.

Department of Justice, Equality and Law Reform (2003) *European Convention on Human Rights Act*. The Stationery Office, Dublin.

Department of Justice, Equality and Law Reform (2008) *Scheme of the Mental Capacity Bill 2008*. Available at: http://www.justice.ie/en/JELR/Pages/Scheme_of_Mental_Capacity_Bill_2008 (Accessed 18 October 2010).

Department of Justice Equality and Law Reform (2009) *White Paper on Crime: Crime Prevention and Community Safety*. Department of Justice, Equality and Law Reform, Dublin 2.

Dixon, J., Manthorpe, J., Biggs, S., Mowlam, A., Tennant, R., Tinker, A. & McCreadie, C. (2010) Defining elder mistreatment: reflections on the United Kingdom Study of Abuse and Neglect of Older People. *Ageing and Society*, 30(3), 403-420.

Dong, X., Simon, M.A. & Gorbien, M. (2007) Elder Abuse and Neglect in an Urban Chinese Population. *Journal of Elder Abuse & Neglect*, 19(3-4), 79 - 96.

Drennan, J. (2003) Cognitive interviewing: verbal data in the design and pretesting of questionnaires. *Journal of Advanced Nursing*, 42(1), 57-63.

Filinson, R. (2006) "No secrets" and beyond: recent elder abuse policy in England. *Journal of Elder Abuse & Neglect*, 18(1), 1-18.

Fulmer, T., Paveza, G., VandeWeerd, C., Fairchild, S., Guadagno, L., Bolton-Blatt, M. & Norman, R. (2005) Dyadic vulnerability and risk profiling for elder neglect. *Gerontologist*, 45(4), 525-534.

Greenberger, H. & Litwin, H. (2003) Can burdened caregivers be effective facilitators of elder care-recipient health care? *Journal of Advanced Nursing*, 41(4), 332-341.

Health Information and Quality Authority (2010) *Protected Disclosure*. Health Information and Quality Authority. Available from http://www.hiqa.ie/protected_disclosure.asp (Accessed October 2010).

Health Service Executive (HSE) (2009) *Open Your Eyes - HSE Elder Abuse Service Developments 2008*. Health Service Executive, Dublin.

Health Service Executive (HSE) (2010) *Open Your Eyes - HSE Elder Abuse Service Developments 2009*. Health Service Executive, Dublin.

Herzog, A.R. & Rodgers, W.L. (1988) Interviewing Older Adults: Mode Comparison Using Data from a Face-to-Face Survey and a Telephone Resurvey. *Public Opinion Quarterly*, 52(1), 84-99.

Kim, J., Dubowitz, H., Hudson-Martin, E. & Lane, W. (2008) Comparison of 3 data collection methods for gathering sensitive and less sensitive information. *Ambulatory Pediatrics*, 8(4), 255-260.

Kumamoto, K., Arai, Y. & Zarit, S.H. (2006) Use of home care services effectively reduces feelings of burden among family caregivers of disabled elderly in Japan: preliminary results. *International Journal of Geriatric Psychiatry*, 21(2), 163-170.

Lachs, M.S. & Pillemer, K. (2004) Elder abuse. *The Lancet*, 364(9441), 1263-1272.

Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A. & Charlson, M.E. (1998) The Mortality of Elder Mistreatment. *Journal of the American Medical Association*, 280(5), 428-432.

Laumann, E.O., Leitsch, S.A. & Waite, L.J. (2008) Elder Mistreatment in the United States: Prevalence Estimates From a Nationally Representative Study. *The Journal of Gerontology Series B: Psychological Sciences and Social Sciences*, 63(4), S248-S254.

Law Reform Commission (2003) *Consultation paper on law and the elderly* (LRC CP 23-2003). Law Reform Commission, Dublin.

Law Reform Commission (2006) Report: *Vulnerable adults and the law* (LRC 83 - 2006). Law Reform Commission, Dublin.

Law Reform Commission (2009) *Consultation paper: Legal Aspects of Carers* (LRC CP 53-2009). Law Reform Commission, Dublin.

Lefante, J.J., Jr., Harmon, G.N., Ashby, K.M., Barnard, D. & Webber, L.S. (2005) Use of the SF-8 to assess health-related quality of life for a chronically ill, low-income population participating in the Central Louisiana Medication Access Program (CMAP). *Quality of Life Research*, 14(3), 665-673.

Lowenstein, A., Eisikovits, Z., Band-Winterstein, T. & Enosh, G. (2009) Is Elder Abuse and Neglect a Social Phenomenon? Data from the First National Prevalence Survey in Israel. *Journal of Elder Abuse & Neglect*, 21(3), 253-277.

Lyons, I., Treacy, M., Drennan, J., Phelan, A., O'Loughlin, A., Lafferty, A. et al. (2009) *Elder Abuse and Legislation in Ireland*. National Centre for the Protection of Older People, Dublin.

Marmolejo, I.I. (2008) *Elder Abuse in the Family in Spain*. Fundacion de la Comunitat Valenciana, Valencia.

McCann, S., Ryan, A.A. & McKenna, H. (2005) The challenges associated with providing community care for people with complex needs in rural areas: a qualitative investigation. *Health and Social Care in the Community*, 13(5), 462-469.

McCormick, M.C., Workman-Daniels, K., Brooks-Gunn, J. & Peckham, G.J. (1993) When you're only a phone call away: a comparison of the information in telephone and face-to-face interviews. *Journal of Developmental & Behavioral Pediatrics*, 14(4), 250-255.

McGee, H.M., Garavan, R., de Barra, M., Byrne, J. & Conroy, R. (2002) *The SAVI Report: Sexual Abuse and Violence in Ireland*. Liffey Press, Dublin.

McGee, H.M., Molloy, G., O'Hanlon, A., Layte, R. & Hickey, A. (2008a) Older people--recipients but also providers of informal care: an analysis among community samples in the Republic of Ireland and Northern Ireland. *Health and Social Care in the Community*, 16(5), 548-553.

McGee, H.M., O'Hanlon, A., Barker, M., Hickey, A., Montgomery, A., Conroy, R. & O'Neill, D. (2008b) Vulnerable older people in the community: relationship between the Vulnerable Elders Survey and health service use. *Journal of American Geriatric Society*, 56(1), 8-15.

Mears, J. (2003) Survival is not Enough: Violence Against Older Women in Australia. *Violence Against Women*, 9(12), 1478-1489.

Mixson, P.M. (2010) Public policy, elder abuse, and Adult Protective Services: the struggle for coherence. *Journal of Elder Abuse & Neglect*, 22(1-2), 16-36.

Morgan, K., McGee, H., Watson, D., Perry, I., Barry, M., Shelley, E., Harrington, J., Molcho, M., Layte, R., Tully, N., van Lente, E., Ward, M., Lutomski, J., Conroy, R. & Brugha, R. (2008) *SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland*. Department of Health and Children, Dublin.

Mowlam, A., Tennant, R., Dixon, J. & McCreadie, C. (2007) *UK Study of Abuse and Neglect of Older People: Qualitative Findings*. National Centre for Social Research, London.

National Council on Ageing and Older People (NCAOP) (2009) *Review of the Recommendations of Protecting Our Future: Report of the Working Group on Elder Abuse*. Department of Health and Children, Dublin.

O'Brien, J.G. (2010) A physician's perspective: elder abuse and neglect over 25 years. *Journal of Elder Abuse & Neglect*, 22(1-2), 94-104.

References

Ogg, J. & Bennett, G. (1992) Elder abuse in Britain. *British Medical Journal*, 305(6860), 998-999.

Oh, J., Kim, H.S., Martins, D. & Kim, H. (2006) A study of elder abuse in Korea. *International Journal of Nursing Studies*, 43(2), 203-214.

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., Tinker, A., Manthorpe, J., Biggs, S. & Erens, B. (2007) *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report*. National Centre for Social Research, London.

O'Loughlin, A. & Duggan, J. (1998) *Abuse, neglect and mistreatment of older people: an exploratory study*. National Council on Ageing and Older People, Dublin.

O'Shea, E. (2006) Developing a healthy ageing policy for Ireland: The view from below. *Health Policy*, 76(1), 93-105.

Perel-Levin, S. (2008) *Discussing Screening for Elder Abuse at Primary Health Care level*. World Health Organisation, Geneva.

Pillemer, K. & Finkelhor, D. (1988) The prevalence of elder abuse: a random sample survey. *Gerontologist*, 28(1), 51-57.

Pillemer, K.A. & Wolf, R.S. (1989) *Helping elderly victims: the reality of elder abuse*, Columbia University Press, New York.

Ploeg, J., Fear, J., Hutchison, B., MacMillan, H. & Bolan, G. (2009) A systematic review of interventions for elder abuse. *Journal of Elder Abuse and Neglect*, 21(3), 187-210.

Podnieks, E. (1992a) National Survey on Abuse of the Elderly in Canada. *Journal of Elder Abuse & Neglect*, 4(1/2), 5-58.

Podnieks, E. (1992b) Emerging Themes from a Follow-up Study of Canadian Victims of Elder Abuse. *Journal of Elder Abuse and Neglect*, 4(1/2), 59-111.

Podnieks, E., Penhale, B., Goergen, T., Biggs, S. & Han, D. (2010a) Elder mistreatment: an international narrative. *Journal of Elder Abuse and Neglect*, 22(1-2), 131-163.

Podnieks, E., Anetzberger, G.J., Wilson, S.J., Teaster, P.B. & Wangmo, T. (2010b) WorldView Environmental Scan on Elder Abuse. *Journal of Elder Abuse and Neglect*, 22(1-2), 164-179.

Reddy, M.K., Fleming, M.T., Howells, N.L., Rabenhorst, M.M., Casselman, R. & Rosenbaum, A. (2006) Effects of method on participants and disclosure rates in research on sensitive topics. *Violence and Victims*, 21(4), 499-506.

Roberts, B., Browne, J., Ocaka, K.F., Oyok, T. & Sondorp, E. (2008) The reliability and validity of the SF-8 with a conflict-affected population in northern Uganda. *Health and Quality of Life Outcomes*, 6, 108.

Rovi, S., Chen, P.H., Vega, M., Johnson, M.S. & Mouton, C.P. (2009) Mapping the Elder Mistreatment Iceberg: US hospitalizations with elder abuse and neglect diagnoses. *Journal of Elder Abuse & Neglect*, 21(4), 346-359.

Straus, M.A. (2007) Conflict Tactics Scales. In *Encyclopaedia of Domestic Violence* (Jackson, N. ed.) Routledge: Taylor & Francis Group, New York, pp. 190-197.

Teaster, P.B., Wangmo, T. & Anetzberger, G.J. (2010) A glass half full: the dubious history of elder abuse policy. *Journal of Elder Abuse and Neglect*, 22(1-2), 6-15.

Turner-Bowker, D.M., Bayliss, M.S., Ware, J.E., Jr. & Kosinski, M. (2003) Usefulness of the SF-8 Health Survey for comparing the impact of migraine and other conditions. *Quality of Life Research*, 12(8), 1003-1012.

Tussing, A.D. & Wren, M-A (2006) Health Service Staffing. In *How Ireland cares, the case for health care reform*. New Island, Dublin.

UCD School of Public Health, Physiotherapy and Population Science (2010) *All Ireland Traveller Health Study: Our Geels*. Department of Health and Children, Dublin.

van Bavel, M., Janssens, K., Schakenraad, W. & Thurlings, N. (2010) Elder Abuse in Europe: Background and position paper. EuROPEAN Available from www.preventelderabuse.eu, Utrecht. (Accessed October 2010)

Ware, J., Kosinski, M., Dewey, J. & Gandek, B. (2001) *How to Score and Interpret Single-Item Health Status Measures: A Manual for Users of the SF-8 Health Survey*. Quality Metric, Boston.

Watson, D. & Parsons, S. (2005) *Domestic Abuse of Women and Men in Ireland: Report on the National Study of Domestic Abuse*. The Stationery Office, Dublin.

Wetzels, P. & Greve, W. (1996) Older People as Victims of Family Violence. *Zeitschrift für Gerontologie and Geriatrie* 29, 191-200.

World Health Organisation (WHO) (2002) *Missing Voices: Views of Older Persons on Elder Abuse*. World Health Organisation / International Network for the Prevention of Elder Abuse, Geneva.

World Health Organisation (WHO) (2008) *A Global Response to Elder Abuse and Neglect; Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report*. World Health Organisation, Geneva.

Winterstein, T. & Eisikovits, Z. (2005) The experience of loneliness of battered old women. *Journal of Women and Ageing*, 17(4), 3-19.

Working Group on Elder Abuse (2002) *Protecting Our Future: Report of the Working Group on Elder Abuse*. The Stationery Office, Dublin.

Worth, A. & Tierney, A.J. (1993) Conducting research interviews with elderly people by telephone. *Journal of Advanced Nursing*, 18(7), 1077-1084.

Yan, E. & Tang, C. (2001) Prevalence and Psychological Impact of Chinese Elder Abuse. *Journal of Interpersonal Violence*, 16(11), 1158-1174.

Yan, E.C-W. & Tang, C.S-K. (2004) Elder Abuse by Caregivers: A Study of Prevalence and Risk Factors in Hong Kong Chinese Families. *Journal of Family Violence*, 19(5), 269-277.

Appendix 1 Elder Abuse Screening Sheet and Questionnaire

Adapted with permission from original questionnaire by Dr M Lachs, Cornell University NY

National Centre for the Protection of Older People

Elder Abuse Prevalence Questionnaire

April-May 2010 – S9-239

Hello, My name is _____, I am working on behalf of University College Dublin. We are carrying out a confidential survey to explore the relationships older people have with their families or people they often come in contact with.

Questionnaire No.				
Interview Start time (24hr)				
Interview End time (24hr)				

Cluster code	
Respondent code	

Qa Firstly Is there a person aged 65 years or older in your household?

No adults 65+ in household	1	*Ineligible – End interview*
One adult 65+	2	*Ask to speak with that adult*
Two or more adults 65+	3	*Ask to speak with adult that fits priority quota (M age 80+ yrs, F 80+ years, Male 65-79, F 65-79)*
Person not available	4	*Arrange to call back later*
Do not know	5	*Call back later to talk with someone else*
Refused	6	*Go to Qb*

ASK IF Qa IS REFUSED

Qb Why were you unable to speak with older person?

If new person comes to the door repeat above intro.

Introduction and Screening

Qc Interviewer – please record gender of respondent:

Male	1
Female	2

Qd What age were you on your last birthday?

If they are not sure, ask what year they were born in and calculate age

			years

Qe Interviewer – please code age

Aged 64 or younger	1	*Close interview*
Aged 65 to 69 years	2	*Continue*
Aged 70 to 79 years	3	*Continue*
Aged 80 years or older	4	*Continue*

I would like to give you more information about this study, is that ok? The survey deals with older peoples experiences of mistreatment, abuse or neglect. We are just as interested in speaking to people who have not experienced this kind of behaviour as those who have.

This is the first major study of its kind in Ireland and it will be used to help protect older people in the future.

Your house was chosen at random (like the lottery), we do not know your name and we will not record your address. Anything you say will be completely confidential, nobody will know you talked to us.

We would really appreciate your help with this survey. It shouldn't take longer than 20 to 40 minutes…
What do you think?

Qf Would you like to participate?

Yes	1	*Continue*
No	2	*Go to Qg*

Qg Okay, I understand that you do not want to/unable to speak with us. Before I go, can you please tell me why?

INTERVIEWER: PLEASE RECORD VERBATIM

Confidentiality Section

Your participation in this study is, of course, voluntary. Some of the questions might be upsetting to some people. If there is any question you would prefer not to answer, just tell me and we will go on to the next question. You can also stop participating at any time.

I would like to give you an information leaflet which explains the study in more detail, also if you wish you can contact these numbers just to verify I am who I say I am and that the study is legitimate. *[Hand Information leaflet to Participant]*

Qh Can we carry out this interview in private without being overheard, as some of the questions are quite sensitive? Is there a room which we can use where we will not be interrupted?

Yes	1	*Go to Q1*
No	2	*Go to Qi*

Qi Can I call back when you may be able to have this conversation in private? Can I arrange a time to call back which would suit you better?

Yes	1	*Record details below*
No	2	*Complete Qg*

Qj Can I ask you for your first name only, so I will know who to ask for when I call back?

Interviewer record appointment details below

Section 1 Household Relations/Health

Cluster code		This must match corresponding screener page
Respondent code		This must match corresponding screener page

MARITAL

Q.1 Some of the questions we ask depend on your marital status. Are you *currently*:

(single code only)

Married (first)	01
Remarried (following widowhood)	02
Remarried (following divorce/annulment)	03
Widowed	04
Widowed partnered (current)	05
Separated (including deserted)	06
Single, never married	07
Single, divorced	08
Single, partnered (current)	09
Do not know	10
Refused	11

IF Q1 IS CODE 4 OR 7, GO TO Q2(ii), other wise ask Q2i.

Q.2 Would you please tell me who currently lives with you in this household?

(***INTERVIEWER NOTE:*** *If granny flat with separate front door and not sharing bathroom or kitchen, then tick No, if shared facilities tick Yes living with children/relatives/other person as appropriate)*

	Q2			If Yes	
	Yes	No	Refused	How many	How are they related to you
I. Are you living with your spouse/partner?	1	2	3		
II. Do you have any children? (include step or adopted children) (if no go to QIV)	1	2	3		
III. Are any of your children currently living with you?	1	2	3		
IV. Are any other relatives living with you? (please specify)	1	2	3		
V. Is there anyone else living with you that we haven't already mentioned? (please specify)	1	2	3		

HEALTH

I would like to begin by asking some questions about your health and general well being.

Q.3 In general, how would you rate your health in the *past 4 weeks*?

Excellent	6
Very good	5
Good	4
Fair	3
Poor	2
Very Poor	1

Q.4 Do you have a long term illness, health problem or disability that has lasted for the *past six months* or more?

Yes	1
No	2

Q.5 During the *past 4 weeks*, how much did *physical health* problems limit your usual physical activities (such as walking climbing stairs)?

Not At All Limited	Limited Very Little	Somewhat/ Moderately Limited	Limited Quite A Lot	Could Not Do Physical Activity
5	4	3	2	1

Q.6 During the *past 4 weeks*, how much *difficulty did you have doing your daily work*, both at home and away from home, because of physical health?

None At All	A Little Bit	Some Difficulty	Quite A Lot	Could Not Do Daily Work
5	4	3	2	1

Q.7 How much *bodily pain* have you had in the *past 4 weeks*?

None At All	Very Mild Pain	Mild	Moderate	Severe	Very Severe
6	5	4	3	2	1

Q.8 During the *past 4 weeks*, how much *energy* did you have?

Very Much Energy	Quite A Lot	Some	A Little	None
5	4	3	2	1

Q.9 During the *past 4 weeks*, how much did your *physical health or emotional problems* limit your usual social activities with family or friends

Not At All Limited	Limited Very Little	Somewhat/ Moderately Limited	Limited Quite A Lot	Could Not Do Social Activity
5	4	3	2	1

Q.10 (a) During the *past 4 weeks*, how much have you been *bothered by emotional problems* (such as feeling anxious, depressed or irritable)?

None At All	Slightly	Moderately	Quite A Lot	Extremely
5	4	3	2	1

Q.10 (b) During the *past 4 weeks*, how much did *personal or emotional problems* keep you from doing your usual work or other daily activities

None At All	Very Little	Somewhat	Quite A Lot	Could Not Do Daily Activities
5	4	3	2	1

I am now going to ask you about your recent contact with health, social or other services.

Q.11 (i) In the past *six months* have you had face to face contact with any of the following services?

Q.11 (ii) *IF YES*, how many times in the past six months have you had contact with?

INTERVIEWER NOTES

1. *If older person says they were admitted to hospital through A&E tick both, but check the number of A&E visits they may be more than hospital admissions*
2. *If older person ask for example or hesitates, list Age action, Friends of the elderly, St Vincent's de Paul*
3. *Please tick frequency that comes closes to what the respondent indicates*

	None	Once	2-3 times	≥4 times	1-2 per weeks	Daily	refused
GP	0	1	2	3	4	5	6
GP Practice Nurse (nurse working in a GP practice)	0	1	2	3	4	5	6
Public health/Community Nurse	0	1	2	3	4	5	6
Social worker	0	1	2	3	4	5	6
Meals on wheels	0	1	2	3	4	5	6
Paid home help	0	1	2	3	4	5	6
Elderly Care Day Hospital (receives medical care)	0	1	2	3	4	5	6
Community Psychiatric Nurse	0	1	2	3	4	5	6
Physiotherapist or Occupational therapist	0	1	2	3	4	5	6
Hospital Consultant or Hospital appointment (e.g. outpatients)	0	1	2	3	4	5	6
Admitted to hospital (stay at least 24 hours)1	0	1	2	3	4	5	6
Visit to the Emergency Department (A&E)1	0	1	2	3	4	5	6
Visits from voluntary groups 2	0	1	2	3	4	5	6
Visit to social or community groups or clubs	0	1	2	3	4	5	6
Other care or support services, (please specify)	0	1	2	3	4	5	6

We have finished the first section, do you need to take a break before we start the next set of questions?

Section 2 Attitudes to Elder Abuse

I am going to ask you some questions about what you understand about mistreatment of older people, these are your opinion there are no right or wrong answers.

Q.12 Can you tell me what, in your opinion, is meant by the term Elder Abuse?

*(**INTERVIEWER:** do not prompt response, if person cannot think of anything record 'Don't know', short response only required)*

People think of different things when they hear the term elder mistreatment or abuse.

Q.13 Would you regard the following types of behaviour as abuse?

	Not abuse	Mild abuse	Moderate abuse	Severe abuse	Don't Know
Deliberately preventing an older person who is mentally competent access to their own money/property	0	1	2	3	4
A family member putting pressure on an older person to give them money or property	0	1	2	3	4
Deliberately embarrassing an older person	0	1	2	3	4
Shouting at an older person	0	1	2	3	4
Calling an older person hurtful names	0	1	2	3	4
Pushing or shoving an older person	0	1	2	3	4
Slapping an older person across the face	0	1	2	3	4
Not providing help with routine activities such as shopping or transport when needed	0	1	2	3	4
Not providing help with personal activities such as dressing, washing, feeding when this is normally expected/provided	0	1	2	3	4
Not providing older people with free medical care	0	1	2	3	4
Selling older people insurance or investment products that they do not fully understand	0	1	2	3	4
Portraying older people in the media (news papers, TV, radio) as a 'burden'	0	1	2	3	4

Q.14 In your opinion how widespread is Elder Abuse in Ireland?

Very widespread	1
Fairly/quite widespread	2
Not very widespread	3
Not at all widespread	4
Don't know	5

Section 3 Activities of Daily Living

I am going to ask you some questions about how well you have been able to look after yourself in your own home over the past 12 months (include any temporary incapacity due to illness/surgery/discharge from hospital)

Q.15i (a) Are you able?

IF NO or Temp incapacity

Q.15i (b) What is your relationship to the *main* person (s) who helps you or does this for you? (Select up to two people, if only identifies one person probe if anyone else)

Q.15i (c) Since turning 65, has there ever been a time when this person hasn't helped you when you thought they should have helped you?

IF YES

Q.15i (d) In the *past 12 months*, how many times has this happened to you?

Q.15i (e) How serious a problem for you was it that this person did not help you?

	(i) To go shopping for food and clothes without any help	(ii) To prepare your own meals without any help	(iii) To do routine jobs around your home (washing dishes, sweeping floors, putting out the bins) without any help?	(iv) To take your medicines in the right doses and at the right times without any help?[1]	(v) To use public transport or drive yourself for routine journeys
a) Are you able to…?					
Yes	1	1	1	1	1
No	2	2	2	2	2
Temp incapacity	3	3	3	3	3
Do not know	4	4	4	4	4
Refused	5	5	5	5	5

IF NO or temp incapacity										
b) Relationship of person	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Spouse/Partner	1	1	1	1	1	1	1	1	1	1
Adult child	2	2	2	2	2	2	2	2	2	2
Other relative	3	3	3	3	3	3	3	3	3	3
Friend[2]	4	4	4	4	4	4	4	4	4	4
Neighbour[2]	5	5	5	5	5	5	5	5	5	5
Other non-relative (known to older person)	6	6	6	6	6	6	6	6	6	6
Paid home-help	7	7	7	7	7	7	7	7	7	7
c) Occasion when person hasn't helped?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Yes	1	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2	2
d) In last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1	1	1	1	1	1	1
Once	2	2	2	2	2	2	2	2	2	2
2-9 times	3	3	3	3	3	3	3	3	3	3
10 or more times	4	4	4	4	4	4	4	4	4	4
e) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1	1	1	1	1	1	1
Somewhat/moderately	2	2	2	2	2	2	2	2	2	2
Very serious	3	3	3	3	3	3	3	3	3	3

INTERVIEWER: *1) if person not on regular medication use the example of a course of antibiotics*
2) if person indicates the neighbour is a friend then tick friend, same throughout questionnaire

If answered yes (i.e. does not need help, code 1) to all 5 questions above skip to Q17a.

Q.15ii (f) Are you able?

IF NO/Temporary incapacity

Q.15ii (g) What is your relationship to the *main* person (s) who helps you or does this for you? (Select up to two people, if only identifies one person, probe if anyone else)

Q.15ii (h) Since turning 65, has there ever been a time when this person hasn't helped you when you thought they should have helped you?

IF YES

Q.15ii (i) In the *past 12 months*, how many times has this happened to you?

Q.15ii (j) How serious a problem for you was it that this person did not help you?

	(vi) To wash and dress yourself without any help		(vii) To get in and out of bed without any help?		(viii) To move about your house without any help (walking aid, walking stick allowed)		(ix) To get to and use the toilet without any help		(x) To cut up and eat your food without any help	
f) Are you able to…?										
Yes	1		1		1		1		1	
No	2		2		2		2		2	
Temp incapacity	3		3		3		3		3	
Do not know	4		4		4		4		4	
Refused	5		5		5		5		5	
IF NO or temp incapacity										
g) Relationship of person	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Spouse/Partner	1	1	1	1	1	1	1	1	1	1
Adult child	2	2	2	2	2	2	2	2	2	2
Other relative	3	3	3	3	3	3	3	3	3	3
Friend[2]	4	4	4	4	4	4	4	4	4	4
Neighbour[2]	5	5	5	5	5	5	5	5	5	5
Other non-relative (known to older person)	6	6	6	6	6	6	6	6	6	6
Paid home-help	7	7	7	7	7	7	7	7	7	7
h) Occasion when person hasn't helped?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Yes	1	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2	2
i) In last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1	1	1	1	1	1	1
Once	2	2	2	2	2	2	2	2	2	2
2-9 times	3	3	3	3	3	3	3	3	3	3
10 or more times	4	4	4	4	4	4	4	4	4	4
j) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1	1	1	1	1	1	1
Somewhat/moderately	2	2	2	2	2	2	2	2	2	2
Very serious	3	3	3	3	3	3	3	3	3	3

Q15iii (a) What was the nature of the temporary incapacity

Q15iii (b) How long approximately did you need the help of or depend on other people

	weeks or		months

Q.16 (a) What age is the person (s) who normally helps you/is your main carer (provides the majority of care)?

Carer 1			Years
Carer 2			Years

Q.16 (b) Do you think the person(s) who normally helps you is able (physically & mentally) to carry out this role?

	Not at all able	Slightly able	Moderately able	Completely able
Carer 1	1	2	3	4
Carer 2	1	2	3	4

Q.16 (c) Record any verbatim comments:

ASK ALL

Q.17 (a) Do you provide personal care on a weekly or daily basis (helping someone to wash, feed, walk, use toilet) Do not include providing care for someone with a temporary incapacity

Yes	1	*Go to Q17b*
No	2	*Go to Q18*

ASK IF Q17A IS YES

Age				Years

Q.17 (b) What age is the main person for whom you provide this care?

ASK IF Q17A IS YES

Q.17 (c) Do you think you are able (physically & mentally) to carry out this role?

Not at all able	Slightly able	Moderately able	Completely able
1	2	3	4

Section 4 Financial Dealings

I am going to ask some questions about your financial dealings with others.

Q.18 (a) Since turning 65 years of age has anyone you live with or spent time with ever done any of the following

IF YES

Q.18 (b) What is this person's relationship to you? (Select up to two people, if only identifies one person, probe if anyone else)

Q.18 (c) In the *past 12 months*, how many times has this happened?

Q.18 (d) How serious a problem was this for you?

	(i) Stolen your money/ possessions/ property/ land or documents?	(ii) Deliberately prevented you access to your money/ possessions/ property/ land or documents?	(iii) Forced or misled you into giving them money, possessions, property, land or your pension book against your will	(iv) Forced or misled you to sign over ownership of your home or property or pension book against your will	(v) Forced, or misled you to change your will (last will/ testament) or any other financial documents against your will?	(vi) Signed your name on cheque/ pension book or other financial documents against your will?	(vii) Misused the power of attorney you gave them or have you been forced, or misled into signing a power of attorney?	(viii) Tried/ pressured you (but not succeeded) in doing any of the previous (to steal money, property, change legal documents, pension book)	(ix) Stopped contributing to household expenses such as rent or food where this has been previously agreed?
(a) Any of the following…									
Yes	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2
Do not know	3	3	3	3	3	3	3	3	3
Refused	4	4	4	4	4	4	4	4	4
IF YES									

(b) Relationship of person	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Spouse/Partner	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Adult child	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2

	(i) Stolen your money/ possessions/ property/ land or documents?		(ii) Deliberately prevented you access to your money/ possessions/ property/ land or documents?		(iii) Forced or misled you into giving them money, possessions, property, land or your pension book against your will		(iv) Forced or misled you to sign over ownership of your home or property or pension book against your will		(v) Forced, or misled you to change your will (last will/ testament) or any other financial documents against your will?		(vi) Signed your name on cheque/ pension book or other financial documents against your will?		(vii) Misused the power of attorney you gave them or have you been forced, or misled into signing a power of attorney?		(viii) Tried/ pressured you (but not succeeded) in doing any of the previous (to steal money, property, change legal documents, pension book)		(ix) Stopped contributing to household expenses such as rent or food where this has been previously agreed?	
Other relative	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Friend	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Neighbour	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Other non-relative (known to older person)	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Paid home-help	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
Medical professional	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Stranger	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
(c) In last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Once	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
2 to 9 times	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
10 or more times	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
(d) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Somewhat/moderately	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Very serious	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

Q.19 (a) Since turning 65 years of age…

IF YES

Q.19 (b) What organisation was involved?

Q.19 (c) In the *past 12 months*, how many times has this happened?

Q.19 (d) How serious a problem was this for you?

Q.19 (e) Did you report this to anybody?

	(i) Have you felt pressured by a bank/ building society/insurance company to buy any of their financial products (such as bonds, insurance policy (excludes car or house insurance)?		(ii) Has a bank/building society/insurance company sold you a financial product or investment or insurance policy that you did not understand (excludes car or house insurance)?	
a) Incidence:				
Yes	1		1	
No	2		2	
Do not know	3		3	
Refused	4		4	
IF YES				
b) What organisation?	**(i)**	**(ii)**	**(i)**	**(ii)**
Bank	1	1	1	1
Building society	2	2	2	2
Insurance Co.	3	3	3	3
Other	4	4	4	4
c) In last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1
Once	2	2	2	2
2 to 9 times	3	3	3	3
10 or more times	4	4	4	4
(d) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1
Somewhat/moderately	2	2	2	2
Very serious	3	3	3	3
(e) Reported?	**(i)**	**(ii)**	**(i)**	**(ii)**
No	1	1	1	1
Family	2	2	2	2
Friends	3	3	3	3
Police	4	4	4	4
Social Worker	5	5	5	5
Financial ombudsman	6	6	6	6
Other (Specify):	7	7	7	7

Section 5 Elder Mistreatment I

No matter how well people get along, there are times when family members or other people you know or count on for help, disagree and get annoyed with each other. People use many different ways of trying to settle their differences. I'm going to read a list of things that people might have said or done.

Q.20 (a) ***Since turning 65 years of age*** **has anyone (a family member or someone you spend time with)…**

IF YES

Q.20 (b) What is this person's relationship to you? (Select up to two people, if only identifies one person, probe if anyone else)

Q.20 (c) In the *past 12 months*, how many times has this happened?

Q.20 (d) How serious a problem was this for you?

	(i) Insulted you, called you names or swore at you	(ii) Threatened you verbally	(iii) Undermined or belittled what you do	(iv) Excluded you or repeatedly ignored you	(v) Threatened to harm others that you care about	(vi) Prevented you from seeing others that you care about or your doctor/ nurse	(vii) Tried to slap or hit you	(viii) Pushed, grabbed, shoved or slapped you	(ix) Removed or prevented you access to equipment such as hearing aids, walking aids	(x) Talked to you in a sexual way that you did not like	(xi) Touched you or tried to touch you in a sexual way you did not like/against your will
(a) Has anyone…											
Yes	1	1	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2	2	2
Do not know	3	3	3	3	3	3	3	3	3	3	3
Refused	4	4	4	4	4	4	4	4	4	4	4

IF YES																						
(b) Relationship of person	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Spouse/Partner	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Adult child	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2

	(i) Insulted you, called you names or swore at you		(ii) Threatened you verbally		(iii) Undermined or belittled what you do		(iv) Excluded you or repeatedly ignored you		(v) Threatened to harm others that you care about		(vi) Prevented you from seeing others that you care about or your doctor/ nurse		(vii) Tried to slap or hit you		(viii) Pushed, grabbed, shoved or slapped you		(ix) Removed or prevented you access to equipment such as hearing aids, walking aids		(x) Talked to you in a sexual way that you did not like		(xi) Touched you or tried to touch you in a sexual way you did not like/against your will	
Other relative	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Friend	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Neighbour	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Other non-relative (known to older person)	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Paid home-help	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
Medical professional	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Stranger	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
(c) In last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Once	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
2 to 9 times	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
10 or more times	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
(d) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Somewhat/ moderately	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Very serious	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

Elder Mistreatment II

Q.21 (a) Since turning 65 years of age has anyone you live with or spent time with ever done any of the following.

IF YES

Q.21 (b) What is this person's relationship to you? (Select up to two people, if only identifies one person, probe if anyone else)

Q.21 (c) In the past 12 months, how many times has this happened?

Q.21 (d) How serious a problem was this for you?

	(i) Hit or tried to hit you with an object		(ii) Kicked, bit or hit you with a fist		(iii) Burned or scalded you		(iv) Given you drugs or too much medicine to control you or make you sleepy		(v) Restrained you in any way e.g. locked you in your room, tied you in a chair		(vi) Threatened you with a knife or gun		(vii) Injured you with a knife or gun		(viii) Forced you or tried to force you to have sexual intercourse against your will	
(a) Any of the following…																
Yes	1		1		1		1		1		1		1		1	
No	2		2		2		2		2		2		2		2	
Do not know	3		3		3		3		3		3		3		3	
Refused	4		4		4		4		4		4		4		4	
IF YES																
(b) Relationship of person	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Spouse/Partner	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Adult child	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Other relative	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Friend	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Neighbour	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5

	(i) Hit or tried to hit you with an object		(ii) Kicked, bit or hit you with a fist		(iii) Burned or scalded you		(iv) Given you drugs or too much medicine to control you or make you sleepy		(v) Restrained you in any way e.g. locked you in your room, tied you in a chair		(vi) Threatened you with a knife or gun		(vii) Injured you with a knife or gun		(viii) Forced you or tried to force you to have sexual intercourse against your will	
Other non-relative (known to older person)	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Paid home-help	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
Medical professional	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Stranger	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
(c) In the last 12 months, how many times?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
None	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Once	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
2 to 9 times	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
10 or more times	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
(d) How Serious?	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**	**(i)**	**(ii)**
Not serious	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Somewhat/moderately	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Very serious	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

Q.22 Record any relevant information that you feel may not already be captured, e.g. not allowed access to grandchildren, or someone experiences physical or psychological abuse because the person they care for has dementia

IF No at Q20 or Q21 skip to Q25, if yes, ask Q23 &Q24

Q.23 Did any of the above behaviour result in physical injury?

None	0
Minor bruises	1
Had to see your GP/Nurse	2
Had to go to the Emergency Dept (A&E)	3
Had to stay in hospital	4
Other (please specify)	5

Q.24 What age were you when you first experienced any of the treatment we have talked about?

Age				Years

Q.25 This study is about *elder abuse and neglect*. We have asked a number of questions about this topic, but I would like to ask one final question: Have you ever experienced abuse or neglect *since turning 65 years* of age which we have not covered?

Yes	1	*Go to 26*
No	2	*Go to Q27*
Do not know	3	*Go to Q27*
Refused	4	*Go to Q27*

Q.26 Would you please describe the abuse or neglect you experienced? *(only if not already covered)*

Q.27 (a) *Before the age of 65 years* have you ever experienced any of the treatment or abuse we have described?

Yes	1
No	2

Q.27 (b) If yes, Please specify:

IF No to15C, or 15H or ALL OF Q18 or Q20, Q21 or Q25 (no experience of any abuse or neglect since 65 years) Skip to Q30 Demographics.

Section 6 Reporting Abuse

ASK IF YES TO 15C, OR 15H OR ANY PART OF Q18 or Q20, Q21 or Q25.

I would like to ask you some questions about what happened in relation to the abuse or neglect you experienced.

Q.28i Since age 65 years have you reported any incidents of financial abuse, mistreatment or neglect to anybody? *(LIST & CIRCLE ALL THAT APPLY)*

Int: Distinguish between reporting of abuse perpetrated by someone known to the older person versus crime by a stranger, e.g they may report a break in to police but not that they are abused by a family member

	Abuse perpetrated by someone known to the older person (family/friend/neighbour etc)	Stranger abuse e.g. break in
Family	01	01
Friend	02	02
Neighbour	03	03
GP	04	04
Community/public health Nurse	05	05
GP Practice Nurse	06	06
Home help	07	07
Hospital Doctor	08	08
Hospital Nurse	09	09
Social worker	10	10
Elder Abuse Senior Case worker	11	11
Police/Gardaí	12	12
Telephone Helpline	13	13
Other (please specify)	14	14
No, did not report abuse or neglect	15	15

Q.28ii What action did you take or was taken on your behalf to prevent recurrence of abuse *(LIST & CIRCLE ALL THAT APPLY)*

No action, the abuse just stopped	1
No action, the abuse is ongoing	2
You spoke with the person causing the abuse	3
A family member/friend spoke to the person(s)on your behalf	4
A professional (social worker/gardaí/medical doctor or nurse) spoke to the person(s) on your behalf	5
You broke contact with/avoid the person(s) involved in the abuse	6
You withdrew (stopped going out) from social life in general	7
A barring or safety order was made against the person	8
Other (please specify)	9

Q28iii Was the action successful?

No – the abuse continued/is ongoing	1
Yes – it became less	2
Yes – it never happened again	3

ASK IF YES TO 15C, OR 15H OR ANY PART OF Q18 OR Q20, Q21 or Q25

*(Ask if any incidents of neglect/personal financial abuse or mistreatment **since age 65 years**)*

Q.29 I understand that it might be difficult for you, but can I ask you some questions about the person(s) that was involved in the behaviour we have talked about?

All questions relate to the time of mistreatment	**Perpetrator 1**	**Perpetrator 2**
i) What age is/was the person at the time the mistreatment started?	☐☐ Years	☐☐ Years
ii) Are/were they male or female?	1. Male 2. Female	1. Male 2. Female
iii) Are/were they married/partnered, separated/ divorced, single?	1. Married 2. Partnered 3. Separated 4. Divorced 5. Single	1. Married 2. Partnered 3. Separated 4. Divorced 5. Single
iv) Does/did the person(s) live with you at the time of the mistreatment?	1. Yes 2. No	1. Yes 2. No
v) Is this person(s) currently living with you?	1. Yes 2. No 3. Sometimes	1. Yes 2. No 3. Sometimes
vi) Where did the mistreatment mainly (most frequently) occur?	1. Your Home 2. A relatives home 3. A friends Home 4. Respite Care 5. Day Care Centre 6. Other	1. Your Home 2. A relatives home 3. A friends Home 4. Respite Care 5. Day Care Centre 6. Other
vii) Are/were they working or unemployed?	1. Working 2. Unemployed	1. Working 2. Unemployed
viii) If working what type of job? (be as precise as possible)		
xi) How are/were they related to you?	1. Spouse/Partner 2. Adult child 3. Other relative 4. Friend 5. Neighbour 6. Other non-relative 7. Paid home-help 8. Medical professional 9. Stranger	1. Spouse/Partner 2. Adult child 3. Other relative 4. Friend 5. Neighbour 6. Other non-relative 7. Paid home-help 8. Medical professional 9. Stranger
x) How long do/did you know the person?	☐☐ Years ☐☐ Months	☐☐ Years ☐☐ Months

All questions relate to the time of mistreatment	**Perpetrator 1**	**Perpetrator 2**
xi) What is/was their highest level of education? (primary, secondary, a trade, university)	1. No education 2. Primary 3. Secondary 4. University 5. Trade 6. Don't know	1. No education 2. Primary 3. Secondary 4. University 5. Trade 6. Don't know
xii) Do they have physical health problems (specify)	1. Yes 2. No If Yes _____ 3. Don't know	1. Yes 2. No If Yes _____ 3. Don't know
xiii) Do/did they have an addiction to alcohol/drugs/gambling (record type of addiction)	1. None 2. Alcohol 3. Drugs 4. Gambling 5. Don't know	1. None 2. Alcohol 3. Drugs 4. Gambling 5. Don't know
xiv) Do/did they have a mental health problem (e.g. dementia, depression)? (Specify)	1. Yes 2. No If Yes _____ 3. Don't know	1. Yes 2. No If Yes _____ 3. Don't know
xv) Do/did they have an intellectual disability?	1. Yes 2. No 3. Don't know	1. Yes 2. No 3. Don't know
xvi) Do they have a criminal record?	1. Yes 2. No 3. Don't know	1. Yes 2. No 3. Don't know
xvii) Any other relevant details record?		

We are nearly finished, do you need to take a break or is it ok to continue?

Record any additional information you feel may be relevant.

Section 7 Demographics

We would like to ask a few questions about your background, just to make sure we are getting opinions from a wide variety of people.

Q.30 What was the highest level of education (full time or part time) you have completed?

Primary education	1
Lower secondary (junior/intermediate cert, O levels, basic skills training)	2
Upper secondary (leaving cert, A levels)	3
Vocational/technical qualification (completed apprenticeship)	4
Third level non-degree (national certificate, nurse certificate)	5
Third level degree or higher (primary degree, masters, PhD)	6
No formal education	7
Do not know	8
Refused	9

Q.31 Do you?

Own your own home	1
Live with relatives in their home[1]	2
Rented accommodation	3
Other (specify):	4
Do not know	5
Refused	6

INTERVIEWER NOTE:

1) If granny flat with separate front door and not sharing bathroom or kitchen then tick other, if shared facilities tick relatives home.

Q.32 How would you describe the place where your household is situated?

In open countryside	1
Village	2
Town (1500+)	3
City (other than Dublin)	4
Dublin City (within M50)	5
Dublin County	6

Q.33 How many people are close, (by this we mean emotionally rather than distance), to you that you can rely on them if you have a serious problem?

None	1
One or two	2
Three to five	3
More than five	4

Q.34 How much friendly interest or concern do people take in what you are doing?

A lot	1
Some	2
Uncertain (not sure)	3
Little	4
None	5

Q.35 How easy is it to get practical help from family if you should need it?

Very easy	1
Easy	2
Possible	3
Difficult	4
Very difficult	5

Q.36 How easy is it to get practical help from neighbours if you should need it?

Very easy	1
Easy	2
Possible	3
Difficult	4
Very difficult	5

Q.37 Are you still in paid employment?

Yes	1
No	2

Q.38 What was (is) your *main occupation* (describe occupation fully and precisely giving the full job title)

Use precise terms such as:	*Do not use general terms such as:*
Retail Store Manager	Manager
Secondary Teacher	Teacher
Electrical Engineer	Engineer

Civil Servants/Government employees should state their grade – senior Admin Officers, Army Personnel/Gardaí should state their rank, Farmer – ask size of farm, own company – what size

Q.39 What was (is) the main occupation of your spouse/partner (see note above, ask if widowed),:

Q.40 Could I ask approximately how much do you *have to live on per week*?

This is the net household income per week, (if a co-habiting couple use combined income), this excludes income from adult children.

€220 or less	1	€869-€1089	5
€220-€438	2	€1090 or more	6
€439-€648	3	Don't know/refuses	7
€649-€868	4		

Q41 What is your ethnic or cultural background? ***(single code only)***

White Irish	1
Irish Traveller	2
Other white background	3
Black/Black Irish/African/Black other	4
Asian/Chinese/Other Asian	5
Other/Mixed background	6

Thank you for your time, I have no more questions, Is there anything you would like to ask me?

I know that some of the information we discussed is sensitive. I want to reassure you this information is confidential and nobody will know you have spoken to me. The survey results will be used by the Health Service Executive (HSE) to develop policies and resources to protect older people living in the community.

If there are issues that have upset you or you would like to talk to someone about, I can give you the contact details of a number of people who can help you. Your GP is also experienced in dealing with such issues and will be able to help. I will also leave you the number of the research centre carrying out this study if you need to find out more information or have any questions after I leave.

Post Interview

Q.42 How confident do you feel that the respondent was able to correctly answer the questions?

Completely confident	1
Somewhat confident	2
Gave it your best guess	3
Not confident at all	4
Do not know	5
Refused	6

Danger

Q.43 Do you believe the respondent was in any kind of danger?

Yes	1
No	2

IF YES

Q.44 Please describe the nature of the danger and contact your field supervisor to report this case to the supervisor.

Distress

Q.45 Do you believe the respondent was in any kind of distress?

Yes	1
No	2

IF YES

Q.46 Please describe the nature the distress, action taken and if concerned contact your field supervisor to report this case to the supervisor.

MRS Conduct Code

I declare this interview has been conducted by following the instructions laid down for this project and according to the MRS code of conduct:

Interviewer Name				
Interviewer Signature				
Date of interview				

Appendix 2 Participant Information Leaflet

National Centre for the Protection of Older People
UCD School of Nursing, Midwifery and Health Systems

UCD Health Sciences Centre
University College Dublin
Belfield, Dublin 4, Ireland

Tel: +353 (0)1 716 6467 Fax: +353 (0)1 7166498
Email: *ncpop@ucd.ie* Web: *www.ncpop.ie*

Participant Information Leaflet
(only given once eligibility of participant is established)

A National Survey to identify the prevalence of Elder Abuse in Ireland

Who is undertaking this research?

This research is being undertaking by University College Dublin (UCD) as part of the work of the National Centre for the Protection of Older People (NCPOP). The National Centre for the Protection of Older People was established by the Health Service Executive (HSE) in 2008 and is based and operated by UCD.

Professor Pearl Treacy from the UCD School of Nursing, Midwifery and Health Systems is leading the research team who are carrying out this survey.

What is this research about?

This survey is looking at older peoples' health and relations with their families, friends and neighbours' or people they frequently come into contact with. We want to talk with people who have both positive experiences and those who may have more difficult relations or experiences with people they are close to or trust. This survey wants to find out how many older people in Ireland may have experienced mistreatment, abuse or neglect. In order to find this information we need to talk to both people who have not had such experiences as well as those who may have experienced abuse.

You can verify the study by ringing this free phone number:

Free phone number 1800 30 30 80 (Mon-Fri 10am-5pm)
Or
The NCPOP in UCD (01) 7166467 (Mon-Fri 10am-5pm)

Why are we doing this research?

We are undertaking this research on behalf of the HSE who fund the National Centre for the Protection of Older People in UCD. We know that mistreatment of older people exists in society but we are not sure how many people are in this situation or how best to help them. This survey is about understanding the circumstances which can lead to the mistreatment of older people. This information will be used by the HSE and the Department of Health and Children to help develop policies and strategies to help protect older people.

How will the data be used?

This data will be used by researchers in UCD to help identify how many older people experience mistreatment, abuse or neglect in Ireland and what factors may put them at risk of abuse. This information will be written as a report and given to the HSE. The results of the study will also be published in academic journals and presented at conferences concerned with the protection of older people in society. It is also possible that the Irish newspapers may want to write about the results of this study.

We will not collect peoples' names or addresses so no individual will be identified in any written material or presentation involving this data.

How was I selected for this study?

You were randomly selected. We pick houses at random and call. I do not know the name of the people who live in this house or how many people live here. Using this approach allows us to identify people who are representative of older people living in the community.

What will happen if I decide to take part in this research study?

Your participation is entirely voluntary. If you initially decide to take part you can subsequently change your mind without difficulty.

If you decide to take part in this study we will ask you a number of questions. The questions are related to your health, how you take care of yourself, who you would seek help from if you needed it, how you get along with your family or people you frequently come into contact with. You can give just yes/no replies to the questions or point to the answer you want to give. Because some of the questions may be sensitive we would like to interview you on your own in a quiet room. It is fine for other people to be in the house at the same time, we would just like that the interview be private. You can stop the interview at any time or not answer any questions you do not feel comfortable answering.

The interview can take between 20-50 minutes depending on peoples past experiences and what they want to tell us.

How will you protect my privacy?

I will not record your name or address on any documents. Once I leave your house no one will know I have talked to you unless you choose to tell people.

All the data we collect will be anonymous. The data will be stored by the research team in UCD on computers which are password protected and encrypted (if the computer is stolen nobody can access the files).

What are the benefits of taking part in this research study?

There is no direct benefit to you in taking part in this survey however the information you provide will help the HSE and the Department of Health and Children to develop policies, legislation and strategies to help protect older people. The survey will also highlight the abuse or mistreatment of older people as an issue in Ireland and will be used for public and professional education. We can provide you with information on local support groups for older people in your area, and if you have experienced any form of mistreatment we can also give you information on groups who may be able to help you such as the Senior Helpline 1850 440 444 or the name of the Senior Elder Abuse Case Worker in your area.

What are the risks of taking part in this research study?

This survey deals with a sensitive issue which some people may find distressing to recall or it may trigger memories which you tried to forget. If you become distressed during the interview then we can stop the interview and you can talk about your experiences without me recording information.

Can I change my mind at any stage and withdraw from the study?

Yes during the interview you can change your mind and withdraw from the study, your information will not be included in the final report. You are under no pressure or obligation to participate, it is voluntary.

However once I leave your house I will not know which interview belongs to you, I will not have a record of your name or address, so you will not be able to withdraw the information at this stage.

How will I find out what happens with this project?

As we do not record individuals names or addresses we cannot write to you and inform you what is happening with the study. However we anticipate that a summary of the report will be published and made available on the website for the NCPOP (www.ncpop.ie). A copy of the report will also be sent to all the older persons organisations such as Age Action Ireland.

Contact details for further information

You or a member of your family may use the toll free number provided to obtain more information about the study **(1800 30 30 80)**. The number will be answered between **10am-5pm, Monday to Friday**.

You can also contact the **National Centre for the Protection of Older People** directly Monday to Friday 10am-5pm.

Contact details are as follows:

Catherine Tormey (Research Administrator)
National Centre For the Protection of Older People
Room B1.13A, Research Unit, School of Nursing, Midwifery & Health Systems
Belfield, University College Dublin, Dublin 4

Phone: (01) 7166467 Fax: (01) 716 6498 Web: www.ncpop.ie

(Contact information left with participants following completion of interview)

Dear Sir/Madam,

Thank you for taking the time to complete this survey. The information you have given us will be very valuable. I would like to reassure you that all the information you have given us will be confidential and you in no way will be identifiable, (no one will know your details, I have not recorded your name or address on any documents connected with this interview).

If you have any questions or concerns about this study or the interview after I have gone please contact either Amárach the company I work for.

Amárach free-phone 1800 30 30 80, between **10am and 5pm Monday to Friday**

Or

Catherine Tormey (Research Administrator)
University College Dublin (UCD) National Centre for the Protection of Older People

Phone: (01) 7166467 Fax: (01) 716 6498 Web: www.ncpop.ie (10am-5pm Mon-Fri)

If any of the issues which came up during the course of the interview has upset you or you would just like to talk to someone you can also contact the

Senior Helpline 1850 440 444. (10am-4pm, 7pm-10pm seven days a week) Confidential helpline run by older people for older people.

HSE Information Line 1850 24 1850 (8am-8pm Monday to Saturday) Public information line, can put you in contact with most appropriate HSE staff to deal with a problem.

Action on Elder Abuse Helpline 1800 940 010 (9am-5pm Mon-Friday) UK based information and counseling service over the phone dealing with elder abuse, operate both in UK and Ireland.

If required

Elder Abuse Senior Case Worker	
Name	Telephone

Appendix 3 Response Rate: Outline of Outcomes from Household Visits

Eligible	
1 Interview completed	2021
3 Interview broken off. Will not complete	2
4 Respondent initially agreed but then did not make themselves available (5 attempts)	24
5 Respondent refused	197
8 Respondent physically ill	57
9 Respondent mentally incapacitated	25
Ineligible	
7 Respondent temporarily absent throughout fieldwork	26
13 Respondent known to interviewer, inappropriate to conduct interview	9
14 Does no qualify Under 65 years	1979
15 Derelict/demolished	61
16 Vacant	123
17 Other (Holiday Home)	3
19 Not needed for quota	25
Unknown Eligibility	
10 Language barrier (write in language)	9
11 Cold call. No one home	1010
12 Could not gain access to address (gated apartment compounds)	37
Household refusal (no opportunity to ask for eligible respondent)	50

Appendix 4 Weighted Prevalence Estimates

The estimate of the prevalence of abuse and neglect based on data weighted for gender, age categories (65-69, 70-79, ≥80 years) and marital status (ever married, single, and widowed) are presented in Table A2. The population estimates were obtained from the 2006 population census. The weighted prevalence estimates account for variation between the survey sample and the general population based on the above factors, but because it resulted in such a small percentage change in the prevalence estimates the un-weighted data was presented in the main report.

The 95% confidence intervals take account of the standard error using a cluster design rather than a simple random sample. All analysis was performed using the complex survey module in SAS V9.0 9 (SAS/STAT User's Guide. *http://support.sas.com*).

Table A2 Prevalence of abuse and neglect based on weighted population and adjusted for a cluster design

	%	Weighted Number of cases	95% CI	Design effect (deff)
Financial	1.29	(26)	0.72-1.86	1.31
Psychological (≥10 or serious impact)	1.20	(24)	0.64-1.76	1.37
Physical	0.50	(10)	0.14, 0.89	1.36
Sexual	0.04	(0.9)	0.00, 0.13	0.89
Neglect (≥10 or serious impact)	0.24	(5)	0.01-0.47	1.10
Interpersonal (physical, psychological, sexual)	1.25	(25)	0.66, 1.84	1.44
Any abuse in past 12 months	**2.07**	**(42)**	**1.33, 2.83**	**1.42**

Statistical advice and support was obtained from CSTAR (Centre for Support and Training in Analysis and Research (www.cstar.ie).

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive