

**A Systematic Literature Review in
Response to Key Themes Identified in
the Report of the House of Commons
Select Committee on Elder Abuse (2004)**

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1. Summary

The House of Commons Health Select Committee on Elder Abuse (Health Select Committee, 2004) attracted considerable media and policy attention. This systematic review highlights its main recommendations relevant to research and sets them within the context of additional recent research not available to the Select Committee. It makes specific recommendations for areas of development in research and policy. The key themes and recommendations arising from this review are:

- Research is needed to consider how consensus over the definition of vulnerability to elder abuse may be achieved, at the same time reflecting older people's perceptions and the legal framework. This research would help establish a standardised operational definition of elder abuse for policy makers, practitioners and researchers alike.
- Monitoring of adult protection and interventions is still in the early stages but there is recognition of the need for robust data collection and analysis by councils with social services responsibilities to aid measurement and performance targets. (Recently commissioned research and development should assist here).
- Agreement is needed about the way to establish more precise figures in relation to the prevalence of elder abuse. Lack of research and the difficulties the public and staff face in whether to report such abuse compound the problems in determining the scale of the problem, but establishing prevalence should be attempted.

- There remain gaps in the knowledge of staff as to what constitutes abuse but training is now commonplace. American studies suggest a positive correlation between workers who receive no training and the incidence of abuse, and training initiatives have been prominent in recent developments in adult protection in the UK. However there has been no real differentiation as to what type of training this should be, to whom, delivery patterns and so on. The effectiveness of different models should be evaluated.
- Despite concerns, there is very little UK research regarding financial abuse and potential measures to combat this in the social care sector, or in the financial sector, social security, legal or criminology arenas.
- Multi-agency working across the UK is still uneven but some examples of good practice are emerging.
- The case for more independent advocacy services for those who have been abused has been raised in research. The capacity of and desired outcomes from such provision are not evident and there is little research on support for abused older people, and what works and why.
- Understanding of abuse within black and ethnic minority communities is described as ‘patchy’ and inadequate but few specific population or practice studies have been undertaken.
- Links between abuse and domestic violence have been highlighted, but understanding of this is under-developed.
- Lack of research regarding sexual abuse of older adults has resulted in less emphasis being given to understanding and addressing the prevalence, causes and contexts of this aspect of adult abuse, and its effects.

2. Introduction

The Health Select Committee announced on 23 October 2003 its intention to conduct an inquiry into elder abuse to examine its prevalence and causes. The Committee recognised that the abuse of older people was often hidden, ignored and had a significantly lower profile than abuse of children (Health Select Committee, 2004). In light of the Health Select Committee's report the Department of Health requested a review highlighting the key research in this area to aid in the development of further policy and research (see Secretary of State for Health, 2004). This review outlines such research, with an emphasis on research commissioned in the last five years in the UK, in order to explore the effectiveness and impact of major policy and regulatory initiatives in relation to elder abuse and also to explore if these recent changes may mean older research findings have been responded to in whole or in part.

3. Methodology

A systematic review of literature dated from 1992 was conducted using the Social Care Institute for Excellence (SCIE) guidelines for preparing a research review (SCIE, 2004).

As the review was intended to be a scoping review and not a fully evaluative review, the exclusion criteria for the purposes of this review are not precise. The coding system for assessing the literature used in this review is taken from the SCIE guidelines (SCIE, 2004). This framework was found to be the most suitable for assessing a wide range of literature and sidesteps the 'effectiveness hierarchy' of

methodology (see Qureshi, 2004 for further discussion). More details of the methodology used can be found in Appendix 1.

4. Aim of the review

The paper addresses key research and policy questions arising from the Select Committee report (Health Select Committee, 2004). These have been synthesised and are:

- The definition of abuse: are all agencies defining abuse in the same manner?
- How prevalent is elder abuse and what research is there to determine the true scale of the problem within the UK?
- What impact has '*No Secrets*' (Department of Health, 2000) had on the development of partnership working and inter-agency data collection and monitoring of elder abuse? Are there examples of good practice to inform policy?
- Does research highlight differences in the settings of elder abuse: are there significant differences between abuse committed in a domiciliary or family setting and abuse in an institutional setting?
- Training of care workers in relation elder abuse: what can research tell us about the correlation of training and the reporting of abuse?
- Improper prescription of medication: are government targets being met?
- What does research tell us about successful strategies and interventions for preventing elder abuse?
- What is the impact of advocacy services for older people?

- What key themes emerge from research amongst black and minority ethnic communities into the subject of elder abuse?
- What is the impact of regulation on elder abuse?

5. Research update in elder abuse

This research update examines evidence from 33 primary, mostly UK research studies (6 of which are qualitative; 27 quantitative), 15 research reviews, 7 practice reviews, 8 audit/inspection reports, 9 editorials, and 3 conference papers. The update uses a set of sub-headings, corresponding with the Health Select Committee report (2004), and introduces each topic, drawing together previous and new research, then summarises the evidence.

5.1. Defining elder abuse

Introduction

The Health Select Committee report (2004) draws attention to the fact that no standard definition of elder abuse exists in the UK and that it has no legal status.

There is also the issue of actually *what* constitutes abuse. The problem is no doubt compounded by the “diverse and complex phenomenon of abuse’ and ‘to understand it, a considerable task of ‘deconstruction’ has to occur’ (McCreadie, 2002 p.4; REVIEW2).

‘*No Secrets*’ (Department of Health, 2000) guidance defines abuse as:

‘...a violation of an individual’s human and civil rights by any other person or persons’ (p.9). The following categories of abuse are used to guide practice and research:

- physical abuse
- sexual abuse (see Brown and Turk, 1992; PQUANT2) for detailed definition)
- psychological or emotional abuse
- financial or material abuse (see Brown, 2003; REVIEW2) for further discussion)
- neglect and acts of omission (including inadequate health care)
- discriminatory abuse (see Brown, Wilson, and Kingston, 2000; OPINION) for discussion about the scope of discriminatory abuse).

Update

Various definitions of elder abuse have been put forward in recent years, including work by McCreadie (2002; REVIEW2), whose research overview of primary and secondary research on elder abuse refers to previous studies (McCreadie, Bennett and Gilthorpe 2000; PQUANT2, McCreadie, Bennett and Tinker 1998; PQUANT3) and reviews (McCreadie 2002a; REVIEW1) to develop and refine the above categories. These provide some evidence from professionals that abuse may occur singly or in combination, in a range of settings: from people’s homes (where the vast majority of older people live), through day centres to care homes and hospitals. These overviews

suggest that abuse affects a heterogeneous group of people. McCreadie (2002; REVIEW2) observes that the literature also suggests perpetrators are even more diverse. They may be portrayed as callous exploiters of an older person's incapacity; relatives who just can't cope; front-line staff; peer group predators; and those who may also be vulnerable.

McCreadie (2002; REVIEW2) believes that it is encouraging that the *No Secrets* guidance recognises the issues clearly and draws attention to the meaning of 'vulnerability', and in relation to elder abuse research, suggests that the criteria for vulnerability are: mental or physical incapacity; physical or mental frailty; physical or mental illness. McCreadie argues that old age itself is not a criterion of being vulnerable, nor is disability in itself. To illustrate this view she provides an example of a rich widower in the early stages of dementia living on his own in a mansion flat, who may be vulnerable because of his dementia, but primarily at risk of abuse because of his wealth and isolation (McCreadie, 2002; REVIEW2).

The '*No Secrets*' guidance defines a vulnerable person as someone: '...who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (Department of Health, 2000. p.8, 9). However, the Health Select Committee argues that this definition should be widened to include those who do not require community care services so as not to exclude those who may be vulnerable but who are not consumers of services from local authority social service departments (Health Select Committee, 2004). The report considers that the '*No Secrets*' definition is based on a health/social care model

and assumes that the vulnerable person must be in need of external support. As yet we have no estimate of the size of the adult population that this would cover; the capacity of services to respond would also need to be quantified. We could estimate that disability might be an equivalent term to vulnerability; in which case figures are available, however many disabled people would argue that disability is not equivalent to vulnerability. Research then is needed to consider how consensus over the definition of vulnerability may be achieved. This would need to reflect older people's perceptions and the legal framework. The response to the Health Select Committee report by the Department of Health considered that the definition of vulnerability was wide enough at this time (Department of Health, 2004a).

McCreadie (2002; REVIEW2) draws further attention to research findings (Homer and Gilleard, 1990; PQUANT3) which indicate that we have to be careful about jumping on the bandwagon of 'let's rescue the elderly' with an exclusive focus on their frailties. Homer and Gilleard (1990; PQUANT3) have suggested that people need to be asked about the kind of help they want. Their six month research study, undertaken in London (Putney and Barnes) focused on the abuse of older people by their family carers. They found that a significantly high level ($p < 0.001$) of abuse by relatives of older people staying in respite care was particularly associated with relatives' abuse of alcohol. Of the 15 male and 41 female carers interviewed (mean age 66 years), 49 carers lived with the disabled older person. Many couples were reported to have longstanding mutually abusive relationships. Homer and Gilleard argue that these abusive situations were graduations from domestic violence in these relationships over a number of years, hence the cautionary note not to 'rescue the elderly'. Homer and Gilleard (1990; PQUANT3) suggest the inappropriateness of the

stereotype: ‘The idea of the typical abused victim [is] being a frail white old woman (75 or over) with a well meaning daughter driven to breakdown by the stress of caring’ (p.1361), and argue mutual abuse between carer and the older person is more pervasive than previously believed.

Pritchard’s ‘*Beyond Existing*’ study (2003; PQUAL2) piloted 3 support groups with older people who had been abused, in follow-up to her previous research (Pritchard, 2000; PQUAL2) Her 2003 study followed 3 groups through a 2-year period and found that those attending did want to talk about their abusive experiences, but they had chosen to deal with abuse at different times in their lives. Qualitative material, or accounts from older people themselves, is presented alongside guidance on how to undertake practical and therapeutic work with male and female survivors. A conclusion from this study is that every victim must be treated as an individual and assistance must be adapted in response to that individuality. The impact on services of providing such support would need to be quantified. This study is one of the few in the UK to present a user perspective and provides valuable insight into older people’s views and the provision of support following abuse. This research perspective will be highlighted later in this review as an area which has generally been under utilised within adult protection (see sections **5.2; 5.3.1; 5.3.2; 6; Recommendations**).

5.1.1. Understanding and awareness of elder abuse from key agencies: are all key agencies defining abuse in the same manner?

Social service departments, the police, the health service, and other key agencies all have a designated role to play in the implementation of the *'No Secrets'* (2000) guidance. However, recent evidence shows that emphasis is placed upon different facets of abuse among key agencies in the field. Taylor and Dodd's study in East Sussex (2003; PQUAL3) used a semi-structured interview methodology to focus on professionals' knowledge and attitudes towards adult protection within Surrey NHS Trust. The study targeted a comprehensive sample of participants (though only focusing geographically on one area) from both health and social services; other statutory organisations; independent and voluntary sector organisations and the police in Surrey, conducting 150 individual interviews with members from relevant organisations. These participants worked with different groups of vulnerable adults whose roles encompassed: home manager, staff nurse, support worker, day service officer and community care assistant. There is no mention of housing workers. This research found gaps in staff knowledge around who can be potential abusers; for example only 41% stated that partners could abuse. Significantly, only half the interviewees in the study mentioned neglect as a form of abuse and this was not considered as abuse by police participants.

'No Secrets' (2000) states that '...the key to protecting vulnerable adults from abuse is engaging 'all responsible agencies' to work together ... [to ensure a] 'consistent and effective response to any circumstances giving grounds for concern' (p.6).

Sumner's (2004; PQUANT2) recent survey (carried out on behalf of the Centre for Policy on Ageing and commissioned by the Department of Health) focused on three main areas of the requirements and recommendations in *'No Secrets'*, which were identified as essential for the development of an inter-agency policy and a local

strategy to ensure its implementation. These were: 1) strategies and plans, 2) procedures and protocols, and 3) guidance and information. Responses were received from 140 of the 152 Councils with social services responsibility in England (92% response rate). The study found that the definition of abuse detailed in '*No Secrets*' had been adopted by 82% of authorities.

Quigley's (1999) practice overview (PRACTICEREVIEW) argues, on the basis of his experience as one of the first Adult Protection Coordinators, that: '... working together is not so much the icing on the cake as substance of the cake itself' (p.40).

With regard to practice in Sheffield, Quigley used adult protection experience to provide an analytical model which he suggests can be used by others working in adult protection to examine their own practice and performance.

Quigley notes (1999; PRACTICEREVIEW) that although agencies may have guidelines in place to allow flexible inter-agency working; whereas an NHS Trust's purpose in respect of adult protection may be to treat an abuse victim's injuries; the police aim, conversely, may be to secure a successful prosecution of the alleged abuser. It must not, however be wrongfully deduced from Quigley's practice review that agencies inevitably are in conflict; rather that their different procedures or cultures may lead to different understandings of the same issues. The perspectives of different partners are the subject of current Department of Health funded research under the Modernisation of Adult Social Care Programme (Penhale, Manthorpe, Kingston, Pinkney and Perkins, 2004, forthcoming).

Research carried out recently by Mathew et al (2004; PQUANT2), for the Nuffield Foundation, examined the impact and effectiveness of the '*No Secrets*' (2000)

guidance, defining effectiveness as ‘the extent to which, on the basis of the guidance, local authorities had been able effectively to establish structures and systems for protecting vulnerable adults.’ The study surveyed (in 2001) 150 local authorities (response rate 80%). Semi-structured interviews with 100 staff were also conducted; over half the participants were social services staff. Eight local authorities participated in this second stage of the research, although 10 were identified as participants, and there were no representatives from inner London boroughs, as these participants withdrew from the study. This study found staff experienced difficulties in promoting a consistent response to abuse because of individual values/experience in addition to training and work history, and that case conferences may fail to bring all the key people together or to have the information to hand to aid decision-making. The authors conclude that a longitudinal study would be beneficial to examine the effectiveness of response by authorities to abuse.

Summary

The problems around defining elder abuse have been highlighted by McCreadie (2002; REVIEW2, 2002a; REVIEW1), McCreadie, Bennett and Tinker (1998; PQUANT3), Pritchard (2003; PQUAL2), Homer and Gilleard (1990; PQUANT3), and Taylor and Dodd (2003; PQUAL3). However, overviews build on earlier work and may give an impression that more research has been done than has actually been undertaken. Furthermore, the bulk of recent studies to date have been small-scale. It would be constructive therefore in future; now relevant issues have been highlighted, to develop these hypotheses and observations into primary research studies, aided by

continuous consultation, to establish a standardised, operational definition of elder abuse, for policy-makers and practitioners alike.

5.2. The prevalence of elder abuse

Introduction

It is clear from the evidence presented to the Health Select Committee (2004) that the prevalence of abuse in the UK is currently very difficult to establish. Attention is once again drawn to the lack of research in the area and links with difficulties in defining abuse.

Update

Drawing on an earlier 1992 study on elder abuse in Britain, Ogg and Munn-Giddings (1993; REVIEW2) contrast the UK prevalence figures with those from the USA and argue that 'mandatory reporting in the USA of elder abuse results in the compilation of comprehensive records..' and '...a substantial amount of research has used these records as a database' (p.401). In the UK '...there is no single source within agencies where elder abuse referrals are recorded' (Ogg and Munn-Giddings, 1993 p.401; REVIEW2). They highlight that this poses problems in trying to ascertain the incidence of elder abuse in a given agency or locality (Ogg and Munn-Giddings, 1993; REVIEW2). Mandatory reporting might therefore be a suitable subject for research to ascertain the legal, technical and resource implications as well as to obtain professionals' and older people's views. However, the implications of implementing

mandatory reporting would need to be carefully considered. The Protection of Vulnerable Adults (POVA) list of those who are judged as unfit to work in adult social care (Department of Health, 2004b) may serve to address a small section of these issues, when it is fully implemented (commenced in July 2004).

Ogg and Bennett's (1992; PQUANT2) study, which is highlighted by the Health Select Committee (2004) as the only UK representative study of elder abuse, used a survey of 2,000 older people living in the community. The survey inquired about any experiences of physical, verbal and financial abuse from family members and close relatives, in order to establish prevalence figures. However, this excluded those living in residential settings and very likely those who were very frail, and therefore did not give a comprehensive picture. The study also used a broad, inexact definition of abuse and was part of a wider community based survey. Nevertheless, it provides a useful baseline from which to develop more comprehensive research on the prevalence of elder abuse. An attempt to estimate prevalence in one London Borough was conducted prior to *No Secrets* by Rushton and colleagues (2000; PQUANT3). Looking at adult abuse as a whole, they found that there had been approximately 60 notifications annually since the implementation of the Borough's vulnerable adults policy in 1995. In their own 8 month period of data collection (1998), Rushton *et al* were informed of 44 cases of suspected abuse by social workers.

The Health Select Committee report (2004) also draws attention to Action on Elder Abuse's estimate of prevalence of abuse analysed from calls to its helpline (paras. 19-20; see Bennett, Jenkins and Asif, 2000; AUDIT). Once again it is necessary to be cautious in using these figures as an indication, as abused older people may not be

able to access a telephone, may not have privacy, or know of the helpline. There is also no way of knowing how accurate the informants are, without knowing more about their situations (see McCreadie, 2002; REVIEW2). Reports from callers nevertheless provide an indication of distribution of types of elder abuse, which can once again set out a good basis for further research, in the absence of any other quantifying data.

5.2.1. Monitoring and evaluation of abuse

The Health Select Committee report (2004) raises concern about the lack of performance indicators to allow for the measurement of the quantity and quality of work undertaken in adult protection (para. 31). Monitoring and evaluation systems in general are being put in place which look set to aid the evaluation of the quality and quantity of work being carried out. Recent primary research among practitioners, undertaken by the Practitioner Alliance against Abuse of Vulnerable Adults (PAVA, 2004a; PQUANT3), highlights that there is still much to be done with regard to the practical implementation of 'No Secrets' (Department of Health, 2000), a large number of practice issues are not being addressed; particularly the estimation of prevention of abuse (PAVA, 2004a; PQUANT3). This study adopted a survey method using two different questionnaires; the first was sent to health and social care practitioners and other professionals such as police and training facilitators (n=300); the latter was sent to 140 Local Authorities in England targeting Assistant Director/Social Services Manager level. Although there is lack of clarity over which practitioners completed the questionnaires and the overall response rate, preliminary findings are similar in respect of Local Authorities and Practitioners. Both groups

reported monitoring of practice/interventions was 'in the early stages of being addressed, or being addressed inconsistently' by 38% of respondents; 'being adequately addressed' by 23%; 'not being effectively addressed by 21% and 'being addressed highly effectively' by only 8% of respondents to the survey (PAVA, 2004b; PQUANT3). Funding from the Department of Health of £431,000 for the charity Action on Elder Abuse, allocated over three years from a Department of Health Section 64 Grant, is supporting a research project to analyse local council statistical information on elder abuse and this project will produce an interim report in Autumn 2004 (Department of Health, 2004a). This research will, in some ways, fill some of the current gaps in knowledge.

Before the implementation of '*No Secrets*' (Department of Health, 2000), monitoring systems by local authorities in respect of adult protection were best described as 'patchy'. Research by Brown and Stein (1998; PQUANT2), across 10 local authorities in 1998, into the effectiveness of monitoring procedures found that: 'Data collected by social services departments varied from one area to another although many common problems were highlighted. Overall the quality of information generated was partial and patchy indicating the newness of the work, lack of agreed procedures, poor recording practice and continuing confusion about who is a 'vulnerable adult', what constitutes 'abuse' and when "intervention is warranted' (p.29).

While empirical research may be useful here inspection reports should also be recognised as "...an important tool for both setting standards of good practice and disseminating information" (McCreadie, 2001, p.43; REVIEW1). McCreadie's (2001;

REVIEW1) analysis was one of the first attempts to make use of local inspection reports to connect findings on different inspection topics. The study examined all Social Services Inspectorate (SSI) reports published between 1994 and 1999 to select examples of good practice and summarise recommendations. McCreadie suggests in the study that "...prevention of abuse might be considered as an important benchmark of quality services" (2001, p.8; REVIEW1) and concludes that the new Social Care Institute for Excellence has considerable potential for connecting SSI findings with research and with comparable "best practice" guides in other disciplines like nursing, occupational therapy, general practice and so on.

Since the implementation of '*No Secrets*' (2000) monitoring and evaluation appear to have improved. Sumner's survey (2004; PQUANT2) reports: 'Good progress has...been made in recognising the need for comprehensive data collection and analysis...' (p.10). Examples of good practice in this area have been self-identified and include Surrey County Council, (see Dodd and Lamb, 2004; PRACTICE REVIEW). The role of the Commission for Social Care Inspection (CSCI) and the Healthcare Commission may also be helpful in data collection and reporting on local issues. The statutory number of inspections undertaken by the National Care Standards Commission (NCSC; predecessor of CSCI) has highlighted a need for a risk assessment tool which it could use to specifically target its limited resources. An appraisal of risk assessment services has recently been conducted by the Centre for Research in Health and Social Care based at Anglia Polytechnic University (Brady *et al.*, 2004; REVIEW2), with a focus on validating the CSCI's newly developed Risk Analysis Indicator Tool (RAIT) (Colam, 2003). The appraisal of the tool argues that prior to the introduction of the RAIT there was no uniform way for the Commission

to determine its priority for inspections but since its introduction there has been a national benchmark established for the assessment of risk posed to service users by an establishment, agency or service. However, in response to the pilot phase of the tool (2003-2004), Brady et al's study exposes various weaknesses in the inspection scoring guidance which may tend to exaggerate the number of higher risk homes, and they conclude that currently the tool does not aid, support or inform risk analysis but records the inspection scoring instead. The appraisal recommends an update of the tool in line with issues raised. Such research needs to be considered in light of adult protection policy, research and professional practice to make clearer links between abuse in different settings, by different perpetrators and to establish means of protection and support for older people.

Summary

Research into the prevalence of abuse is clearly out-dated (see Ogg and Bennett, 1992; PQUANT2), and there needs to be a comprehensive study which incorporates all possible settings and victims of elder abuse. In the USA, Pillemer (1986; PQUANT2) conducted a case control study; this type of study being "...the only means whereby the antecedents to abuse can be identified: by comparing abused and non-abused older adults and comparing the independent variables" (Manthorpe and Watson, 2002, p.541; OPINION). Pillemer also emphasises the "importance of moving from studies of victims to moving out to the general population" (Pillemer, 1986, p.239-263; PQUANT2) to gain better comparisons. The Health Select Committee recommends that "...multi-disciplinary research is commissioned by the

Department of Health to ascertain the level of the problem,” (p.49, para.3). This research could perhaps utilise USA approaches, such as those above, to help with methodological issues in assessing the prevalence of abuse. It has been noted earlier that funding has also been granted by the Department of Health to Action on Elder Abuse to establish a national recording system (Department of Health, 2004a). The role of helpline calls to Action on Elder Abuse in suggesting approaches (see its report “*Hidden Voices; Hidden Rights; Hidden People*”, (Help the Aged, 2004; AUDIT) provides some insight into statistics from the helpline, but does not provide the population study along the lines of Pillemer’s work. Responses to this report should not confuse the area by suggesting that helpline calls are either unhelpful or a cause for alarm; they are useful records; no less and no more. Inspection reports and regulatory bodies have been highlighted above (see (McCreadie, 2001; REVIEW1, Brady *et al.*, 2004; REVIEW2) both as a valuable source of evidence about statutory agencies’ responses to abuse and to aid learning from one another’s best practice, while also developing links with research.

5.3. The settings of elder abuse

5.3.1. Perpetrators and settings of abuse

Introduction

The Health Select Committee report (2004) highlights McCreadie’s view (2002; REVIEW2) that “...abuse takes place in a range of settings.”(p.14, para. 32) and notes

that "...a number of submissions [to the Health Select Committee] drew particular attention to the potential for abuse to occur behind closed doors" (p. 14, para. 34).

Update

A non random sample of Community Nurses (718 in number) responding to a survey by the Community and District Nursing Association (CDNA; PQUANT3) (cited in George, 2003; OPINION), reported that, in their experience, the main 'perpetrator' of abuse was most likely to be the older person's partner (45 %), followed by a son (32%). In most cases the nurses recalled, the main perpetrator was said to be the principal carer, and in 78% of cases the abuse took place in the older person's home. Caution must be taken here, as the findings are nurses' opinions and subject to what they encounter in the course of their work mainly in the community, and also the timescale (i.e. how many instances of abuse over what period) is unknown from the study.

Also focusing on abuse in the home setting; a recent qualitative study by Jeary (2004; PQUAL3) on adult protection case conferences reported the views of over 50 adult protection case conference participants or policy makers, who represented a wide range of public, private and voluntary sector organisations. They had experience of cases of domestic violence between elderly partners and between others with mild learning disabilities. Professionals reported that the victims chose unequivocally to remain in the allegedly abusive situation (Jeary, 2004; PQUAL3). Although the study was small and undertaken in one city's social services department, so generalised

conclusions must be made with caution, it made use of qualitative techniques to examine in depth the adult protection process and the dilemmas involved for professionals. The processes of case conferences have been further discussed with reference to the chair's role (Manthorpe and Jones, 2003; PRACTICEREVIEW). Older people's perceptions have not yet been researched in relation to this area.

McCreadie *et al*'s survey (2000; PQUANT2) found that the most common risk situation reported by GPs (in Tower Hamlets and Birmingham) was that in which the main perpetrators were carers with problems of their own e.g. psychological, alcohol misuse and so on. The second most common risk situation was an older person with dementia who was alone all day indicating possible neglect.

Similarly, a study involving perpetrators of abuse by Campbell-Reay and Brown in 2001 (PQUANT3) examined risk factor characteristics in carers who said they had physically abused or neglected their older relatives. This study investigated 19 carers who had abused relatives and who were referred to a clinical psychologist by their GP or psychiatrist (9 had physically abused, and 10 had neglected their relatives). Using 5 standardised psychological assessments to determine any differences between the two groups (i.e. Conflict Tactic scale; Strain scale; Beck Depression Inventory; Beck Anxiety Inventory and Cost of Care Index), significantly higher conflict and depression scores were found in the physical abuse group, while the neglect group had significantly higher anxiety scores. Though this UK study only incorporated 19 perpetrators, a larger scale American research project entitled "Family Relationships in Later Life" was conducted by Williamson and Shaffer in 2001 (PQUANT2). Such

a large-scale study has not been replicated in the UK even though there has been a concentration in the UK on family carers and the home setting in relation to abuse.

5.3.2. Training and reporting of abuse

The Health Select Committee report (2004) highlights the need for staff to have adequate training in order to identify and report abuse, a view also expressed by staff themselves (see CDNA survey 2004; PQUANT3).

Drawing on initial monitoring figures of incidence of abuse by the Surrey Adult Protection Committee, Taylor and Dodd (2003; PQUAL3) identify variance in reporting across the different groups of vulnerable adults. For example, in the year 2000/1, 55% of reported abuse (although the actual total number of reports is not stated) related to adults with learning disabilities, 20% to older adults and 14% to people with mental health problems. In the following year (2001/2) 41% of reported abuse (of 224 allegations reported) related to people with a learning disability and 33% related to older adults. Because people with a learning disability are numerically much fewer than vulnerable older people or people with mental health problems, there is an underlying implication that it might be staff recognition of abuse that is behind the figures rather than prevalence of abuse itself.

Taylor and Dodd's (2003; PQUAL3) interviews with staff reveal that many were reluctant to report unless they felt confident abuse had occurred. The majority; 75% (of 150 participants), stated that they would only report if they had concrete evidence. One participant reported: 'I would want some evidence...whether it was an injury or

some physical marks' (p.28). There was also an unwillingness to break confidentiality; 20% of staff mentioned reluctance to report. The dilemmas facing social care staff in abuse cases are reported as complex, when they find themselves torn between respecting the person's right to autonomy and a responsibility to put protective measures in place as far as practicable. Some interviewees in Jeary's (2004; PQUAL3) study report that decision-making in these circumstances is influenced by a need to 'cover one's back' (Jeary, 2004. p.18; PQUAL3). The Taylor and Dodd (2003; PQUAL3) study also indicates a potentially positive effect of training on the subject of abuse for staff, as participants with a recognised professional qualification were found to be more knowledgeable on issues of abuse, although they were more likely to be concerned about a negative outcome for the victim subsequent to reporting.

Similarly, the survey of nurses by the Community and District Nursing Association, outlined earlier, found that although 88% of them report encountering elder abuse during the course of their work, only 44% report receiving formal training on the subject (CDNA, 2004; PQUANT3). Almost all consider that training would be beneficial.

Taylor and Dodd's (2003; PQUAL3) study identifies a belief among staff that, since a person with a physical or sensory disability is able to report abuse because they are mentally able to do so, perpetrators would be deterred from abusing. This is in contrast to the view expressed by the Health Select Committee that '...much abuse is not reported because many older people are unable, frightened or embarrassed to report its presence' (2004. p.3).

The possibility of collusion is also an issue highlighted by Taylor and Dodd's (2003; PQUAL3) study, where a minority of staff (over 10%) said they might be reluctant to report if the perpetrator was a member of the staff team. There is reference to 'putting it down to a bad day'. This reluctance to report can be seen in the context of a recent case reported in the press where a former care worker was allegedly sacked for 'whistle-blowing' about a home where residents were naked in communal areas (George, 2003; OPINION).

Pritchard (2002; PQUANT3) also argues that workers sometimes hide behind the principle of choice and therefore fail to identify abuse, highlighting examples where staff made an assumption (a value judgement) that vulnerable men, who were previously neglected by their spouses in terms of hygiene, chose to live in squalor. It seemed to her, on the basis of interviews, that they had not chosen to live like that, but staff involved had perhaps presumed that, as this was the norm when they encountered the men, this was their choice. When the men were admitted to care homes, they talked about the embarrassment they had suffered while living in the squalid conditions, and indicated that they would have welcomed help (Pritchard, 2001a; PQUANT3).

The area of staff training and reporting is therefore many-faceted. The well-respected methodology of the randomised controlled trial was used in a study carried out in 2002 by Richardson, Kitchen and Livingston (PQUANT1) which examined the effect of education on knowledge and management of elder abuse amongst nurses, care assistants, care managers and social workers (n=79) who worked with older people

within a North London Community Health Trust and Social Services Department. They observe that identifying, documenting and reporting of abuse were carried out inconsistently. The authors argue that, whilst an educational course goes some way in improving this, it needs to be targeted to take into account the baseline knowledge. The study identifies a lack of knowledge around good 'management' in dealing with elder abuse. This implies that the way staff are trained needs to be taken into account as well as the amount of training they receive.

A Canadian study by Goodridge *et al* (1996; PQUANT2) identifies a correlation between staff/patient conflict and abuse, in particular over issues of personal hygiene and the wish of 'patients' to go outside the care facility. Staff burn-out, characterised by physical, psychological and spiritual exhaustion, is highlighted by other authors (Pillemer and Moore, 1989; PQUANT1 Eastman, 1994; OPINION) as a feature of environments where abuse occurs. It is further suggested that workers lack models to help them understand the authority, boundaries and intimacy issues posed by this type of work (Clough, 1999; PRACTICEREVIEW).

Research by Juklestad (2001; PQUAL3) in Norway explores the causes of abuse in institutions. Though caution must be taken in including findings from research based in a different country, the study lists some points drawn from investigations into nursing homes in 1994, 1999 and 2000 and may have utility in its 'cause and effect' findings about staff. The study draws similar conclusions to previous research in finding that that the risk of abuse is greater if the staff:

- receive little support from management
- lack training

- receive inadequate guidance
- have low self esteem
- have poor personal standards
- work in isolation.

In the UK context, work from the inspectorates (see earlier section **5.2.1.**) may also provide useful data and this should be analysed (Clough and Manthorpe, 2004; REVIEW2).

Summary

Using comparative analysis to illustrate research evidence in abuse in institutions (see above; Goodridge, 1996; PQUANT2, Pillemer and Moore, 1989; PQUANT1, Juklestad, 2001; PQUAL3) is illustrative, as the problem with studying abuse is not only compounded by the changes in the UK over recent years, e.g. with changes arising from the NHS and Community Care Act 1990 and regulatory reform, but also by the great variety of care settings. Although on the surface a more “homely” environment may be an obvious improvement on de-personalised institutional practices, there may still exist power hierarchies (see Penhale, 1999; OPINION, Cambridge, 1998; AUDIT), which can lead to situations where staff are reluctant to report, as noted in the Taylor and Dodd study (2003; PQUAL3). Drawing on recent research from another country for evidence highlights the lack of UK research in elder abuse.

Clough (1999b; REVIEW2), The Independent Longcare Inquiry (Buckinghamshire County Council, 1998; AUDIT), Cambridge's Inquiry (1998; AUDIT) and more recently the Rowan ward investigation (Commission for Health Improvement, 2000; AUDIT) provide valuable insights into institutional abuse among people with learning disabilities and older people in NHS settings. However, as Glendenning, author of several research papers and books concentrating on elder abuse in residential institutions, pointed out "We need to understand why maltreatment of patients in residential settings occurs at all. We need to know much more about staff-patient conflict and the issues of restraint, over-medication, withholding of medication and under-nutrition within the context of long-term care." (1999, p.186; PRACTICEREVIEW). It would be useful to develop further UK research evidence on inter and intrapersonal causes and effects of elder abuse to feed into the knowledge base and the inspection and regulatory processes may have much to offer here. How to use a variety of mechanisms such as practitioners' overviews, research and inspection reports to establish a base of knowledge, was one of the issues raised at an Action on Elder Abuse research seminar in 2002 funded by the Department of Health (Action on Elder Abuse, 2002).

It is noted that the Health Select Committee (2004) refers to a need to measure the extent and impact of training. Staff appear to acknowledge that they have an important and responsible role in identifying abuse. The CDNA nursing study (2004; PQUANT3) prompted a response by the CDNA, and guidelines for community nurses on recognising abuse have since been written (CDNA, 2004a). It is not clear how such professional guidelines interact with training and guidance at local level agreed by agencies such as NHS Trusts and local authorities.

Professional views predominate in UK studies and these do not necessarily provide an accurate indication of all the issues in elder abuse. Studies which have incorporated service users' views have tended to be small scale and qualitative (Pritchard, 2003, PQUAL2; Pritchard, 2000, PQUAL2) There is a need for research from user perspectives. The Modernising Adult Social Care research programme has recently funded a study looking at user and carer perspectives in relation to partnerships in health and social care, which should provide some useful insights into methods of obtaining user views (see Petch, Cook and Miller, 2004, forthcoming).

5.4. Physical abuse

Introduction

The misuse of medication within care settings is one of the areas relevant to older people, and attention was drawn to it by the Health Select Committee (2004, p.19, para. 74). The report highlights that “The over-prescription of medications, particularly of anti-psychotic medication for people with dementia, is sometimes used in the care environment as a tool for managing service users and ensuring that the care of people with dementia is easier for the staff ” (Health Select Committee, 2004, p.18, para. 50). In contrast, little research exists in respect of potential misuse of medication in domiciliary settings. Other aspects of physical abuse are more commonly reported in studies of abuse, inquiry reports, press accounts and legal proceedings.

Update

In response to concerns about medication monitoring, the 10 year National Service Framework for Older People set a target that by April 2002 ‘...all people over 75 should have their medicines reviewed at least annually and those taking 4 medicines or more should have them reviewed 6 monthly, in reality these targets have not been met’ (Health Select Committee, 2004, p.50-51,). A recent survey found that only 29% of GP practices had achieved this target. In addition 12% of care homes had failed to meet the National Minimum Standard on medication (Official Report, 15 July 2003, cited in Burstow, 2004; OPINION). This is, of course, not to suggest that this is inevitably an area of abuse.

Some studies have focused on prescribing of medication. A quantitative study undertaken in South London of 22 nursing homes, covering 935 residents aged 65 years and over, found that 24.5% were prescribed antipsychotic medication, of which 82.2% was judged to be clinically inappropriate (Osborne, Hooper, Ka, Swift and Jackson, 2002; PQUANT3). The authors conclude that neuroleptic prescribing in nursing homes is “suboptimal” and the drugs are used for “inappropriate indications” (Osborne et al., 2002, p.5; PQUANT3). Agreement as to whether the conclusions refer to ‘bad practice’ or abuse is not evident, or if and how such practise should relate to adult protection policies and systems. The findings of this study reflect one geographical area and although the sample was taken from urban, inner city and rural areas, the authors advise caution in generalising throughout the UK as a whole.

Nevertheless, the results concur with findings of an earlier study carried out in Glasgow (McGrath and Jackson, 1996; PQUANT3).

Research is in the process of being commissioned in this area by the National Patient Safety Agency (2004) following the recommendations of the Health Select Committee report. The Government response to the Health Select Committee (Secretary of State, 2004; OPINION) focuses on this area, agreeing that the area of medication is a serious problem, and that it has since taken steps to address it. The response makes reference to “The new Quality and Outcomes Framework [which] incentivises medicines management”, which awards points and money to GPs if they are able to demonstrate that over 80% of their patients (those of whom are prescribed four or more medicines/in receipt of repeat medicines) have a medication review recorded in the relevant time period (Secretary of State, 2004, OPINION). ‘In addition, work undertaken by the Medicines Partnership Taskforce for Primary Care Trusts will determine the extent of medication reviews, and the results of this will be made shortly’ (Secretary of State, 2004, p8; OPINION). Knowledge of practice also seems likely to be assisted by the Commission for Social Care Inspection and the Healthcare Commission inspections following the concerns expressed by the Health Select Committee (2004, p.22; para. 65) around the failure of some care homes to meet the National Minimum Standard in this area.

5.5. Financial Abuse

Introduction

The Health Select Committee report (2004) recommends that the ‘...prevention, detection and remedying of financial abuse be included as specific areas of policy development by adult protection committees’ (p.51; para. 82).

Drawing on research for examples of good practice in the UK is problematic as little exists (Walsh and Bennett 2000, p.22; OPINION). For example, a study by Rowe, Davies, Baburaj and Sinha (1993; PQUANT2), investigating the financial affairs of 25 older people with dementia who were in-patients or attending hospital, considers that their financial affairs were apparently ‘handled inappropriately’ in 24 of the cases. A study by Langan and Means (1995; PQUANT3) reports that when older people are admitted to residential care social services department staff often experience difficulty accessing their financial details. In this study several homes’ managers report such problems and voice other concerns such as money being siphoned off; relatives keeping back some of the personal allowance; difficulty getting relatives to pay for items and so on. Relatives and residents were not interviewed, and financial accounts were not examined. Such concerns are also reflected in a recent study in Australia by Tilse, Wilson and Setterland (2003; PQUANT2), which examines types of financial abuse reported by care workers. In the UK callers to the Elder Abuse Response help line have cited financial abuse by both children and partners of victims. This type of abuse was the third highest form of abuse cited by callers, with psychological abuse being the most prevalent and physical

abuse ranked second (Bennett, Jenkins and Asif, 2000; AUDIT). In England, the Mental Capacity Bill (2004) may provide increased safeguards but without a clear baseline of evidence, it will be hard to make comparisons. Research into any new Mental Capacity Act could usefully consider various methodological approaches and could draw on Scotland's earlier developments and research (see Wilkinson, 2004; REVIEW2).

Summary

The recent study of the implementation of *No Secrets* by Mathew et al (2004; PQUANT2) referred to earlier, highlights practitioners', concerns about financial abuse. Its authors recommend exploring collaborative work between police and social services in this area. Once again, there has been little research done to date on financial abuse in its own right. If this is remedied by adult protection committees bringing situations more to the fore, awareness of circumstances surrounding financial abuse may grow. Any research should involve the financial sector as well as the Pensions Agency, the proposed Link-Age initiative and other agencies with adult protection interests.

5.6. Tackling Elder Abuse

Introduction

The Health Select Committee report (2004) urges all local authorities to establish multi-agency adult protection committees and cites good practice in the development of such committees. Research on their role is emerging.

Update

Sumner's (2004) survey of local authorities notes that the development of adult protection committees is widespread. However, a recent study by PAVA (2004a; PQUANT3) highlighted that '...many respondents felt that a large number of practice issues/areas were not being effectively addressed in their geographical areas; one of these being measures to "address the prevention of abuse"' (p.1). Conversely, the study also notes that '...some respondents reported very positive initiatives/efforts in some local authority areas, which would suggest that much is possible in relation to developing effective services and practice'.

Similarly, Sumner (2004; PQUANT2) argues that '...the full implementation of these stated goals...' (i.e. recognising the need for comprehensive data collection and analysis, integration of local authority codes of practice with other policy areas such as personnel practices and staff training) '...remains aspirational for many authorities. It is necessary that progress in these areas will form a focus of attention over the coming year.' (p.11).

The role of inspection reports in adult protection is relevant to tackling abuse. A recent inspection carried out by the Social Services Inspectorate for Wales (SSIW) in May 2003 examines the nature, range and quality of services within adult protection within Caerphilly County Borough Council (AUDIT). Findings were consistent with research (Sumner, 2004; PAVA, 2004) in that basic assessment and service delivery systems are in place but good practice is 'inconsistent'. There had been no monitoring of adult protection activity until recently and the profile of adult protection remains low. Furthermore, adult protection arrangements are described as lacking infrastructure and leadership. The report makes 15 recommendations designed to assist the authority in further development of services for vulnerable adults.

Department of Health research commissioned as part of its evaluation of the Modernisation of Adult Social Care (Penhale *et al*, 2004) may also assist here with its survey of local authority partnerships in adult protection and interviews with key stakeholders to establish a better knowledge base of the working of adult protection committees. A policy discussion paper produced by Better Government for Older People and Action on Elder Abuse (Eastman and Harris, 2004; REVIEW2) brings together views from a variety of adult protection co-ordinators and others interested in this area to identify areas where tighter definitions and clearer direction may be required to place elder abuse in a context of citizenship and rights.

5.6.1. Advocacy services

The role of advocacy services is emphasised in the Health Select Committee report (2004). A recent study of issues in adult protection in one area by Jeary (2004;

PQUAL3) found no cases of formal advocacy schemes being used to represent victims' views and cites cases where the lack of formal advocacy schemes led to such representatives as a victim's relative or a frontline worker attending adult protection conferences in an advocacy role. Although the relative or worker attending the adult protection conference would 'normally' have the victim's best interests at heart, the author draws attention to a case where a relative's daughter 'apparently' had her own 'agenda'. Jeary (2004; PQUAL3) stresses '...a need for clarity about the role the advocate is undertaking. This may vary widely depending on the circumstances of the alleged abuse and the nature of their relationship with the victim' (p.16) The study concludes with '...strong arguments in favour of offering the victim an "independent advocate" to be "alongside" him or her through the adult protection process' (p.19). Research on advocacy in elder abuse is confined to such hypotheses and no evaluations have yet been undertaken.

5.6.2. Elder Abuse: black and minority ethnic communities

The Health Select Committee (2004) recommends that more advocates be drawn from black and minority ethnic communities and, further, that the training given to social care workers relating to ethnicity is assessed to ensure it takes account of elder abuse. It is not known what the best model of such training should be and no UK evaluations have so far been detected in this area.

The 1998 National Conference on Elder Abuse within Ethnic Minority Communities was the first to focus on this issue in the UK (Action on Elder Abuse, 1998). The conference report suggests that: 'Case studies show that when abuse occurs in the

family or by a member of the same minority ethnic group, the abused older person will not, in most likelihood, take any form of legal address against the abuser. It then becomes of vital importance that the older person is safeguarded and monitoring and support of the situation secured,' (1998). The conference report acknowledges the need for more than case study reports (many of these anecdotal) and the 'need for focused research on elder abuse in minority ethnic groups...' (Action on Elder Abuse, 1998. p.2).

It is also recognised that 'There is now greater acceptance that elder abuse does exist within minority ethnic groups...However, racism and discrimination at the institutional and/or personal level can make identification and disclosure, referral and response difficult for the abused ethnic minority older person, their family or carer/s and for service providers' (Action on Elder Abuse, 1998). Such issues have not been addressed by research and there is no consensus about what such research might focus on or how this might be achieved.

Qualitative research by Patel (1999. p.34; PQUAL2) reports that families from black and ethnic minorities are sometimes reluctant to pay for care and concluded therefore older people may be

- kept at home longer, despite high care needs
- receive fewer services
- be at risk of elder abuse.

Patel also suggests that in financial assessments, where the income of the entire household is taken into account, this might lead to:

- resentment by some family members
- family break up
- elder abuse.

Patel (1999; PQUAL2) argues that since service development by social service departments in the mainstream for black and minority ethnic groups is patchy and inadequate, the same is true for areas such as dementia and elder abuse. Little comparative work exists as yet to test out these views.

5.6.3. Registration of domiciliary care workers

Concern over the quality of service providers was highlighted by the Health Select Committee (2004), with its recommendation that ‘...the Government should attend to the issue of registering domiciliary and other social care workers as a matter of the utmost urgency’(p54). However, this remains problematic. From 1st April 2003 staff have to be accredited with an NVQ level 2 in care within three years of registering (Hayes, 2004; OPINION). There are 25,000 domiciliary care workers expecting to be registered on courses every year but in a letter by the Joint Advisory Group on domiciliary care to the social care training body (Training Organisation for the Personal Social Services/TOPPS) the advisory group expresses concern about a shortfall in places. Studies cited by Bennett and Kingston (1993; REVIEW1), Decalmer and Glendenning (1997; PRACTICEREVIEW), and Clough (1996;

PRACTICEREVIEW), who make reference to the ‘few American studies’, all report a much higher incidence of abuse by workers who had received no training (cited in Bennett, Jenkins and Asif, 2000; AUDIT). This issue links back to the arguments for adequate training discussed earlier in this review, but also points to the lack of evidence of the effects of training, especially over the longer term.

Summary

The Health Select Committee (2004) does draw attention to mandatory training as a priority and recommends that “...this omission be corrected as soon as possible.” (p.27;para. 93). Further suggestions from examining the evidence on training, as well as the need for large-scale research discussed earlier, suggest an up to date, robust evidence base to draw knowledge from would be helpful.

It is noted in the House of Commons report (2004) that there are no plans by the Department of Health to repeat Sumner’s (2004; PQUANT2) survey, which is referred to as “rather complacent” (p.45, para. 171). As Sumner’s study concludes that progress in adult protection “...remains aspirational.” (p.11), there is no doubt that monitoring of progress is necessary. The boundary between research and inspection in this area is unclear, however, and greater clarity of roles and exchange of data and ideas would be beneficial. If Sumner’s study is not repeated, a potentially valuable longitudinal data set will not be available. This might be worth considering further.

6. Limitations of the research evidence

A breakdown of the research evidence used to inform this review highlights a bias in the evidence base towards small scale qualitative research and overviews (of both practice and research). The use of qualitative research is expected given the nature of elder abuse as a socially constructed problem, and a phenomenon experienced by people. There are also small scale studies which have combined both quantitative and qualitative research techniques, and have produced informative results. However, overviews give the impression that more research exists than in reality occurs. The bias towards the use of small scale and descriptive studies in the evidence base is also a factor which may be remedied by greater investment in larger scale studies. There is surprisingly little research on the views of older people about elder abuse and neglect, either generally or of more specific aspects and few links to criminological evidence and theory.

7. Key Areas not included in the House of Commons Report

Introduction

Attention is drawn here to three areas which have not been referred to in the Health Select Committee report, which are identified as domestic violence, the training of doctors and sexual abuse.

Update

There is little detail in the Health Select Committee report regarding links between abuse and domestic violence, although it does welcome the Domestic Violence, Crime and Victims Bill and "...hopes it will provide additional protection for older people" (Health Select Committee, 2004). The Government response to the Select Committee (Secretary of State, 2004; OPINION) reiterates its view that a wider definition of a 'vulnerable adult' may "...sweep all cases of domestic violence and other forms of harm into a scheme meant to protect vulnerable adults" (Secretary of State, 2004, p.2; OPINION). However, there is some evidence that older victims of abuse can be '...elderly graduates of domestic violence further stressed by the disabilities associated with ageing' (Homer and Gilleard, 1990, p.1361; PQUANT3 (see earlier reference in Section 5.1). A recent report by Blood (2004; REVIEW2) on behalf of Help the Aged and the Housing Associations' Charitable Trust claims that lack of training for professionals and healthcare workers results in the assumption that domestic violence is not an issue for older women and that staff are consequently unlikely to accurately identify signs. Marks of physical injury are often attributed to falls, and if an older woman discloses incidences of such violence these may be put down to confusion or dementia. The report identifies a common belief held by staff that the situation couldn't be serious or else the older woman would have left earlier. The report recommends further research to ascertain the level of the problem, which is identified as occupying the space between both social issues of domestic violence and elder abuse.

An early American study by Pillemer and Finkelhor (1988; PQUANT1), which was the first large-scale random sample survey of elder abuse and neglect in the USA, reports that (with regard to relationships) spouses were the most likely to be abusers (60% of abuse 'situations' were found to be spouse abuse). Although these findings are not necessarily comparable with those of the UK, similar conclusions are drawn from a Leicester based study, by Smith, Baker, Buchan and Bodiwala (1992; PQUANT3), which reports that 5% of the population of 59 years and older attending an Accident and Emergency ward were victims of domestic violence. Of these, interestingly, 14 victims were male and 2 were female. An important aspect of both the USA and UK studies is the illumination of domestic violence as an issue relating to older people. Furthermore, the links between abuse and other forms of crime should not go unrecognised (see Griffiths, Roberts and Williams, 1997; OPINION).

Although the Health Select Committee report (2004) makes reference to training for nurses and domiciliary care workers, it is useful to highlight that a survey of medical schools and colleges in the UK by Kingston, Penhale and Bennett (1995; PQUANT2), found that elder abuse was less likely to be on the syllabus than on qualifying courses for nursing and social work. A recent Council report by the Royal College of Psychiatrists (2000) drew attention to abuse in institutions, with the aim of defining the role of doctors in the prevention, detection and management of abuse, to raise awareness, improve practice, and to highlight the responsibility of doctors to influence the settings where they treat patients (Royal College of Psychiatrists, 2000; PRACTICEREVIEW). There is little known of medical practices outside the inquiries relating to hospital care (Commission for Health Improvement, 2003, AUDIT; Penhale and Manthorpe, 2004, REVIEW2)

Not surprisingly, in light of the lack of research in this area, there is little attention in the Health Select Committee report to sexual abuse of older adults; despite the early observations of Holt (1993; PQUANT3), who challenged the ageist assumption that older people cannot be sexually abused. Holt received reports from 90 social workers of sexual abuse of older adults in the UK and found female victims outnumbered male victims by 6 to 1. However, this study is not representative and the social workers' reports were not verified.

Nevertheless, recent qualitative research by Jeary (2004a; PQUAL2) explores 52 cases of sexual abuse among older people, identifying issues and emerging themes. Semi-structured interviews (it is not stated how many) were undertaken with professionals either responsible for case-managing offenders, or providing sex offender treatment programmes. Focus groups were conducted with managers of residential and domiciliary care settings and documentary analysis was used to analyse largely risk assessment documentation. Themes emerge from the study around three main sets of circumstances in which alleged sexual abuse may be found, which include one third of all cases in the study involving abuse within a residential setting. Examples are also given of sexual abuse in domiciliary care settings, such as a case study in which two female home care workers, who did not like a particular male client, deliberately acted in a provocative manner towards him. The study also raises concerns about abuse in 'sheltered' or 'older people's' accommodation. Conclusions include recommendations to policy makers and practitioners in social care about potential avenues for exploration around sexual abuse of vulnerable people.

8. Conclusions

This paper has highlighted recent research in response to the key recommendations outlined in the Health Select Committee report (2004) on elder abuse. The main messages from the analysis conducted for this review of recent research into the area of elder abuse are that:

- From the perceptions of professionals and commentators perpetrators of abuse are diverse and exist in a range of settings and relationships (see McCreadie, 2002, REVIEW2; McCreadie, Bennett and Tinker, 1998, PQUANT3; McCreadie 2002a, REVIEW2; Campbell-Reay and Brown, 2001, PQUANT3) see section **5.3.1**. However, few studies have been identified, particularly of staff.
- Monitoring of adult protection and interventions is still in its early stages but there is recognition of the need for good data collection and analysis to aid measurement and performance targets (Sumner, 2004, PQUANT2, PAVA, 2004, PQUANT3) see section **5.2.1**.
- There are gaps and some variations in staff knowledge in the social care and health care sectors as to what constitutes abuse and the most appropriate response (Taylor and Dodd, 2004; PQUAL3) see section **5.1.1**. Few studies cover other areas such as housing.
- If training of staff across the health and social care sectors in the identification of elder abuse is expanded, staff will better identify and be more confident about reporting abusive situations (Taylor and Dodd, 2004; PQUAL3) see

section **5.3.2**. American studies suggest that there is a positive correlation between workers who receive no training and the incidence of abuse.

- If recognition of the possibility of financial abuse is better developed then more needs to be known about what constitute effective measures to combat this (Langan and Means 1995; PQUANT2) see section **5.5**.
- Multi-agency working across the UK is still uneven but there are some examples of good practice (Mathew *et al* 2004; PQUANT2 Quigley, 1999; PRACTICEREVIEW) see section **5.1.1**.
- There is a view that independent advocacy services and support services may benefit those who have been abused (Jeary, 2004, PQUAL3; Pritchard; 2003, PQUAL2) see sections **5.6.1.; 5.1.**, but there is little evidence of what is most effective to support those who have been abused.
- Knowledge of elder abuse among black and ethnic minority groups is limited (Patel, 1999, PQUAL2) see section **5.6.2**.

9. Recommendations

Drawing from the above this review recommends the following priorities for research:

- Due to the difficulties in distinguishing between USA based research and research conducted in the UK in the area of adult protection, an annotated bibliography of past and current UK based research would be a useful tool to guide future research studies and prevent duplication. It would also indicate where further research is necessary in order to confirm or verify results.
- There is a need for more primary research in elder abuse and less emphasis on secondary sources and overviews. There are few studies which incorporate older people's views directly compared to those considering professional perspectives.
- Requests for training have been prominent in recent developments in adult protection; however there has been no real differentiation as to what type of training this should be, to whom, delivery patterns and so on. The effectiveness of different models should be evaluated. Further suggestions from examining the evidence on training suggest an up to date, robust evidence base to draw knowledge from would be helpful.
- Mandatory reporting might be a suitable subject for research to ascertain its legal, technical and resource implications as well as to obtain professional and older people's views of its acceptability.
- The boundary between research and inspection in adult protection is unclear, and greater clarity of roles would be beneficial. If Sumner's survey is not

repeated, a potentially valuable longitudinal data set will not be available. This might be worth further consideration.

- Overviews have begun to dominate the literature and create the illusion that more work has actually been done than is actually the case. The Department of Health should ensure that current research is communicated, perhaps with an organisation such as Action on Elder Abuse maintaining a list of current and recent research together with investigators' contacts.
- There is a need for research to establish precise figures of the prevalence of elder abuse. There is a dearth of research on elder abuse which, compounded with difficulties in reporting cases, has led to difficulty in establishing precise figures. A consensus about the best method for undertaking such a study could represent a useful initial development.
- Research is needed to consider how consensus over the definition of vulnerability may be achieved. This would need to reflect both older people's perceptions and the legal framework.
- The Mental Capacity Bill, if enacted, may provide increased safeguards against financial abuse and other forms of abuse, but without a clear baseline of evidence, it will be hard to make comparisons. Research into any new Mental Capacity legislation could usefully consider various methodological approaches and could draw on Scotland's earlier developments and research.
- The bulk of recent studies to date have been small-scale. It would be constructive, now relevant issues have been highlighted, to develop these hypotheses and observations into primary research studies, aided by continuous consultation, to establish a standardised, operational definition of elder abuse, for policy-makers, practitioners and researchers alike.

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11. Appendices

Appendix 1:

Method

A search of research and academic literature from 1996 to 2004 was conducted utilising texts, journals, on-line source material and the SCIE Knowledge Review framework (SCIE, 2004) was used as a basis for evaluating the research.

Some compromises to these guidelines had to be made in this short review because of the short-time scale. Where compromises were made, they are acknowledged.

Project Management

The project team involved professionals of a variety of disciplines. The project team were: Professor Jill Manthorpe (Professor of Social Work, King's College London); Bridget Penhale (Senior Lecturer in Gerontology, University of Sheffield); Paul Kingston (Professor of Primary Care, University of Wolverhampton); Lisa Pinkney (Research Associate; Psychology) and Neil Perkins (Research Associate; Social Policy); working on Partnerships and Regulation in Adult Protection project, for the Modernisation of Adult Social Care research programme.

The research team represented a collaboration of institutions: King's College London; the University of Wolverhampton and the University of Sheffield.

Project management was accomplished through regular email communications between the team and fortnightly meetings of the project team in which updates on the progress of the literature review and strategic next steps were identified.

The research associates implemented the inclusion and exclusion criteria for the majority of the papers identified and reviewed the literature.

Inclusion and exclusion criteria applied to the studies retrieved by the literature search:

Inclusion criteria:

Studies commissioned in the last five years 1999 onwards (any studies referred to before this are mainly for supporting evidence).

Subject matter relating to older people and abuse

Sample either Male or Female

Any type of study design

Mainly UK studies, but other countries used where there is a lack of UK evidence.

Exclusion criteria:

Subject matter relating to groups of vulnerable adults other than older people unless it includes older people as a subgroup.

Newspaper articles/media

Studies commissioned before 1999, unless containing relevant evidence.

Sources of studies for review

In line with the SCIE framework (SCIE, 2004) the sources of data searched for the purposes of this review, included:

Electronic bibliographic databases

Reference lists from relevant primary literature and review articles

Professional journals

Journals, grey literature (unpublished material, theses and conference proceedings etc.)

Concise Searching of the Internet using search engines such as “Google”

Electronic bibliographic databases

The databases searched were:

Ageinfo

Ageline

AMED (Allied and Complementary Medicine Database)

ASSIA (Applied Social Science Index and Abstracts)

CareData

CINAHL (The Cumulative Index to Nursing & Allied Health)

The Cochrane Library & CCTR (Cochrane Controlled Trials Register)

ELSC

Medline

PsychInfo

SCI (Science Citation Index Expanded)

SSCI (Social Sciences Citation Index)

SIGLE (System for Information on Grey Literature in Europe)

Hand searching

Due to some of the literature using secondary references from earlier sources, relevant primary literature and review articles were identified and the reference lists from these were hand-searched. Key journals were identified and hand-searched both to ensure inclusion of relevant studies and to cross-check the reliability of the computerised searches.

Books and book chapters identified using the COPAC database were obtained and hand-searched for data. All the books in the bibliography were hand-searched for inclusion criteria.

Journals hand-searched from 1999

The following journals produced the most studies in the search:

Journal of Adult Protection
Age and Ageing
Ageing and Society
Community Care
Journal of Elder Abuse and Neglect
Care and Health
Health and Social Care in the Community

The following journals were considered highly relevant to the review topic:

British Journal of Social Work
British Medical Journal
Ageing and Mental Health
Journal of Social Policy
Journal of Family Welfare and Law
Journal of the Royal Society of Medicine

Internet Searching

As the field is fairly specific, it was possible to make use of internet searches using search engines (primarily “Google”). International references not located elsewhere were found using this method.

Reference and data management

Reference managing software, Endnote (ISI Researchsoft, 2001) was used to manage the reference collection, distribution and bibliographic citations.

Selection of studies to be included

All references retrieved through the initial search methods were assessed by application of the study criteria to abstracts and titles of articles in the first instance. This is deemed methodologically acceptable in the guidelines produced by the Social Care Institute for Excellence (SCIE, 2004).

A data summary sheet (see Appendix 3: Summary sheet) was used taken from the SCIE framework on which the design and results of each study were summarised and categorised.

Appendix 2: Data Extraction templates (Moriarty, 2002; Long et al, 2000)

Examples of classification systems and quality appraisal frameworks⁵

Primary quantitative studies

PQUANT 1	<ul style="list-style-type: none"> • Primary research studies. • Mainly quantitative, almost always using a randomised or quasi-experimental design but also includes studies with random stratified population samples or across multiple sites where clear attempts have been made to achieve comprehensive coverage. • Contains detailed information about techniques for sample selection, data collection, and appropriate analysis of data. • Also includes studies reporting on the development of a standardised instrument where detailed information on reliability and validity is reported.
PQUANT 2	<ul style="list-style-type: none"> • Primary well-designed non-experimental studies, controlled statistically if appropriate. • Includes studies using case control, longitudinal, cohort, matched pairs, or cross-sectional random sample methodologies. • Contains detailed information about techniques for sample selection, data collection, and appropriate analysis of data. • Also includes studies reporting on development of standardised instrument but with limited information on reliability and validity or where tested with a limited sample.
PQUANT 3	<ul style="list-style-type: none"> • Individual well-designed study but limited in scope, either because it is based upon a single area or is examining a hard to research area. • May also include studies with limited analyses and/or reporting.
PQUANT 4	<ul style="list-style-type: none"> • Individual study, weak methodology and analysis.

Primary predominantly qualitative studies

PQUAL 1	<ul style="list-style-type: none"> • Primary research studies. • Mainly qualitative. • Evidence of theoretical or purposeful sampling, adequate description, data quality, theoretical and conceptual adequacy, potential for assessing typicality.
PQUAL 2	<ul style="list-style-type: none"> • Well-designed study but where there is greater descriptive analysis. • Limited potential for assessing typicality.
PQUAL 3	<ul style="list-style-type: none"> • Adequately designed primary study but limited to a single method and/or lacking information on analysis.
PQUAL 4	<ul style="list-style-type: none"> • Individual study, weak methodology and analysis.

⁵ Moriarty, J. (2002) *Assessment of Older People with Mental Health Problems*, National Institute for Social Work Research Unit, Kings College, London.

Reviews

REVIEW 1	<ul style="list-style-type: none"> Review which describes deliberate procedures for locating, appraising, and analysing primary study results. Also includes reviews by acknowledged expert in the field which show awareness of comprehensiveness (e.g. international literature, literature from different disciplines, seminal and recent studies) and contribute to the development of theoretical concepts.
REVIEW 2	<ul style="list-style-type: none"> Comprehensive review drawing together evidence. Identifies 'what works' and where information is lacking. May include systematic reviews where only a single database or source of information was used.
REVIEW 3	<ul style="list-style-type: none"> Comprehensive review but limited to descriptive accounts of the literature.
REVIEW 4	<ul style="list-style-type: none"> Review limited in scope and understanding of the topic.

Other examples of classification systems

DESCRIP	<ul style="list-style-type: none"> Descriptive study e.g. service development or programme, often published before final evaluation. Case studies and practice guides.
PRACTICE REVIEW	<ul style="list-style-type: none"> Article primarily aimed at practitioners which discusses the literature but is more of a commentary, aimed at identifying practice issues.
OPINION	<ul style="list-style-type: none"> Professional opinion based on author's evidence and that of others aiming to identify problems or themes, e.g. editorials.
AUDIT	<ul style="list-style-type: none"> Information from audit and inspection reports.

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Templates for extracting and summarising data from studies

This template is based upon the evaluative tool for qualitative studies developed by Long et al. (2000).

Type of study	Qualitative. Rated as: <input type="checkbox"/> PQUAL 1 <input type="checkbox"/> PQUAL 2 <input type="checkbox"/> PQUAL 3
Topic area	Which of the four main areas of the review does it cover? <input type="checkbox"/> Users' and carers' experiences of assessment <input type="checkbox"/> Standardised measures and good practice <input type="checkbox"/> Improving user and carer participation <input type="checkbox"/> Sharing information.
Overview	
Bibliographic details	<ul style="list-style-type: none"> • Author, title, publication, year.
Purpose	<ul style="list-style-type: none"> • What are the aims of the study? • What are the aims of the paper/book/chapter being reviewed?
Key Findings	<ul style="list-style-type: none"> • What are the key study findings?
Evaluative summary	<ul style="list-style-type: none"> • Draw together brief comments on the study as a whole and its strengths and weaknesses. • Is further work required? • What are its implications for policy, practice and theory, if any?
Study	
Study	<ul style="list-style-type: none"> • What type of study is it?
Intervention	<ul style="list-style-type: none"> • What, if any, is the intervention? • Is there a comparison intervention?
Outcome criteria	<ul style="list-style-type: none"> • What outcome criteria are used in the study?
Setting	
Area and care setting	<ul style="list-style-type: none"> • What is the geographical and care setting for the study?
Rationale	<ul style="list-style-type: none"> • What is the rationale and appropriateness for this choice?
Detail	<ul style="list-style-type: none"> • Is there sufficient detail about the setting?
Time period	<ul style="list-style-type: none"> • Over what period did the data collection take place?

Sample

Inclusion criteria	<ul style="list-style-type: none"> Who was included in the study?
Exclusion criteria	<ul style="list-style-type: none"> Who was excluded?
Selection	<ul style="list-style-type: none"> How was the sample selected?
Size	<ul style="list-style-type: none"> What is the size of the sample and groups comprising the study?
Appropriateness	<ul style="list-style-type: none"> Is the sample appropriate in terms of its ability to meet the aims of the study, the depth of data that it enables to be collected, and its breadth?
Ethics	<ul style="list-style-type: none"> Was ethical committee approval obtained? Was informed consent obtained? Does the study address ethical issues adequately?
User/carer centredness	<ul style="list-style-type: none"> Are there any other indications of responsiveness to the needs of users and carers beyond ethical committee approval (e.g. carer/user involvement in study, ways of feeding back study data or findings)?

Data collection

Methods	<ul style="list-style-type: none"> What data collection methods were used?
Role of researcher	<ul style="list-style-type: none"> What is the role of the researcher within the setting?
Fieldwork	<ul style="list-style-type: none"> Is the process of fieldwork adequately described?
Data analysis	<ul style="list-style-type: none"> How are the data analysed? How adequate is the description of the data analysis? Is adequate evidence provided to support the analysis? (e.g. use of original data, iterative analysis, efforts to establish validity and reliability.) Is the study set in context in terms of findings and relevant theory?
Researcher's potential bias	<ul style="list-style-type: none"> Are the researcher's/researchers' own position, assumptions and possible biases outlined? Indicate how they could affect the study in terms of analysis and interpretation of the data.

Policy and practice

Generalisation	<ul style="list-style-type: none"> To what extent are the study findings able to be generalised? Are the conclusions justified?
Implications for policy	<ul style="list-style-type: none"> What are the implications for policy?
Implications for practice	<ul style="list-style-type: none"> What are the implications for practice?

Appendix 3:

Search by database: July 2004

Database	'Elder abuse'	'Elder abuse' limited by year 1999-2004	'Elder abuse' + 'UK'	
AMED	38	16	1	
Ageline	1182	362	7	
Ageinfo	800	186	28	
MEDLINE	981	317	1	
Cochrane Library (full)	5	5	4	
CareData	462	123	123	
ASSIA	164	52	43	
Psychinfo	530	140	2	
CINAHL	904	430	9	
SCI	10	10	1	
Social Services Abstracts	342	149	10	
Sociological Abstracts	174	58	2	

Appendix 4:

Key UK Studies:

Inquiry reports

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*.
Buckingham: Buckinghamshire County Council. Report on case of two homes for people with learning disabilities suspected of wilful neglect of their residents.

Camden and Islington NHS Trust (1999) *Beech House Inquiry – Report of the internal inquiry relating to the mistreatment of patients residing at Beech House, St Pancras Hospital during the period March 1993-April 1996*.
London: Camden and Islington NHS Trust.

Commission for Health Improvement (2003) *Investigation into Matters Arising from Care on Rowan ward, Manchester Health and Social Care Trust*,
London: Commission for Health Improvement

Research based studies

Eastley, R. J. et al. (1993). Assaults on professional carers of elderly people. *British Medical Journal*, 2 October 1993, p 845. This study aimed to establish the rates of assaults on staff caring for elderly people in various residential settings.

Langan, J. (1995) In the best interests of elderly people? The role of local authorities in handling and safeguarding the personal finances of elderly people with dementia. *Journal of Social Welfare and Family law*, **19**(4), pp 463-477. Draws on research into the policies and procedures of 27 local authorities

Langan, J. & Means, R. (1996) Financial Management and Elderly People with Dementia in the UK: As much a Question of Confusion as Abuse? *Ageing and Society* 16 (1996) p.287-314 (see above).

McCreadie, C., Bennett, G. & Tinker, A (1998) Investigating British general practitioners' knowledge and experience of elder abuse: report of a research study in an inner London borough. *Journal of Elder Abuse and Neglect*, **9**(3), p. 23-39. Includes finding that 84% of a sample of 62 GPs believed they had an older patient in an abuse situation.

Ogg, J. & Bennett, G. (1992) Elder abuse in Britain. *British Medical Journal*, **305**, 24 October, pp 998-999. Report of a national survey which questioned older people about abuse by family members or close relatives.

Richardson, B., Kitchen, G. & Livingston, G. (2002). The effect of education on knowledge and management of elder abuse: a randomised controlled trial.

Age and Ageing **31**, p. 335-341. Education programme evaluated among various staff groupings.

Overviews

Bennett, G. & Kingston, P. (1993) *Elder Abuse: concepts, theories and interventions*. London: Chapman & Hall. Research overview and link to services.

Decalmer, P. & Glendenning, F. (eds) (1997) *The mistreatment of elderly people*. Second edition. London: Sage. Collection of chapters covering issues, service responses and professional interventions.

Manthorpe, J. (1999) Older People. *Community Care Research Matters*, October 1993-April 2000, p. 34-36. An overview of recent research on financial protection, institutional abuse and abuse within ethnic minority communities.

McCreadie, C. & Tinker, A. (1993) Abuse of elderly people in the domestic setting: a UK perspective. *Age & Ageing*, **22**, January 1995, p. 65-69. Distinguishes the different kinds of abuse, and draws conclusions about the need for future research.

McCreadie, C. (1996) *Elder Abuse: Update on Research*. Institute of Gerontology, London. Explores research in the areas of definition, abuse in domestic and communal settings, financial abuse and interventions by various bodies.

Ogg, J. & Munn-Giddings, C. (1993) Researching elder abuse, *Ageing and Society*, **13**, September 1993, p. 389-413. Discusses the methodological and ethical issues which need to be considered when researching elder abuse.

Penhale, B. (1999) Bruises on the Soul: Older Women, Domestic violence and Elder abuse. *Journal of Elder Abuse and Neglect* **11** (1) p.1-22. A general examination of the abuse of older women is presented, with examples from six cases from social work practice.

Policy Overviews:

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