LSE Research Online

Article (refereed)

Gail Wilson

Abuse of elderly men and women among clients of a community psychogeriatric service

Originally published in British journal of social work, 24 (6). pp. 681-700

© 1994 Oxford University Press.

You may cite this version as:
Wilson, Gail (1994). Abuse of elderly men and women among clients of a community psychogeriatric service [online]. London: LSE Research Online.
Available at: http://eprints.lse.ac.uk/archive/00001030
Available in LSE Research Online: April 2007

LSE has developed LSE Research Online so that users may access research output of the School. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in LSE Research Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (http://eprints.lse.ac.uk) of the LSE Research Online website.

This document is the author's final manuscript version of the journal article, incorporating any revisions agreed during the peer review process. Some differences between this version and the publisher's version remain. You are advised to consult the publisher's version if you wish to cite from it.

http://eprints.lse.ac.uk
Contact LSE Research Online at: Library.Researchonline@lse.ac.uk

Abstract

This paper reports on a study of elder abuse among clients of an outer London community psychogeriatric service. Staff reported elder abuse in their case loads over a period of one year. Reported cases were linked with referrals. Rates of abuse for different staff and for different age and ethnic groups were calculated. Women were very much more likely to be abused than men and were less likely to be abusers. Clients were frequently reported as abusing their carers. Staff reporting rates varied widely. Training and the time available to win the trust of clients appeared to be important variables. The staff response was limited by lack of managerial support and by lack of developed strategies for dealing with abusive situations. Separation was the most common response to physical violence in the home. Financial abuse was mainly dealt with by social services. Staff abuse was largely ignored.

Abuse of Elderly Men and Women among Clients of a Community Psychogeriatric Service

Despite the growing attention in the British literature (McCreadie, 1991; Pritchard, 1992; Biggs and Phillipson, 1992; Bennet and Kingston, 1993; Decalmer and Glendenning, 1993), and a welcome increase in the ability of professionals to admit to the existence of the problem, there has been little research on elder abuse in the UK. The aim of the project reported below was to combine staff concern over elder abuse with a wider view of the problem. The project started from the premise that older people are subject to ageism and hence socially devalued in many ways that lay them open to abuse. Previous work has often concentrated on abuse in domestic settings. Other types of abuse have often been ignored, for example, abuse which occurs in institutions, or where the abuser is not a member of the family but is an employee of a service, or simply someone who sees the chance of committing a crime that is less likely to be detected than usual. However incidents such as mugging, wrongful arrest, or harassment by sheltered housing wardens can have serious mental or physical health consequences for the victim. Staff need to be aware of these types of abuse so that they can provide extra support and prevent deterioration in abused clients or patients. They were therefore included in this service based study.

Definitions

The term elder abuse is itself open to question because it ignores gender. In reality there is abuse of older men and abuse of older women. Equally abusers are not ungendered. However, so far definitions are all unisex.

Most studies of elder abuse begin by noting the lack of any agreed definition of the problem (Zdorkowski and Galbraith, 1985; Breckman and Adelman, 1988; Filinson, 1989; Wolf and Pillemer; McCreadie, 1991) and suggest that progress is therefore inhibited. In fact, definitions do

not need to be very tightly drawn in most contexts (see for example Stevenson, 1989: 22). As long as staff in any service can agree on what they term abuse and neglect, much needed development of detection and treatment can take place.

Some American studies and state laws include self abuse or self neglect as a category (see for example Sprey and Matthews, 1989). Self neglect has long been recognised in England and Wales. Such cases have traditionally been dealt with under Section 47 of the National Assistance Act 1948. This clause, which denies rights to the person concerned, can itself be seen as a form of abuse. Pritchard (1992) states that health service staff are more likely to see self neglect as an abuse category than social service staff.

The definitions used in the present study were derived from Brillon (1987) and were:

Physical violence against clients
Physical violence by clients
Abuse of clients by principal carers
Abuse of clients by staff
Abuse of clients by others (not carers or staff)
Other abuse

"Physical violence" included punching, scratching, slapping and pushing but also enforced transportation to a distant mental hospital without proper legal procedures. "Physical violence against clients" was subdivided into violence by the principal carer, violence by others in the household, violence by paid employees (including the police and private sector care workers), mugging and violent breakins. The three cases of suspected sexual abuse were counted as physical violence even though they were not accompanied by physical attacks.

"Violence by clients" was similarly divided between violence to principal carers, to others in the household and to staff. Since all staff were under retirement age the six cases of violence to staff were not counted as elder abuse but were recorded since the category was important to the staff concerned.

The distinction between client and carer made sense in terms of the way clients were referred to the service but not in the way staff viewed the situation. The service was basically an additional support

for people over 65 with mental health difficulties. Staff acted as assessors and co-ordinators of care packages, as well as providing a definite service such as mental health monitoring or rehabilitation. Although the emphasis was on the wishes of the client as opposed to the carer, staff usually included principal carers in their definition of 'client'. This resulted in a different distribution of abuse cases from that found by others who concentrated on clients or patients respectively, for example the SSI (1992) or Homer and Gilleard (1990).

The category "Abuse by carers" was intended to cover behaviour that was harmful to the client but did not involve actual physical violence. The sub-categories were: withholding food; gross neglect; incorrect attention to medical needs; and theft, fraud and other financial exploitation.

The only instances of "Staff abuse" which were directly reported by staff were theft (3) but three instances of physical violence were recorded in interviews with clients and reports by former members of the service.

The last two categories of "Abuse of clients by others" and " Other abuse" were an attempt to capture the very great variety of abuse which elderly people may suffer. Burglary and financial exploitation by non-resident relatives or neighbours were subcategories. "Other abuse" was most frequently used by staff to mention verbal abuse and harassment which they found either extremely stressful to work with (for example in discordant marriages), or which they saw as very harmful to the client (mostly harassment by neighbours or wardens in sheltered housing).

Theft, burglary, mugging and some rapes are more likely to be one-off fortuitous events. Many would say that they should not be included in elder abuse. However this research was intended to consider abuse from the point of view of the elderly client. The research was also service based and staff had to deal with the after affects of fortuitous events such as burglary or rape. Such cases were therefore included when they were known to staff and when staff saw them as an issue.

Psychological or emotional abuse, in the home and outside, was not counted in the study. The problems of arriving at an agreed set of definitions with a multi-professional, multi-ethnic staff group were too great given the lack of time and the type of group work which would have been necessary. Ideally it should be included in any survey of elder abuse because virtually all staff thought that it was more common than physical abuse.

Method

The study area was an outer London borough with a mixed social class composition. Some housing estates were highly deprived and dangerous. Female consultant psycho-geriatricians were reluctant to venture onto them without a male nurse as escort. Other parts consisted of neat semi-detached suburban houses. There were large ethnic minority communities, mainly Afro-caribbean and Asian, and a substantial Irish population.

A simple questionnaire asked all the staff in the community psychogeriatric service to record any case over the previous year where they considered abuse or neglect might have taken place. The categories of abuse were those listed above. In addition staff recorded the sex, ethnicity and relation of the abuser to the victim if these categories seemed appropriate, and recorded the action they had taken. In complex cases, or cases where clients were abusing their carers, they commented in the space left for notes. In each case they were asked to record how certain they were that abuse or neglect was occurring. Certainty ranged from absolute in cases where the abuser had asked for help or admitted what was happening when challenged, to vague unease when bruises were seen but were said to have resulted from falls. All staff were interviewed and were able to make additional points about their cases. Since the reporting of abuse was very variable and under reporting was widespread (see Table 1), all reported cases have been treated as probable abuse for the purposes of this analysis. The cases mentioned by staff were matched with client records in order to calculate the percentage of abuse cases on the open case load.

Reporting rates of staff

The service was multi-disciplinary and there were differences in the way staff worked and in the experience they brought to their jobs. Table 1 shows that there were very wide variations in rates of reporting elder abuse, both between staff in the same profession and between professional groups. These differences arose in part from the different ways that staff worked and in part from individual differences between staff (see also Bookin and Dunkle, 1989 who found that staff diagnoses of elder abuse were influenced by their feelings about client or carer). The service was area based and it is not clear how far the characteristics of the neighbourhood influenced rates of reporting. It appeared that elder abuse was common to all areas and it was impossible to argue that incidence was higher in middle class areas or in poor areas.

Community psychiatric nurses were mainly involved in assessing new referrals and in longer term monitoring of mental patients. Except when they were offering a programme of counselling or

teaching special skills such as relaxation, their contacts with clients tended to last around thirty minutes and to take place roughly fortnightly. The average CPN caseload was 33 and the average rate of reported elder abuse was 16% with a range from 11% to 21%.

Table 1 Distribution of reports of elder abuse by different members of staff

	Case Load	Abuse Cases	Abuse cases as a % of caseload %
CPN 1	33	5	15
CPN 2	19	2	11
CPN 3	31	4	13
CPN 4	33	7	21
CPN 5	59	10	17
CPN 6	23	3	13
Total Community Psychiatric Nurses	198	31	16
FA 1	14	6	43
FA 2	10	4	40
FA 3	5	2	40
FA 4	4	2	50
FA 5	5	3	60
FA 6	13	4	31
FA 7	8	3	38
FA 8	9	7	78
FA 9	6	5	83
FA 10	11	3	27
FA 11	12	4	33
Total Family Aides	97	43	44
Others 1	10	5	50
Others 2	7	1	14
Others 3	30	9	30
Others 4	18	1	6
Total Others	65	16	25

Family aides on the other hand had much lower case loads (average nine) and spent much more time with clients. They carried out programmes of re-education for dementing or depressed clients who had lost skills of daily living, took clients for walks and to the shopping centre and tried various ways of motivating them to maintain their independence and look after themselves. Their opportunities to get to know clients' and carers' problems was very much greater than for any other staff. The average rate of abuse reported in their case loads was 44% with a range from 31 to 83%. It appeared that the two family aides reporting over 70 percent of their case load as abused may have been over enthusiastic and have slipped in cases from the previous year. However, even if this was so they still recorded very high rates of abuse.

Specialist staff are shown as "Others" in Table 1. One psychologist dealt with a relatively large number of cases where marital relations were bad and this accounts for the high proportion of abuse cases on his list. The social worker was highly experienced with this client group and reported a relatively high number of abuse cases even though she did not have very much client contact. In contrast the occupational therapist was strongly oriented towards psychoanalytic methods and tended to see problems as internal to the client rather than external. She recorded the lowest rate of abuse cases (6%).

It could be argued that the variations shown in Table 1 are a function of the types of case referred to different staff. This argument presumes that complex cases where a great deal of input was needed were more likely to be referred to psychologists or family aides. If these were the cases where marital relations were worst and/or carer stress was greatest then abuse rates were likely to be highest. However, it appeared more likely that staff varied in their ability to perceive abuse. Such variations may be a function of the type of interaction between staff and client, as for example when a nurse who is trained as a mental health worker does not enquire deeply into financial circumstances, or when a member of staff has too little contact with a client to gain her confidence. Family matters, which are often perceived as shameful such as financial abuse or violence, will not be revealed until trust has been established. The greater opportunities which family aides had for gaining client trust appeared to be the main reason why this group of staff reported more instances of abuse.

There were differences in the types of abuse reported. Nurses were more likely to report physical abuse and family aides were more likely to report financial abuse (see also Bookin and Dunkle, 1989). However there was no reason to think these differences were more than marginally influenced by differences in client groups. A research project which looked at larger numbers might establish variation due to class, type of housing, ethnic composition or rural-urban mix, but the present data suggested that any such differences were much smaller than differences in staff reporting rates. There were no differences in rates of reporting elder abuse when staff were grouped according to ethnic origin.

The conclusion from this data seems inevitable: if staff were more broadly trained and had greater opportunities to establish trusting relationships with clients more abuse would be reported. Since the level of reporting is already very high (see Table 1) this is very worrying.

The 21 staff reported between them 115 instances of abuse or suspected abuse. Some staff reported more than one form of abuse for a single case, and different staff reported the same case, or different types of abuse for the same case.

It was not possible to link all the cases of reported abuse to centrally held records of open cases. Service records indicated that 279 cases had been open during the year. There were 92 reports of abuse which could be linked to centrally held case records and these reports referred to 59 cases (21%). Some of the discrepancy arises because staff in multi-agency services do not all fill in central records as they should. In other cases client records may still have been in the pipeline. In yet others they may have been referred as part of a different service.

Characteristics of abuse cases

Although clients who were referred to the community psychiatric service were older than the average for the population as a whole there was no statistically significant difference in the age of clients and age of people who were reported as abused (see Table 2).

Table 2 Distribution by age of clients and reported abuse cases

	Cases			
Age at referral	Abuse No	Total No	Abuse %	Total %
65-69	7	45	12	16
70-74	10	56	17	20
75-79	17	68	29	24
80-84	12	55	20	20
85-90	11	37	19	13
90+	2	18	3	7
Total	59	279	100	100

Ethnic elders were poorly represented in the client group. This under representation was a reflection of the age structure of ethnic elders in the borough concerned. While some 40% of the total population was of ethnic minority origin, the numbers who had reached retirement age were a much smaller percentage and those over 75 were even smaller.

Table 3 Ethnic distribution of clients and reported abuse cases

	Cases			
	Abuse No	Total No	Abuse %	Total %
Ethnicity				
Jewish	2	13	3	5
Afro-caribbean	8	20	14	7
White UK	41	184	70	66
White Irish	5	36	8	13
White European	1	14	2	5
Asian	1	8	2	3
Other	1	4	2	2
Total	59	279	100	100

Table 3 might at first sight suggest that there were differences in rates of reported abuse in different ethnic groups. However, the differences were too small to be statistically significant. More research based on larger numbers might show ethnic differences, but equally it might not.

Living arrangements are an important factor in elder abuse in non-residential settings. As Table 4 shows abuse was less likely to be suffered by elderly people who lived alone than by those who were in households with more than one person. Living as a couple made it most likely that abuse would occur. The differences here were significant at the 1% level using a chi-square test.

Table 4 Living arrangements of clients and abuse cases

	All cases	Abuse group	
	No.	No	%
Lives alone			
Women	122	21	17
Men	35	3	9
Lives with others			
Couple	77	26	34
Other	45	9	20
Total	279	59	21

Table 4 suggests that gender differences were also important but the importance of gender is more clearly shown in Table 5 which is based on households where abuse of some type was reported over the year. Table 5 shows that nearly three quarters (71%) of abuse victims were women and that twice as many lived in couples as lived alone (29 as against 14). The number of cases where there was no clear victim in the eyes of recording staff reflect the fact that victims and abusers may be hard to define. This is particularly true in cases of marital conflict.

Table 5 Gender and living arrangements of those subject to abuse

	Lives alone		Lives with others		Total	
	No	%	No	%	No	%
Gender of victim						
Women	14	61	29	80	43	71
Men	3	13	2	6	5	8
Women and men			3	9	3	5
No clear victim	6	26	2	5	8	14
Total	23	100	36	100	59	100

It was possible to define abuse as directed at one person in 48 households. Out of 279 households in the sample, 241 contained a woman, either living alone (122), or with someone else. There were 43 (18%) reports of abuse against women in these households. The corresponding figures for men were much lower. One hundred and fifteen households contained a man (35 living alone) but only five men were reported sole victims. This difference in the gender of abuse cases is statistically significant at the 5% level (chi-square test). This finding that elder abuse of people with mental health problems is highly gendered accords with Pritchard (1992) who does not analyze abuse by sex but whose data (p.61) suggests that abusers were male and victims were female.

Types of abuse

Abuse was recorded under the headings listed above on p . Physical violence predominated as shown in Table 6. The various types of physical violence make up over half the total number of reports. Financial abuse (including theft) follows at 23%. Neglect with only 9% of reports was either harder to detect or less widespread.

Table 6 Types of abuse

	No. of reports	% total
Physical violence by the carer or others in the household	21	19
Physical violence by client to carer or others in the household	23	21
Physical violence by staff etc	6	5
Other violence (mugging, rape etc)	8	7
Abuse by carer (neglect, withholding food or medical treatment)	10	9
Financial abuse by carer	3	2
Other financial abuse	16	14
Theft by staff	3	2
Other theft (non violent)	5	5
Other abuse	18	16
Total	113	100

Note: A carer was defined as the principal carer resident in the same household as the older person. Violence or abuse by non-resident carers or relatives was recorded under 'other'. Physical abuse by an older client was recorded if the person abused was also over 65.

It is unlikely that Table 6 gives an accurate indication of the relative frequency of different types of abuse, even in the area surveyed. As Table 1 shows the rates at which individual staff reported abuse varied very greatly and it is clear that there was under reporting.

Abuse or violence by staff was certainly under reported. Later discussion revealed that some nurses thought it was normal that patients' possessions 'fell off the trolley' between casualty and the wards. One untrained member of staff who was responsible for two cases of staff violence saw the use of force as an unpleasant but essential part of her work. Others may have been less open about their methods.

Incidence of abuse

If the data is taken as a measure of how much elder abuse staff can be expected to report and, where possible, to deal with, there seems no reason to think that the findings are biassed. The SSI (1992) followed a method which was very similar and produced a much lower incidence of abuse and a different mix of abuse cases. The difference arises most probably because the SSI chose to study all older people not just those with mental illness.

The client group was clearly not representative of the elder population in general. There is no suggestion that an abuse rate of 1 in 5 is to be expected for all elders. However it seems reasonable to conclude that abuse rates of well over 20% are to be expected in elderly mentally ill clients of health and social services. Under reporting by staff combined with the exclusion of psychological abuse would suggest that rates of between 30 and 50% are to be expected in this highly selected group of people - mainly women (see also Levin et al., 1989; Grafstrom et al,1992; Northamptonshire Social Services, 1993 which all indicate high levels of abuse in households with a dementing person).

The characteristics of elderly mentally ill people who come to the attention of health and social services may or may not differ from those who do not. The presumption is that they will be more frail (and hence probably older) and more likely to upset their carers and neighbours (and hence either more seriously ill or in more advanced stages of dementia). If this is the case it follows that the general population of elderly mentally ill men and women will be less likely to be abused than those who have been referred to health and social services.

Interpersonal and Societal Aspects of Elder Abuse

There is a tendency to individualise a phenomenon such as elder abuse. However an approach which concentrates on interpersonal aspects of domestic situations ignores that fact that there are powerful forces within society which facilitate certain forms of abuse. In terms of professional practice, it is essential to begin by siting elder abuse in relation to the distribution of power within society, rather than seeing it wholly in individual terms (Filinson, 1989, see also Annetzburger (1989) who found most old age abuse was by sons who were mentally ill or had alcohol or drug problems).

Citizenship rights

While citizenship rights are theoretically available to all, many groups are systematically disadvantaged by social structures which empower some groups and disempower others. Such groups cannot rely on protection from the law, on a reasonable expectation of freedom from personal assault, or on access to income and services, in the same way as more favoured citizens. Such reductions in citizenship entitlements can apply to ethnic minorities and women but they also

apply to elders. Elder abuse can be seen as an extreme manifestation of ageism in a society which devalues old people, as well as a consequence of it.

The elders in the present study suffered the added stigma of mental illness or dementia. Older mentally ill people, though varied in their characteristics, share the chances of being seen as a very marginal group in our society. As inhabitants of the margin they are likely to be devalued as people and as citizens. For many purposes they will be all but invisible. Certainly the absence of any serious consideration of elder abuse in the caring professions for so many years reinforces the thesis that older people have few rights and get little consideration.

Gender

Ageism and lack of concern for older people leads to reduced citizenship rights for old people in all classes and ethnic groups. However deprivation of citizenship is compounded by the distribution of power which relates to gender. The distribution of power in a patriarchal society cannot be ignored. It is one factor in a process which concentrates abuse in one sex and abusers in the other. In the present study this is clearly shown in Table 5. As mentioned above under definitions, the term elder abuse also obscures the very different social positions of men and women in most societies. It is known that gender differences are less marked in old age in many respects. However it seems that research evidence will increasingly show that gender differences in power relations remain in old age. As one result, abuse is concentrated on women in old age as it is in younger age groups and the abusers, in terms of physical violence, are overwhelmingly male.

Some early writings on elder abuse may now be seen as something of a moral panic - a fear that female carers of the old and frail were going against their natures and resorting to violence (for example Eastman, 1984). We now know that women can on occasion resort to violence, particularly if they are unsupported and have to care for people with very difficult behaviour characteristics. Equally research is slowly establishing the fact that male caregivers are more likely to be violent than female caregivers and that their victims are more likely to be women than men. Research which does not take account of gender or which concentrates on abuse of clients to the exclusion of abuse by clients obscures these important relationships.

Caregivers as victims

There are cases of elder abuse where 'victim' and 'abuser' can be clearly defined. However it is probably more common for there to be some ambiguity (Steinmetz, 1988). Abusers may also be victims themselves (Homer and Gilleard, 1990). It is here argued that the ability to see abusers as victims should extend beyond the interpersonal to wider social structures.

Informal caregivers

Many informal carers are doing work which would be performed by two or three shift workers if the person they were caring for was in an institution. Help from outside the home may be too little and too late. They are effectively performing unpaid labour for society, though very few of them would see it this way. In addition their work is hardly recognised. While organisations such as the National Association of Carers have done much to put their concerns on the policy agenda, most attention has gone to younger generation carers leaving elderly spouse carers as a persistently disadvantaged group. Spouse carers suffer all the social deprivations caused by old age as well as the stresses of caring. The numbers in this situation are set to increase. Demographic change and the planned reduction in spending on residential care will increase the number of frail old people who are forced to live in the community, even though they may need more care than their relatives or other informal carers can provide. An increase in rates of abuse related to carer stress seems inevitable.

With state pensions higher than unemployment benefit and the spread of occupational pensions, the temptation to steal or defraud an old person may be high in all income groups. Here both victims and abusers may include men and women who are relegated by society to a life on the margins, denied an adequate standard of living or the ability to take part in the normal life of society. Similarly housing stress or simple greed may cause younger relatives to take possession of a house and arrange for an older person to be institutionalised.

To make these points about social deprivation is not to condone elder abuse or to suggest that deprivation is a cause of elder abuse, or to argue that elder abuse is confined to deprived sections of the population. All the evidence suggests that elder abuse in the home can occur in any class and also in any ethnic group. It is however possible that some forms of abuse differ across classes.

Formal caregivers

Paid care staff as well as informal carers are victims of a society that measures the worth of those who care by the worth accorded to those they care for. Caring for the old is not a job that carries social status. Until recently it was assumed to need no training and very little pay. In such situations staff are likely to suffer from stress and poor morale. Like informal carers they may resort to abuse.

Abuse or deficit of care?

It follows from the above discussion that staff need to see elder abuse in a broad framework or they will miss important categories of abuse among their clients or patients. Professionals have until recently been trained to concentrate on the individual client or patient. However table 6 shows that there were almost as many reported cases of violence by clients as against clients. This suggests very clearly that the 'deficit of care model' (Bennett, 1990) is unsatisfactory on its own. The aim of the model is to encourage staff to avoid moral judgments and to concentrate on whether the patient is receiving adequate care.

As indicated above, many abusers are themselves abused, either by the person they abuse or in broader terms by the expectations placed upon them by a relatively uncaring society. In such cases the argument that it is easier for staff to identify lack of care than to ask them to make moral judgments about who is an abuser and who abused shows an understanding of the complexity of many elder abuse cases and a sympathy with staff dilemmas which has often been lacking. However a concentration on clients is liable to lead staff to overlook the problems of the carer. It may well be that violence to carers was under-reported, even in a service where staff were very well aware of the needs of carers. A deficit of care model is very poorly adapted to helping staff detect abuse of carers.

A medical model (such as the deficit of care model) may also result in low reporting rates for financial abuse. Lack of money may be seen as less life threatening than physical abuse. Or financial aspects may be routinely ignored. It is easy for medically trained staff to underestimate the long term physical and mental health threat caused by poverty in advanced old age. A deficit of care model could result in financial abuse being ignored unless it leads to eviction, hyperthermia or obvious malnutrition.

The wide variety of types of abuse and abusive situations also reinforces the need to consider elder abuse from different perspectives rather than limit training to one model. In early literature (Eastman, 1984) abusers were characterised as being mainly overstressed caring daughters. This

arose partly from a concentration on abuse as an aspect of family dynamics rather than a manifestation of wider social forces. A more modern view would suggest that a concentration on interpersonal relationships is not enough, even when considering abuse within the household.

Action in abuse cases

The research showed that there was frequently very little staff could do once they had identified an abuse case. Lack of managerial support was one problem. This was identified by Eastman in 1984 and was still an obstacle to better practice in the present study. Even more basic was the lack of adequate strategies. Table 7 shows how staff reacted. In several cases staff recorded up to three different courses of action. There is some overlap between the categories. For example the type of 'separation' that allowed a carer to go out while a family aide looked after the client could also be classified under 'increase in services'. The classification chosen reflects the dominant aim of the action as expressed by staff e.g whether the input of extra services was seen in terms of reducing stress on the carer or in terms of separating two protagonists.

Table 7 Staff Action in Response to Elder Abuse

	Staff					
Action	Psych	CPN	Physio	FA	Other	Total
Separate	1	7	-	9	4	21
Increase service	1	2	1	3	1	8
Counselling/ therapy	6	4	1	3	-	14
Monitor medication	-	3	-	2	-	5
Advocacy	-	-	-	8	1	9
Refer on/Case conference	1	5	-	11	1	18
Other	-	3	-	5	3	11
No action	-	8	4	9	9	30

Abbreviations: Psych: psychologist, CPN: Community Psychiatric Nurse, Physio: Physiotherapist, FA: family aide.

Table 7 shows that different types of action were favoured by different professional groups. This further emphasises the importance of training so that all staff can be aware of all strategies. The two most common approaches to abuse were to separate the abused and the abuser, and to refer the case

to another service. Separation was by far the most common approach to violence by carers. At its simplest the aim was to allow the carer a break. This could be achieved by sending clients to day centres or the day hospital or getting them to attend a club. Alternatively a family aide might visit to motivate a client for two to three hours a week, so allowing the carer to go out. Very demented clients or those who were resistant to change were referred to voluntary organisations to try and get a sitter who would come in for a certain number of hours a week and mind the client. Longer breaks in respite care were arranged in a few cases. If the situation became unmanageable in some way, separation was made final by arranging for the client to go into some form of long term care.

It appeared that the aim of separation was to move the victim away from the abuser. This contrasts with American practice where removal of the abuser is often undertaken. Moving the victim lends support to the common perception that an abused person will be further victimised by losing their home and being institutionalised - a strong reason for hiding the existence of abuse.

In cases where a client was physically abusing his carer (or her carer, but only one case was recorded), the staff response was more complicated. The aim here was to help the wife to cope with the client's behaviour and/or to alter the behaviour. Counselling or therapy was offered to the wife.

An increase in services was designed to reduce the stress on the carer. This type of action could involve increasing the community psychogeriatric service input, particularly by introducing a family aide or it could mean providing other services such as home help or meals on wheels. In some cases an increase in services represented better monitoring. Abusers were less likely to strike if they knew the client or her finances were being watched, and that abuse would be detected. Monitoring medication usually meant an increase in CPN visits until a regime had been established and the carer had understood the reasons for a better regime.

Advocacy was only recorded as a strategy by family aides and the social worker. It seems unlikely that other staff did no advocacy work but they did not mention it when discussing how they coped with abuse. Dealing with bullying wardens of sheltered accommodation, checking that clients could not be evicted by the Housing Department or relatives and confronting financial abusers were some of the instances of advocacy on behalf of abused clients.

Referral to another service was most common in cases of financial abuse. Social Services were the normal agency which held pension books or got Court of Protection orders. In some cases community psychogeriatric workers looked after clients' finances and arranged to pay off their debts

but this usually only happened when area social service staff appeared unable to cope and a psychiatric service worker took on the task in desperation.

The staff who reported cases of theft were angered by what they saw as inaction on the part of the local authority. In one case relatives successfully prosecuted a home help. In others, witnessed by the researcher, a case of suspected theft by a paid community volunteer was ignored by psychiatric service workers since there were no staff to replace the voluntary agency input. Similarly suspected theft by private care agency staff was passed over.

Other actions or strategies for responding to abuse were diverse. Examples included helping a carer to move to sheltered accommodation so that she would feel less stressed by her neighbours, getting the bank to send itemised accounts in order to keep a check on thieving neighbours, and calling the police.

The high number of no action cases (almost a third) is misleading. One-off instances of abuse such as burglary and mugging can have a severe effect on clients but there is little that community care staff can do about them directly. In other cases when referral came very late in the life of an abused or abusing client, death or entry to long term care could prevent any action being taken.

Finally there were cases where action seemed too difficult. It should be remembered that no client in this sample was referred because of abuse. Staff were assigned the case for other reasons. Abuse either emerged as the case progressed or, in a very small minority of cases (three out of 279), it was mentioned on a referral form as a possible area of concern. It can be argued therefore that staff were not in post to deal with abuse and that they had some justification for ignoring it. However the interviews did not support this argument. Staff were highly stressed by most of the cases of abuse reported and it was an inability to devise and carry out appropriate interventions rather than choice that led to lack of action.

Conclusions

It is by now clear that however abuse of older men and women is defined (and controversy continues over definitions), it is not a rare phenomenon. This paper indicates that very high rates of elder abuse and neglect are to be expected among elderly mentally ill clients of health and social services. Although the study was based in one area and covered only one year of service delivery, there is no reason to believe that other EMI services would not similarly find abuse rates of 30-50%

if a concentrated attempt to look at the lives of users and their carers was undertaken. Equally there is no implication that such high rates are to be found in the general population.

Rates of reporting varied greatly between individual staff and across professions. Those with a nursing background reported more physical abuse and those from social services were more likely to detect financial abuse. Training is needed to enable all staff to come to terms with emotions and beliefs that prevent them from seeing different types of elder abuse. Such training should be based on an understanding of the way power is distributed in society. In particular, women elders, whether carers or being cared for, were shown to be very much more at risk of abuse than men, and very much less likely to be abusers themselves. An understanding of the power relations embodied in gender differences is essential if staff are to be alert to the possibilities of abuse in the domestic setting.

Staff in the community psychogeriatric services had a strong tendency to look beyond their immediate clients. As a result a very high level of abuse by clients was detected as well as high levels of abuse of clients. Pritchard (1992) also found high levels of carer abuse.

A great deal of work is needed before we have adequate strategies for dealing with elder abuse. Front line staff need much more support from managers. The research showed that separation of the protagonists was the main staff response to physical violence. Separation could take several forms. Any separation that meant removing the victim from her home seems likely to increase the level of victimisation and to create a folk culture where disclosure is something to be avoided at all costs. There were legal remedies for financial abuse but they were slow and often unsuitable. Advocacy and the threat of detection were often the only ways in which staff could fight financial abuse.

Staff abuse could not be a major issue in a project which relied on staff to report abuse. It was almost certainly under reported, both in the community and in institutions. It is to be hoped that in future when there are many more opportunities for private and state caregivers to work unsupervised in the community with very frail people, employers will be quick to take action against either violence or dishonesty. The law is not well suited to protect the rights of frail elderly people. They are likely to find appearance in court extremely harrowing and exhausting even if they are mentally competent. Employers and managers can however, make it known that certain types of behaviour from staff will not be tolerated.

(1) I would like to thank the Nuffield Foundation who partly financed the research on which this paper is based and Susannah Brown, London School of Economics, for help with the statistics.

References

Annetzburger, G.J., (1989), 'Implications of Research on Elder Abuse Perpetrators', in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Bennett G., (1990), 'Actions on elder abuse in the 90s: new definitions will help', Geriatric Medicine, 20, 5, 45-48

Bennet, G. and Kingstonm, P., (1993), Elder Abuse, Chapman and Hall, London

Biggs. S and Phillipson, C., (1992). Understanding Elder Abuse: A Training Manual for Professionals, London, Longman Group UK

Bookin, D. and Dunkle, R.E., (1989), 'Assessment Problems in Cases of Elder Abuse' in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Breckman R.S. and Adelman R.D., (1988), Strategies for Helping Victims of Elder Mistreatment, Sage, Beverley Hills

Brillon, Y., Victimization and Fear of Crime Among the Elderly, Toronto, Butterworths

Decalmer, P. and Glendenning, F., (1993), The Mistreatment of Elderly People, Sage, London

Eastman, M., (1984), Old Age Abuse, Mitcham, Age Concern England

Filinson, R., (1989), Introduction in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Fulmer, T., (1988), 'Elder Abuse' in Straus M.B., (ed.), Abuse and Victimisation Across the Lifespan, Baltimore, the Johns Hopkins University Press

Grafstrom, M., Norberg, A. and Winblad, B., (1992), '"Abuse is in the eye of the beholder". Spontaneously reported accounts by family members of abuse of demented persons in home care. A total population-based study', Stockholm Gerontology Research Centre, Stockholm

Galbraith, M. W., (1989), 'A Critical Examination of the Definitional, Methodological and Theoretical Problems of Elder Abuse', in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Homer, A. and Gilleard, C. J., (1990), 'Abuse of Elderly People by Their Carers', British Medical Journal, 301, 1359-1362

Levin, E., Sinclair, I. and Gorbach, P., (1989), Family, Services and confusion in Old Age, Avebury, Aldershot

McCreadie, C., (1991), Elder Abuse: an exploratory study, London, ACIOG, Kings College London.

Northamptonshire Social Services Department, (1993), 'A Report on elder Abuse in Domestic Settings in Northamptonshire November 1991 - October 1993'

Phillips, L.R., (1989), 'Issues Involved in Identifying and Intervening in Elder Abuse', in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Pritchard, J., (1991), The Abuse of Elderly People a handbook for professionals, London, Jessica Kingsley Publishers

Renvoise, (1978), Web of Violence, London, Routledge and Kegan Paul

Rinkle, V., (1989), 'Federal Initiatives', in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

Sprey, J. and Matthews, S.H., (1989), 'The Perils of Drawing Policy Implications from Research', in Filinson, R., and Ingman, S. R., Elder Abuse Practice and Policy, New York, Human Sciences Inc

SSI, (1992), Confronting Elder Abuse, HMSO, London

Steinmetz S.K., (1988), Duty Bound Elder Abuse and Family Care, Sage, Beverley Hills

Stevenson, O., (1989), Age and Vulnerability, London, Edward Arnold

Tomlin, (1989), Abuse of Elderly People: an unnecessary and preventable problem, London, British Geriatric Society

Wolf, R.A. and Pillemer, K.A., (1989), Helping Elderly Victims, New York, Columbia University Press

Zdorkowski, R.T. and Galbraith, M.W., (1985), 'An Inductive Approach to the Investigation of Elder Abuse', Ageing and Society, 5, 4, 413-429