Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# OPEN YOUR EYES

## *There is No Excuse for Elder Abuse*

**HSE Elder Abuse Services 2013**

## Table of Contents

# FOREWORD

The HSE Elder Abuse Service, which was established almost seven years ago, has been at the forefront in responding to the serious issue of elder abuse in Ireland. Over the last number of years, robust structures and supports have been put in place in order to provide a co-ordinated and holistic approach to addressing elder abuse.

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

One of the unique features of the service provided by the HSE has been the establishment of a comprehensive database to capture and analyse referrals to the service. The database is integral to the provision of information on referral patterns and management of cases within the HSE. It contributes to the development of policy, service provision and public awareness. Since 2007 over 13,000 referrals have been recorded and assessed by Senior Case Workers.

National media and public awareness campaigns have been undertaken to raise the knowledge, understanding and consciousness of the existence of elder abuse in Ireland. These campaigns have focused on identifying the types of abuse that can be perpetrated as well as bringing attention to the signs and symptoms of abuse in order to aid recognition. An increasing number of pathways for information and assistance that can support older people and their families have been provided.

Training is a vital element in the battle against elder abuse. Training has continued to be rolled out to staff, both in the HSE and in community, to private/voluntary agencies, as well as the business sector. Training is provided primarily by HSE elder abuse staff. Since 2007, a total of 38,934 participants have received training on elder abuse. This number is a testament to the dedication and commitment of staff.

The establishment by the HSE of the National Centre for the Protection of Older People (NCPOP) further enhanced the elder abuse service within Ireland. Research into the prevalence, nature and experience of elder abuse has contributed to a more tailored response with more meaningful interventions provided for older people. The NCPOP's current programme will be of great benefit to family carers, providing insight into the caregiver role and identifying where our service can provide necessary and additional support.

The elder abuse service has evolved over the past number of years with increasing emphasis being placed on prevention. Encouraging people, as they age, to plan for future healthcare and financial needs are critical to maintain independence, promote health and enhance quality of life, as well as to reduce risks, especially from abuse and exploitation.

The HSE has recently produced an online information booklet that outlines practical ways for older people to maintain their independence and stay connected to their communities as well as advising when professional advice should be sought regarding finances and future wishes. In addition, the NCPOP is currently exploring screening tools and empowerment models that will enable older people to have greater control of their lives and the choices and decisions affecting them.

These efforts, coupled with the National Positive Ageing Strategy and the Government's Healthy Ireland Policy means that there is a concerted effort to break down barriers that prevent older people from realising their potential and a momentum to engage with families and communities to enable older people to maximise their health, independence and quality of life.

It also must be recognised that progress in addressing elder abuse has been achieved against a backdrop of increasing pressures, such as reducing budgets and staff numbers. It is a testament to the hard work and dedication of all those involved in the elder abuse service, including HSE staff, healthcare professionals, voluntary organisations, community groups, statutory agencies, the business community, members of the National Elder Abuse Steering Group, Area Steering Groups and the NCPOP.

We look forward to continuing our working relationships to develop and grow the elder abuse service to meet the needs and wishes of older people.

**Frank Murphy**
**Chair, National Elder Abuse Steering Committee**

# 1.0 THE HSE ELDER ABUSE SERVICE

## 1.1 Introduction

This is the sixth year of reporting on the key activities, developments and referrals within the HSE's elder abuse service. This report tracks the efforts to progress the achievement of service goals such as increased awareness of the issue of elder abuse, the development of policy documents in order to support the service and research to improve our understanding to inform future service direction. In addition, analysis of referrals assists in gaining insight into the nature and type of abuse being perpetrated, where abuse occurs, characteristics of both the abused and the abuser, and the range and type of supports offered and availed of by older people.

The last few years have been challenging for the HSE generally, and the elder abuse service has not been immune to the challenges. Funding pressures have impacted on the service's ability to deliver on a range of activities and training. It is likely that these funding pressures will continue for the foreseeable future and it is important that we continue to find creative, innovative and cost-effective ways to achieve our goals and objectives.

## 1.2 Definition

Elder abuse is defined as:

> "*A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights.*"

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

The different types of abuse, which may result from deliberate intent, neglect, thoughtlessness or ignorance, were categorised in *Protecting Our Future*[1] as follows:-

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

### 1.2.1 Self-Neglect

*Protecting Our Future*[1] does not include self-neglect as this was not set out in the terms of reference for the Working Group. However, self-neglect has been the second most reported reason for referral to the HSE elder abuse service since 2008, accounting for approximately 20% of all referrals.

Research indicates that self-neglect is medically significant, resulting in higher morbidity and mortality. Responding to cases of self-neglect can be a complex process – self-neglect in older people is often not just a personal preference or a behavioural idiosyncrasy that becomes apparent in old age, but a spectrum of behaviours associated with increased morbidity, mortality and impairments in activities of daily living.

Therefore, self-neglect referrals should be viewed as alerts to potentially serious underlying problems, requiring evaluation and treatment.

In the *Review of Protecting Our Future*[2] the difficulties in addressing the issue of self-neglect were acknowledged. The concept of competence or capacity of the individual to assess his/her own situation and make decisions relating to it is central to this issue, as is the right to self-determination. Unless the person is assessed to have impaired capacity, he/she is entitled to lead his/her life as s/he sees fit. But the report stressed the importance of having appropriate services available, regardless of whether they were availed of or not. The Review also stressed the importance of developing clear protocols to assist healthcare staff in identifying symptoms of self-neglect and addressing these. Clear and speedy referral pathways to assess diminished capacity, along with awareness and prevention measures aimed at individuals, families and communities, were also highlighted.

A Working Group on Extreme Self-Neglect was established in 2008, to develop guidelines and procedures for healthcare staff when referrals are received or where situations of extreme self-neglect are suspected. The Group conducted a literature search on self-neglect, examined international approaches to this issue and researched various definitions for self-neglect. The Group presented a paper on their findings to the National Elder Abuse Steering Committee. Following minor modifications, the *paper 'HSE Policy and Procedures for Responding to Allegations of Extreme Self-Neglect'*[3] was accepted by both the National Elder Abuse Steering Committee and the HSE Management Team.

In that policy self-neglect is defined as "*the inability or unwillingness to provide for oneself the goods and services needed to live safely and independently"*[3].

Self neglect is a complex issue and one which can be extremely difficult to resolve. As in all situations, a person's personal preferences and lifestyle choices must be respected. These choices can be, and very often are, at odds with society's expectations. This can make efforts to deal with such situations even more challenging. The issue of self neglect in Ireland may require further examination and research in the future.

## 1.3 Elder Abuse Service Structure

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

### 1.3.1 National Elder Abuse Steering Committee

The National Elder Abuse Steering Committee, established in 2007, oversees the HSE's elder abuse, service nationally and works to ensure that the recommendations contained within *Protecting our Future,* as well as those contained within the review of that report in 2009 - '*Protecting our Future, Review of the Recommendations of the Report of the Working Group on Elder Abuse*'[2] - are implemented. In addition, the Committee has a lead role in implementing the findings of the most recent research on elder abuse, in particular that conducted in Ireland by the National Centre for the Protection of Older People (see Section Three). This Committee has a multi-agency and multi-disciplinary membership to enable it to address specific, emerging or complex elder abuse issues. (See Appendix One for membership).

### 1.3.2 Area Elder Abuse Steering Groups

The work of the Committee is supported at regional level by four Area Elder Abuse Steering Groups based in the four HSE administrative areas, i.e., HSE West, HSE South, HSE Dublin Mid Leinster and HSE Dublin North East. These Groups ensure local implementation of nationally agreed approaches to elder abuse and resolve any significant issues arising in their own areas or bring these to the attention of the appropriate forum. They act as a conduit for communication between local agencies, advocacy groups and the National Committee.

The Area Elder Abuse Steering Groups have worked well in the consistent application of elder abuse policy, awareness raising and communication. However, it must be acknowledged that the Groups have faced challenges recently in meeting their remit due to retirements, the public service recruitment moratorium and the imposition of significant travel restrictions. Their future role and function was considered in 2013 and is likely to be revisited in 2014.

### 1.3.3 Dedicated Officers for the Protection of Older People

The workings of the National Elder Abuse Steering Committee and the Area Elder Abuse Steering Groups are supported by Dedicated Officers for the Protection of Older People. These Officers are largely responsible for policy and protocol development, training, advice and consistency in application of elder abuse policies, procedures and guidelines. Currently, there are three Dedicated Officers for the Protection of Older People in post with the position in Dublin North East being temporarily vacant.

### 1.3.4 Senior Case Workers for Protection of Older People

Senior Case Workers for the Protection of Older People (SCWs) assess all referrals of alleged elder abuse reported to them and work in a sensitive and respectful manner in trying to resolve elder abuse issues.

There are currently 29 SCWs in post. Vacancies exist in the former Local Health Offices of Kildare/West Wicklow and West Cork. Where there is no SCW in post, referrals are managed by the General Manager with onward referral to the appropriate service for follow up.

***Responding to Elder Abuse Concerns / Referrals***

Cases of elder abuse can be very intricate and may involve dealing with complex interactions between family, neighbours, friends or businesses.

When responding to a referral or a concern, SCWs start every case with the presumption that the older person has mental capacity and, as such, has a right to self-determination. This means that they have the right to make decisions for themselves even though others may not necessarily agree with the decisions made.

Upholding this right to self determination can, in itself, be an important protection for older people. However, it can involve risk for the older person and very often the role of the SCW is to work with the older person to minimise this risk while respecting his or her wishes.

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

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

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

Many health professionals have expressed an apprehension and reluctance in communicating with older persons about their abuse concerns. It can be difficult to raise the subject of abuse.

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

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

In talking to an older person about abuse, we must also listen, not only to what the older person says but to how he/she is saying it, including body language and gestures. This will give a fuller understanding and appreciation of their concerns. The SCWs' own language and how questions are asked can make it easier for an older person to open up and share concerns.

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

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

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

**Training and Development**

In conjunction with the National Steering Committee for Elder Abuse, Senior Case Workers contribute to the development of operational policies and procedures for assessment, identification, intervention and protection in cases of suspected elder abuse. Senior Case Workers also offer advice and information and provide training as required. They participate in the design and development of awareness raising and training modules and deliver these modules to relevant stakeholders. This training contributes to continual professional development and reflects current knowledge of best practice. The training is provided at a local and national level to anybody working with older people in either the HSE or the private/voluntary sector.

Senior Case Workers also contribute to the review and strategic development of services provided along the continuum of care.

# 2.0 HSE Elder Abuse Working Groups

The National Elder Abuse Steering Committee comprises 28 members from a variety of organisations/ agencies. The full membership is listed in Appendix One. While the Group was established in 2007, the membership has changed over the years in response to developments and challenges. The Committee oversees and ensures a nationally consistent approach in the provision of elder abuse services delivered by the HSE. The National Elder Abuse Steering Committee is responsible for implementing the recommendations arising out of the report of the Working Group on Elder Abuse, *Protecting Our Future*[1], as well as examining and acting on recommendations outlined in relevant subsequent publications. These include national reports such as the *Review of Protecting Our Future*[2], various NCPOP research and publications and international reports. To address the various challenges and emerging issues related to elder abuse the National Elder Abuse Steering Committee established a number of working groups in 2013 with particular expertise and skills in the required areas.

The various working groups were:

- Media and Public Awareness
- Staff Awareness and Curricula
- Staff Resident Interactions in Residential Care Services
- Financial Abuse of Older Persons.

In addition, the National Elder Abuse Steering Committee assisted, through one of its members, in the drafting of a Vulnerable Adults Policy which is likely to be made available in 2014.

The activities of the above Working Groups during 2013 are outlined below.

## 2.1 Media and Public Awareness Working Group

National and international research studies consistently and universally advocate the importance of increasing elder abuse awareness and education. Indeed, many studies have proposed that awareness raising and education are the most powerful weapons in the battle against elder abuse. Many people do not recognise their own behaviours, or that of others, as abusive. Indeed, many of the Senior Case Workers for the Protection of Older People have observed that even pointing out that an individual's behaviour is abusive may be sufficient to stop the unwanted behaviour.

Media and public awareness campaigns have been a feature of the HSE elder abuse service since its inception in 2007. These campaigns have helped highlight the issue of elder abuse, increase knowledge and understanding of the issue and assist older people to speak out about abuse. During these campaigns, the topic of elder abuse has been publicised through a variety of media, including newspapers, television and radio.

The effect of these efforts has been evident across society. Community and voluntary agencies, including older person advocacy organisations, now include elder abuse as part of the training for staff and organise information sessions on the issue. Many professional bodies have added elder abuse as a module in their continuing education programmes and have invited Senior Case Workers for the Protection of Older People to address members in recognition of the importance of the issue. One of the most obvious indicators of the effectiveness of the awareness raising efforts has been the increase in the level of referrals to the HSE elder abuse service over the past seven years.

Referrals of alleged elder abuse have increased each year since this data has been gathered. A total of 2,437 referrals were received into the service in 2013, an increase of almost 32% since 2008 which recorded 1,840 referrals. Of the main abuse types referred, there has been a significant increase in referrals of financial abuse, both in real terms and as a percentage of overall referrals from 16% in 2008 to 22% in 2013. This can be partly contributed to the increased awareness of this type of abuse as a result of targeted information campaigns.

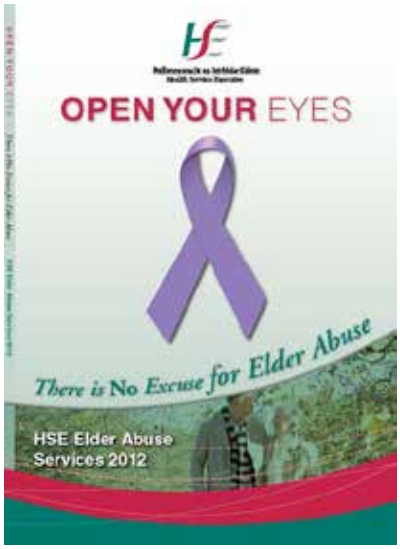
Although the rising referral rate over the past number of years is indicative of a growing awareness of the issue of elder abuse and the services available, it nonetheless remains that elder abuse, as an issue in society, is under-reported. The NCPOP's prevalence report[4] suggests prevalence rates of 2.2% or 10,000 older people experiencing abuse in a 12 month period. With referrals to the HSE at less than one third of this, further efforts are required to promote prevention, expand the recognition and understanding of elder abuse, inform on the dedicated structures available for reporting concerns and the pathways and means for obtaining support.

### 2.1.1 Campaign Elements

Despite the budgetary challenges facing the HSE, its elder abuse service undertook key activities designed to maximise recognition, response, awareness and understanding among the general public/community groups as well as media exposure. These activities consisted of:

- Launch of *'Open Your Eyes, HSE Elder Abuse Services 2012'*[5] publication.
- Development and distribution of *A Guide to Organising a Group Viewing of the 'Open Your Eyes to Elder Abuse in Your Community'*[6] *DVD*
- National Elder Abuse Conference to mark *World Elder Abuse Awareness Day, June 15th* in University College Dublin on June 13th, in collaboration with the National Centre for the Protection of Older People (NCPOP), and the International Network for the Prevention of Elder Abuse (INPEA).

### 2.1.2 Open Your Eyes, HSE Elder Abuse Services 2012




The publication of the *Open Your Eyes HSE Elder Abuse Services 2012*[5] document had two objectives. Firstly, it provided information on the developments in the elder abuse service and detailed the efforts and advances in areas such as awareness raising and training. The work of the National Centre for the Protection of Older People was also reviewed along with its research projects that added to our understanding of elder abuse and guided policy and service direction.

Secondly, the document provided a detailed analysis of the elder abuse referrals received into the service in 2012.

◄ *'Open Your Eyes HSE Elder Abuse Services 2012'*[5] *document.*

Data relating to referrals of alleged elder abuse to the HSE have been collected since 2007, with 2008 representing the first full year of data collection. Analysing referral data assists the HSE to estimate the extent of elder abuse in Ireland as well as estimating the extent of under-reporting. The data also provides a detailed breakdown of the different types of abuse perpetrated in Ireland, insights into issues of concern for those causing abuse, along with outcomes and details of supports offered. This analysis feeds into service delivery and performance monitoring.

The *Open Your Eyes HSE Elder Abuse Services 2012*[5] document was published in July, 2013. The report generated significant media attention and several press and radio interviews were conducted following its release. Commenting on the report, Minister of State with responsibility for Older People, Ms. Kathleen Lynch T.D. said: *"It's disturbing that a small number of older people should suffer abuse in this country. However, there are services available for those people and it is encouraging that a greater number of older people are coming forward each year to voice their concerns. I would urge anyone who is concerned about abuse to seek help and support from the HSE which has a dedicated service in place for older people experiencing abuse. I would like to acknowledge our partners in the community, voluntary and business sectors who are continuing to work closely with the HSE to respond to elder abuse and who are committed to meeting the challenges ahead."*

The full report is available to download from the HSE wesbite at www.hse.ie

### 2.1.3 A Guide to Organising a Group Viewing of the 'Open Your Eyes to Elder Abuse in Your Community' DVD


In 2011, the HSE undertook an evaluation of the core materials used in its 2010 elder abuse awareness campaign, namely the community DVD, '*Open Your Eyes to Elder Abuse in Your Community*'[6], and the information booklet. The Irish research company, Millward Brown Lansdowne, was commissioned to conduct the qualitative research.

The evaluation by Millward Brown Landsdowne of the DVD highlighted a number of key points that included the requirement for a one *page "how to use the DVD"* to be part of future dissemination.

Although the DVD was designed so that no specialist experience or training is required to deliver a viewing to a group, it was recognised that, following the evaluation findings, a brief guide to assist facilitators in voluntary and community groups to organise viewings of the DVD would prove beneficial.

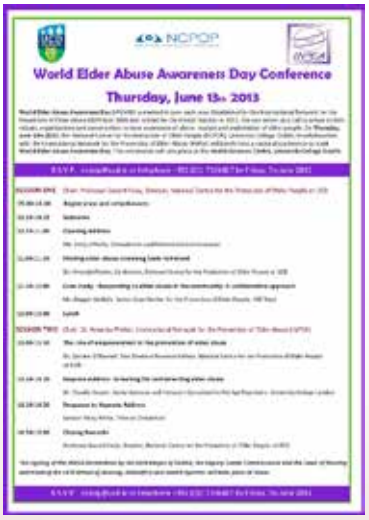
The guide, which was developed by HSE Dedicated Officers in consultation with the Senior Case Workers, is divided into a number of sections covering:

- advice on how to prepare and plan for a viewing,
- how to conduct the viewing,
- how to manage discussion / questions post viewing, and
- considerations for specific groups (carers, caring for people with dementia and older people)

The guide was widely distributed in early 2013 to organisations who had previously received the DVD. A guide now accompanies every community DVD requested.

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

World Elder Abuse Awareness Day (WEAAD) was instigated by the International Network for the Prevention of Elder Abuse (INPEA) to raise awareness of elder abuse and to promote comprehensive global responses. The day, which is held annually on June 15th, is in support of the United Nations International Plan of Action which recognises the significance of elder abuse as a public health and human rights concern. World Elder Abuse Awareness Day has been ratified by the United Nations.


World Elder Abuse Awareness Day Conference
Thursday, June 13th 2013

▲ *Open Your Eyes' National Elder Abuse Conference Programme*

The day serves as a call to action for all individuals, organisations and communities to raise awareness about abuse, neglect and exploitation of older people. Numerous events and activities are organised globally to mark the day.

For the past four years, a national conference has been organised jointly by the HSE, the National Centre for the Protection of Older People (NCPOP) and the International Network for the Prevention of Elder Abuse (INPEA). In 2013, the event, which was held in the Health Sciences Centre, UCD, took place on Thursday, June 13th.

The conference affords professionals, voluntary and community groups, as well as the general public, the opportunity to come together to broaden their understanding and to learn about developments in addressing and preventing elder abuse, both in a national and international context.

***Opening Address***

The conference was opened by Mr. David Nutley, Senior Investigator at the Office of the Ombudsman. Mr. Nutley challenged society's perception of ageing. Age is not a limiter. People nowadays are living longer and continue to lead full and active lives. However, some older people have challenges to face but with support, they can be empowered to overcome these.

Mr. Nutley spoke about domestic abuse and child abuse and how these abuses had remained hidden from society. It is only when people speak out about experiences can the veil of secrecy and shame be removed. With awareness comes change, improved services and policies. Mr. Nutley stressed the duty that society, as a whole, has to respond. As elder abuse does not have the same high profile as domestic or child abuse, it is even more incumbent on us to enable and empower older people to come forward, voice concerns and put in place supports to offer a life free from fear and one filled with hope, dignity and respect.

*'Pictured left to right are Dr. Attracta Lafferty, NCPOP; Ms. Brenda Hannon, HSE; Ms. Maggie McNally, HSE; Dr. Deirdre O'Donnell, NCPOPl; Mr. David Nutley, Office of the Ombudsman; Dr. Mary Casey, UCD; Professor Gerard Fealy, NCPOP.*

***Elder Abuse Screening Tools***

To assist with identifying and uncovering elder abuse within society, Dr. Amanda Phelan, Co-Director of the NCPOP and the Irish INPEA representative, profiled the work undertaken in assessing the suitability of using internationally recognised screening tools in an Irish setting. Screening has been used primarily in a medical context, examining the distribution of diseases that follow typical pathways to allow for early detection and optimise treatment outcomes. Elder abuse is more complex, in that not only does it involve the person, it also encompasses the various social, economic and political issues that can have a bearing on the individual. Screening tools, therefore, have to be sensitive to the various influences at play.

Given this, screening has been demonstrated internationally to highlight cases of abuse or potential abuse that have enabled interventions at early stages, thus producing positive outcomes for older people. Screening tools have also been shown to highlight potential abuse even when older people themselves do not recognise behaviours as such.

Elder abuse screening tools can be a vital component to case finding. These standardised questionnaires stimulate an analysis of the older person's situation. Uncovering potential or existing elder abuse can enable effective treatment options to be put in place at an early stage and can result in better outcomes for the older person. In all cases, the perspective of the older person should be taken into account and any action must give consideration to the degree of happiness for the older person. Similar to the principles contained within *Children First*[7], no action should be taken that would be detrimental to the older person.

## OPEN YOUR EYES

Two screening tools are currently under examination to determine their reliability in an Irish context. The tools involved are the *Canadian Elder Abuse Suspicion Index (EASI)*[8] and the *Older Adult Financial Exploitation Measure (OAFEM)*[9] developed in Chicago. A mixture of cognitive interviewing and surveys has been employed to review the instruments. In addition, criteria have been set to determine the inclusion or non-inclusion of participants in the study. Both the acute and community, and urban and rural settings are represented.

Dr. Phelan summed up her presentation by asking what society we wished to live in. One that chooses to be blessed to have time to spend with older people or one that chooses to discard older people leaving them alone and un-cherished.

▲ *Delegates at the National Elder Abuse Conference marking World Elder Abuse Awareness Day 2013*

***Addressing Elder Abuse – A Collaborative Approach***

Senior Case Worker for the Protection of Older People, Ms. Maggie McNally, outlined the collaborative approach adopted by the HSE in addressing referrals of elder abuse. She offered two definitions of collaborative working with the key elements being shared planning, decision-making and problem solving, with an emphasis on communication, co-operation and reducing the risk to the older person.

Elder abuse cases can be very complex, with no single agency able to put together all the pieces of the puzzle that can effectively resolve the issues facing the older person. These complex cases may require the input of many services and agencies to offer the older person a comprehensive suite of interventions that can address their situation. In these cases, working alone may not be effective or optimal. In addition, the older person cannot be expected to navigate the various service structures in an effort to access supports, particularly if they are in an abusive situation.

Ms. McNally detailed the HSE case process which comprises referral, assessment, planning, intervention and review and she presented a sample case to demonstrate the process and highlight collaborative working in operation.

Critical to the concept of collaborative working is a requirement for different agencies and services to come together in a case conference. The older person, where possible, should attend also. At these case conferences, information is exchanged, risk level determined and an action plan is formulated. Depending on the needs of the older person, a multitude of services and agencies can be involved. This can require a significant level of communication, cooperation and co-ordination between the various agencies/services.

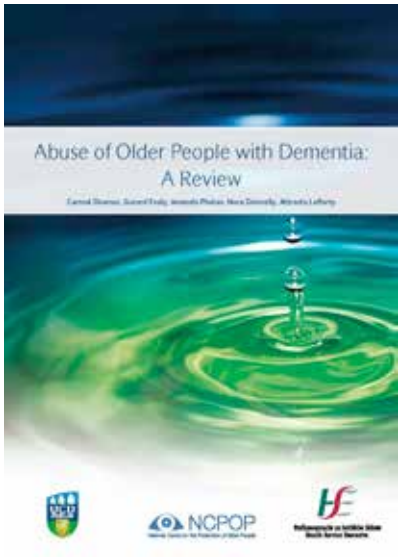
Collaborative working offers a number of benefits. Not only does it contribute to enhanced and improved outcomes for the older person, it also offers the opportunity for strengthening partnerships and breaking down professional barriers. Cross-agency co-operation improves understanding and awareness of the issues faced by the individual agencies and other services. In addition, increased collaboration improves problem solving and increases staff morale by supporting professionals who might otherwise work in isolation.

The challenges to this type of working are the time and commitment involved. Communication can be difficult when dealing with a number of services and agencies. Adapting to the professional language protocols of each service/agency can be demanding, There is also the risk of an over reliance on referring on and not enough direct action.

Despite the possible pitfalls, collaborative working offers a degree of protection for an older person from ‘falling through the cracks’, provides appropriate and timely supports with reduced working at cross purposes and wasteful overlap or duplication of services. More importantly, it places the older person at the centre of care.

## OPEN YOUR EYES

*Launch of the NCPOP 'Abuse of Older People with Dementia – A Review'*




The afternoon session commenced with the launch of the National Centre for the Protection of Older People's report '*Abuse of Older People with Dementia – A Review*'[10]. Referring to the report, Professor Gerard Fealy, Centre Director, commented: '*There is still a considerable gap in our knowledge of abuse in people with dementia and further research is needed to ascertain which preventative measures and interventions are the most effective in comprehensively addressing abuse in this group of at-risk older people*'.

The aim of the report was to collate, analyse and summarise published literature on abuse of community-dwelling older people with dementia, in order to inform future research.

➤ *NCPOP publication, Abuse of Older People with Dementia: A Review*

There are 41,740 people with dementia in Ireland, most of whom are over 65 years of age. A significant proportion of these older people, 23,058, live in the community where care is provided, in the main, by family caregivers, within an embryonic and disjointed community support services infrastructure. It is widely accepted that the effects of dementia can render older people more susceptible to exploitation by others and can severely impair their ability to seek help, advocate for themselves or remove themselves from potentially abusive situations.

Studies have revealed a higher level of prevalence of abuse among older people with dementia as compared to the general population of community-dwelling older people. However, research on abuse of older people with dementia has tended to focus on psychological and physical abuse and, to a lesser extent, neglect, largely overlooking other types of abuse such as financial abuse which is the most common.

This review affirms the research literatures findings that disruptive or aggressive behaviour by older persons with dementia and the related burden experienced by the caregiver are significant risk factors in abuse.

Ascertaining the risk factors that contribute to a higher risk of abuse or neglect in an older person with dementia is important in order to offer appropriate screening for elder abuse and to deliver effective interventions to prevent or ameliorate its occurrence.

Healthcare professionals who routinely come into contact with older people and their carers have a significant role to play in detecting abuse. Although to date no abuse screening tools have been developed or validated to use with older people with dementia, screening, nonetheless, is recommended. To assist health and social care professionals, guidelines to facilitate the determination of cognitive or decisional capacity in the context of abuse prevention should be developed.

This review offers an important source of existing research on abuse of older people with dementia in the community. The review highlights the need for further work in this area, in particular the need to ascertain which preventative measures and interventions are most effective in comprehensively addressing elder abuse of people with dementia.

***The Role of Empowerment in the Prevention of Elder Abuse***

Dr. Deirdre O'Donnell, National Centre for the Protection of Older People, examined how empowering older people can lead to better outcomes resulting in a better quality of life. Dr. O'Donnell offered the Cochrane definition of empowerment - "*the intentional, dynamic and ongoing process, centred in the local community, involving mutual respect, critical reflection, caring and group participation, through which people, lacking an equal share of valuable resources, gain greater access to and control over these resources".*[11]

Valuable resources include finance, housing, health, transport, information, knowledge, environment and psychological considerations such as self-esteem, problem solving skills, etc. The distribution of power over these valuable resources is not equal in society.

Central to control over these resources is choice. Self-mastery, self-determination and capacity to make choices and realise decisions for ones-self are critical elements of empowerment as they demonstrate the ability to access, mobilise and control resources.

*Pictured left to right; Assistant Garda Commissioner John Nolan with Ms. Maggie McNally, HSE greeting Dr. Deirdre O'Donnell, NCPOP*

There are three identified domains to empowerment, namely intrapersonal, interactional and socio-political.

The intrapersonal domain refers to the individual and a sense of self-belief or self-esteem that, through ones own efforts, one can attain goals. The interactional domain deals with awareness regarding services and resources and knowledge on how to mobilise and utilise these resources. The socio-political domain looks at behavioural change - translating intention into action and exerting control.

To translate the model of empowerment for older people we need to take a strengths-based perspective. Outcomes of well-being can be achieved when the older person can chose their own goals, utilising their own strengths and resources to attain these goals. The dilemma facing practitioners wishing to devise interventions is balancing concerns of risk and vulnerability, coupled with the issue of capacity and the need to foster self-determination with the duty and desire to protect from abuse.

The study currently being undertaken by the NCPOP is that of developing a definition of later life empowerment (phase one) and designing an intervention that would enable older people to protect themselves (phase two).

Phase One, which is almost complete, consisted of a number of focus group discussions as well as analysis of qualitative interview data of elder abuse survivors to understand later life empowerment and the role that power and empowerment plays in the experience of abuse. The data is currently being compiled but initial findings are supporting the key concepts of empowerment, such as awareness and education

(interactional); ability and confidence to speak out (intrapersonal); and a belief that change can happen and that older people can influence their environment (socio-political).

For Phase Two, it was decided to design an intervention which would empower older people to protect themselves from elder abuse, and specifically, financial abuse. The proposed intervention will be grounded in the principles of autonomy, respectful consultation and preventative pro-action. The intervention is expected to be completed by June 2014.

Appropriate empowerment interventions can enable older people to gain control over aspects of their lives and influence decisions that affect their quality of life and well-being. These interventions should support a participative process which is driven by the older person. The outcomes of these interventions should reveal the consequences of empowerment, giving the older person a sense of mastery, resource mobilisation skills, an understanding of the socio-political context, situation specific perceived control and increased social participation.

***Keynote Speaker: Screening for and Detecting Elder Abuse***

Dr Claudia Cooper, Senior Lecturer and Honorary Consultant in Old Age Psychiatry at University College London, spoke about detecting elder abuse and explored the factors that contribute to behaviours becoming abusive.

Dr. Cooper outlined that, in her years as a junior doctor, had become concerned about the management of elder abuse cases. Clear cases of elder abuse were referred to the appropriate services and thoroughly investigated. However, when speaking with carers and family members, it became clear that the lines of what constituted elder abuse were blurred. Stressful situations were resulting in inappropriate responses towards the person in care. These didn't fit into any predefined model of elder abuse. However, these needed to be explored and questions asked, even if all the answers hadn't been developed as yet.

As part of Dr. Cooper's research to identify the traits and events that exert pressure on the caring relationship, she undertook *The Carers for People with Memory Problems Study* (CARD study)[12]. This study was the first to examine rates of abuse and the factors associated with abuse in a representative population of carers of people with dementia. To determine the study's hypothesis, a literature review was carried out. This revealed that carers of people with dementia who are more anxious, exhibit dysfunctional coping strategies and who experience greater carer burden are more likely to report more abusive behaviours.

*◄ 'Delegates at the National Elder Abuse Conference marking World Elder Abuse Awareness Day 2013*

The study invited carers who were providing at least four hours of care a week to a person in their own home to participate in the study. The carers were interviewed to explore areas such as coping skills, how much burden they experienced, feelings of anxiety or depression and the ability of the person in their care to carry our activities of daily living. The carers also completed a Modified Conflict Tactics Scale as a measure of abuse.

Most carers reported some form of abuse but this varied across a spectrum from shouting / yelling or using a harsh tone of voice at the lower end, to threatening or causing physical harm at the upper end. The reporting of severe abuse was rare but the existence of some abuse was common. The study also examined the traits and coping mechanisms of carers. It found that carers who were highly burdened, less happy with services, anxious or depressed were more likely to engage in abusive behaviours. In addition, the more disruptive or demanding the person with dementia, the greater the stress that was placed on the relationship and, consequently, the higher the risk was of abuse. The study also found that the coping strategies employed by carers impacted on the risk of abuse, with those who demonstrated pro-active strategies such as seeking assistance, respite or additional services at less risk of engaging in abusive behaviours as against those who displayed dysfunctional coping strategies such as venting, being in denial or despair.

This research led to another study, the *Cost effectiveness of a manual based coping strategy programme in promoting the mental health of family carers of people with dementia (the START (STrAtegies for RelaTives) study): a pragmatic randomised controlled trial*[13]. This study examined if the risk of abuse or abusive behaviour could be reduced by providing carers with a coping base to better prepare them for their caring role. Could carers, who are more anxious and experience greater carer burden, be trained to cope more pro-actively and thus lessen the likelihood of abuse? In the CARD study, participants reported a year on that the incidence of abusive behaviours had increased. Behaviours, which were considered mildly abusive at the time of the study, had escalated. Lack of interventions at an early stage was identified as a causal factor. The increase in abuse also resulted in a corresponding increase in reported anxiety and depression, symptoms of dysfunctional coping strategies.

It is expected that the START study, would provide more information on the effectiveness of interventions on coping strategies and on the incidence of abuse and abusive behaviours following these.

Elder abuse among professionals is underdetected, underreported and underestimated. The need to improve the detecting and reporting of elder abuse among healthcare professionals was the subject of a study by Dr. Cooper. In that study Dr. Cooper and her team examined the effect of adding elder abuse training to the mandatory education of junior doctors.

During the study, Dr. Cooper found that only 40% of doctors who worked with older people detected elder abuse in the past year and that only half of these were reported. A group of 40 trainee psychologists were selected for the study. They were assessed on the knowledge and management of elder abuse, as well as undertaking a caregiver scenario questionnaire. They then underwent a 20 minute presentation on elder abuse. All participants improved both their knowledge and identification of elder abuse. In addition, a greater level of confidence was expressed in the management of elder abuse. However, this did not translate into action as there was no increase in older people or their carers being asked about abuse. Some of the reasons for this was a fear of causing offence, fear of harming the therapeutic relationship and, for people with dementia, being unsure how to ask.

The study highlights the need to consider more complex interventions to change behaviour and improve the questioning and communication skills of health professionals.

In the final study presented by Dr. Cooper, abusive behaviour in care homes was examined. A total of 36 care workers in four care homes participated in the study. These homes were considered to be of average to good quality.

The key barriers experienced to delivering good quality care were time and lack of sufficient training to deal with challenging behaviours/situations. The lack of time was highlighted as impacting on care as carers felt that residents were left waiting for personal care which could result in an incident that could affect the residents' dignity. Additionally, lack of time resulted in a number of shortcuts being used and this can result in dangerous practices. Also, lack of time may lead to residents' emotional needs being neglected as time to chat or interact with residents is not possible. Carers also highlighted the lack of skills in dealing with difficult situations. This has resulted in inappropriate care practices such as the misuse of restraints or threatening behaviour from carers.

More research into care and practices in care homes is needed. Lack of resources, especially care worker time, and knowledge about managing challenging behaviour and dementia were judged to be important underlying reasons behind the instances of abuse described within the study.

It is apparent that the causes of elder abuse are complex but that early intervention can offer an opportunity to address these and support relationships. More work is needed to identify effective educational and training interventions for healthcare professionals to enable improved detection and reporting of elder abuse. Much progress has been achieved in combating elder abuse, but there is much to be done to improve our understanding of this issue and to design and implement interventions that will be effective and offer solutions for older people and their carers.

***HSE Response***

Mr. Paschal Moynihan, Specialist, Older Person Services, HSE West and member of the HSE National Elder Abuse Steering Committee delivered the response to the conference and keynote address. Mr. Moynihan praised the informative and interesting topics delivered by the day's speakers and acknowledged that the presentations provoked questions and challenges for those involved in the planning and delivery of services. However, he was confident that all would leave the conference with renewed vigour and enthusiasm for the challenges ahead.

He stressed the importance of the conference, not only as a shared learning forum but also as an awareness tool and urged delegates to spread the knowledge gained from the day.

In reference to Dr. Cooper's address, Mr. Moynihan commented about the study on the training intervention designed for trainee psychologists. He noted the positive outcomes from the intervention expressed by the trainees such as increased awareness, knowledge and confidence to address elder abuse but also noted the continued reluctance to ask about abuse. He stressed the importance of providing, in tandem with awareness sessions on the issue, supports to address elder abuse and guidance on how to refer on concerns, taking into account the needs and wishes of the older person. Training and awareness are important elements in combating abuse and have been central to efforts of the HSE and the NCPOP in combating abuse.

Findings from Dr. Cooper's study on abuse in care homes cited the lack of resources, time and difficulty in managing challenging behaviour as issues that contribute to abusive practices and behaviours. Dr. Cooper's study on family carers caring for people with dementia also reported that carers admitted to engaging in abuse behaviours. The most common form of physical abuse reported was screaming / yelling or using a harsh tone of voice, while the more severe forms were least reported such as slapping or hitting. Mr. Moynihan questioned if the small reported incidence of this type of abuse was due to the 'consent' for participating in the study. The consent stated that confidentiality would be respected except where an older person was being seriously harmed.

Both studies by Dr. Cooper pointed to similar predicators of abuse such as carer anxiety and carer burden, together and the hours of care provided. The studies also outlined strategies for addressing these factors such as improving the coping skills of carers and treatment for carers suffering depression and anxiety. Mr. Moynihan acknowledged supports for carers should be improved and efforts made to reduce the burden of care.

Mr. Moynihan noted that Dr. Cooper's studies echoed the findings of the NCPOP's study *Older People in Residential Care Settings; Results of a National Survey of Staff-Resident Interactions and Conflicts*[14]. The studies were consistent in that issues including carer stress, lack of supports and training deficits contribute to the likelihood of abuse.

*Conference Attendance*

A large cross-section of society was represented at the National Elder Abuse Conference with delegates from the HSE, private nursing homes, An Garda Síochána, the Department of Social Protection, the Department of Justice and Equality, and older persons' voluntary and community groups.

◄ *Delegates at the National Elder Abuse Conference marking World Elder Abuse Awareness Day 2013*

A total of 206 delegates attended the national conference. This was down slightly (7%) from last year. However, 197 people connected to the conference via live streaming on the National Centre for the Protection of Older People's website. This demonstrates the importance of enabling alternative access to the conference and the significant level of interest in elder abuse.

*Purple Ribbon*

Delegates were again encouraged to show their support for World Elder Abuse Awareness Day by wearing a purple ribbon. These were distributed at registration. The purple ribbon is recognised internationally as an emblem supporting the fight against elder abuse and it is hoped to promote the wearing of the purple ribbon or the colour purple among healthcare staff and the general public on and around June 15th.


▲ *'World Elder Abuse Awareness Day Purple Ribbons*

The signing of a Declaration Against Elder Abuse is promoted by the International Network for the Prevention of Elder Abuse as a public and highly visible means for

senior figures in public life to demonstrate their commitment to address elder abuse.

▲ *World Elder Abuse Awareness Day Signing of the INPEA Proclamation Against Elder Abuse. Pictured from left to right (back): Ms. Brenda Hannon, HSE; Professor Gerard Fealy, NCPOP; Dr. Amanda Phelan, UCD; Dr. Mary Casey, UCD; Dr. Attracta Laferty,*


*NCPOP;(front) Lord Mayor of Dublin, Councillor Naoise Ó Muirí; Assistant Commissioner of An Garda Síochána John Nolan*

As part of the conference proceedings, the Lord Mayor of Dublin, Councilor Naoise Ó Muirí; Assistant Commissioner of An Garda Síochána, John Nolan and Dr. Mary Casey, lecturer in the School of Nursing (attending on behalf of Dr. Martin McNamara, Dean and Head of the UCD School of Nursing, Midwifery & Health Systems) signed the INPEA Proclamation Against Elder Abuse.

*Exhibition Area*

A number of information stands were also available on the day to allow delegates to browse information on a number of voluntary organisations that provide services to older people. Organisations that hosted information stands were Age Action Ireland, Third Age, Caring for Carers Ireland, Alzheimer Society of Ireland and The Carers Association. An Garda Síochána were also represented to provide information on their community policing service.


*Exhibition Area at the National Conference marking World Elder Abuse Awareness Day 2013* ▲

The NCPOP's stand provided access to delegates to their many research publications while HSE Senior Case Workers for the Protection of Older People were in attendance at the HSE stand to discuss the elder

abuse service or any concerns in an informal setting.

*Conference Evaluation*
Of the 206 delegates at the conference, 43.2% completed an evaluation form. 70% rated the conference as very important with 87% stating that the conference increased their knowledge of elder abuse.

### 2.1.5 Advertising & Publicity

Press releases were issued in advance of the publication of the HSE elder abuse services document for 2013 and the national conference. Both these events generated significant media interest with a number of articles published and media interviews conducted at local, regional and national level.

### 2.1.6 HSE Website – Elder Abuse Section

The HSE website hosts a dedicated section that provides information and resources on elder abuse. HSE elder abuse publications can be viewed online or downloaded. Access is also given to the community awareness DVD. In addition, the section also provides contact details for Senior Case Workers, the HSE Information Line and contact information for the ordering of materials and general queries.


▲ *HSE Elder Abuse Section on www.hse.ie*

To access the elder abuse section on the HSE website, please follow the following URL (address) www.hse.ie/go/elderabuse

The website has continued to prove to be a valuable information resource with the HSE elder abuse section accessed 43,039 times in 2013, an increase of over 24% from 2012.

### 2.1.7 The HSE Information Line

The HSE Information Line provides the public with easy access to information on a range of health and social service topics. The Information Line can provide callers with the details of HSE staff in local areas that can assist with elder abuse concerns or refer these concerns to the relevant Senior Case Worker for the Protection of Older People. The line, which can be accessed on 1850 24 1850, operates Monday to Saturday, 8am to 8pm.

All publicity, information and education material features the HSE Information Line.

The HSE Information Line received a total of 334 calls relating to elder abuse in 2013.

## 2.2 HSE Staff Awareness and Curricula Working Group

The HSE elder abuse service continues to be the main provider of elder abuse training for all agencies providing services for older people. This section outlines training that took place in 2013, in a variety of sectors across many disciplines, and provides an overview of those agencies that were specifically targeted in 2013 for elder abuse training.

### 2.2.1 HSE Elder Abuse Training

The elder abuse training provided by the HSE comprises primarily of two half day courses.

***Recognising and Responding to Elder Abuse in Residential Care Settings***
This training programme, which utilises the DVD and training workbook, is aimed at all staff working in residential care settings such as those in private nursing homes, public long stay facilities and voluntary centres.

The training programme has been designed to:

- Increase knowledge and understanding of what elder abuse is
- Help staff identify care practices that might lead to or contribute to elder abuse
- Help staff recognise elder abuse
- Explain the actions that need to be taken if it is suspected that elder abuse is taking place

***Elder abuse awareness raising workshop***
The Level I elder abuse workshop is a half day (3 hours) basic level training workshop aimed at those working within health and social care services for older persons, in particular, HSE Staff from community, acute and mental health services, nursing home staff and voluntary agencies providing services for older persons.

The aim of this half day workshop is to increase participants' awareness and knowledge of elder abuse and ensure they are in a better position to recognise it and report concerns.

*Objectives*
By the end of the workshop participants are expected to have:

- Discussed and defined what is meant by the term 'elder abuse'.
- Received information on the scale of the problem in Ireland and an overview of elder abuse referrals received by the HSE.
- Examined the different types of elder abuse and indicators of each.
- A better understanding of how to recognise when elder abuse may be taking place.
- Received the HSE policy *'Responding to Allegations of Elder Abuse'*[15] and discussed their own responsibilities under this policy (HSE participants only).
- Considered the underlying principles within which all elder abuse responses should be framed.
- A clear understanding of how and where to report concerns of elder abuse.

In addition to the above course, the elder abuse service also offers *Train the Trainer* (TTT) courses to enable services and organisations to become self-sufficient in the delivery of elder abuse training to staff.

The training figures presented herein include courses delivered directly by the HSE service (Dedicated Officers and Senior Case Workers) as well as that which is delivered by TTT recipients – those who have completed the TTT training and are now directly delivering elder abuse courses in their own workplaces. All participants completing TTT courses are asked to communicate with the Dedicated Officers in the HSE in relation to the delivery of training. This takes the form of completing standardised feedback forms on each session delivered and allows the HSE to include those courses in training figures presented here.

***Elder Abuse Awareness Raising Workshops / Presentations***
In addition to the standardised course mentioned above, the elder abuse service also responds to numerous requests for elder abuse awareness raising workshops from many groups and organisations. These figures are also presented below.

### 2.2.2 2013 Training Figures

In 2013, 8,695 individuals attended elder abuse training/awareness raising. This is an increase of 2,472 compared with 2012. Since training records began in 2007, a total 38,959 individuals have received elder abuse training. Figure 1 shows the breakdown of this training by HSE area.

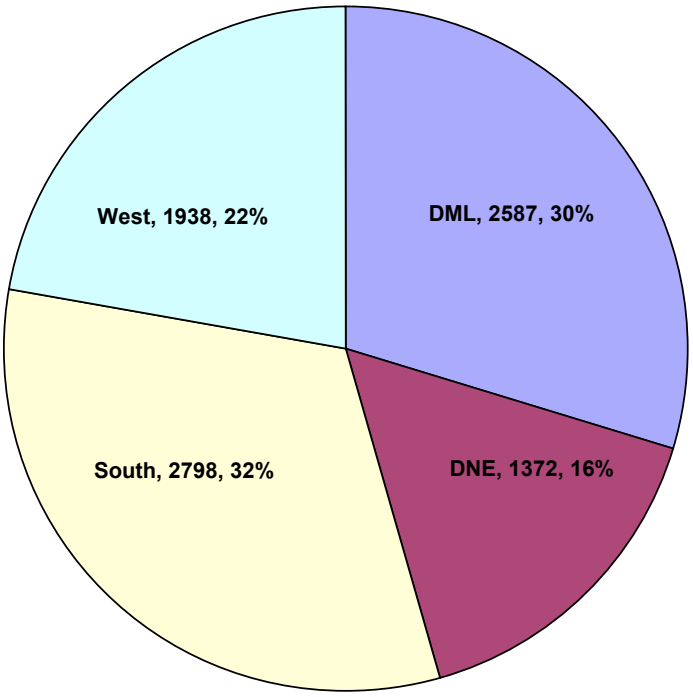



**Fig 1: Training Participants by HSE Area**

***Profile of training attendees***
The distribution of attendees from across HSE areas varied from 16% in HSE DNE to 32% in HSE South. The highest number of training attendees from any one Local Health Office area was 697 in Cork North Lee (Fig. 2).

44% of attendees were HSE Staff and a further 34% work in the private sector. The Community and Voluntary sectors were represented by 16% of attendees (7% and 9% respectively). The profile of attendees by sector remains consistent with last year with one exception. The number of attendees within the community and voluntary sector has decreased from 22% in 2012 to 16% in 2013 (Fig 3). Support workers comprising of home helps, home care workers, care assistants and nurses aids represented the largest employee grouping attending training at 44% followed by nursing 26%. (See Fig 4 and Table 1)

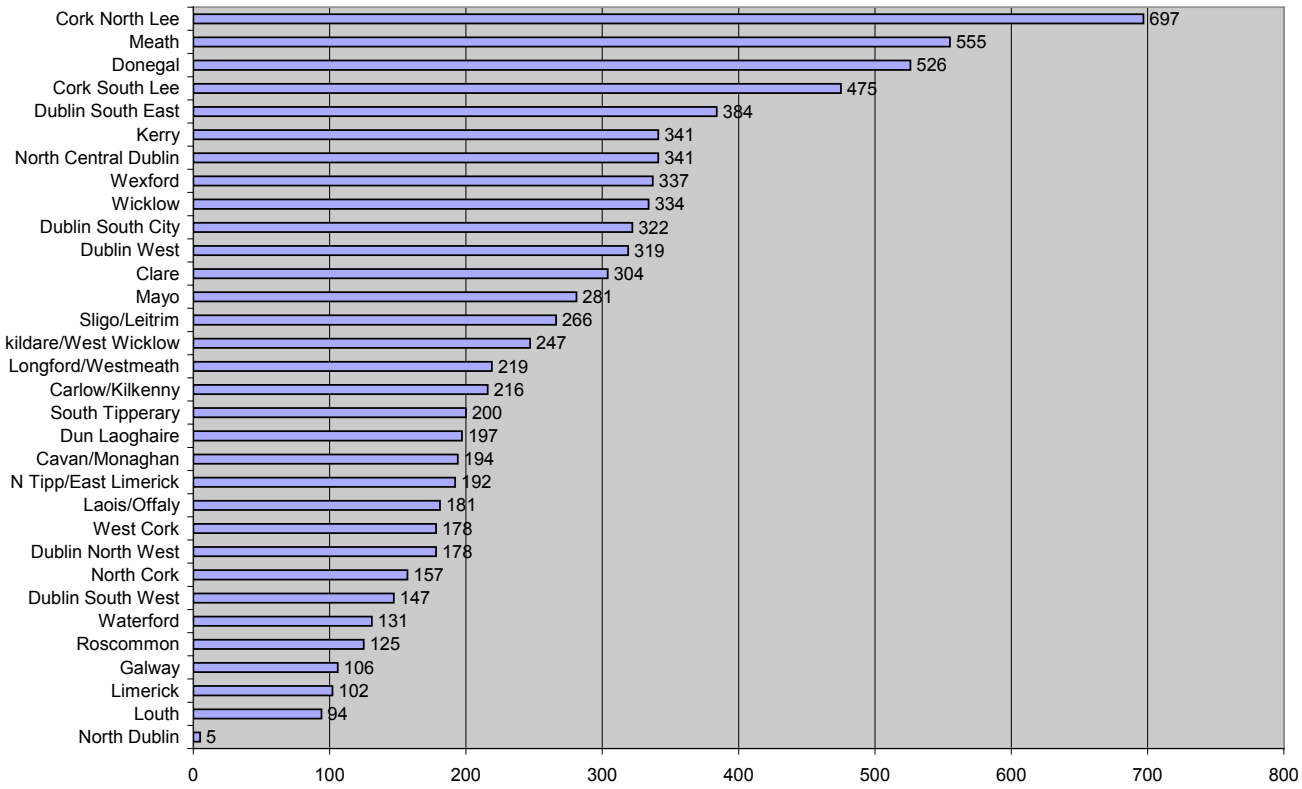



**Fig. 2: Number of training participants by Local Health Office Area (LHO)**

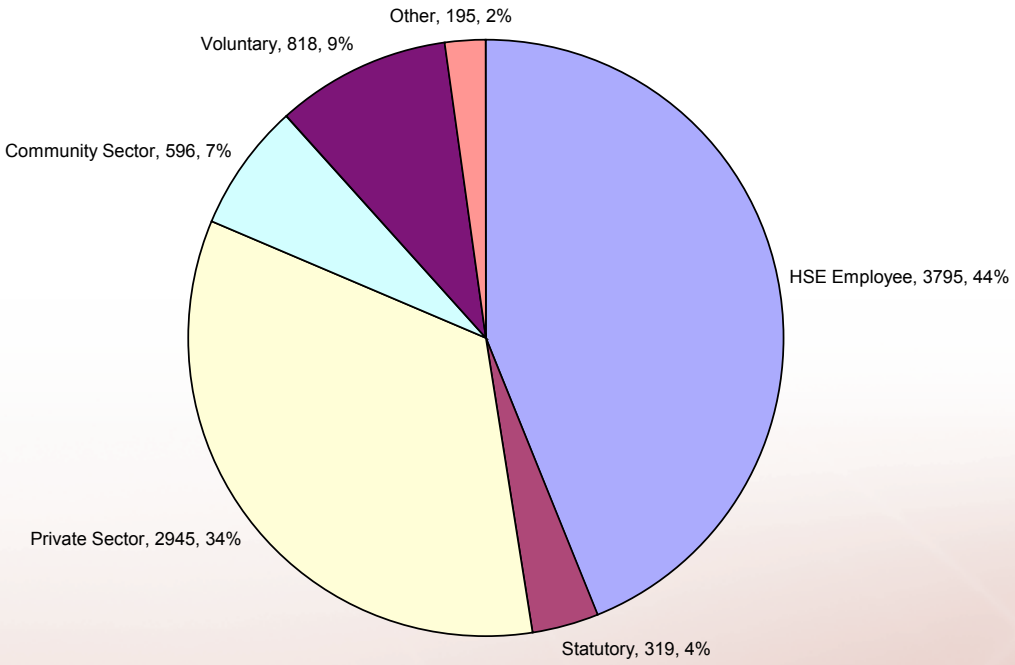



**Fig 3: Training participants by Employment Sector**

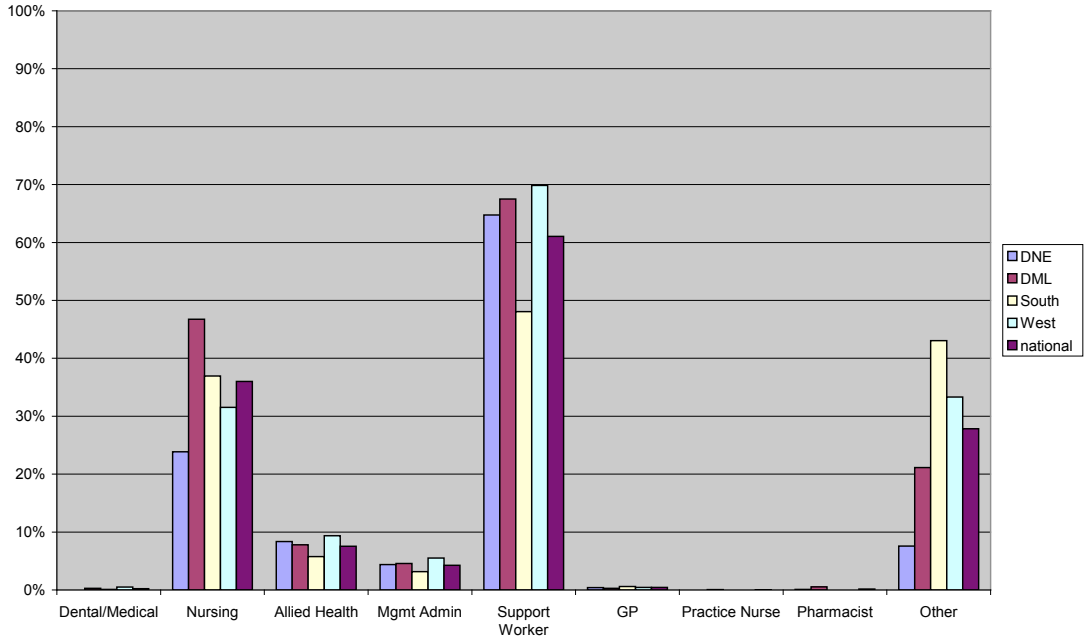



**Fig 4: Training participants by job description**

**Table 1: National and Regional Frequency of Training Participants by Sector**

| | Dental/ Medical | Nursing | Allied Health | Mgmt Admin | Support Worker | GP | Practice Nurse | Pharmacist | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| DNE | | 299 | 105 | 55 | 812 | 5 | | 1 | 95 | **1372** |
| DML | 5 | 810 | 135 | 79 | 1170 | 5 | 1 | 9 | 366 | **2580*** |
| South | 2 | 745 | 116 | 64 | 969 | 12 | | | 868 | **2776*** |
| West | 6 | 371 | 110 | 65 | 822 | 5 | | | 392 | **1771*** |
| National | **13** | **2225** | **466** | **263** | **3773** | **27** | **1** | **10** | **1721** | **8499** |

* Missing Classification Data: DML 7 cases, South 22 cases West 167 cases

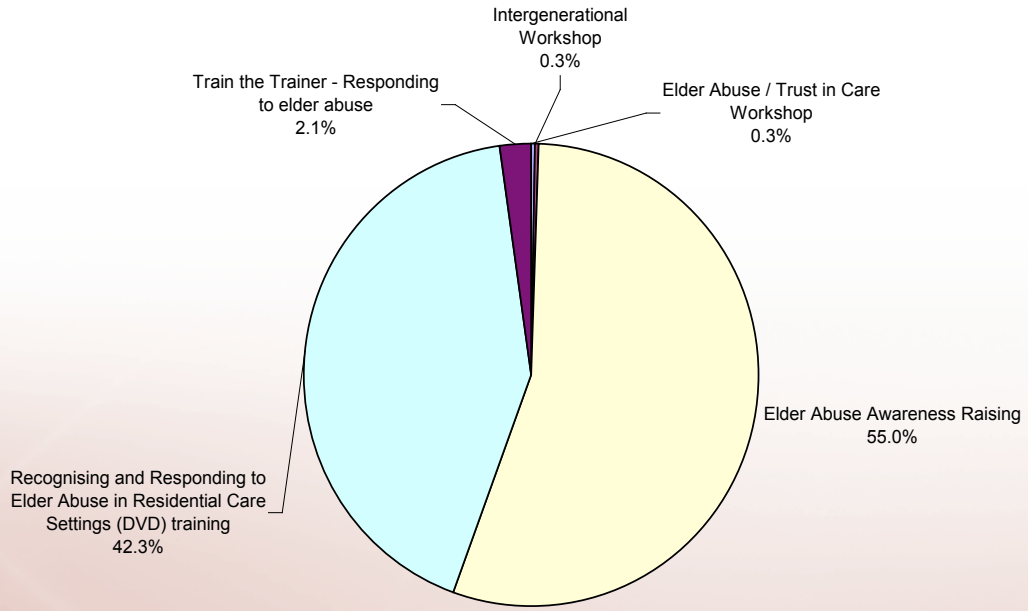



**Fig 5: National Breakdown of Training Programme Provided**

### 2.2.3 Trainers

In total, 61.3% of elder abuse training is delivered by HSE Elder abuse staff (Dedicated Officers and SCWs). This varies across HSE areas and LHOs. Elder abuse awareness workshops and the residential DVD training are the most frequently attended programmes.

Nationally, 37.1% of the elder abuse training described above is delivered by non elder abuse staff. This figure is seen as a positive indication of the impact the TTT approach is having. TTT participants are delivering elder abuse training in their own workplaces and are reporting back to the elder abuse service on the delivery of that training. TTT participants come from varying sectors. They are represented within HSE services (Older Persons Services, Mental Health Services, HSE residential settings, Centres for Nurse and Midwifery Education), Private Nursing Homes and other private and community organisations.

Tables 2 and 3 depict the proportion of training delivered by HSE and non-HSE trainers and the proportion delivered by elder abuse and non-elder abuse staff.

**Table 2: Training delivered by HSE and non-HSE trainers**

| HSE Area | | Frequency | % |
|---|---|---|---|
| DML | HSE | 1253 | 49% |
| | Other | 1268 | 49% |
| | HSE & Other | 61 | 2% |
| | **Total** | **2582** | **100%** |
| DNE | HSE | 793 | 58% |
| | Other | 574 | 42% |
| | **Total** | **1367** | **100%** |
| South | HSE | 1701 | 61% |
| | Other | 1008 | 36% |
| | HSE & Other | 77 | 3% |
| | **Total** | **2786** | **100%** |
| West | HSE | 1564 | 81% |
| | Other | 369 | 19% |
| | **Total** | **1933** | **100%** |

**Table 3: Training delivered by elder abuse and non-elder abuse staff**

| HSE Area | | Frequency | Percent |
|---|---|---|---|
| DML | SCW/DO | 1138 | 44% |
| | Other | 1443 | 56% |
| | **Total** | **2581** | **100%** |
| DNE | SCW/DO | 545 | 40% |
| | Other | 809 | 59% |
| | SCW/DO & Other HSE | 13 | 1% |
| | **Total** | **1367** | **100%** |
| South | SCW/DO | 721 | 26% |
| | Other | 1988 | 71% |
| | SCW/DO & Other Agency | 77 | 3% |
| | **Total** | **2786** | **100.0** |
| West | SCW/DO | 893 | 46% |
| | Other | 674 | 35% |
| | SCW/DO &Other HSE | 314 | 16% |
| | SCW/DO & Other Agency | 52 | 3% |
| | **Total** | **1933** | **100%** |

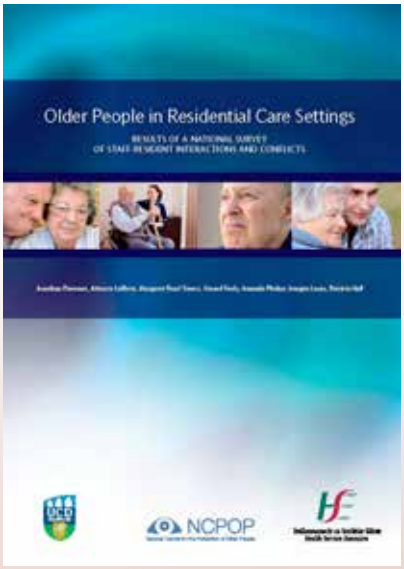
### 2.2.4 Additional Training Information

In addition to the training activity accounted for above, the elder abuse service continues to provide input to professional bodies such as the Irish College of General Practitioners (ICGP) and the Royal College of Physicians of Ireland (RCPI). In 2013, 166 medical staff were in attendance at elder abuse seminars provided by these bodies, with elder abuse staff providing presentations. In September 2013, the elder abuse service took part in the RCPI's *Hot Topic* Seminar, where issues such as abuse, capacity and consent were presented by the medical and legal profession, alongside the elder abuse service.

HSE e-learning continued to be developed. Filming for an e-learning project was completed in July 2013 and has moved to the editing stage of production. It is anticipated that this will be available in early 2014.

## 2.3 National Working Group on Staff Resident Interactions in Residential Care Settings

In December, 2012, the National Centre for the Protection of Older People (NCPOP) published the results of a national study in a document entitled *"Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts"*[14].




This research was commissioned by the HSE which established the NCPOP in order to create a better understanding and widen the knowledge base of elder abuse in Ireland.

International research suggests that older people in residential care are at a greater risk of neglect and abuse than those living in the community. The aim of the study was to measure the extent to which staff working in residential care homes in Ireland experienced conflict with residents, observed potentially neglectful or abusive behaviours towards residents, or themselves engaged in neglectful or abusive behaviours towards residents in their care.

## OPEN YOUR EYES

Currently, there are 129 public residential units in Ireland with a further 430 private or voluntary nursing homes. There are approximately 23,000 older people in long term residential care. It is widely acknowledged that older people in long term residential care are among the most vulnerable in society. Hence, it is important to identify the extent of abuse and neglect in residential settings so that efforts can be made to minimise its occurrence and effects.

This major national study was the first of its kind in Ireland and the findings and conclusions of the report are not only of interest to, but have implications for, those involved in residential care for older people in Ireland.

The report proposed the establishment of a sub group to undertake a complete examination of the findings of the report and to examine in detail the implications. In response, the HSE National Elder Abuse Steering Committee set up a *National Working Group on Staff-Resident Interactions in Residential Care Settings.* At the outset, it was agreed that this group would examine the recommendations, with particular focus on public residential units.

Members of the Working Group were proposed/chosen on the basis of their knowledge and expertise in the areas of the care of older people and in elder abuse. HIQA, an independent Authority established to drive continuous improvement in Ireland's health and social care services and as the body responsible for registration and inspection of nursing homes, was invited to nominate a representative to the Group. The NCPOP, as authors of the report, was also invited to nominate a representative onto the Group.

It was agreed that the most practical method of achieving the Group's terms of reference was to categorise the recommendations under three broad headings, namely:

- Education and training
- Raising awareness of neglect and abuse and policy development
- Nursing home and staffing issues

The Working Group was divided into three sub groups, each tasked with developing an action plan in relation to the recommendations made in the report relative to their assigned category. Once completed, each of the sub groups' action plans were amalgamated into a final document and presented to the National Elder Abuse Steering Committee at its meeting on 9th December, 2013.

The report of the Working Group was approved by the National Elder Abuse Steering Committee and the final action plan has been forwarded to the Older Persons Governance Group for consideration and implementation.

# 3.0 THE NATIONAL CENTRE FOR THE PROTECTION OF OLDER PEOPLE

## 3.1 Introduction

Since its launch in November 2009, the National Centre for the Protection of Older People has produced extensive research on elder abuse. This research has broadened our knowledge of the issue and increased our understanding of the nature and impact of elder abuse in Ireland. These projects and studies have also assisted in the development of policy and guided the direction of HSE services and interventions.


The National Centre has succeeded in placing elder abuse in the wider social context as opposed to within the context of the HSE only. This has enabled engagement with government departments, voluntary, community and business organisations and institutions to address issues such as financial abuse, ageism and discrimination.

The Centre has produced significant research data over the past four years with the most notable being its study on abuse and neglect of older people in Ireland, the first ever elder abuse prevalence study undertaken in Ireland. The study, '*Abuse and Neglect of Older People in Ireland, Report on the National Study of Elder Abuse and Neglect*'[16], suggests that over 10,000 older people had experienced abuse in Ireland in the previous year.

This section provides an overview of the research and dissemination activities of the National Centre for the Protection of Older People (NCPOP) at UCD during the reporting period 1st October, 2012 to 30th September, 2013. The Centre's constitution and governance structures are set out, followed by a brief progress report for each of the research projects and a summary of the Centre's dissemination and outreach activities during the reporting period.

## 3.2. Constitution and Governance

### 3.2.1 HSE-UCD governance structures

The HSE Steering Group and the HSE Management Group oversee the research and related activities of the Centre. The Centre team met with the HSE Steering Group on a number of occasions during the reporting period to provide updates on the progress of the research projects and other activities. In 2013, meetings were held in February, May and September and a meeting of the HSE Management Group took place in June 2013. These meetings comprised formal presentations of the work of the Centre, including its dissemination and outreach work.

### 3.2.2 Board of Programme Directors

The National Centre for the Protection of Older People is an approved Academic Centre of UCD. A Board of Directors assumes overall responsibility for the governance of the Centre and is responsible for ensuring the scientific excellence of the research undertaken by the Centre. The Board members are: Professor Gerard Fealy (Chair), Dr Amanda Phelan, Professor Denis Cusack, Dr Martin McNamara, Professor Cecily Kelleher, Dr Anne O'Loughlin and Professor Suzanne Quin. Professor Tony Fahey, UCD School of Applied Social Sciences, joined the Board of Directors in June 2013. The Board met on two occasions in the reporting period.

Professor Gerard Fealy is the Director of the National Centre for the Protection of Older People at UCD and Dr Amanda Phelan, the Co-Director of the Centre. The Centre has three full-time staff members, namely an Associate Centre Director, a Research Assistant and a Research Administrator. In addition, the Centre has recruited a post-doctoral research fellow (level 1) for a two-year period to provide additional research support to the Centre's programme of research.

The Centre held regular team meetings throughout the reporting period to plan and project manage the various research projects, engage in peer-review of work undertaken and plan dissemination and outreach activities.

### 3.2.3 International Advisory Group

The Centre has several international experts who act as advisors to the Centre. These include Professor Simon Biggs, School of Social and Political Science, University of Melbourne and Professor Karl Pillemer, Cornell Institute for Translational Research on Ageing. In 2013, Professor Jill Manthorpe, King's College London, Dr. Claudia Cooper, University College London and Ms. Bridget Penhale, University of East Anglia were appointed as international advisors to the Centre. The Centre continues to liaise with other international scholars and researchers in the field of elder abuse, who advise on individual projects, as appropriate. These include Professor Mark Yaffe, McGill University and Professor Kendon Conrad, University of Illinois at Chicago.

### 3.2.4 User Group

The Centre's User Group comprises representatives from agencies, groups and individuals with a remit for older people's advocacy. The members include Care Alliance Ireland, Health Information and Quality Authority, Third Age Foundation and the Department of Social Protection. The User Group discusses the various research projects and advises on aspects of the programme of research, with particular reference to their relevance and application to older people. The User Group met on two occasions during the reporting period.

## 3.3 Programme of Research

A programme of research commenced in October 2011 and comprises four major field studies and three desktop reviews.

### 3.3.1 Studies

- The reliability of the Elder Abuse Suspicion Index (EASI)[8] in the Irish setting.
- Pilot study to examine the appropriateness of the Older Adult Financial Exploitation Measure (OAFEM)[9] in the Irish setting.
- Caring for older relatives: Caregivers' experience of stress, coping and conflict.
- Preventing elder abuse through empowerment.
- An evaluation of the HSE national training programme for the prevention of elder abuse.

### 3.3.2 Reviews

- Abuse of older people with dementia: A review.
- Developing a risk-management framework for the protection of older people in residential care.
- A systematic review of the effectiveness of interventions in elder abuse.

Each of these projects is summarised below, together with a status report.

## 3.4 Studies

### 3.4.1 The reliability of the Elder Abuse Suspicion Index (EASI) in the Irish setting

Following a comprehensive review of screening tools for elder abuse conducted by the Centre in 2012, the Elder Abuse Suspicion Index (EASI) [8] was identified as having particular merit as a tool for use by healthcare professionals who work with older people. The aim of the study is to test and refine the Elder Abuse Suspicion Index (EASI) [8] for piloting in the Irish setting.

*Progress to date*

Over 700 assessments using the EASI tool had been completed at the time of reporting. In an effort to reach a target number of 1,000, additional pilot sites were identified in 2013 and a registered nurse was recruited for a four-month period in 2013 to ensure a targeted and sustained data collection process. This strategy resulted in a greatly improved sample. The anticipated date for completion of the study is June, 2014.

### 3.4.2 Pilot study to examine the appropriateness of the Older Adult Financial Exploitation Measure (OAFEM) [9] in the Irish setting

In 2010, the Centre identified financial abuse as the most common form of abuse of community-dwelling older people in Ireland. Following a review of empirically-tested elder abuse screening tools, the Older Adult Financial Exploitation Measure (OAFEM)[9] was identified as a useful tool in identifying financial abuse of older people, including the cumulative level of financial abuse.

*Progress to date*

Piloting of the tool among the target study participants has been completed and the retrospective user survey has also been completed. All data have been returned and data analysis has been completed. The anticipated date for completion of the study is Quarter 1, 2014.

### 3.4.3 Caring for older relatives: Caregivers' experience of stress, coping and conflict

Providing care to an older relative can be a rewarding and worthwhile experience. However, with the growing proportion of older people in Ireland (CSO 2007; 2012), especially those with chronic illnesses, family caregivers are being placed under increasing pressures. The demands of the caregiving role can have adverse outcomes for some carers and may lead some to experience caregiver burden. This can often lead to poor health, depression and may place carers at greater risk of engaging in potentially harmful behaviours towards the older people to whom they provide care.

*Progress to date*

Following ethical approval by the UCD Human Research Ethics Committee, questionnaires were posted to a random sample of 4,000 caregivers in receipt of carers allowance in July and August 2013. With the support of the Department of Social Protection, three mail contacts were made with the sample in order to assure a high response rate. Over 2,000 completed questionnaires were returned, yielding a response rate of 58 per cent. The anticipated date for completion of the study is June, 2014.

### 3.4.4 Preventing elder abuse through empowerment

Empowering an older person to recognise, develop and use their strengths and resources is important for their well-being and enables them to assert their rights as citizens and protect themselves from potential mistreatment. Empowerment involves making informed choices and decisions about one's life and encompasses the power to participate and be involved in public life. Partnership between older people, policy makers and service providers is critical to a sense of empowerment.

*Progress to date*

This study comprises of two phases with Phase 1 completed at the time of reporting. This phase resulted in a rich conceptual understanding of empowerment as it relates to the protection of older people and was grounded in the perspective of older people themselves and their advocates and those who have experienced elder abuse. Phase 2, to design an intervention which would empower older people to protect themselves against financial abuse, is currently in progress.

However, the main outline of a proposed intervention which is grounded in empowerment principles of autonomy, respectful consultation and preventative pro-action has been designed. The proposed intervention will include a dedicated website, an information booklet and other tools. The anticipated date for completion of the study is Quarter 2, 2014.

#### 3.4.5 An evaluation of the HSE national training programme for the prevention of elder abuse

Since 2007, the HSE has been conducting the national training programme aimed at raising awareness, increasing understanding and encouraging actions around elder abuse among staff working with older people (see Section Two). The HSE commissioned the Centre to conduct an evaluation of the training programme as part of its remit to conduct research into aspects of elder abuse and its prevention.

*Progress to date*

Following ethical approval from the UCD Human Research Ethics Committee, all interviews have been completed and the group quasi-experimental design and randomised controlled trial elements have also been completed. All data handling has been completed and the report of the study is being prepared. It is anticipated that this study will be completed in Quarter 1, 2014.

## 3.5 Reviews

#### 3.5.1 Abuse of older people with dementia: A review

This review has been completed and was launched at the World Elder Abuse Awareness Day (WEAAD) conference 2013. The review is available in hard copy and is available to download from www.ncpop.ie

#### 3.5.2 Developing a risk-management framework for the protection of older people in residential care

Approximately 6% of the older population in Ireland are in receipt of residential care. The vast majority are cared for in high quality, safe and supportive settings. However, a small number experience mistreatment, neglect and abuse. In 2009, the Health Information and Quality Authority (HIQA) introduced standards to set out what a quality, safe service for an older person living in a residential facility should be. These standards[17] aim to promote quality and safety in Ireland's health and social care services, and since July 2009 HIQA assumed responsibility for independent registration and inspection of public, private and voluntary residential care services for older people.

*Progress to date*

Inspection reports from approximately eleven nursing homes that were subjected to mandatory closure within a two year period (2010 to 2012) have been collated together. Documentary analysis is ongoing but it is anticipated that a report will be completed in Quarter 1, 2014.

#### 3.5.3 A systematic review of the effectiveness of interventions in elder abuse

The increasing global ageing population and greater knowledge of the prevalence, risks and impact of elder abuse demand reliable, up-to-date evidence for effective health and social care interventions for older people at risk of mistreatment. A critical understanding of published studies that report on interventions for preventing and managing elder abuse is essential in informing the development of effective and sustainable elder abuse interventions.

*Progress to date*

Peer-reviewed full text articles and research publications which described individual interventions were reviewed and annotated with specific attention paid to the evaluation design methods employed and the conclusions of the studies, in terms of the efficacy of the interventions. A database has been prepared summarising each of these articles. The report of the review is in preparation and it is anticipated that the final report will be completed in Quarter 1, 2014.

## 3.6 Dissemination and Outreach

The Centre engaged in a number of dissemination and outreach activities during the October 2012 to September 2013 reporting period. These included the launch of a major report entitled *Older People in Residential Care Settings: Results from a National Survey of Staff-Resident Interactions and Conflicts*[14] as well as a series of public seminars. Other dissemination activities included the preparation of a newsletter, journal publications and conference presentations.

### 3.6.1 Report Launch

On 6th December 2012, the report *Older people in residential care settings: Results from a national survey of staff-resident interactions and conflicts*[14] was formally launched at the UCD Health Sciences Centre.

The report examined the interactions and conflicts between staff and residents in residential care homes in Ireland, so as to identify both the prevalence and predictors of neglect and abuse of older people receiving care in these settings.

The study was based on a survey of over 1,300 care staff in 64 private and public nursing homes throughout Ireland.

Among key findings of the study were that a little under half of care staff reported that they observed neglectful behaviours by other staff occurring on two or more occasions in the previous year.

Dr. Jonathan Drennan, co-author of the report presented the main findings and outlined the number of factors that were found to be associated with the risk of neglect and abusive behaviours in residential care settings. These included low levels of staff job satisfaction, emotional exhaustion and burnout, poor staff commitment to their organisation and experiences of stress in the organisation. The psychological and physical health of staff were other factors identified as being associated with the physical and psychological abuse of residents. Also speaking at the launch were Professor Karl Pillemer, Cornell Institute for Translational Research on Ageing, and Mr. Paschal Moynihan, HSE West.

Mr. Frank Murphy, Chair of the HSE National Elder Abuse Steering Committee, commended the NCPOP on the research and went on to say that *"this report will further enhance our understanding of elder abuse in Ireland and on factors that can lead to abuse. While confirmation of abuse in nursing homes is disappointing, this research can help provide all of us with the knowledge on the factors that lead to abuse and help us to minimise its occurrence".*

The report received considerable media coverage around the time of the launch, including items on RTE News, the major national newspapers, and the Nursing Homes Ireland magazine. The full report together with the speakers' presentations and PowerPoint slides are available to download from www.ncpop.ie

### 3.6.2 World Elder Abuse Awareness Day (WEAAD) Conference, 2013

In collaboration with the International Network for the Protection of Older People (INPEA) and the HSE, the Centre hosted its annual conference to mark World Elder Abuse Awareness Day (WEAAD) on 13th June, 2013 at UCD.

### 3.6.3 Seminar Series 2012–2013

As part of the NCPOP seminar series, four seminars were held during the reporting period. Details of presentations and speakers are summarised in Table 4.1.

| NCPOP seminar series 2012–2013 | | |
|---|---|---|
| **Date** | **Speaker** | **Seminar title** |
| **October 2012** | Ms. Mary Rose Day, Lecturer, University College, Cork | Self-neglect: An Irish context |
| **December 2012** | Professor Karl Pillemer, Cornell Institute for Translational Research | Advice for living from the oldest (and wisest) Americans |
| **February 2013** | Dr Amanda Phelan, Co-Director of NCPOP at UCD | Examining the domain of financial abuse of older people |
| | Ms. Louise Hughes, Age Cymru, Wales | Financial abuse in Wales: A preventative approach to scams for people with dementia |
| **April 2013** | Ms. Joyce McKee, Regional Adult Safeguarding Officer, HSCB, NI | How does a bumblebee fly? Adult safeguarding in Northern Ireland |

The NCPOP seminars attracted attendees from a variety of professional and lay backgrounds, including staff from statutory organisations, advocacy and charity agencies, researchers, academics, legal and financial professionals, older self-advocates and family carers. The seminars provided a forum for interesting discussions in areas pertaining to ageing and elder abuse. Video recordings and PowerPoint presentations from all of the NCPOP seminars are available to view and download from www.ncpop.ie

### 3.6.4 NCPOP Website and Newsletter

The NCPOP website is updated with resources and publications from national and international sources on a regular basis. Presentations, PowerPoint slides and video recordings from all of the NCPOP seminars and WEAAD conferences are available to download from the site. The website features news of upcoming events relating to the field of elder abuse, NCPOP reports and other recent reports and publications. The website received over 21,500 visits during the reporting year, which represents an increase of 60 per cent on the previous reporting year. The unique visitors remain constant at approximately 60 per cent of all visits. The website had, on average, 1,800 visits per month.

The NCPOP *Newsletter*, which is designed to communicate the activities of the Centre, was circulated to 1,750 mailing list subscribers in June 2013.

### 3.6.5 Conference papers and publications

As an approved academic centre of UCD, the Centre is required to disseminate its research to the academic community at national and international conferences and in peer-reviewed journals. Below is a list of conference papers and publications for the current reporting period.

*Conference papers*

Lafferty, A., Treacy, M.P., Fealy, G., Drennan, J. and Lyons, I. (2012) *It is like being in a prison: Older people's accounts of mistreatment and abuse.* Tackling Elder Abuse and Dignified Care, Brunel University, London, 19 October

An update on the work of NCPOP was also delivered to the National Elder Abuse Steering Committee (NEASC) in 2013.

# 4.0 ELDER ABUSE NATIONAL STATISTICS

As elder abuse cases are formally reviewed on a six monthly basis and case length averages at four months, very often the profile represented at year end does not capture the full dataset. Therefore, as has been customary in previous reports an update on 2012 referrals will be presented first followed by a review of available data in 2013. Initially a profile of total referrals received in 2013 will be presented followed by referrals where there is a person causing concern - with particular emphasis on substantiated cases-and finally referrals relating exclusively to self neglect.

## 4.1 Methodology of Data Collection

The process for elder abuse referrals is such that all alleged or suspected elder abuse referrals made to the Senior Case Workers for the Protection of Older People are recorded on a '*Record of Initial Referral - Form 5'* (see appendix 4). At the referral stage a unique identifying number is assigned to each referral to allow it to be tracked through the service while ensuring anonymity. All Forms 5 are forwarded to the Dedicated Officers for the Protection of Older People for validation, coding and inputting into MS Excel. Subsequent from this a reassessment is completed by the Senior Case Worker, either on case closure or at six-monthly intervals, and recorded on a '*Follow-up on Record of Initial Referral - Form 6'* (see appendix 5).

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

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

It is important to be mindful that this database is live with information on cases updated on a constant basis. The data is classified according to the year of referral. There can be a marginal difference in figures that are presented in the HSE Performance Monitoring Reports (PMR) and the position reported on within this document. This is due to late or revised submissions made from the SCWs. There can be many factors that can account for delays including the non replacement of SCW during maternity or sick leave periods. In the following sections, the full sample size is reflected as an N value. This value varies depending on the availability of data. The HSE administrative areas are summarised as DNE (HSE Dublin North East), DML (HSE Dublin Mid Leinster), South (HSE South) and West (HSE West). As the database is constantly updating it is important that, within reports such as this, the most up-to-date position is reflected.

Based on the review of data in 2012, and in consultation with the Dedicated Officers, SCWs and the National Elder Abuse Steering Committee revised Forms 5 and Forms 6 were introduced for all new cases in 2013 in addition to all open cases from previous years that are still subject to review. The main amendments are summarised in table 4.

**Table 4: Summary of Changes to Elder Abuse Recording Forms 2013**

**Form 5: Senior Case Worker Record of Initial Referral amendments**

- Increased categorisation regarding the referral source
- Addition of measure to classify where did the concern first originate
- Regrouping of information regarding the number and gender of the alleged person causing concern

**Form 6: Elder Abuse Follow-up on Record of Initial Referral amendments**

- Inclusion of a measure to categorise the abuse type substantiated in accordance with those used in *Abuse and Neglect of Older People in Ireland, Report on the National Study of Elder Abuse and Neglect* [4]
- Additional options regarding the legal action taken
- Additional client intervention options
- Inclusion of a classification on the professional that conducted a medical assessment
- Inclusion of a measure on professional/services consulted with during SCW assessment
- Addition of a case outcome measure for substantiated cases to identify if the abuse is ongoing, has lessened or has stopped.

## 4.2 Update on 2012 Referrals

As reported in the HSE Elder Abuse Service Developments 2012, there were 2,460 referrals made to the elder abuse service in 2012. 1,924 had an alleged person causing concern. When analysis was presented at year end 39%, of these cases remained open the majority being in the HSE West (N=212). In total, 1,305 (68%) had a review carried out with the remainder due for their six month follow-up in 2013. The case outcome profile of these cases was 32% substantiated, 33% confirmed non-abuse and 35% inconclusive.

At year end 2013, these cases were again analysed in order to capture more complete information on case outcomes. There were no late submissions therefore the total referrals remain consistent with that reported last year. There was an increase in the number of cases with a person causing concern from 1,923 reported in 2012 to 1,970. At this time point 1,934 have now been reviewed at either 6 months or on case closure, representing a 98% review rate. Nationally, only 154 cases remain open, 58 of which are in HSE West. This is a reduction from 15% to 10% in the case closure rate from last year.

**Table 5: National and Area Summary of Referral Status-2012 Referrals with a Person Causing Concern**

| | DNE | | DML | | South | | West | | National | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % |
| Open | 25 | 5 | 27 | 6 | 44 | 5 | 58 | 10 | 154 | 6% |
| Closed | 477 | 90 | 410 | 89 | 804 | 89 | 457 | 81 | 2148 | 87% |
| Closed RIP | 29 | 5 | 23 | 5 | 56 | 6 | 48 | 9 | 156 | 7% |
| Total | 531 | 100 | 460 | 100 | 904 | 100 | 563 | 100 | 2458 | 100% |

**Table 6: National and Area Summary of Outcome of Cases-2012 Referrals with a Person Causing Concern**

| | DNE | | DML | | South | | West | | National | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % |
| Substantiated | 198 | 43 | 157 | 39 | 174 | 25 | 142 | 34 | 671 | 34 |
| Confirmed non abuse | 146 | 32 | 94 | 24 | 231 | 34 | 108 | 25 | 579 | 29 |
| Inconclusive | 118 | 25 | 146 | 37 | 284 | 41 | 172 | 41 | 720 | 37 |
| Total | 462 | 100 | 397 | 100% | 689 | 100% | 422 | 100% | 1970 | 100% |

**Allegation substantiated**: Where substantial evidence exists that the client has been abused.
**Not substantiated**: Where a professional assessment has concluded that the abuse has not taken place.
**Inconclusive**: Where it has not been possible to either prove or disprove the allegation.

Follow-up analysis of these 2012 cases illustrates only a marginal change in the case outcome profile with 34% of cases now reported as substantiated - on a regional basis HSE South, West and DML had the same rate of confirmed abuse whereas DNE increased from 38% of cases confirmed to 43% (Table 6).

In comparison to year end data in 2012 there was a notable reduction in the number of cases classified as “confirmed non abuse.” This is most evident in DNE - reducing from 38% of cases to 32%. This was highlighted in the 2011 data and this has clearly been addressed with year on year reductions evident.

Integral to our understanding of elder abuse, is the profile of cases that are substantiated, in terms of the abuse perpetrated by whom and where they reside. Table 7 provides information in relation to the top four abuse categories. In the cases reported, adult children were found to be the most common perpetrator of physical abuse, neglect, psychological and financial abuse - this was most likely to be a son by a ratio of 2:1. Neglect and psychological abuse were found to have the highest prevalence, where between 57% and 60% of abuse perpetrated within each abuse category is perpetrated by sons. While spousal abuse does not emerge as an issue in relation to financial abuse, it is certainly significant in relation to the other three categories, most notable, physical abuse. This indicates the interplay between domestic violence and elder abuse. “Other relatives” which includes in-laws, grandchildren, nieces /nephews are a significant group in the perpetration of financial abuse, second only to adult children. In two thirds of substantiated psychological, physical and neglect cases, the perpetrator resides with the older person, while for financial abuse this figure is only 30%.

**Table 7: Profile of Substantiated Cases 2012**

| | Psychological | Financial | Physical | Neglect |
|---|---|---|---|---|
| No of Cases Substantiated* | 528<br>47% | 255<br>23% | 147<br>13% | 168<br>15% |
| Perpetrator | | | | |
| Son/Daughter | 57% | 44% | 47% | 60% |
| Spouse | 22% | 7% | 27% | 17% |
| Other Relative | 14% | 22% | 14% | 12% |
| Carer | 2% | 5% | 4% | 7% |
| Neighbour | 3% | 8% | 3% | 4% |
| Gender of Perpetrator** | | | | |
| Male | 66 | 53 | 64 | 50 |
| Female | 28 | 37 | 33 | 35 |
| 1 Male/1 Female | 5 | 8 | 3 | 13 |
| Living with Victim | | | | |
| Yes | 65% | 30% | 67% | 67% |

***The total exceeds the referral number due to certain cases substantiating more than one abuse type.**
****Note category does not add to 100% as cases involving three or more perpetrators are recorded on forms but not included in this table.**

Due to the inclusion of revised forms in 2013, cases that were subject to review during the year have additional information collated on them - most notable is a classification on abuse type. There were 407 cases that had their case reviewed using the new forms.

In terms of physical abuse 52% related to being "*pushed, grabbed or shoved"* and a further 22% related to "*attempting to or succeeded in hitting, biting or kicking a client"*. For psychological abuse *"insulting the client, calling him/her names or swore at them"* (37%), *"threatening the client verbally"* (29%) and *"preventing the client from seeing others that they care about or care about them (family/professionals)"* (16%). When financial abuse is identified it related to being *"forced or misled…..into giving money/possessions or pension book against their will"* (34%), *"stolen money/possessions or documents*" (24%) and *"not contributing to household expenses"* (15%). Those that experienced neglect were most likely to be denied assistance in "*shopping for food/ clothes or travel outside the home"* (27%) and prevented from *"doing routine jobs around the house and moving about the house"* (25%). Table 8 provides a comprehensive summary of all abuse categories.

On a positive note, in cases where abuse was substantiated, intervention by the SCW in collaboration with multi-agencies and multi-professionals saw a cessation of abuse in 59% of cases, a reduction of abuse in a further 30%. In 11% of cases abuse is ongoing. Looking only at the cases where abuse is still ongoing, cross comparison with interventions offered found that a much greater proportion of clients were more likely to refuse interventions when compared to the overall group.

**Table 8: Profile of Abuse Type Substantiated- 2012 Case Reviewed**

| PHYSICAL | Frequency | % within Category |
|---|---|---|
| Removed or prevented the client's access to equipment such as hearing aids, walking aids | 2 | 3% |
| Pushed, grabbed or shoved the client | 39 | 52% |
| Attempted to or succeeded in hitting, biting or kicking the client | 17 | 23% |
| Burned or scalded the client | 2 | 3% |
| Given the client drugs or too much medicine to control them or make them sleepy | 0 | 0% |
| Restrained the client in any way e.g. locked them in a room, tied them in a chair | 3 | 4% |
| Threatened the client with an implement | 6 | 8% |
| Injured the client with an implement | 6 | 8% |
| **Total physical categories** | 75 | 100% |
| **PSYCHOLOGICAL** | | |
| Insulted the client, called him/her names or swore at him/her | 93 | 38% |
| Threatened the client verbally | 73 | 29% |
| Undermined or belittled the client | 0 | |
| Repeatedly ignored or excluded the client | 27 | 11% |
| Threatened to harm others that the client cares about | 15 | 6% |
| Prevented the client from seeing others that they care about or care for them e.g. family / professionals | 40 | 16% |
| **Total psychological categories** | 248 | 100% |
| **FINANCIAL** | | |
| Not contributing to household expenses such as rent or food against the clients wishes | 23 | 15% |
| Stolen money/possessions or documents | 37 | 24% |
| Deliberately prevented client from accessing money/possessions/ property/land or documents | 17 | 11% |
| Forced or misled the client into giving them money/ possessions/ or pension book against their will | 52 | 34% |
| Forced or misled the client to sign over ownership of their home or property against their will | 3 | 2% |
| Forced or misled the client to change their Will (Last Will and Testament). | 3 | 2% |
| Signed the client's name on cheque/pension book or other financial documents against their will? | 6 | 4% |
| Forced or misled the client into granting a power of attorney or had power of attorney misused. | 2 | 1% |
| Tried/pressured the client (but not succeeded) in doing any of the above to (steal money, property, change legal documents, pension book) | 7 | 5% |
| Has a financial institution (bank/insurance company) applied undue pressure on the client to buy products? | 1 | 1% |
| **Total financial categories** | 151 | 100% |
| **NEGLECT** | | |
| **Where the client requires assistance with the tasks below- has the client been repeatedly refused it:-** | | |
| To go shopping for food/clothes or travel outside the home | 24 | 27% |
| To prepare their own meals or eat | 13 | 15% |
| To do routine jobs around the house and move about the house | 22 | 25% |
| To take medicines in the right doses at the right time | 12 | 14% |
| To get out of bed/wash/dress themselves | 10 | 11% |
| To care for toileting needs | 7 | 8% |
| **Total neglect categories** | 88 | 100% |

## 4.3 Summary of Total Referrals 2013

In total, there were 2,437 referrals made to the service in 2013. This represents a marginal decrease of 1% in referrals from the previous year. From a regional perspective, there was a decrease in the referral rate in HSE DNE and South of 6% and 3% respectively The service is now established eight years and there is a likelihood that we have reached a levelling off in terms of annual referrals - note that in Fig. 5 the rate of increase evident in early years is contrasted with the levelling off response in the last 2 years. A summary of referral rates by region is presented in table 9 and the profile across all LHOs is presented in fig 7.

**Table 9: All Referrals by HSE Area 2008-2013**

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | % Cases 2013 | Change 2012-13 | Change 2008-13 |
|---|---|---|---|---|---|---|---|---|---|
| DNE | 433 | 431 | 430 | 582 | 535 | **503** | **21%** | -6% | 16% |
| DML | 254 | 278 | 407 | 447 | 460 | **482** | **20%** | 5% | 90% |
| South | 877 | 805 | 811 | 798 | 902 | **876** | **36%** | -3% | 0% |
| West | 323 | 402 | 463 | 475 | 563 | **576** | **23%** | 2% | 78% |
| Total | 1887 | 1916 | 2111 | 2302 | 2460 | **2437** | **100%** | -1% | 29% |

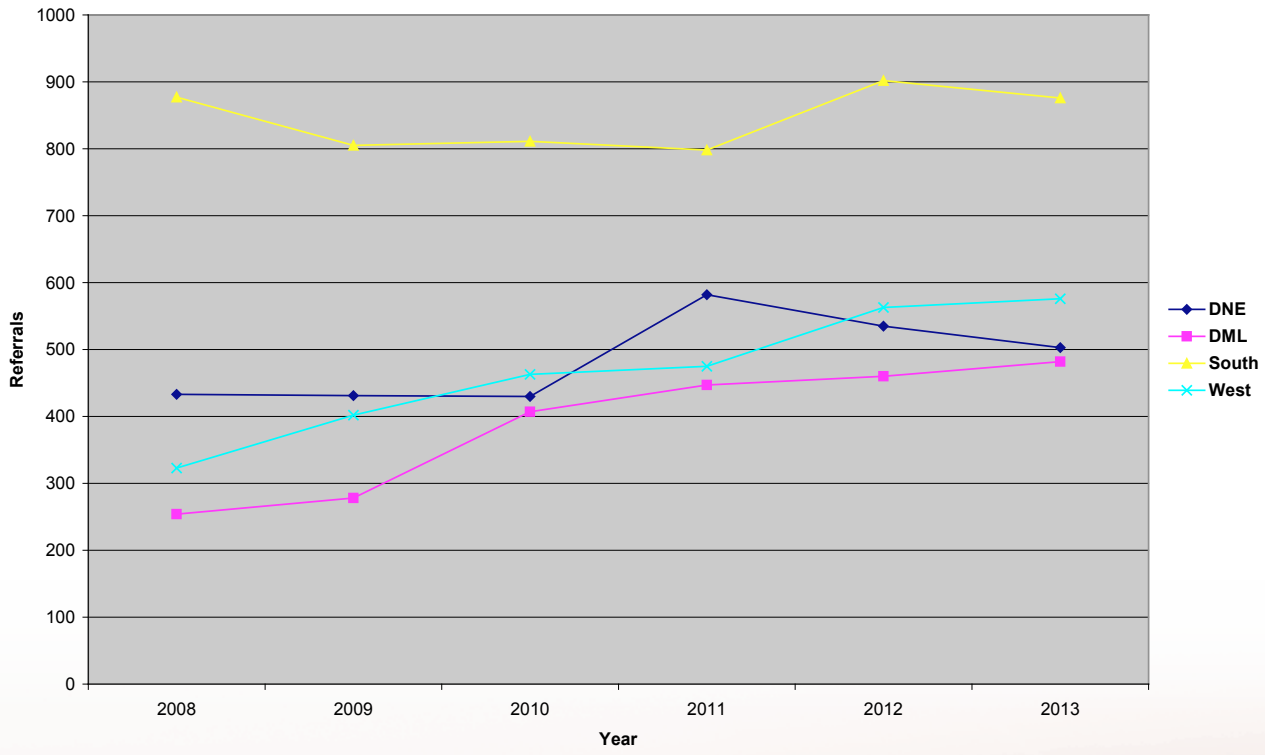



**Fig 5: Total Referrals by HSE Area from 2008 to 2013**

Figure 6 provides a graphical representation of the cumulative referrals by month in 2013.

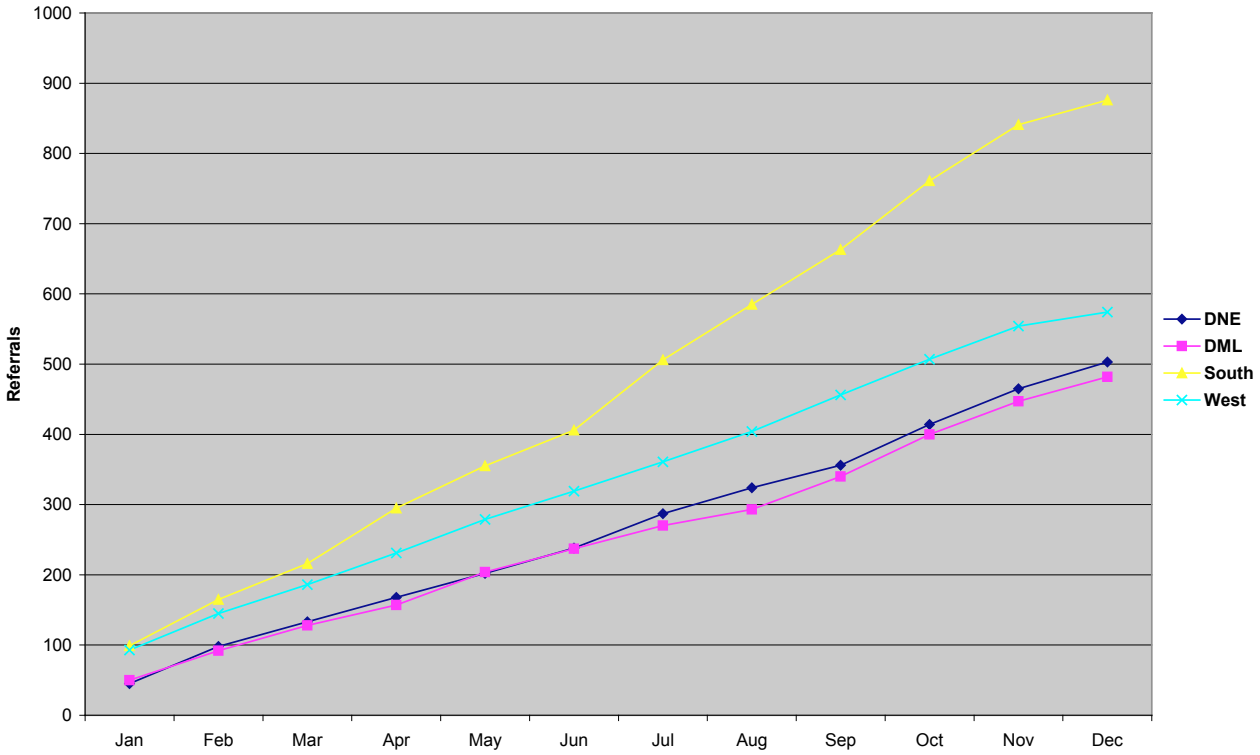



**Figure 6: Cumulative Profile of Referred Cases by HSE Area in 2013**

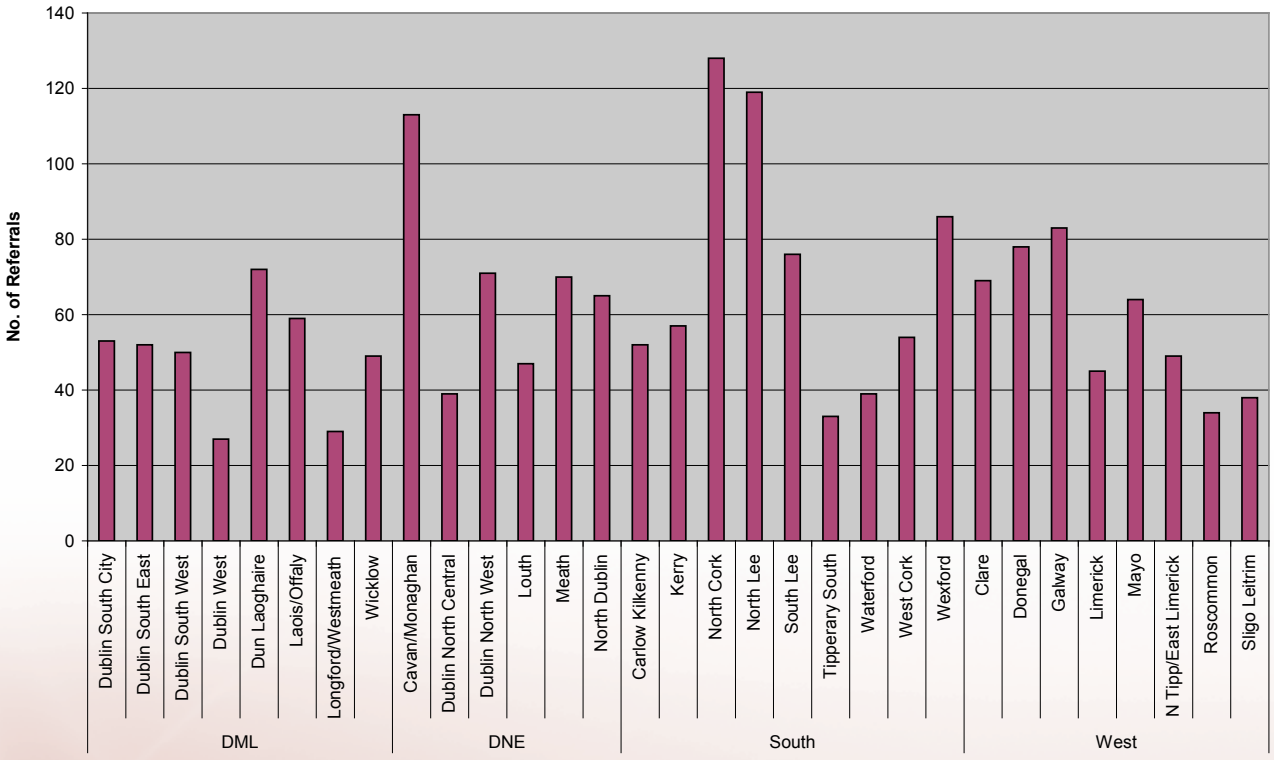



**Fig 7 Total Number of Referrals in 2013 by Local Health Office**

Analysis of referrals by local health office shows large variations in case numbers and therefore caseload. The highest referrals are in North Cork, North Lee and Cavan/Monaghan, with each of these areas exceed 110 referrals for 2013.

### 4.3.1 Gender/Age Classification

Female clients represent 61% of referrals ranging from 36% in DML to 41% in HSE West. The ageing population is evident in year on year statistics, illustrating the growth in the referral rate/1000 population in the over 80s category. In 2013 this increased from 8.92 to 9.27 with the largest increase in HSE South with 360 referrals over 80 years in 2012 rising to 418 in 2013. This resulted in an increase from 10.41 to 12.09 in the rate/1,000 population over 80 years. (See table 10)

**Table 10: Total Referrals 2013 Data Age Categorisation of Referral Rate /1,000 Population by HSE Area**

| | Total Over 65 Years | | | 65-79 Years | | | 80+ Years | | |
|---|---|---|---|---|---|---|---|---|---|
| | Pop. | No of Referrals | Rate/1,000 Population | Pop. | No of Referrals | Rate/1,000 Population | Pop. | No of Referrals | Rate/1,000 population |
| DNE | **107225** | 476 | 4.44 | 82214 | 225 | 2.74 | 25011 | 251 | 10.04 |
| DML | **141521** | 452 | 3.19 | 107646 | 233 | 2.16 | 33875 | 219 | 6.46 |
| South | **146189** | 804 | 5.50 | 111609 | 386 | 3.46 | 34580 | 418 | 12.09 |
| West | **140458** | 547 | 3.89 | 105395 | 244 | 2.32 | 35063 | 303 | 8.64 |
| National | **535393** | 2279 | 4.26 | 406864 | 1088 | 2.67 | **128529** | 1191 | 9.27 |

**Of 2,437 referrals-missing data=94 cases revising total to 2,343 of which 64 cases were for those aged 65+ years.**

### 4.3.2 Reason for Referral

A total of 3,217 abuse categories were classified - 74% of cases had one alleged abuse type, with a further 22% identifying two. When two abuse types are alleged, psychological abuse, is the most likely to be associated with another abuse type. Fig 8 illustrates the breakdown of the abuse categories in 2013 with a drop of 3% from 2012 in alleged psychological abuse while a slight increase is evident in relation to financial and physical abuse.

Table 11 illustrates the comparative change across time. It is evident that a clear pattern has emerged with alleged psychological abuse, financial abuse and self neglect dominating referrals. At a regional level referrals relating to alleged self neglect remain highest in HSE South, 23% of all referrals. This is consistent with analysis from previous years. In the HSE West- abuse pertaining to neglect exceeds both the national average and the regional levels reported across all other areas. In relation to psychological abuse a higher level is reported in DML than all other areas. It is worth noting that DML also presents with the highest number of cases that have more than one abuse type alleged. The level of alleged financial abuse exceeds the national average in both the Dublin regions. (Fig 9)

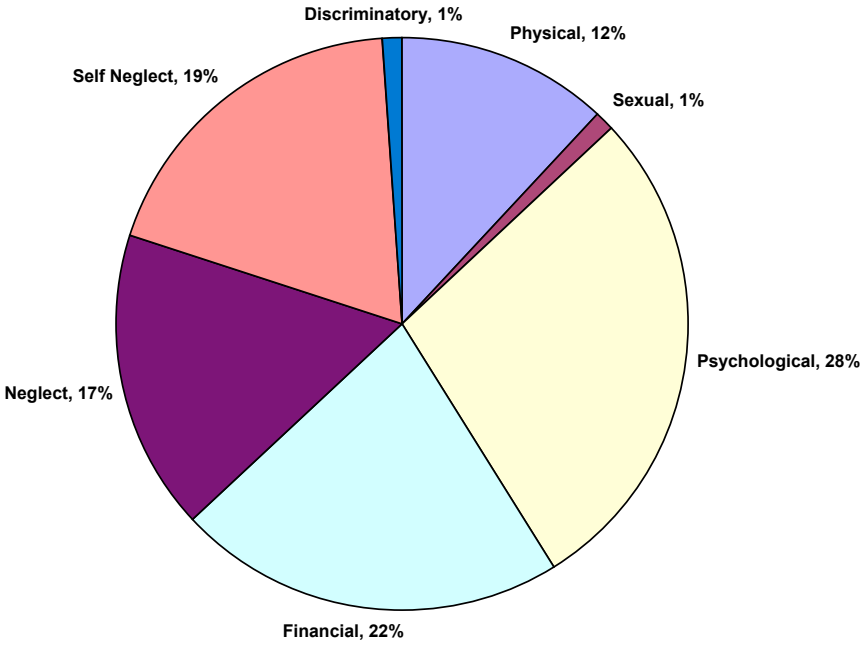



**Figure 8: Multiple Response Analysis of Reason for Referral Abuse Categories - All Cases 2013.**

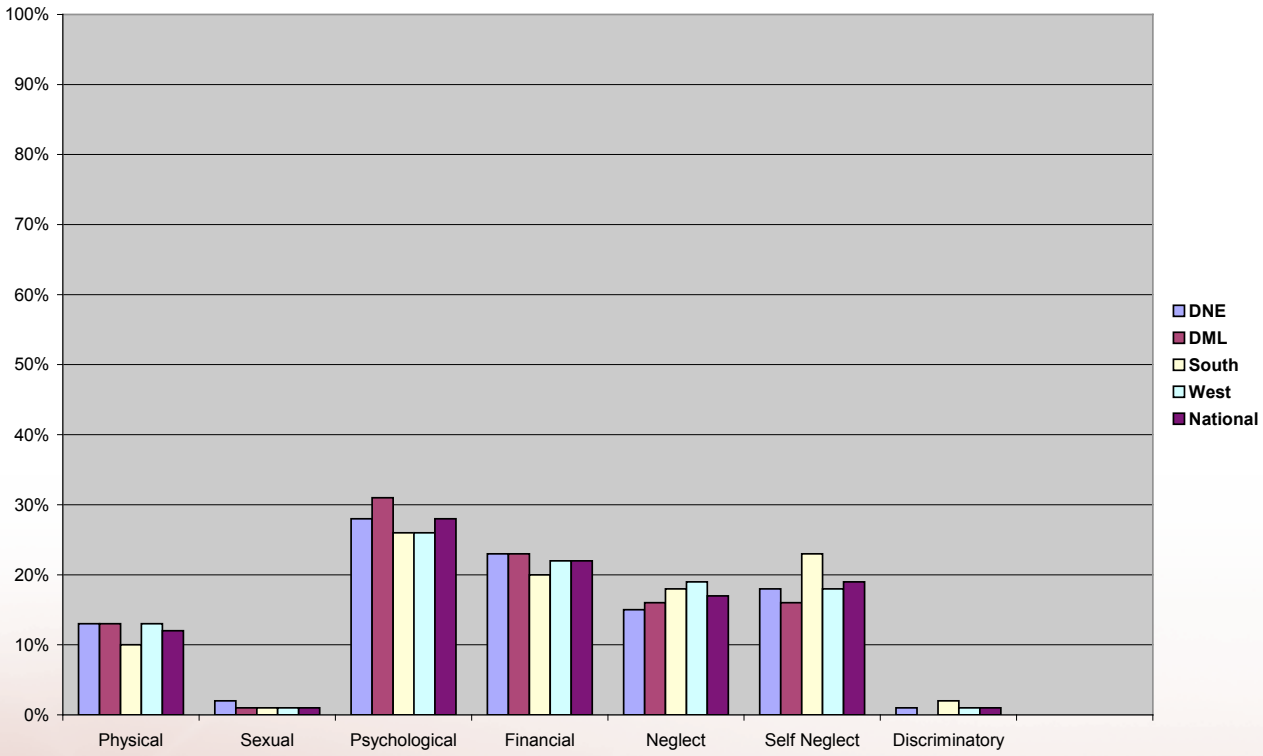



**Figure 9: Profile of Abuse Categories Nationally and by HSE area-All Cases 2013**

In the following sections more in-depth analysis will be provided pertaining to cases with an alleged perpetrator, with self neglect cases dealt with independently in section 4.5.

**Table 11: All Referrals Classified by Alleged Abuse Category for each year 2008-2013**

| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|
| Total Referrals | | N=1840 | N=1870 | N=2110 | N=2302 | N=2460 | N=2437 |
| Rank Alleged Abuse Category | 1 | Psychol. **26%** | Psychol. **28%** | Psychol. **26%** | Psychol. **29%** | Psychol. **30%** | Psychol. **27%** |
| | 2 | Self Neglect **20%** | Self Neglect **21%** | Self Neglect **21%** | Financial **19%** | Financial **21%** | Financial **22%** |
| | 3 | Neglect **19%** | Financial **18%** | Financial **19%** | Self Neglect **18%** | Self Neglect **19%** | Self Neglect **19%** |
| | 4 | Financial **16%** | Neglect **17%** | Neglect **19%** | Neglect **17%** | Neglect **16%** | Neglect **17%** |
| | 5 | Physical **12%** | Physical **12%** | Physical **14%** | Physical **10%** | Physical: **11%** | Physical **12%** |

## 4.4 Analysis of Total Referrals 2013 Excluding Absolute Self-Neglect

### 4.4.1 Age & Gender

In total, 1,900 referrals in 2013 had an alleged person causing concern. Of these, 87 cases involved a self-neglect component in association with another abuse type and are therefore included in the analysis within this section.

Referrals relating to females clients continue to dominate by a ratio of 2:1. Younger males are increasingly likely to be referred (65-74 years) while 55% of females referred are in the over 80 age category, consistent with 2012 figures. Applying the Census 2011 population statistics there has been an increase in the referral rate in the over 80s category nationally from 7.26/1,000 population reported in 2012 to 7.49, with the HSE South having the oldest cohort of referrals (Table 12).

**Table 12: 2013 Referrals with Person Causing Concern- Age by Referral Rate /1000 Population by HSE Area**

| | Total Over 65 Years | | | 65-79 Years | | | 80+ Years | | |
|---|---|---|---|---|---|---|---|---|---|
| | Pop. | No. of Referrals | Rate/1,000 Population | Pop. | No. of Referrals | Rate/1,000 Population | Pop. | No. of Referrals | Rate/1,000 population |
| DNE | **107225** | 381 | 3.55 | 82214 | 172 | 2.09 | 25011 | 209 | 8.36 |
| DML | **141521** | 365 | 2.58 | 107646 | 189 | 1.76 | 33875 | 176 | 5.20 |
| South | **146189** | 593 | 4.06 | 111609 | 265 | 2.37 | 34580 | 328 | 9.49 |
| West | **140458** | 435 | 3.10 | 105395 | 185 | 1.76 | 35063 | 250 | 7.13 |
| National | **535393** | 1774 | 3.31 | 406864 | 811 | 1.99 | **128529** | 963 | 7.49 |

**Of 1,900 referrals missing data=75 cases revising total to 1,825 of which 1,774 cases were for those aged 65+ years.**

### 4.4.2 Referral Characteristics

Within this year's analysis both the referral source and where the concern first originated is presented. This enables any discrepancies between these two variables to be explored. Anecdotal evidence suggested that while the PHN is the primary referral source since data collection commenced, it is likely that the concern could have originated from another source and was brought to the attention of the PHN who then processed the referral.

The 2013 profile indicates that the PHN continues to be the main referral source in all areas (33%), followed by family (12%) and hospital (12%) (see Fig 10). Comparison by HSE Area indicates that referrals from the PHN service continue to be more dominant in the HSE South and West. Self referrals are highest in HSE DML, residential referrals are highest in DNE and family referrals greatest in HSE South.

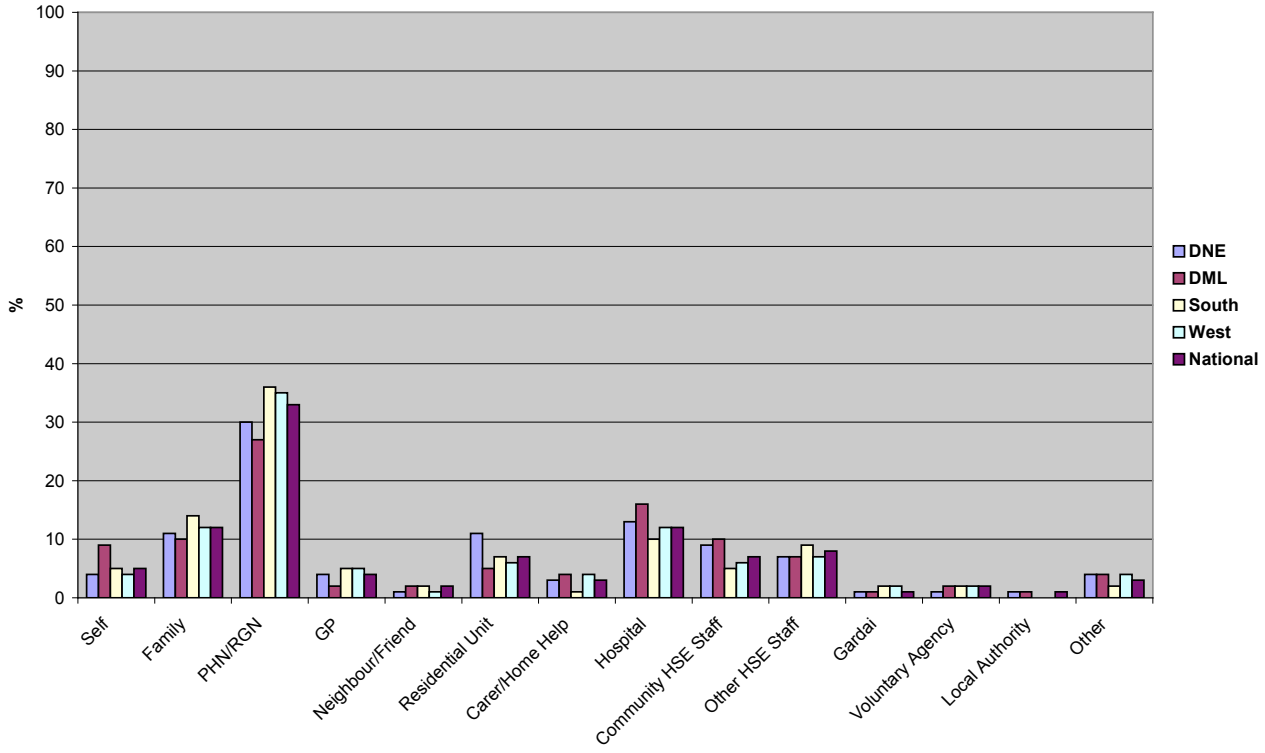



**Figure 10: Profile of Referral Source Nationally and by HSE Area 2013**

Examining where the concern first originated illustrates that 19% of concerns originate from older people themselves with a further 27% accounted for by family members. This is valuable information in the context of older people being empowered to be proactive regarding their mistreatment at the hand of others. Further analysis by gender found that females were marginally more likely to self refer (19% versus 17%), males were more likely to have family member (29% versus 26%) and neighbour/friend raise concerns (4% versus 1%) while PHN involvement was consistent for both genders.

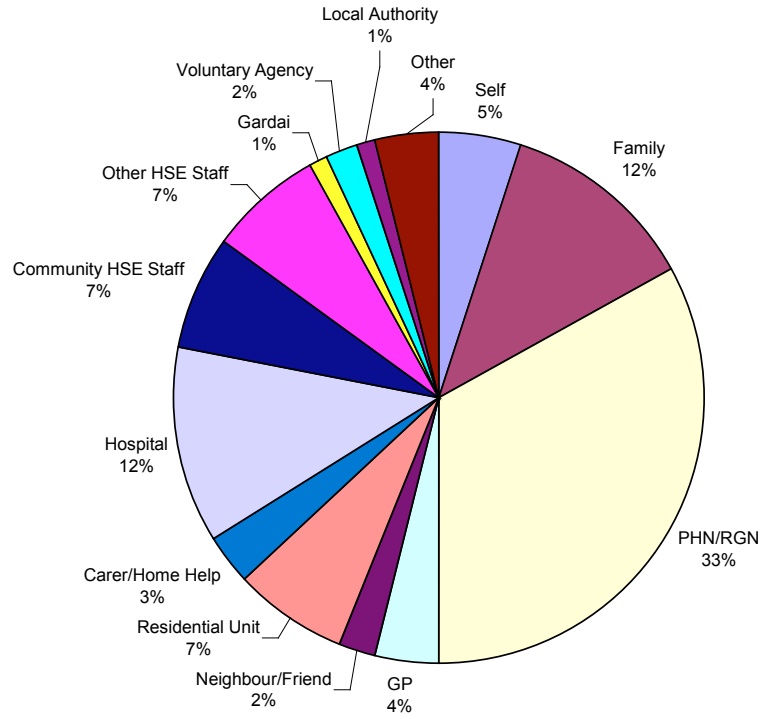



**Fig 11 Profile of Referral Source Nationally**

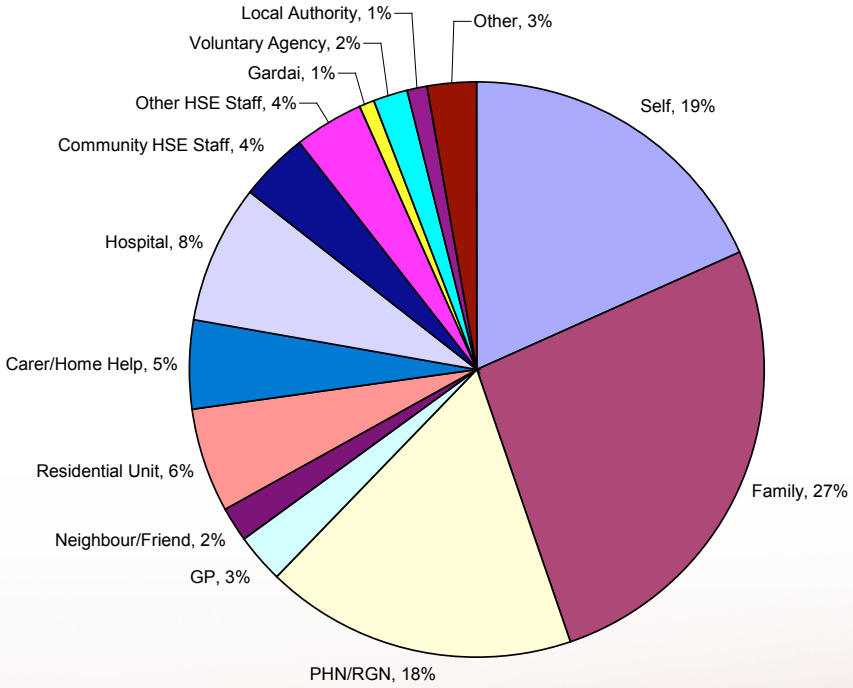



**Fig 12 National Profile of Origin of Concern**

In 2013, there were 2,680 alleged abuse categories reported among the 1,900 referrals. Psychological abuse, financial abuse and neglect were the main abuse types alleged. While the profile is consistent with that reported over the past four years there was a reduction in referrals of psychological abuse from 36% to 33% while an increase was observed in financial abuse, neglect and physical abuse in comparison to 2012 data. (Table 13)

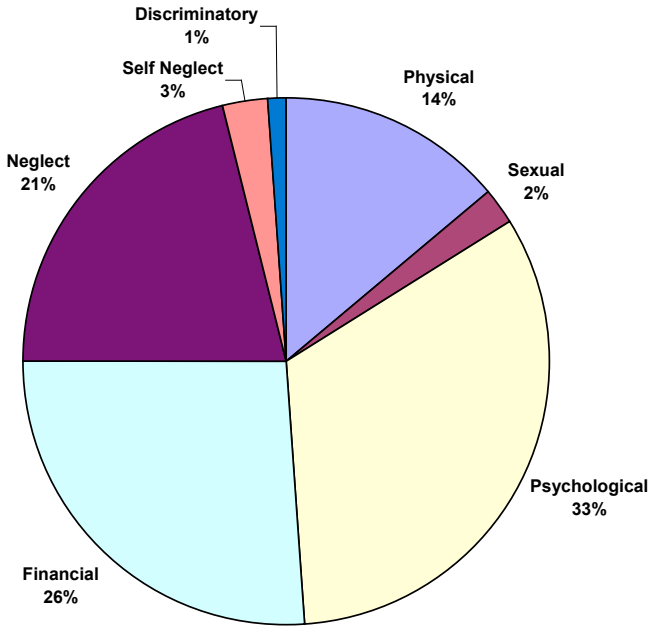



**Figure 13: Multiple Response Analysis of Reason for Referral**

In total 81% of clients resided at home, 7% in a private nursing home, 6% in a relative's home and a further 4% in public continuing care (Figure 14). In 95% of cases the alleged abuse was documented as occurring in their primary place of residence.

**Table 13: Summary of Alleged Abuse Categories with removal of self-neglect 2008-2013**

| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|
| Total Referrals | | **N=1481** | **N=1435** | **N=1629** | **N=1867** | **N=1923** | **N=1900** |
| Rank Alleged Abuse Category | 1 | Psychological **29%** | Psychol. **34%** | Psychol. **31%** | Psychol. **34%** | Psychol. **36%** | Psychol. **33%** |
| | 2 | Neglect **22%** | Financial **22%** | Financial **23%** | Financial **23%** | Financial: **25%** | Financial **26%** |
| | 3 | Financial **19%** | Neglect **20%** | Neglect **22%** | Neglect **23%** | Neglect **19%** | Neglect **21%** |
| | 4 | Physical **15%** | Physical **14%** | Physical **13%** | Physical **12%** | Physical **13%** | Physical **14%** |

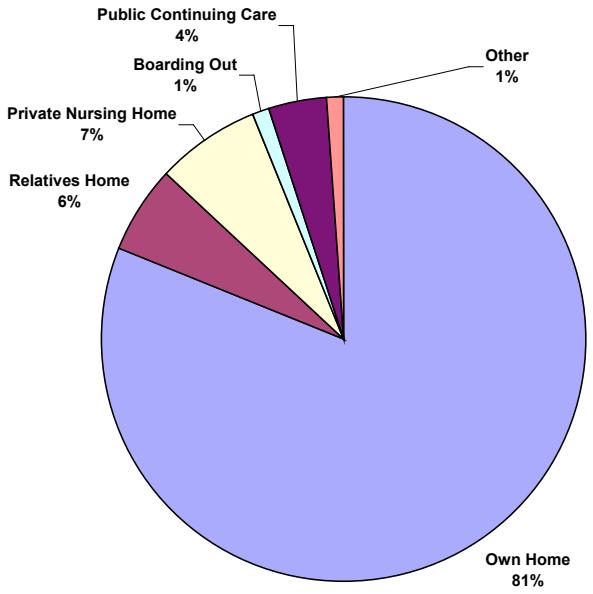



**Figure 14: National Breakdown of Place of Residence**

### 4.4.3 Characteristics of Person Causing Concern

In 2013, 78% of cases had one alleged perpetrator with this increasing to 90% when two perpetrators are considered. In cases where there was one person causing concern, this person was more likely to be male (50% of cases in contrast to 39%). In over half the cases the alleged abuser and alleged victim reside together thus compounding the issue for the older person. This will be explored further when looking at substantiated cases.

Table 14 illustrates a profile of the alleged perpetrator comparing 2013 data to figures presented from the previous 5 years. The alleged perpetrators are usually those with the closest relationship to the older person namely son/daughter, partner and other relative.

**Table 14: Cumulative Profile of Alleged Person Causing Concern 2008-2013**

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| Son/daughter | 44% | 43% | 44% | 43% | 46% | 45% |
| Partner/ husband/wife | 17% | 18% | 16% | 18% | 17% | 19% |
| In-Law* | Included as a new category in 2013 | | | | | 5% |
| Other relative | 19% | 19% | 18% | 18% | 20% | 15% |
| Neighbour/ Fried | 4% | 6% | 5% | 5% | 5% | 7% |
| Carer/staff | 7% | 4% | 6% | 6% | 5% | 4% |
| Other service user | 2% | 1% | 2% | 1% | 1% | 2% |
| Voluntary | 0% | 0% | 0% | 0% | 0% | 0% |
| Other | 8% | 8% | 8% | 9% | 6% | 4% |

### 4.4.4 Status & Outcome of Cases

Of the 1,900 referrals with a person causing concern in 2013, 742 (39%) remained open at year end - the highest proportion of open cases was in the DML (49%) and lowest in HSE South (25%). The case closure rate has been consistent year on year. In total, 1,307 cases were subject to review at year end, reflecting a 68% review rate consistent with the level reported in 2012. Given that a certain proportion of cases will not have reached their six month review date by year end, the fact that over two thirds of cases were reviewed in a timely manner shows responsiveness within the service. In terms of case outcome, nationally only 27% of cases were found to be substantiated. This ranged from a high in DML 38% to a low in HSE South of 21%.(Table 16).

**Table 15 National and Area Summary of Referral Status-2013 Referrals with a Person Causing Concern**

| | DNE | | DML | | South | | West | | National | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % |
| **Open** | 182 | 45% | 190 | 49% | 162 | 25% | 208 | 45% | 742 | 39% |
| **Closed** | 216 | 53% | 193 | 49% | 462 | 72% | 231 | 50% | 1102 | 58% |
| **Closed RIP** | 7 | 2% | 8 | 2% | 19 | 3% | 21 | 4% | 53 | 3% |
| **Total** | **405** | **100%** | **391** | **100%** | **643** | **100%** | **460** | **100%** | **1899** | **100%** |

**Table 16 National and Area Summary of Outcome of Cases-2013 Referrals with a Person Causing Concern**

| | DNE | | DML | | South | | West | | National | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % | No. of Referrals | % |
| **Substantiated** | 66 | 28% | 93 | 38% | 108 | 21% | 89 | 28% | 356 | 27% |
| **Confirmed non abuse** | 83 | 34% | 45 | 18% | 124 | 25% | 80 | 26% | 332 | 26% |
| **Inconclusive** | 90 | 38% | 110 | 44% | 273 | 54% | 146 | 46% | 619 | 47% |
| **Total** | **239** | **100%** | **248** | **100%** | **505** | **100%** | **315** | **100%** | **1307** | **100%** |

**Allegation substantiated**: Where substantial evidence exists that the client has been abused.
**Not substantiated**: Where a professional assessment has concluded that the abuse has not taken place.
**Inconclusive**: Where it has not been possible to either prove or disprove the allegation.

Of the 356 substantiated cases in 2013, 273 had just one type of abuse substantiated (77%) with a further 70 (20%) having two types of abuse confirmed. This trend has been evident year on year.

There are many consistencies evident in the characteristics of substantiated cases in 2012 and 2013. (Table 17)

- Psychological abuse was the most likely type of abuse to be confirmed.
- Adult children are the main perpetrators of psychologica, financial abuse, physical abuse and neglect. This association is strongest in relation to neglect.
- When financial abuse is considered, the profile of abusers widens to include “other relatives”, “neighbour/friend” and “carer/staff” which correlates with the lowest cohabitation rates.
- Male perpetrators dominate, however this varies depending on the abuse type, being highest for physical abuse.
- Male/female joint perpetration of abuse is highest when considering psychological abuse and neglect.
- Over two thirds of clients experiencing physical and/or psychological abuse reside with the perpetrator, rising to 76% in cases of neglect.
- A close association is evident between increasing age and risk of neglect.

**Table 17 Profile of Substantiated Cases 2012 and 2013**

| | 2012 Cases | | | | 2013 Cases | | | |
|---|---|---|---|---|---|---|---|---|
| | Psychol. | Financial | Physical | Neglect | Psychol. | Financial | Physical | Neglect |
| No of Cases Substantiated* | 528-47% | 255-23% | 147-13% | 168-15% | 413-51% | 133-16% | 146-13% | 109-15% |
| Perpetrator | | | | | | | | |
| Son/Daughter | 57% | 44% | 47% | 60% | 50% | 37% | 48% | 55% |
| Spouse | 22% | 7% | 27% | 17% | 31% | 5% | 33% | 27% |
| Other Relative | 14% | 22% | 14% | 12% | 6% | 23% | 8% | 12% |
| Carer/staff | 2% | 5% | 4% | 7% | 3% | 10% | 3% | 3% |
| Neighbour/Friend | 3% | 8% | 3% | 4% | 3% | 15% | 3% | 2% |
| In-law | | | | | 4% | 6% | 3% | 1% |
| Gender of Perpetrator** | | | | | | | | |
| Male | 66% | 53% | 64% | 50% | 60% | 50% | 66% | 50% |
| Female | 28% | 37% | 33% | 35% | 36% | 41% | 34% | 26% |
| 1 Male/1 Female | 5% | 8% | 3% | 13% | 3% | 8% | | 19% |
| Living with Victim | | | | | | | | |
| Yes | 65% | 30% | 67% | 67% | 66% | 33% | 65% | 76% |

***The total exceeds the case number due to certain cases substantiating more than one abuse type.**
****Note category does not add to 100%- as cases involving 3+perpetrators are not included in this table.**

In total, 137 incidents of substantiated physical abuse were documented. Further classification indicated clients who experienced physical abuse were *"pushed, grabbed or shoved"* and/or were hit, bit or kicked or attempts made at same. Those experiencing psychological abuse were insulted including name calling and verbal threats. Preventing the client from seeing others that care about or for them was also a significant, representing 17% of all psychological abuse cases. In relation to clients experiencing financial abuse - they were most likely forced /misled into giving money/possessions or property away against their will, had documents or money stolen or were prevented from accessing their assets. In cases of neglect clients were mainly refused help in doing routine jobs around the house/moving about the house, taking medications and looking after their personal hygiene.

**Table 18 Profile of Abuse Type 2013 Cases Type**

| PHYSICAL | Frequency | % within Category |
|---|---|---|
| Removed or prevented the client's access to equipment such as hearing aids, walking aids | 5 | 4% |
| Pushed, grabbed or shoved the client | 55 | 40% |
| Attempted to or succeeded in hitting, biting or kicking the client | 39 | 28% |
| Burned or scalded the client | 3 | 2% |
| Given the client drugs or too much medicine to control them or make them sleepy | 3 | 2% |
| Restrained the client in any way e.g. locked them in a room, tied them in a chair | 5 | 4% |
| Threatened the client with an implement | 15 | 11% |
| Injured the client with an implement | 12 | 9% |
| **Total physical categories** | 137 | 100% |
| **PSYCHOLOGICAL** | | |
| Insulted the client, called him/her names or swore at him/her | 100 | 34% |
| Threatened the client verbally | 94 | 32% |
| Undermined or belittled the client | 0 | - |
| Repeatedly ignored or excluded the client | 31 | 10% |
| Threatened to harm others that the client cares about | 22 | 7% |
| Prevented the client from seeing others that they care about or care for them e.g. family / professionals | 50 | 17% |
| **Total psychology categories** | 297 | 100% |
| **FINANCIAL** | | |
| Not contributing to household expenses such as rent or food against the clients wishes | 11 | 9% |
| Stolen money/possessions or documents | 31 | 24% |
| Deliberately prevented client from accessing money/possessions/property/ land or documents | 20 | 16% |
| Forced or misled the client into giving them money/ possessions/ or pension book against their will | 40 | 31% |
| Forced or misled the client to sign over ownership of their home or property against their will | 7 | 5% |
| Forced or misled the client to change their Will (Last Will and Testament). | 0 | |
| Signed the client's name on cheque/pension book or other financial documents against their will? | 8 | 6% |
| Forced or misled the client into granting a power of attorney or had power of attorney misused. | 1 | 1% |
| Tried/pressured the client (but not succeeded) in doing any of the above to (steal money, property, change legal documents, pension book) | 8 | 6% |
| Has a financial institution (bank/insurance company) applied undue pressure on the client to buy products? | 2 | 2% |
| **Total financial categories** | 128 | 100% |
| **NEGLECT** | | |
| **Where the client requires assistance with the tasks below- has the client been repeatedly refused it:-** | | |
| To go shopping for food/clothes or travel outside the home | 5 | 6% |
| To prepare their own meals or eat | 14 | 16% |
| To do routine jobs around the house and move about the house | 21 | 24% |
| To take medicines in the right doses at the right time | 21 | 24% |
| To get out of bed/wash/dress themselves | 16 | 18% |
| To care for toileting needs | 11 | 12% |
| **Total neglect categories** | 88 | 100% |

### 4.4.5 An Garda Síochána & Legal Involvement

In only 9% of cases the SCW contacted An Garda Síochána informally to discuss an elder abuse case. However notifications made from the HSE Elder Abuse Service to An Garda Síochána is at a rate of 22%. This can include any complaint/report or notification made to An Garda Síochána about the alleged abuse from any professional involved in the case or a family member /concerned other, not exclusively the SCW. Table 19 provides a summary of Garda involvement since 2008.

**Table 19: Interaction with An Garda Síochána on Elder Abuse Cases 2008-2013**

| | 2008 (n=1493) | 2009 (n=1412) | 2010 (n=1503) | 2011 (n=1094) | 2012 (n=1305) | 2013 (n=1307) |
|---|---|---|---|---|---|---|
| **Garda Consultation** | 12% | 16% | 18% | 15% | 13% | 9% |
| **Garda Notification** | 10% | 20% | 23% | 23% | 20% | 22% |

In keeping with the non-adversarial approach of the service a low level of legal action was again recorded in 2013. In total there was legal recommendation in 246 cases with 113 resulting in legal action. The most common legal actions related to domestic violence (24%), criminal proceedings (20%) and ward of court (19%). "Other legal actions" accounted for 28% of cases with power of attorney being the main action identified.

### 4.4.6 Issues and Interventions for Client

In thirty-four percent of cases clients were documented as having a health issue. Where issues where documented it was most likely to be one rather than multiple issues, for an individual client. Physical health issues were the most prevalent followed by dementia and mental health.

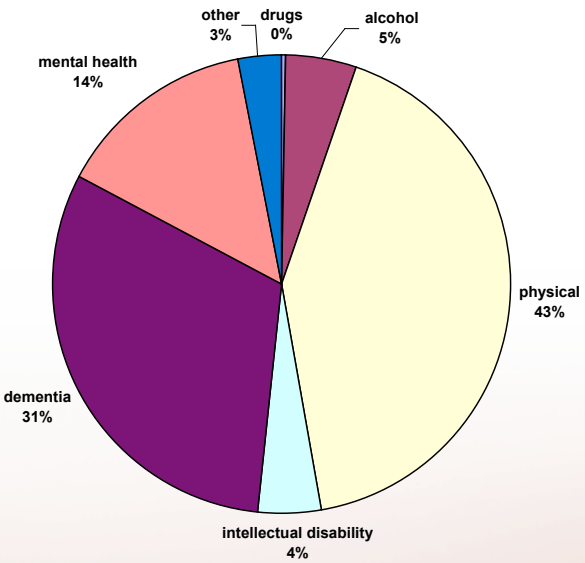



**Figure 15: National Breakdown of Issues for Client (991 issues listed for multiple analysis)**

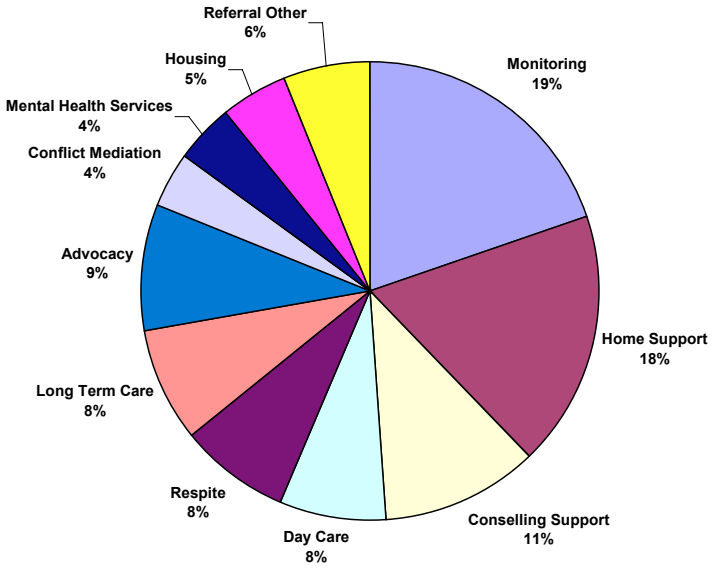



**Figure 16: National Profile of Services Offered to Clients (2502 responses)**

In total, 69% of clients referred to the service availed of an intervention, a further 14% were not offered a service, while 17% had declined the services offered. Monitoring, home support and counselling/support are the most services most availed of. Ten percent were referred to "other services" with mental health and housing/local authority services the most common.

### 4.4.7 Issues and Interventions for the Person Causing Concern

In 2013 there were 440 alleged perpetrators that were listed by the Senior Case Worker as having at least one possible health issue reported. A summary of health issues is presented in figure 17 - alcohol and mental health issues predominate. "Other issues" continue to be internal family issues and carer stress.

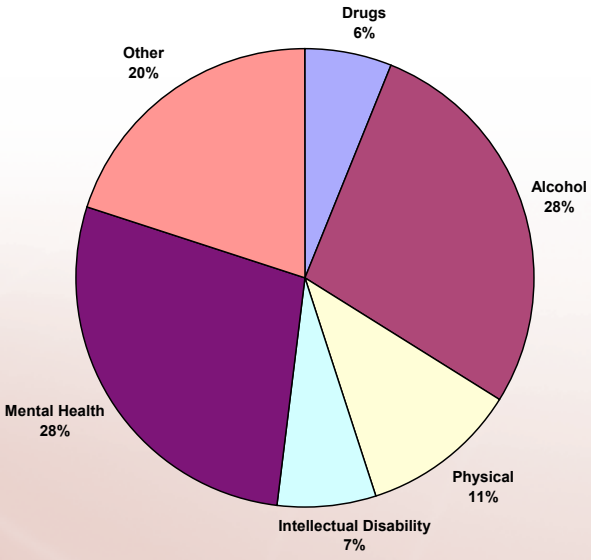



**Figure 17: National Profile on Issues for the Person Causing Concern (512 responses)**

In keeping with previous years statistics, support offered and referral to another service most notably mental health and addiction services prevail**.** (Table 20)

**Table 20: Interventions Provided to the Alleged Person Causing Concern 2008-2013**

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| **Garda Action** | 12% | 17% | 17% | 13% | 11% | 14% |
| **Support Offered** | 51% | 50% | 49% | 46% | 56% | 53% |
| **Disciplinary Action** | 4% | 2% | 4% | 6% | 4% | 1% |
| **Service Refused** | 15% | 10% | 9% | 14% | 11% | 21% |
| **Referral Other Service** | 18% | 21% | 20% | 20% | 18% | 11% |

### 4.4.8 Medical Consultation/Assessment

In the 2013 data, there was additional information reported to capture medical consultations and assessments with the older person. In relation to medical consultations, 721 clients had assessments carried out, which equates to 55% of the 1,307 reviewed clients. These assessments were carried out by GPs (52%) followed by Geriatricians (28%) and Mental Health Physicians (15%).

In conducting a comprehensive assessment the SCW consults with various professionals and agencies. New measures introduced in the 2013 dataset enable the multi-professional/agency involvement to be quantified. Results indicated that engagement with the Public Health Nurse is key within this process together with collaboration with the GP given their close association and frequent contact with this client group (Table 21).

**Table 21: Profile of Professional Services Consulted with During Assessment**

| Professionals | N | % |
|---|---|---|
| PHN | 872 | 29% |
| GP | 471 | 16% |
| Geriatrician | 135 | 5% |
| Mental Heath | 195 | 7% |
| Nursing Home | 229 | 8% |
| Medical Primary Care SW | 161 | 5% |
| OT | 128 | 4% |
| Physiotherapy | 69 | 2% |
| Home Carer | 215 | 7% |
| Local Authority | 48 | 2% |
| Probation & Welfare | 2 | 0% |
| An Garda Siochana | 122 | 4% |
| Solicitor | 69 | 2% |
| Other | 258 | 9% |

Case outcome information in 2013 indicated that in cases where abuse was substantiated, intervention by the SCW in collaboration with multi agencies and multi professionals saw a cessation of abuse in 55% of cases and a reduction of abuse in a further 34%. In 10% of cases abuse is ongoing.

## 4.5 Self-Neglect

In this section we profile the cases where self neglect is the sole reason for referral and there is no person causing concern. The level of reporting in relation to these cases has remained constant in 2013 with a total of 537 referrals made to the service. These cases are complex in nature, managing the balance between protecting adults at risk from self neglect against their right to self determination. The highest proportion of referrals is in the HSE South, double that of the next highest area, HSE West. Nationally, the gender breakdown is almost on a par. However this varies across the areas. In HSE West, males comprise of 62% of referrals - with further LHO analysis indicating greater number of referrals from rural locations.

**Table 22: Gender Breakdown by HSE Area 2012 Referrals**

| | DNE | | DML | | South | | West | | National | |
|---|---|---|---|---|---|---|---|---|---|---|
| Male | 53 | 55% | 47 | 52% | 112 | 48% | 72 | 62% | 284 | 53% |
| Female | 44 | 45% | 44 | 48% | 120 | 52% | 44 | 38% | 252 | 47% |
| Total | 97 | 100% | 91 | 100% | 232 | 100% | 116 | 100% | 536 | 100% |

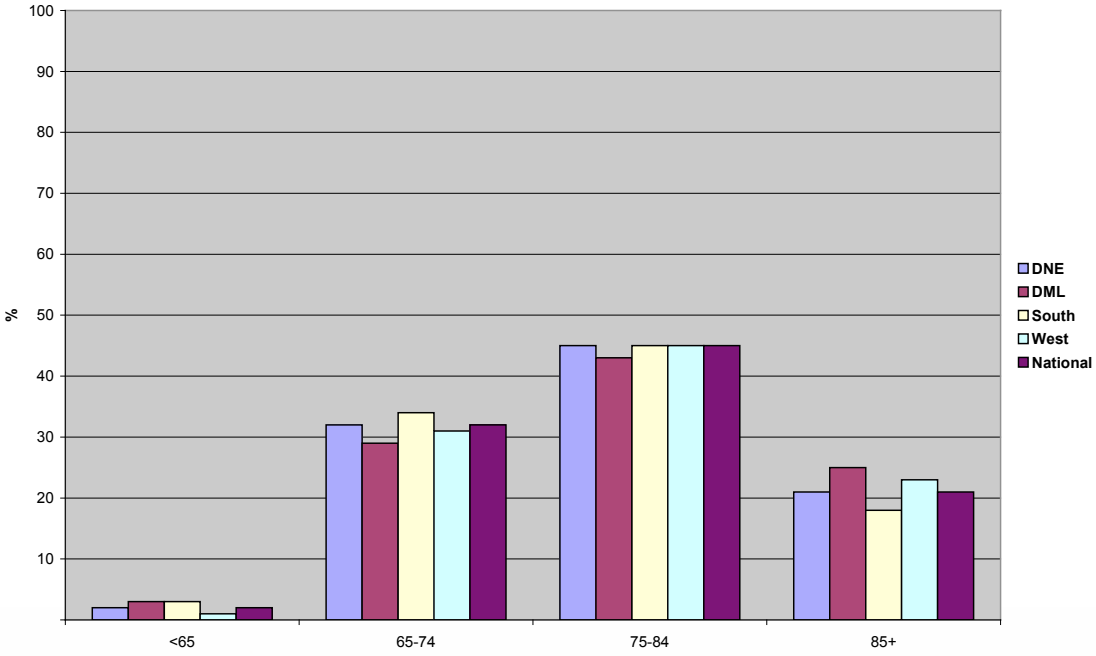



**Figure 18: National and Area Profile of Self-Neglect by Age Category**

Chi square analysis indicated that there was a significant association between gender and age category (14.853, DOF 3, p=.002). Younger males are more likely to be referred (65-74 year age category) while the over 85 year age category shows a higher representation from females. In the HSE South, which has the great proportion of referrals nationally, in the 65-74 year age category, male referrals are twice as likely as females.

In the 2012 Service Developments Report, the high proportion of referrals from DML in the under 65 year age category was highlighted. In 2013 this has decreased from 9% of referrals to 3%. Nationally, 59% of referrals came from the PHN service, ranging from 54% in HSE West and DML to a high of 60% in HSE South. Hospital staff are another main referral group particularly in HSE

West. National statistics indicate that GP referral is marginally higher for self neglect cases relative to elder abuse cases - with the highest level of referral in HSE South at 7%. When origin of the concern was assessed, there was an increase in cases related to family and friends documented as 14% and 6% respectively. Almost exclusively, (96%) of clients reside at home with the balance living in sheltered housing and nursing homes.

**Table 23: National and Regional Profile of Referral Source**

| | DML | DNE | South | West | National |
|---|---|---|---|---|---|
| Self | 1% | | | | |
| Family | 4% | 5% | 5% | 3% | 5% |
| PHN | 54% | 59% | 60% | 54% | 57% |
| GP | 4% | 2% | 7% | 3% | 5% |
| Neighbour/Friend | 1% | 3% | 2% | 3% | 2% |
| Residential Unit | 1% | | | 1% | 1% |
| Carer/Home Help | 3% | | | 2% | 1% |
| Hospital Staff | 9% | 9% | 8% | 19% | 11% |
| HSE Community/PCCC Staff | 11% | 7% | 2% | 3% | 5% |
| Other HSE Staff | 4% | 5% | 7% | 3% | 5% |
| Gardai | 2% | 2% | 5% | 2% | 3% |
| Voluntary Agency | 2% | 2% | 1% | 3% | 2% |
| Local Authority | | 2% | 2% | 2% | 2% |
| Other | 2% | 3% | 2% | 2% | 2% |

Currently, there are 191 cases open - representing 36% of all self neglect cases with results on a par with 2012. The provision of services and supports to individuals that are neglecting themselves, does not involve legal or Garda involvement to the same extent as elder abuse cases more generally. Garda consultation occurred in 4%, Garda notification in 9% and legal action in 3% of cases.

In total, 62% of clients availed of a service, a further 27% declined the service offered while the balance 11% were not offered any service. Home support and monitoring were the dominant services offered. Of particular significance to the older person is the fact that, when looking at overall service provision, the provision of residential care has increased from 8% in 2012 to 12% in 2013. “Other services” related to addiction and cleaning services.

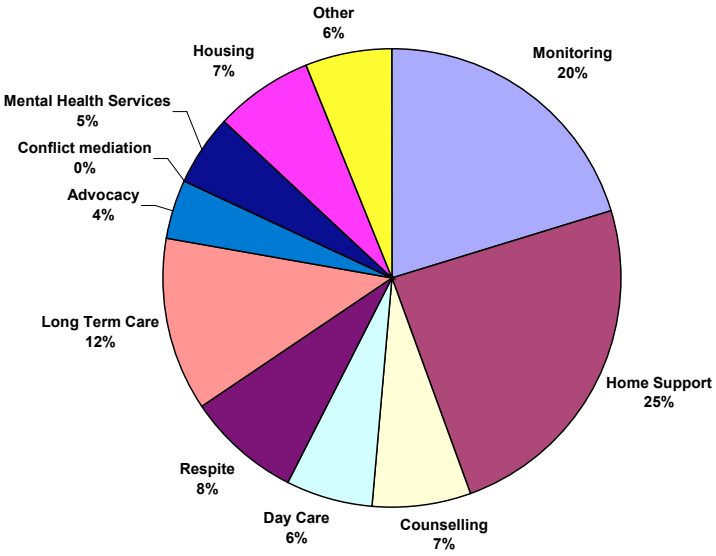



**Fig 19: Profile of Client Interventions for Self Neglect Cases 2013**

Within this group 161 clients had a documented health issue - these related to physical, mental health, dementia and alcohol (fig 13). In comparison to cases of elder abuse the impact of alcohol issues is highly significant in self neglect (18% Vs 5%).

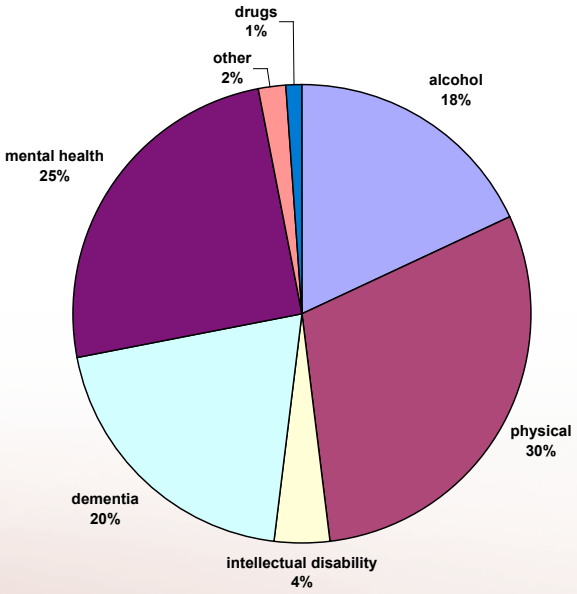



**Fig 20: Identified Issues for the Client**

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# APPENDICES

## Appendix 1
## Membership of the National Elder Abuse Steering Committee

Mr. Frank Murphy, Integrated Services Manager, Mayo, Lead Older Persons Services, HSE West *(Chairperson)*

Mr. Paschal Moynihan, Specialist, Services for Older People, HSE West

Ms. Brenda Hannon, Specialist, Services for Older People, HSE Dublin Mid Leinster

Ms. Bridget McDaid, Dedicated Officer for the Protection of Older People, HSE West

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

Ms. Ger Kane, Domestic Violence, HSE

Ms. Maria Moran, Consultant in Psychiatry of Old Age, HSE

Ms. Hilary Scanlon, Services for Older People, HSE South

Ms. Anne Boland, Director of Public Health Nursing, HSE West

Ms. Maura Seabrooke, Senior Case Worker for the Protection of Older People, HSE Dublin Mid Leinster

Ms Marguerite Clancy, Senior Research & Information Officer, HSE West

Ms. Margaret Kerlin, Team Coordinator, A/Director of Nursing, HSE West

Mr. Pat Doherty, Alzheimer Society of Ireland

Mr. Tony Flynn, COSC, The National Office for the Prevention of Domestic, Sexual and Gender-based Violence

Inspector Declan Daly, An Garda Síochána

Ms. Mo Flynn, CEO, Our Lady's Hospice Ltd., Harold's Cross & Blackrock

Ms. Miriam McGuinness, Area Manager, Older Person Services, HSE West

Ms. Louise O'Mahony, Irish Banking Federation

Mr. Eamonn McCarthy, Dedicated Officer for the Protection of Older People, HSE South

Mr. Frank McHugh, Senior Case Worker for the Protection of Older People, HSE Dublin Mid Leinster

Ms. Margaret McMenamin, CNS, Psychiatry of Old Age, HSE

Ms. Roisin Maguire, Specialist, Older Person Services, HSE Dublin North East

Ms. Jacinta Brennan, Senior Case Worker for the Protection of Older People, HSE South

Mr. Seamus Egan, Senior Case Worker for the Protection of Older People, HSE West

Mr. John Farrelly, Health Information and Quality Authority

Ms. Amanda Casey, Head Medical Social Work, Mater Hospital

Ms. Mary Saunderson, Services for Older People, Department of Health

## Appendix 2
## 'Open Your Eyes' Elder Abuse National Conference Programme

# World Elder Abuse Awareness Day Conference

## Thursday, June 13th 2013

**World Elder Abuse Awareness Day** (WEAAD) is marked in June each year. Established by the International Network for the Prevention of Elder Abuse (INPEA) in 2006 and ratified by the United Nations in 2011, the day serves as a call to action to individuals, organisations and communities to raise awareness of abuse, neglect and exploitation of older people. On **Thursday, June 13th 2013**, the National Centre for the Protection of Older People (NCPOP), University College Dublin, in collaboration with the International Network for the Prevention of Elder Abuse (INPEA) will jointly host a national conference to mark **World Elder Abuse Awareness Day**. The conference will take place at the **Health Sciences Centre, University College Dublin.**

R.S.V.P. ncpop@ucd.ie or telephone +353 (0)1-7166467 by Friday, 7th June 2013

| | |
|---|---|
| **SESSION ONE** | Chair: Professor Gerard Fealy, Director, National Centre for the Protection of Older People at UCD |
| 09.00-10.30 | **Registration and refreshments** |
| 10.30-10.35 | **Welcome** |
| 10.35-11.00 | **Opening Address**<br>Ms. Emily O'Reilly, Ombudsman and Information Commissioner |
| 11.00-11.30 | **Piloting elder abuse screening tools in Ireland**<br>Dr. Amanda Phelan, Co-director, National Centre for the Protection of Older People at UCD |
| 11.30-12.00 | **Case study - Responding to elder abuse in the community: A collaborative approach**<br>Ms. Maggie McNally, Senior Case Worker for the Protection of Older People, HSE West |
| 12.00-13.00 | **Lunch** |
| **SESSION TWO** | Chair: Dr. Amanda Phelan, International Network for the Prevention of Elder Abuse (INPEA) |
| 13.00-13.30 | **The role of empowerment in the prevention of elder abuse**<br>Dr. Deirdre O'Donnell, Post-Doctoral Research Fellow, National Centre for the Protection of Older People at UCD |
| 13.30-14.30 | **Keynote Address: Screening for and detecting elder abuse**<br>Dr. Claudia Cooper, Senior Lecturer and Honorary Consultant in Old Age Psychiatry, University College London |
| 14.30-14.50 | **Response to Keynote Address**<br>Senator Mary White, Tithe an Oireachtais |
| 14.50-15.00 | **Closing Remarks**<br>Professor Gerard Fealy, Director, National Centre for the Protection of Older People at UCD |

***The signing of the INPEA Declaration by the Lord Mayor of Dublin, the Deputy Garda Commissioner and the Dean of Nursing and Head of the UCD School of Nursing, Midwifery and Health Systems will take place at 10am.***

R.S.V.P. ncpop@ucd.ie or telephone +353 (0)1-7166467 by Friday, 7th June 2013

## Appendix 3
## Elder Abuse Record of Initial Referral - Form 5

### FORM 5: Senior Case Worker's Record of Initial Referral (2013)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**Local Health Office:** _____ **Date Referred:** _____

**Client Referral No.:** _____ **Any Previous Client Referral No.:** _____

**Date of 1st Response:** _____

**1. Gender:** Male ☐ Female ☐

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

**3. Who referred to SCW? *tick one option*)**

Self ☐ Family ☐ PHN/Community RGN ☐ GP ☐ Neighbour/Friend ☐ Residential Unit ☐

Carer/Home Help ☐ Hospital Staff ☐ HSE Community / PCCC staff ☐ Other HSE Staff ☐ Gardaí ☐

Voluntary Agencies ☐ Local Authority ☐ Other ☐ *(please specify)* _____

**4. Where did concern first originate? *tick one option*)**

Self ☐ Family ☐ PHN/Community RGN ☐ GP ☐ Neighbour/Friend ☐ Residential Unit ☐

Carer/Home Help ☐ Hospital Staff ☐ HSE Community / PCCC staff ☐ Other HSE Staff ☐ Gardaí ☐

Voluntary Agencies ☐ Local Authority ☐ Other ☐ *(please specify)* _____

**5. Reason for Referral (*tick as many alleged abuse types as apply*)**

Physical Abuse ☐ Sexual Abuse ☐ Psychological Abuse ☐ Financial / Material Abuse ☐

Neglect / Acts of Omission ☐ Self-neglect ☐ Discrimination ☐

**6. Primary Place of Residence (*tick one option*)**

Own Home ☐ Relatives Home ☐ Private Nursing Home ☐ Boarding Out / Sheltered Accommodation ☐

Public Continuing Care (e.g. HSE CNU / Welfare Home) ☐ Other ☐ *(please specify)* _____

**7. Location where Alleged Abuse took Place (*tick one option*)**

Place of Residence as Above ☐ Day Care ☐ Unknown ☐ Other ☐ *(please specify)* _____

If the allegation of abuse relates to the environment, practices or systems of work within an organisation where there is no one individual / group of individuals causing concern, please tick here ☐ and skip Qs 8-11. Qs 8-11 should also be skipped in cases where self-neglect is the only reason for referral.

**8. Number of Persons Allegedly Causing Concern** _____

**9. Gender of Person(s) Allegedly Causing Concern (*please state number for each gender*)** Male _____ Female _____

**10. Person Alleged Causing Concern (*tick as many as apply*)**

Son/Daughter ☐ Partner/Spouse ☐ In-Law ☐ Other Relative ☐ Neighbour/Friend ☐ Carer/Staff ☐

Other Service User ☐ Volunteer ☐ Other ☐ *(please specify)* _____

**11. Is Person(s) Allegedly Causing Concern Living with the Older Person? (*tick one option*)**

Yes ☐ No ☐ Sometimes ☐ Don't Know ☐

**12. Have you Consulted with the Gardaí?**

Yes ☐ No ☐

**13. Referral to Gardaí?**

Yes ☐ No ☐ If yes, by whom: _____

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

***Date Received by Dedicated Officer:*** _____

# Appendix 4
# Elder Abuse Follow Up on Record of Initial Referral - Form 6

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

## FORM 6: Senior Case Worker's Follow-Up Record of Initial Referral (2013)

**Local Health Office:** _____ **Date Referred:** _____

**Client Referral No.:** _____ **Any Previous Client Referral No.:** _____

**1. Status of Case (a)** Ongoing ☐ Closed ☐ Client Deceased ☐ Person Allegedly Causing Concern Deceased ☐

**2. Status of Case (b)** Allegation Substantiated ☐ Confirmed Non-Abuse ☐ Inconclusive ☐

**3. If allegation has been substantiated, complete the details in the box provided below** *(use one row for each abuse type and / or perpetrator)*

| Type of abuse substantiated<br>*State 1 per row* | Relationship to client of person against whom abuse has been substantiated<br>*State 1 per row* | Gender of perpetrator | Is perpetrator living with client | Detail of abuse substantiated<br>(include as many as apply) |
|---|---|---|---|---|
| *Physical; Financial / material; Sexual; Neglect / Acts of omission; Psychological; Discriminatory* | *Son/Daughter; Spouse/Partner; In-Law; Other relative; Neighbour / friend; Carer /Staff; Other Service User; Volunteer; Other (please specify)* | *Male or Female* | *Yes; No; Sometimes* | see notes for coding |
| e.g. Physical | Son | Male | Yes | 11, 16 |
| e.g. Extreme self-neglect | n/a | n/a | n/a | n/a |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Note on Qs 4-16.** For first form 6 on each client please answer all questions. For second and subsequent form 6s on each client please update Qs 3-16 with any new information / changes only since the previous form 6 was completed. **If no changes please leave blank.**

**4. Have the Gardaí been notified?** Yes ☐ No ☐ If yes, by whom: _____

**5. Legal Action Recommended to Client?** Yes ☐ No ☐

**6. Legal Action Taken?** Yes ☐ No ☐

**If yes:** Ward of Court ☐ Domestic Violence Act ☐ Nursing Home Regulations / Act ☐ Family Law ☐

Mental Health Legislation ☐ Criminal Proceedings ☐ Other *(please specify)* _____

**7. Service Offered to Client Referred** Yes ☐ No ☐ Service Offered but Declined ☐

**8. Indicate Client Interventions that have been put in place * not restricted to SCW interventions* (*tick as many as apply*)**

Monitoring ☐ Home Support Services ☐ Counselling/Support ☐ Day Care ☐ Respite Care ☐ Long-Term Care ☐ Advocacy ☐

Mediation/Conflict Resolution ☐ Mental Health Services ☐ Housing Support ☐ Referred Other Service *(please specify)* _____

**9. Any Actions Taken Re: Person Allegedly Causing Concern (*tick as many as apply*)** Garda Action ☐ Support Offered ☐

Disciplinary Action ☐ Service Offered but Declined ☐ Referred Other Service *(please specify)* _____

**10. Suspected / Possible Issues for Person Allegedly Causing Concern (*tick as many as apply*)**

Drug ☐ Alcohol ☐ Physical ☐ Intellectual Disability ☐ Mental Health ☐ Other ☐ *(please specify)* _____

**11. Suspected / Possible Issues for Client (*tick as many as apply*)**

Drug ☐ Alcohol ☐ Physical ☐ Intellectual Disability ☐ Dementia ☐ Mental Health ☐ Other ☐ *(please specify)* _____

**12. Case Meetings held?** Yes ☐ No ☐ If yes, please state **total** number since case was opened: _____

**13. Case Conference held?** Yes ☐ No ☐ If yes, please state **total** number since case was opened: _____

**14. Family Meetings Held?** Yes ☐ No ☐ If yes, please state **total** number since case was opened: _____

**15. Medical Assessment of Client?** Yes ☐ No ☐

**If yes:** GP ☐ Geriatrician ☐ Mental Health Physician ☐ Other ☐ *(please specify)* _____

**16. Professionals / Services Consulted with during SCW Assessment** PHN ☐ GP ☐ Geriatrician ☐ Mental Health ☐

Nursing Home ☐ Medical/Primary Care Social Worker ☐ Occupational Therapist ☐ Physiotherapist ☐ Home Carer ☐ Local Authority ☐

Probation and Welfare ☐ Gardaí ☐ Solicitor ☐ Other ☐ *(please specify)* _____

**17. Case outcome (to be completed on case closure of substantiated cases only)**

The abuse is ongoing ☐ the abuse has lessened ☐ the abuse has stopped ☐

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

**Date case closed (if applicable):** _____ ***Date Received by Dedicated Officer:*** _____

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Information Line

**1850 24 1850**

Website

**www.hse.ie**

**OPEN YOUR** EYES - *There is No Excuse for Elder Abuse*

**HSE Elder Abuse Services 2013**