



USE AS ABUSE A FEASIBILITY STUDY OF ALCOHOL-RELATED ELDER ABUSE

Small Grant Final Report

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EXECUTIVE SUMMARY

Alcohol-related elder abuse is largely absent from the elder abuse and domestic violence literature. Although alcohol misuse is consistently identified as a risk factor for abuse, the problem manifests itself in a variety of ways and is not well understood theoretically or in direct practice with older people and their families. Thus, it remains an important area for research to more thoroughly understand its role in elder abuse, how to prevent or remove this risk factor, and how to assess and intervene when it emerges in practice.

The aim of this feasibility study was to begin to explore the alcohol-related elder abuse problem in England and begin to characterise its role in cases of elder abuse, how practitioners were responding in these situations, and identify areas for further investigation. Funded by Alcohol Research UK, this study was the first of its kind in England. The methods adopted in this investigation included a review of the literature and existing data sets, a review of case files from one local authority adult safeguarding team and in-depth interviews with a sample of safeguarding and specialty alcohol practitioners.

The findings from our investigation corroborate much of the existing literature that has primarily been produced in North America. Furthermore, these insights help to illuminate the subject area in England, extend our understandings in relation to community-based interventions and identify opportunities for further enquiry. The major findings are as follows:

- Alcohol misusing elder abuse victims tended to be male, slightly younger than other victims, and abused by someone outside the family system. Their vulnerability for abuse seemed to be exacerbated by issues such as declining health, social isolation and possibly longstanding problems with alcohol.
- Alcohol misusing elder abuse victims were twice as likely to be financially abused than non-alcohol misusing victims.
- Alcohol misusing perpetrators tended to be male and a family member.
- Physical abuse was more commonly identified by practitioners in cases with alcohol misusing perpetrators.

- Specialty alcohol practitioners described their role as minimising the vulnerability to misuse alcohol and thereby reducing the risks for abuse. Safeguarding practitioners reported their role as a regulated one and their priority was to respond to referrals of older alcohol misusing victims who lacked mental capacity.
- Practitioners were most challenged by cases where alcohol misuse had led to self-neglect or where the perpetrator was an alcohol misusing family member.
- Evidence-informed community-based interventions were not identified.

We conclude that this study offers an opportunity to expand our empirical understandings of alcohol-related elder abuse with a view to further mixed methods exploration in some of the following areas:

- Further definition and characterisation of alcohol misuse as a risk factor for elder abuse (e.g., constructing explanations for who is misusing, nature of the misuse and abuse, relevance in family care system, self-neglect, relationship with other risk factors);
- Exploration of practitioner assessment tools in relation to alcohol misuse and elder abuse; and
- Developing and testing interdisciplinary social interventions, including education and training for practitioners and older people.

BACKGROUND AND STUDY AIMS

1.1 Introduction

In 2000, the Department of Health's *No Secrets* outlined a national framework for the development of local multi-agency codes of practice for the protection of vulnerable adults, representing one of the first policies that formalised the link between vulnerability, at any age, and abuse. As such, local council social services departments were required to act as lead agencies in developing strategic partnerships to implement the guidance on adult safeguarding.

Elder abuse falls within this guidance, and in 2012-13, 61 percent of all referrals to safeguarding in England were for people aged 65 years and older (Health and Social Care Information Centre (HSCIC), 2013). Alcohol misuse¹ as a risk factor for abuse in older age is consistently identified in the literature, and yet little is understood about the nature of this relationship, its impact on older people and families and what interventions are most effective. Its relevance to older people and abuse is significant in light of some of the adult drinking patterns in England.²

It is not possible within the scope of this report to critique this volume of literature as might be ideal. To set out the relevant background literature relevant to alcohol-related elder abuse, it is necessary to first consider elder abuse or elder mistreatment³ more broadly. Its introduction to the reader helps to illuminate the problem of elder abuse with alcohol involvement by the victim or the perpetrator. Older people and domestic violence are often overlooked in the traditional domestic violence literature, but we also draw on some of it here. Following on, the current state of knowledge pertaining to alcohol-related elder abuse is more specifically considered.⁴

¹ Throughout this report (apart from the background literature) we adopt the term alcohol misuse rather than alcohol or substance abuse.

² According to the General Lifestyle Survey (2011), 34 percent of men and 28 percent of women drank more than recommended on at least one day in the last week, and 18 percent of men and 12 percent of women drank heavily (twice recommended) on at least one day last week. Twenty percent of men and 12 percent of women over 65 years of age reported exceeding guidelines at least once in the last week, and 6 percent of men and 2 percent of women drank heavily at least once in the last week.

³ The terms elder abuse and elder mistreatment are used interchangeably within this report.

⁴ Due to the limited scope of this report we do not present a large volume of literature that repeatedly identifies the need for practitioner education and training in the areas of elder abuse and alcohol misuse (e.g., Pillemer et al., 2011; Wadd et al., 2011).

1.2 Elder abuse

The International Network for the Prevention of Elder Abuse (INPEA) conducted the first world wide environmental scan on elder abuse 2010 and confirmed elder abuse as a social problem around the globe (Podnieks et al., 2010). With an ageing population and increasing numbers of vulnerable older people, it was argued that this problem was gradually receiving attention in both the global north and south. Research, albeit limited, was also beginning to clarify how abuse or mistreatment manifested itself. Broader efforts, such as those of both the World Health Organisation and INPEA, were focusing on awareness campaigns, education and training, and lobbying policymakers to ensure laws and services were in place to protect some of society's most vulnerable citizens.

Although its conceptualisation is widely contested (De Donder et al., 2011; McDonald, 2011; Lowenstein, 2009), elder abuse is most commonly 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”* (WHO, 2002, p. 3). Types of elder abuse include: (i) physical (e.g. pushing, slapping, hitting, overmedicating); (ii) psychological/emotional/verbal (e.g. mental pain or distress through verbal or nonverbal acts such as abusive language, shouting, threats, humiliation, isolation); (iii) sexual (e.g. non-consensual sexual contact of any kind); (iv) financial/material (e.g. illegal or improper use of funds, property or assets); and (v) neglect (e.g. refusal or failure of those responsible to provide essential assistance) (WHO, 2002). In addition to these five categories, other types of abuse sometimes considered are the violation of human rights and self-neglect. Self-neglect is defined by Gibbons and colleagues (2011) as *“the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to their community”* (p. 16). In this definition the issue of intentional or non-intentional neglect or harm is purposively highlighted, but is also a relevant consideration in the other categories of abuse.

Methodological challenges have meant that prevalence rates, including where, when and how elder abuse happens, remain problematic and poorly understood

(DeDonder, 2011). In addition, the sensitivity of the topic has meant that older people have been hesitant to talk. Thus elder abuse remains largely 'hidden' (Lowenstein, 2009) and under reported (Podnieks et al., 2010; McGarry and Simpson, 2009). Although WHO (2002) estimated that between 4-6 percent of community-dwelling older people (65 years and older) experienced abuse, DeDonder and colleagues (2011) found reported rates in the literature ranging from 0.8 to 29.3 percent. These inconsistencies are explained by the various methodological issues identified in the literature, for example, the use of various operational definitions of elder abuse, choices of measurement instrument and other considerations such as sample age, when the abuse occurred, cultural differences and so forth (DeDonder, 2011; Podnieks et al., 2010).

In the UK, the only prevalence study was conducted by O'Keefe and colleagues in 2007. It was not immune to some of the methodological challenges mentioned above and as a result this figure should be considered with a critical lens. Conducting interviews with 2,111 people over the age of 66 selected from government commissioned health surveys, the study concluded a prevalence rate to be 2.6 – 4 percent, or approximately 277,000 to 342,400 community-dwelling older people. The most common form of mistreatment 'in the past year' was neglect (1.1%) followed by financial abuse (0.7%). Women were abused more than men, and the perpetrator more commonly a family member. Other characteristics associated with abuse included declining health, living in rented accommodation, and mental health issues such as loneliness and depression. A tendency to overlook multiple forms of abuse was noted here as in many other elder abuse studies.

Other studies have identified similar findings regarding the characteristics of victims and perpetrators. In the national profile of elder abuse referrals in Ireland (N = 1,508) (Clancy et al., 2011), sixty-seven percent of the victims were women and rates of abuse were as follows: emotional/psychological (29%), neglect (22%), financial (19%), and physical (15%). Interestingly, in 36 percent of cases where more than one of type of abuse occurred, emotional and financial abuse was the most frequent combination. Victims tended to be older (80 years and older), have dementia or another mental health problem (11.8% and 27.2%), living in their own home, and abused by a son or daughter (43%). These characteristics were reasonably consistent with the UK prevalence study and a case study of adult protection two

English local authorities (Milne et al., 2013). Only 23 percent of the cases in the Irish profile were substantiated and these tended to be cases of physical abuse where, not surprisingly, there is often more objective evidence obtained by way of a police investigation to support the claims.

Using stratified random digit dialing, Amstadter and colleagues (2010) conducted telephone interviews with 5,777 people over the age of 60 years across the United States. One in ten described one form of mistreatment of which most had not been reported. For example, 4.6 percent reported emotional abuse and 1.6 percent physical abuse. This study identified key differences in the characteristics of the abuse according to gender. Women who had been emotionally abused tended to need help with activities of daily living and be perpetrated against by a relative. Men were more likely to be dependent on the perpetrator. In terms of physical mistreatment, men were more likely to be abused by individuals who were unemployed and have a history of legal problems whereas women were more likely to be living with the perpetrator who was more likely to be a relative.

Penhale's (2010) review of the empirical literature also reinforced many of the above characteristics associated with abuse. More importantly though, she drew specific attention to whether the literature supported the most recognised risk factors for abuse. In brief, it was evident that there was support for 'intra-individual dynamics' (psychopathology of the abuser such as mental health problems or substance abuse). In regards to the risk for 'intergenerational transmission of violence', Penhale (2010) argued that there was little evidence to support this as a risk factor, but noted the difficulty in researching this area. For the issues of 'dependency' and 'stress' (either victim or perpetrator) she acknowledged there was conflicting evidence, but on review there was more support for dependency and stress to be a risk rather than protective factor. Finally, for 'social isolation' as a risk factor, the evidence was inconsistent. Given more recent evidence suggesting that ageism, poverty and minority status were also risk factors (Podnieks et al., 2010), Penhale (2010) concluded that assessments of risk and interventions should be multi-level considering and addressing issues at the micro, meso and macro levels pertinent to the individual/family system and type of abuse (thus avoiding the tendency to aggregate risk factors for all forms of abuse). This recommendation would also support the more recent arguments, and those of the authors of this

report, for an integrated theoretical understanding of abuse that combines social, cultural, psychological and structural understandings to corroborate a more comprehensive understanding of why it occurs and how to intervene (McDonald, 2011).

1.3 Alcohol and domestic violence

Considering alcohol and the domestic violence literature more broadly, we confront additional challenges in the state of the art knowledge. Research has been limited by issues such as access to data, the invisibility of the problem, how to ask the right questions, social context and attitudes, among others (Plant et al., 2002). It would appear, though, that there is an unchallenged understanding that there is a 'significant overlap' between alcohol and domestic violence, and yet still a daunting task to unravel the complex associations for victims and for perpetrators. The problem is exacerbated by the fact that domestic violence and substance abuse are usually distinct entities in both policy and practice (Humphreys et al., 2005; Krug et al., 2002). Nevertheless, given we are to understand that domestic violence does not 'age out' (Band-Winterstein and Eislovits, 2009), this body of literature has significance when we consider elder mistreatment.

What is generally understood in relation to domestic violence and alcohol misuse? According to Humphreys et al. (2005), survivors of domestic violence are vulnerable to drug and alcohol abuse. For example, Swan et al. (1993) found 60 percent of women across eight substance abuse services (N = 360) reported experiencing current or past domestic violence. Further explanations regarding whether women used substances to cope with the abuse or whether the abuse made them more at risk for abuse or whether a cyclical pattern existed is still necessary. In regards to perpetrators of violence the arguments are much stronger that there is an overlap with substance abuse (Humphreys et al., 2005). For example, a study examining the British Crime Survey revealed that 44 percent of perpetrators of domestic violence were under the influence of alcohol (Budd, 2003). Similar findings were reported by Hutchinson (2003) following an analysis of 419 police call outs for domestic violence. Not unexpectedly, further explanations on the relationship with amount consumed, what was consumed and when (i.e., when sober or when drunk), remain contested (Humphreys et al., 2005).

There are two remaining points that we need to draw attention to in order to further understand the complexities when examining domestic violence (and elder abuse) and alcohol misuse. First, theoretical explanations appear to be fragmented, and where a comprehensive model exists such as an ecological one as argued by Krug et al. (2002), further research is required to fully understand its relevance in multi-level intervention strategies. And, there remains a significant hurdle with respect to interagency involvement and their response to dual problems with, as per an ecological or integrated theoretical approach, a host of complex origins (Humphreys et al., 2005).

1.4 Alcohol-related elder abuse

Research that attends to alcohol-related elder abuse has not escaped the problems highlighted above. Having said this, alcohol as a risk factor has received no more or no less attention than most other risk factors for abuse. For example, in the very recent review of safeguarding referrals in two local authorities by Milne et al. (2013) there is no mention of alcohol at all. This may reflect Penhale's (2010) critique that risk factors tend to be judged as a whole for all types of abuse rather than detailed consideration of which risk factor (s) is more or less relevant for each form of abuse. In the late 1970's and early 1980's in North America, early investigations attended to practitioner awareness of elder abuse and perceptions of what it looked like including potential causes. Reports by Douglass et al. (1980), Jacobs and Dentel (1984), Lau and Kosberg (1979) and Kosberg (1988) began to suggest that substance abuse had a possible role in elder abuse, and Pillemer and Finkelhor (1989) inferred that alcohol reduced a carer's ability to deal with stress or increase their tolerance for abuse infliction. As the 1980's progressed more specific evidence began to emerge, although an in-depth understanding of the dynamic nature of alcohol and abuse remained practically unexplored. Wolf and colleagues (1986) investigated cases across three projects for older people and found that perpetrators of physical and financial abuse were prone to alcohol abuse. It was not clarified what was understood by being prone to alcohol abuse, however. Further comparisons of 59 abused with 49 non-abused older people found that one third of the abusing caregivers had a problem with alcohol. In a small study conducted by Bristowe and Collins (1989) comparing 29 abusive cases with 39 case controls, alcohol was also

identified as a problem in the abusive cases. Examining 204 substantiated abuse cases by adult children, Greenberg et al. (1990) found that over half the sample (44% of sons and 14% of daughters) was abusing alcohol or drugs.

As the 1990's progressed Anetzberger and colleagues (1994), as part of a larger family violence investigation, compared 23 physically abusing adult caregiver children with 39 non-abusing caregiver children. The samples were drawn from social services and participants were interviewed by the investigators using a structured format. Adult children were predominantly White with incomes under \$20,000 per year, and more likely to be unmarried males. Abused victims were younger than their non-abused counterparts, and both groups tended to be female. In relation to alcohol misuse specifically, abusers were twice as likely to be drinking during the period of time being investigated, and tended to drink more frequently and more heavily. Two thirds of the abusers drank on a daily basis (27.3% non-abusers), and were significantly more likely to state they drank to feel good and to get drunk. Only one fourth of the abusers thought they had a drinking problem, but half reported they had been told by someone else there was a problem.

Hwalek and colleagues (1996) used the elder abuse management information system in Illinois to explore whether substances were a risk factor predicting specific forms of abuse, a factor related to the severity of the abuse and a variable related to a risk for future abuse. The authors point out that practitioners were trained in using the established recording system, but it did not emphasise substance abuse identification. The sample consisted of 552 closed substantiated cases. The findings indicated that 4 percent of victims and 13 percent of abusers were recorded as abusing substances. When the abuser had a substance abuse problem the victim was also likely to a substance abuser (9%). Abusers were likely to be men, a child of the victim and not primarily responsible for the victim's care. Cases involving perpetrators who were abusing substances were more likely to involve physical and emotional abuse, and less likely to involve neglect. Financial abuse was unrelated to a perpetrator abusing substances and this was similarly found by Sharon (1991). Finally, at intake victims with substance abusing abusers were rated at high risk for future abuse (24%) compared with 16 percent of cases where substance abuse had not been identified.

A large interview study by Brownell and colleagues in New York (2000) provided another more thorough consideration of alcohol-related elder abuse through an exploration of abuser pathology and criminal justice engagement. In the study time frame there were 161 perpetrators with detailed information on their mental health (including substance abuse) (Black, 41%; White, 36%; and Hispanic, 23%). Of these 82 (51%) were identified as substance abusers. Further reported details indicated that 52 abused both drugs and alcohol, 15 only drugs and 15 only alcohol. Most were male (70%), unemployed (91%), lived with the victim (83%) and were adult children (59%). The types of abuse identified were psychological (64%), financial (64%), physical (45%) and neglect (18%).

Additional empirical literature has given only scant attention to alcohol-related abuse. Two of these were larger scale studies to profile elder abuse more generally and draw out some data pertaining to substance abuse. Recalling from Section 1.2, the first study collected self-report data from a random sample of older people (N = 5,777) with one in ten sampled reported experiencing abuse. To determine if the perpetrator had problems with drugs or alcohol, the participants were asked, "*Did that person have a problem with alcohol or drugs at the time of the incident?*" (Amstadter et al., 2010, pg. 48). In relation to the 254 older people (4.6%) who reported emotional abuse, 28.9 percent of the female and 22 percent of the male perpetrators were reported to have a substance problem. Only 86 (1.6%) of the sample reported being physically abused. Significant percentages of these abusers were reported to have a substance problem (65.9% male and 53.8% female). For sexual abuse (0.6%), 21.7 percent of female and 26.5 percent of male perpetrators were reported to have a substance problem. Clancy et al.'s (2011) profile of elder abuse cases in Ireland revealed that 8 percent of 1,068 victims and 31 percent of 586 alleged abusers also had alcohol misuse identified although it is not clear how the misuse was defined.

A number of smaller scale studies draw out the significance of alcohol in cases of physical abuse and support some of the previous evidence. Some 45 percent of English carers receiving respite admitted to administering some form of abuse and "harmful" alcohol consumption was identified as significant in relation to cases of physical abuse (Homer and Gilleard, 1990). Campbell Reay and Browne (2001) reported that seven of nine carers who physically abused an elderly relative

consumed over 21 units per week. Finally, Freidman et al. (2011) studied the files of 41 cases of physical abuse seen in an emergency department (123 case controls) and in the final multivariable logistic regression model, victims of severe traumatic elder abuse were more likely to be female, to have a neurological or mental disorder, and to abuse drugs or alcohol. They reported that based on narratives from emergency staff, in many cases, both the victim and abuser were drinking before the assault.

The above studies avoid serious consideration of an older victim who is misusing alcohol. Conversely, a recent randomly selected sample (N = 4,467) of older people aged 60-84 years across seven European cities found alcohol misuse among older people (64.2%) to be positively associated with psychological abuse and negatively associated with financial abuse. The psychologically abused older drinkers were consuming three or more drinks a day (Tredal et al., 2013).

Issues such as cognitive impairment or frailty as a result of alcohol misuse and increasing a person's vulnerability for abuse were sometimes captured in grey literature (e.g., Spencer, 2005) or in textbooks (e.g., Bradshaw and Spencer, 1999). Other concerns identified by Bradshaw and Spencer (1999) included older people drinking to cope with abuse and carers or others encouraging older people to drink to exploit them. These facts were principally based on practitioner perceptions; nevertheless similar concerns were reported by Choi and Mayer (2000) in a case-controlled study of an adult protection unit in New York State.

1.5 Self-neglect

Self-neglect, as a specific form of abuse for older people who drink, did emerge in the literature. We consider some of the literature here despite it sometimes being classified as a problem distinct from other forms of abuse, and it not characteristically a problem addressed by adult protection services in the United Kingdom.

It would appear that there was general agreement that characteristics such as dementia, mental health problems, and substance abuse were significant risk factors for self-neglect (Gibbons et al., 2011; Braye et al., 2011; Spensley, 2008;

Blondell, 2000). Choi and Mayer (2000) found a significant difference in the percentage of self-neglect cases with a substance abuse problem (10.4% of 192 cases) versus alcohol and other forms of abuse. From a review of the literature, Blondell (2000) presented a detailed review of the areas of possible neglect and possible consequences and these are outlined in Table 1 below. We would argue that external risk factors also require thorough consideration. An essential theme drawn from the literature was the challenge in identifying abuse and neglect by others apart from self-neglect (Choi and Mayer, 2000).

Table 1: *The possible consequence of alcohol misuse and self-neglect in older people*

Areas of neglect	Consequences
Basic needs (e.g., food, sleep, neglecting physical health)	Geriatric squalor syndrome Malnutrition Poor health care Acute medical problems Chronic disease
Safety needs (e.g., home security, fire, falls, mugging)	Unintentional injuries: burns motor vehicle accident drowning falls Suicide Victim of assault/violence Victim of neglect
Psychosocial needs (e.g., social engagement)	Depression Dementia (Wernicke-Korsakoff Syndrome) Social isolation: loss of independence estrangement from family estrangement from neighbours/health and social services loss of friends Low self-esteem

The literature on self-neglect was also complex and there appeared to be no definitive understanding of causation or effective intervention strategies. Interestingly, the Braye et al.'s (2011) review of self-neglect highlighted considerable uncertainty among practitioners on how to manage it in the community. More importantly, an assessment of decision-making capacity was regarded as the first point for any professional action. Values such as autonomy and self-determination versus dignity and duty to care seemed to frame any additional interventions.

1.6 Study aims and research questions

The purpose of this feasibility study was to collect substantive pilot data to scope the extent of alcohol-related elder abuse and neglect, and evaluate data sources and research methods to consider the development of a larger study on the role of alcohol misuse in cases of elder abuse and neglect. The research questions were as follows:

- What is the relationship between alcohol misuse and elder abuse and neglect?
- To what extent does alcohol misuse feature in elder abuse and neglect cases referred to local authority Safeguarding Adults Teams, and what are the key characteristics of such cases?
- How do local authority Safeguarding Adults Teams and specialised alcohol treatment programmes perceive the role of alcohol misuse in relation to the problem of elder abuse and how are they responding to the problem?
- What other professionals are mobilised by Safeguarding Adults Teams and specialised alcohol treatment programmes when there is alcohol-related elder abuse and neglect, and how do they work together to address the issue (s)?

STUDY DESIGN

2.1 Methods

In addition to conducting a review of the literature, including existing secondary data, new data was obtained from the following methods:

- Using data from the case reporting requirements from one local authority Adult Safeguarding Team, descriptive detailed analysis was undertaken to identify the occurrence of alcohol-related elder abuse and neglect and case characteristics. We focused on the most recent 2-year period (2010/11 and 2011/12) as this reflected the government's introduction of comprehensive reporting requirements in adult protection.
- A purposive sample of practitioners was recruited from a safeguarding team and specialty alcohol programmes for older people for in-depth interviews using the critical incident technique.

Ethics approval was obtained from the School of Health Sciences and Social Care Research Ethics Committee, Brunel University.

2.2 Data collection and analysis

2.2.1 Literature review

The literature was reviewed using a number of electronic data bases including PsycINFO, Medline, Social Sciences Citations Index and Google Scholar. Dates used for the search included 1980 to 2013⁵. Some of the key words included in the search were: elder abuse, elder mistreatment, alcohol abuse and elder abuse, alcohol and older people, alcohol and interpersonal violence, older people and domestic violence. The literature was not screened for quality given this was not a systematic review.

⁵ Elder abuse research began to emerge in the 1970's in the United States. 1980 marks the beginning of 'second generation studies' and it was at this time that researchers began using higher methodological standards in terms of sampling and instrument selection (Lowenstein, 2009).

The UK Data Service was searched for datasets which included the following combination of terms: alcohol and abuse and alcohol and violence. Datasets were excluded if:

- Data was limited to young adults or children;
- Data was collected prior to 2000;
- The study was conducted in Scotland, Wales or Ireland only; and
- The study was conducted in a specific population such as homeless people or people with mental health problems.

2.2.2 Adult safeguarding case reporting

The local authority in one borough in southeast England with a dedicated Adult Safeguarding Team agreed to participate in the study. According to the 2011 census, the borough's total population was 273,936 with 47,964 (17.5%) people over the age of 60 years. Over half of the population were White British (60.6%). The largest ethnic minority group was Asian or Asian British and made up 25.3 percent of the total population (Office for National Statistics (ONS), 2012). The Adult Safeguarding Team was made up of 12 qualified social workers (10.5 fulltime equivalents) overseen by a manager. Within this local authority's structure, this team investigated all reports of abuse⁶ (i.e. adults at risk)⁷ and they sat within a wider multi-agency response to safeguarding within the local authority as per *No Secrets* (Department of Health (DH), 2000), *Safeguarding Adults* (Association of Directors of Adult Social Services (ADSS), 2005) and the *Mental Capacity Act* (DH, 2005).

Specific procedures and policies were established locally and regionally, and on contact, cases progressed as follows: (a) alert of 'concern' to team; (b) referral and safeguarding procedures initiated; (c) decision; (d) safeguarding plan; (e) review; (f) recording; and (g) monitoring (ADSS, 2005). Importantly, *No Secrets* (2000) emphasised the justification for intervention for people 'at serious risk' of 'significant harm' to prioritise attention to those in greatest need.

⁶ Abuse within the No Secrets Guidance is defined as "a violation of an individual's human and civil rights by another person or persons" (DH, 2000, pg. 9).

⁷ By definition, an adult at risk is an adult 18 years of age and older "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (DH, 2000, pg. 8-9).

As a result of the recommendations emerging from an investigation by the government on recording systems in adult protection (Action on Elder Abuse, 2006), this local authority introduced comprehensive case reporting mechanisms in 2010 and these were maintained via a computerised data system.

All 'alert' case files during the study period were reviewed. No files were excluded. The principal investigator and research assistant (local authority employee) received training on the computer software in advance of data collection commencing and were only permitted access to safeguarding files that were identified by number. This activity was also carefully monitored by the service manager and data protection officer. A review protocol and data abstract tool were developed by the researchers and piloted to ensure the right data or key characteristics would be captured in the review. The established tool that enabled the researchers to collect anonymised data is available in Appendix 1. It is important to note that the files reviewed primarily contained information on the safeguarding investigation and not a holistic assessment of the victim and/or perpetrator. Alcohol misuse was abstracted by the researchers when the investigative report and/or accompanying correspondence identified alcohol as a problem or suspected problem (e.g., "*son always drinking or drunk*"; "*Mrs X has a long standing problem with alcohol*"; "*Mr X was drunk at the time of the incident*"). In instances where alcohol was identified, the researchers also recorded any relevant narrative data (e.g. "*Mr X goes to the Off License once a week or he gives his bank card to his neighbour who buys the cider for him.*")

The file review was conducted from October 2012 until February 2013. The research assistant conducted the majority of reviews with limited assistance from principal investigator who had restricted access to information retained in the files. A sample of files (N = 20) were reviewed by both principal investigator and research assistance to ensure consistency and agreement in data abstraction. The research assistant was then responsible for inputting the data into SPSS (19.0) for analysis. The data was cleaned by statistical advisor who also assisted in this stage of data analysis.

The data set for analysis consisted of 1,197 cases, each containing up to 155 pieces of information on victims and alleged perpetrators. First, basic descriptive statistics were obtained for victims and perpetrators. These data were then broken down by

type of abuse and associations were examined between victim and perpetrator characteristics and types of abuse. Associations were then assessed for statistical significance ($\alpha = 0.05$) and for strength of relationship using chi-square and related statistics (phi-coefficients).

2.2.3 Practitioner interviews

The safeguarding practitioners were recruited from the same local authority. The principal investigator attended a staff meeting to present the aims of the study and outline the expectations of participation. A detailed information sheet was circulated and volunteers asked to contact the researcher directly.

The specialty alcohol practitioners were recruited via a small UK-wide network of older people's alcohol services. Similarly, the principal investigator attended a network meeting to share details of the study. A follow-up email was sent to recruit volunteers to participate in an interview.

During the course of the study the research team was in contact with Action on Elder Abuse (AEA). AEA is a specialist charity that is actively engaged in elder abuse through a variety of activities including education and training, community development and government lobbying. As a result of contact, one member of staff expressed interest in participating in an interview and is included within the safeguarding figures provided in Table 2.

All of the interviews were conducted by the principal investigator. The interviews were conducted using the critical incident technique (CIT) (Flanagan, 1954). The critical incident technique is a well established qualitative research approach that involves participants describing in detail (those experienced and/or observed) relevant incident (s) of a specific activity (i.e., a case of abuse or vulnerability to abuse where alcohol is involved). The outcomes of using this technique are typically practical ones, often involving recommendations for training and education or the need for further knowledge in the area of concern (Kain, 2004). The semi-structured interview schedule is available in Appendix 2.

Table 2: *Interview sample characteristics (N = 12)*

	Safeguarding	Specialty alcohol
Gender		
Male	1	1
Female	5	5
Age		
21-30	1	
31-40		2
41-50	1	1
51-60	4	2
61+		1
Ethnicity		
White British/Scottish	5	6
Asian	1	
Length of time in current post		
1-5 years	5	2
6-10 years		1
11-15 years		2
16-20 years		
20+		1
Unknown	1	
Qualifications		
Qualified social work	5	1
Qualified counsellor		4
Nurse		1
Other	1	
Total	6	6

The interviews, lasting from 60-90 minutes, were audio-recorded. In one instance, permission was not obtained to record the interview and alternatively detailed notes were made. Given the practical nature of the interviews and the investigator not required to have a particular 'closeness' to the data, the interviews were not transcribed verbatim. In this instance, the analysis proceeded consistent with a 6-step approach outlined by Halcomb and Davidson (2006) and which is consistent with the CIT as outlined by Flanagan (1954). The steps involve: (1) audio-recording of the interview and concurrent note taking; (2) reflective journaling immediately post-interview; (3) listening to the audio-recording and amending/revising field notes; (4) preliminary content analysis; (5) secondary content analysis; and (6) thematic review (pg. 41). Data analysis was also conducted by the principal investigator.

FINDINGS⁸

3.1 Secondary data

3.1.1 Existing literature

As noted in Section 1 of this report (and not repeated here), there was a relatively small body of literature specifically addressing alcohol-related elder abuse. It typically originated in North America and had significant limitations due to some of the methodological challenges inherent in conducting investigations in this area. Studies exploring elder abuse or alcohol problems in the older population sometimes revealed relevant data pertaining to alcohol-related elder abuse, but this body of work was also restricted. Briefly, the key themes emerging in the literature were:

- Prevalence rates for alcohol-related elder abuse were not available.
- Intra-individual dynamics (including alcohol misuse or other mental health problems) were a risk factor for elder abuse; however, the complex associations between risk factors (including overlapping risk factors) and abuse (including overlapping forms of abuse) were not well understood.
- Perpetrators who misused alcohol were likely to be men and related to the victim.
- Perpetrators who misused alcohol may neglect, psychologically/emotionally, financially or physically abuse their victim (statistical significance varying across studies).
- Older victims who misused alcohol may be a risk factor for self-neglect, financial and physical abuse.
- Evidence for effective interventions specific to alcohol-related elder abuse was not available.

3.1.2 Other existing data sets

We originally intended on conducting a secondary data analysis of the elder abuse prevalence study conducted in 2007. The researchers learned, however, that a secondary analysis had been conducted by Biggs et al. (2013). Using the sample

⁸ The study findings were presented at a practitioner seminar on 18 October, 2013 (see Appendix 3 for all dissemination activities to date). There were no substantial changes to the interpretation of the data as a result of the feedback from practitioners, and for the most part, practitioner feedback confirmed the analysis was grounded in the data and relevant to the practice context.

from England specifically, Biggs and colleagues were able to merge variables from the prevalence study with data extracted from the 2005 Health Survey for England and conduct multivariate analysis to explore a wider range of factors possibly associated with an individual's experience of abuse. The older person's level of alcohol consumption was not significantly associated with any form of abuse. Detailed information on perpetrators was not available. It is worth emphasising, however, that the methodology of the elder abuse prevalence study has been highly criticised (Fitzgerald, unknown date).

Using the UK Data Service two datasets of interest were identified; the Crime Survey for England and Wales (2011-2012) and the Adult Psychiatric Morbidity Survey (2007). The Crime Survey for England and Wales had a number of self-completion modules which include drinking behaviour and interpersonal violence. However, only those aged 16-59 were asked to complete these modules, therefore this study was excluded.

The Adult Psychiatric Morbidity Survey (2007) contained useful information on alcohol misuse and intimate partner abuse across the age range. The Adult Psychiatric Morbidity Survey was a stratified random probability sample survey of psychiatric morbidity in adults (aged 16 and over) living in private households in England. The survey used a two-phase approach for the assessment of several disorders. The initial interview had face-to-face and self-completion components and lasted an average of 90 minutes. Interviewers carried out structured assessments and used screening instruments for a range of psychiatric disorders, as well as asking questions on other topics, such as general health, service use, risk factors and demographics. The initial interview was followed up with an assessment conducted by a clinically trained research interviewer for a sub-sample of respondents. During the survey, initial questions about any alcohol consumption were asked by the interviewer face to face. All respondents who drank alcohol, even if just occasionally, were routed to the remaining alcohol use questions which were administered using computer-assisted self-completion interview. These included questions from the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993; Bush et al., 1998). A score of ≥ 8 on AUDIT is indicative of a risk of hazardous or harmful drinking. AUDIT score data was available for 1,907 individuals aged 65 and over.

The survey also asked respondents if their “partner” had ever in the last 12 months:

- Prevented them from having fair share of household money
- Prevented them from seeing friends/relatives
- Frightened them by threatening to hurt you or someone close to you
- Pushed, held or pinned them down or slapped them
- Kicked, bit or hit them with a fist or something else
- Choked them or tried to strangle them
- Threatened them with a weapon
- Threatened to kill them
- Used a weapon against them
- Used some kind of force against you

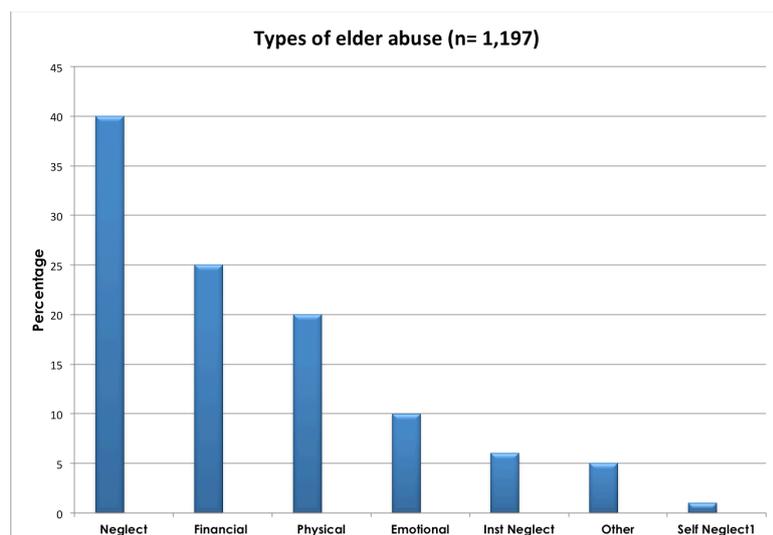
Pearson's chi-squared tests were used to investigate the association between hazardous or harmful drinking (AUDIT score 8+) and the questions on intimate partner abuse. Two variables were positively associated with having an AUDIT score 8+; ever been threatened by a partner with a weapon (3.4% versus 1.3%, $p = 0.023$) and partner ever used a weapon against them (2.6% versus 0.8%, $p = 0.021$).

3.2 Analysis of case files

Figure 1 presents the prevalence rates for types of abuse on referral (N = 1,197). Neglect was the most common form of abuse (40%) followed by financial (25%) and physical (20%). In terms of national statistics for the 2012-13 reporting year, the most common forms of abuse were physical (28%) and neglect (27%) (HSCIC, 2013). As a point of interest, some recent literature has suggested that rates of financial abuse appear to be on the increase (Manthrope et al., 2012; Davies et al., 2011).

As outlined in Table 3, of the 975 unique cases referred to safeguarding the majority were women with a mean age of 80.6 years. Most of the sample lived in their own home (owned or rented), although the media tends to report on abuse in care homes or hospitals. Only 4 percent of the sample included people from ethnic minority groups. These findings are also consistent with national safeguarding statistics (HSCIC, 2013).

Fig 1: Rates of types of elder abuse



The reported rates of alcohol misuse (i.e., where alcohol was identified as a problem or suspected problem within the investigative report and accompanying correspondence), 5 percent of victims and 41 percent of perpetrators (N = 133), were not too dissimilar to those emerging in the Irish national profile of elder abuse (8% and 31%) (Clancy et al., 2011). In terms of the victims misusing alcohol little further information was available in relation to, for example, units consumed and how often, alcohol as a factor in the abusive incident, or whether they had sought treatment. The missing data rates for perpetrators was very high even on basic information like age (valid N = 117, 88% missing) or gender (valid N = 573, 41% missing). Further narrative data on characteristics of alcohol misusing victims and perpetrators is presented later in this section.

Table 3: Safeguarding referral characteristics

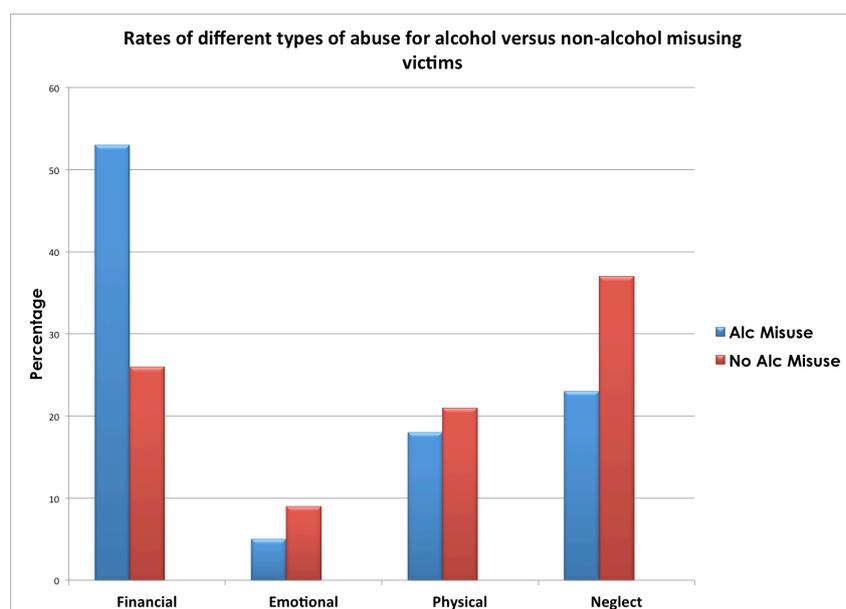
	Victim*	Perpetrator**
Female	66%	21% (n = 483)
Mean age	80.6 (range 60-101)	63.8 (n = 105)
Alcohol misuse	5%	41%
White British	96%	-
Living alone	27%	-
Own home (owner occupied or rental)	45%	-
Residential care	37%	-

*Based on 975 unique cases.

**Based on cases with valid information. Sample size shown in brackets.

Examining the type of abuse and where victim alcohol misuse was identified, 53% experienced financial abuse versus 26% where no alcohol misuse was identified (Figure 2). This greater rate of financial abuse in alcohol misusing victims was statistically highly significant ($z = 3.36, p < .001$). However, victim alcohol misuse was not significantly associated with physical or psychological/emotional abuse or neglect. Thus it appeared that a victim's alcohol misuse was related to financial abuse, but not to other forms of abuse.

Fig 2: Rates of different types of abuse for alcohol versus non-alcohol misusing victims



Looking at the sample of victims misusing alcohol further, Table 4 presents additional interesting characteristics that were found to be statistically significant. It appeared that alcohol misusing victims compared to other victims of abuse tended to be somewhat younger, more likely to be male, more likely to suffer financial abuse, more likely to be abused by an alcohol misusing perpetrator, and more likely to be abused by friends or neighbours – but less likely to be abused by professional carers.

Rates of abuse by relatives and by spouses/partners were also examined between alcohol misusers and non-alcohol misusers, but there were no significant differences in these rates.

Table 4: *Statistically significant differences between characteristics of alcohol misusing versus non-alcohol misusing victims*

	Alcohol misuse victims N = 41 (5%)	Other victims N = 866 (95%)	Statistical tests of difference*
Mean age	72.6	81.4	T(905) = 5.46, p <.0001
Male (%)	75	25	z = 7.14, p <.0001
Financial abuse (%)	53	26	z = 3.36, p <.001
Perpetrator alcohol misuse (%)	66	33	z = 2.18, p <.05
Friend/neighbour perpetrator (%)	24	6	z = 2.08, p <.05
Professional carer perpetrator (%)	20	54	z = 4.04, p <.001

Additional narrative data was abstracted on the cases where alcohol was a feature in the case record. We did recognise that practitioners were recording required 'facts' and not necessarily subjective impressions about the case (Hayes and Devaney, 2004). In terms of victims where alcohol misuse appeared to be problematic in relation to the abuse, reported information tended to indicate that most of these individuals had longstanding problems with alcohol. Each victim was recorded as having a minimum of five health related problems, many of which might be associated with long term alcohol misuse. For example, cerebral vascular accidents (CVA), cardiac problems, diabetes, and hypertension were commonly reported. However, in the quantitative data, the mean number of physical health problems did not differ significantly between the alcohol using versus non-alcohol misusing victims (2.51 vs 2.33, $t = .66$, ns). Only CVA was significantly associated with alcohol misuse by the victim, with a rate of 39% versus 15%, chi square = 17.92, $p < .0001$). Chronic obstructive pulmonary disease was not uncommon and possibly associated with heavy smoking which was also frequently reported in narrative data (no significant association, however). Of the 41 victims, 15 were identified as having cognitive impairment and the majority of these with associated behavioural problems (no significant association in statistical analysis). Mental health problems (e.g., anxiety and depression), mobility problems, and generalised weakness and forms of self-neglect were also frequently reported. Statistically, there were associations with alcohol misuse for depression (19.5% versus 9.2%, chi square = 4.76, $p < .05$) and "other mental health issues" (19.5% versus 7.6%, chi square = 7.46, $p < .01$), but not frailty or self-neglect.

There were nine cases where both the victim and perpetrator were recorded as drinking. In 6 of these cases, the perpetrator was a friend or neighbour, the victim had a longstanding alcohol problem and had become socially distant from family. The older person seemed to have become vulnerable to other misusers over time – victims being reliant on the perpetrators to purchase alcohol, their home being used as a drinking refuge and “people hanging around”, or perpetrators taking money and other personal items from the older person.

Local authority involvement primarily focused on longer term care management with particular attention to financial management for those who were deemed to have no capacity. Although capacity issues were identified in only a minority of the cases, older victims were often encouraged to assign responsibility for their financial affairs to family or an alternative appointeeship. Liaising with family (where they existed), home carers and general practitioners was not uncommon.

In only 10 cases was the elder abuse substantiated or partially substantiated. The abuse in these instances was financial with the exception of one. Therefore, most cases were not substantiated or inconclusive, and closed or passed on to care management for monitoring. Care management was frequently already engaged given the victims' multiple physical health problems. Alcohol services were recorded as being involved in only two of these cases.

What was known about the perpetrators where alcohol was identified as a feature associated with the abuse? There appeared to be two different types of scenarios that were referred to safeguarding. More common was the case of a family member misusing alcohol (and drugs) (e.g., spouse, child, grandchild). In the 34 cases where an alcohol misusing family member was identified as the perpetrator, 31 were identified as a husband, son, grandson or stepson. The other, but less common scenario was a friend or neighbour who was abusing alcohol and an older person.

Exploring the family cases in more depth, it appeared evident that in many instances these were families with longstanding domestic issues. This was not unexpected given the problem of domestic violence with alcohol involvement is

very well documented in the literature (Humphreys et al., 2005). The nature of this abuse was recorded as either emotional/psychological, financial, physical or neglect and sometimes a combination of two or more.

In 18 of the 31 cases, physical abuse was recorded and this appeared consistent with some of the literature (Friedman et al., 2011). Reports of a husband pushing or hitting his wife or a son throwing an object at the older person were not uncommon; however, a large amount of detail was not recorded.

3.3 Interviews

The interviews revealed that, for the most part, alcohol-related elder abuse was not well understood by practitioners. In addition, each group had differing views on the nature of the problem and how best to respond, and the practice culture for each appeared to reinforce these views. Table 5 provides a summary of the key themes that emerged. They are separated for the purposes of presentation, but we recognise that there is considerable overlap in some areas. For speciality alcohol practitioners, they tended to deliver a relationship-based intervention with few 'rules' to direct their approach. Strikingly different was the work of the safeguarding practitioners where the determination of whether someone had capacity or not seemed to be the key driver underpinning their work. This was not surprising given safeguarding practice is highly regulated, focuses on autonomy, and is also struggling with the impact of austerity measures in local authorities. Unfortunately, while safeguarding is consistent in its availability across the country, speciality alcohol services for older people are an added resource found in very few localities.

Table 5: Key themes from practitioner interviews

	Alcohol Practitioners	Safeguarding Practitioners
Characterising alcohol-related elder abuse	<ul style="list-style-type: none"> - harm reduction (i.e., minimising vulnerability to drink and vulnerabilities that are consequences from drinking) - alcohol increases risk for victimization - results in reduced capabilities and often self-neglect - substance use in later life is complex and understood within a life course perspective (e.g., family systems, childhood trauma, loneliness and social isolation; loss of status) 	<ul style="list-style-type: none"> - protection and/or minimising of risk of abuse (e.g., physical, sexual, emotional, financial abuse) - alcohol not recognised as a risk for victimization - alcohol does limit ability to remove risks for abuse - perpetrator who abuses alcohol is not within their sphere of activity - self neglect could be managed by other providers
Intervention strategies	<ul style="list-style-type: none"> - relationship building and sustained engagement - goal identification towards change - improving social engagement and environments 	<ul style="list-style-type: none"> - mental capacity assessment - crisis management - care management support - monitoring
Recommendations for enhanced responsiveness	<ul style="list-style-type: none"> - health promotion and prevention strategies (alcohol focus) - attention to stigma and discrimination (older drinkers) - improved inter-agency collaboration 	<ul style="list-style-type: none"> - practitioner education/training (elder abuse and alcohol abuse) - improved inter-agency collaboration - skilled care management ("These cases don't fit the boxes on the form")

3.3.1 Characterising alcohol-related elder abuse

The specialty alcohol practitioners tended to refer to a harm minimisation approach. This approach included a more holistic understanding of the older person in relation to minimising vulnerability associated directly with drinking (e.g., how much and how often) and vulnerability emerging as a consequence of drinking. This was consistent with the work of Wadd et al., (2011) who reported a similar approach used to understand and tackle older age drinkers. These understandings were reported by a female practitioner:

...They don't know all the damage that they're doing. They think that when they were younger if they had a few drinks, they think they can still do that. So they're the risks of falling and hurting themselves. Isolating themselves further. So then they lose their confidence, big thing around depression and anxiety. Instead of retiring and getting on, whatever's

happening, dealing with their lives. They withdraw even more so it becomes a spiral of drinking and making things worse///⁹ And because I think they are vulnerable they are vulnerable to perhaps making new relationships with people that aren't necessarily someone they would have done before because they're vulnerable. So that can be quite risky for them because they're not aware of what they're going through. They think they need someone in their lives, but perhaps it's not the best thing for you at time. (713-0026, 42.50)^{10,11}

These comments draw out the issues related to why the person was drinking in the first instance (i.e., coping with a life transition and isolation) and then subsequently increasing their vulnerability for abuse by making undesirable friendships. Similar examples were repeatedly provided by other alcohol practitioners and each drawing out the significance of these 'friendships' in relation to financial abuse specifically. Victimization in this instance appeared to involve 'friends' using the older person's home as a squat and/or taking or stealing money to buy alcohol or drugs. One practitioner described a man with a mild learning living in a neighbourhood where other problem drinkers had been housed. She stated: *"if he provided them with drink and they didn't steal///He didn't know how to get rid of them///He described them as his friends"* (713-0023, 1.02). It is worth noting that the alcohol practitioners put considerable emphasis on the role alcohol played in reducing an older individual's capability to cope with multiple vulnerabilities in addition to the potential for elder abuse (e.g., self-care, maintaining good health, sustaining a social network).

In other examples, the 'friends' were family members. It seemed that in these instances there was more recognition of the life course, patterns within family relationships that were reinforcing or escalating problematic behaviour, or other unresolved issues (e.g., child abuse). In these instances, both the older victim and a child or grandchild also had difficulties with alcohol misuse. A practitioner described a 79 year woman who was recently widowed and due to housing issues moved to a neighbourhood where she knew no one. The practitioner reported that the older woman had little confidence to get out to meet new people. As a result she

⁹ /// denotes that words have been omitted at the discretion of the researcher where they did not contribute to the overall understanding of the meaning(s) intended by the speaker.

¹⁰ 713-number is code used to identify participants. The number following the participant code is the identifier for the location of this segment in the interview.

¹¹ All quotes appear verbatim. Any language errors or omissions are those of the speaker.

remained in her flat drinking. A son who had a longstanding drug related problem would leave his mother alone drinking because “*that suited him*” for getting money from her (713_0027).

The first example, which highlighted the downward spiral in the some of the lives of older drinkers, also drew out further risks (e.g., falls, depression, anxiety) that may contribute to another less understood or even recognised form of abuse which is self-neglect (May-Chahal and Antrobus, 2012). Whereas the alcohol practitioners described cases that would constitute self-neglect, this was more the central concern raised by safeguarding practitioners.

Within the safeguarding arena, alcohol was not a standard line of enquiry when conducting a safeguarding investigation. As such, alcohol was not specifically recognised as a risk factor for victimisation. Their emphasis tended to be focused on minimising the risk of abuse and not necessarily identifying or understanding the underlying cause (s). Alcohol misuse, whether by the older victim or perpetrator, seemed to add another layer of complexity, but not one that would be central to their consideration for minimising risk. Given this regulated, but narrower focus, alcohol-related elder abuse seemed to be more understood in relation to cases that involved high levels of self-neglect.

For the most part safeguarding practitioners described complex cases with high levels of self-neglect, including some vulnerability for abuse, which tended to be problematic for multiple care providers. In these instances, for example, their priority focus appeared be on problems that could more quickly resolved using local authority services - offering to manage the person's finances, address any housing issues, encouraging attendance at day programmes or dining centres, or putting carers in place. A female safeguarding practitioner stated:

...safeguarding per se might discharge from the caseload, but there will systems in place, there will be the client financial affairs///and then there is the care agency///we will probably look at 3 calls a week, just to ensure, one call for shopping because we don't want to take away certain things. He somehow still remembers how to work a washing machine. He loves washing so why take that away from him///but then 3 calls and these are our monitoring systems///any concerns they will get

back to us///we've protected the money but his access to drugs or alcohol, he's been off alcohol for 18 months, but if his so-called mates put him back on alcohol, can we stop that, perhaps not. (713_0034, 34.32)

As seen here, safeguarding was the primary focus for the practitioner (i.e., financial protection) and the alcohol and drug problems noted but not directly acted on. Additionally, carers were central in terms of overall safeguarding monitoring following closure by the practitioner.

When any issues of mental capacity emerged, safeguarding services was more apt to stay engaged. This was not unexpected given their statutory duty. One practitioner described a woman known to social services who had been drinking heavily since young adulthood and was recently diagnosed with alcohol-related dementia. The older woman recently lost her partner and was moved into new housing to distance her from people who were taking advantage of her (e.g., financial, sexual and physical abuse). The local authority had also taken over responsibility for her finances. Various services had been involved, albeit only temporarily, and safeguarding had assumed overall management of the case, including carers managing the alcohol consumption. She was eventually placed in residential care for protection. The complexities of the problems unfolded as follows:

...she was left with nothing and not matter what strategies we put in placement to manage her finances they found new ways to abuse her///they were finding when the carers walked in and she was in bed with some men/// People would move in. It was in a very poor state, her home///they'd sleep on the floor. It was an empty shell of a place, really. Then again, carers would bring over food and they would eat it within days///a scheme they [mental health services] had set up to control her alcohol. A quarter of a bottle of whiskey a day topped up with water because she was on a large amount of alcohol. (713_0029, 18.49).

In this situation, issues around self neglect became more complex when mental capacity issues arose. In this instance, the safeguarding practitioner remained actively involved and often taking over management as other service providers came and went. Perhaps in recognition of the likelihood of the interwoven vulnerabilities, such as in the above case, practitioners repeatedly raised the issue

that cases of self-neglect due to alcohol were more akin to a care management function than a safeguarding one.

3.3.2 *Intervention strategies*

As indicated above, alcohol practitioners first focused on reducing alcohol to minimise vulnerability for abuse. This view tended to be a holistic one meaning they seemed eager to initiate or be part of a multi-agency response given multiple vulnerabilities, and they demonstrated some flexibility to ensure the older person was supported as much as possible. Their focus on minimising various forms of vulnerability also meant that their approach was more preventative and safeguarding discourse appeared to be reserved for when a crime had been committed. On the other hand, safeguarding practitioners focused on confirming whether abuse had occurred or not and, on occasion, minimising risk for further abuse. More importantly, older people who lacked capacity to understand their risks or make decisions to minimise these risks were their priority. Alcohol misuse was rarely a specific focus within this role and perpetrators were also not a focus of their work.

All speciality alcohol practitioners spoke of the significance of building a relationship with an older person. One very experienced practitioner shared her working with a single man in his eighties who had been financially abused by couple for about 10 years. She described that the couple were also buying his alcohol and he was very fearful to report the situation to anyone. Social services investigated and explained the missing funds by his spending money on alcohol and gambling:

...alcohol can mask the problem///that satisfied social services. We will pursue to build the helping relationship///social services time is fairly structured. They don't have the time to get to the bottom of it///the couple were very crafty. (713_0023, 8.28)

She further explained their smaller caseloads permitted doing home visits up to three times a week and that's how they got to know people – perhaps look beyond the “mask”. Over time they uncovered how the couple were managing to abuse this man and eventually the police were engaged.

In terms of furthering their interventions, these practitioners spoke of strategies to reduce the alcohol consumption and thereby removing their vulnerability. Their strategies involved goal identification and improving social engagement and/or social environments. The setting of a goal acted as a motivator to reduce or eliminate the substance and is consistent with behavioural approaches to alcohol treatment approaches with older adults (Cummings et al., 2006). Again, the approach of dealing with the alcohol to directly or indirectly reduce vulnerability for abuse was emphasised. And in terms of improving social networks, this was argued as a method to reduce vulnerability to drink as well as lessen the likelihood of older people befriending people who would otherwise take advantage of them.

An abusive situation where each specialty alcohol practitioners appeared challenged was a parent-child one where both were drinking or where the adult child was an alcoholic. For example, a practitioner described a situation of an 88 year old frail mother who took in her 60 year alcoholic son:

...her expectations of what we could do were unrealistic in that we could not stop her son's drinking and that's what she wanted because in his periods of sobriety actually she like him being there because he did the gardening, and he helped her, and a companion. But in his times he was drunk he was, you know, he'd fall down the stairs///Umm, setting the house alight because he smoked and he fall asleep on the sofa and she would find burn marks. So a fear for her own safety, umm, but an unwillingness to, umm, accept that really the only course of action that was going to ensure her wellbeing was for him to leave. (713_0027, 34.48)

Safeguarding did not engage because the older woman had capacity to decide to live at risk with her son. The alcohol practitioner later argued that this was not an informed choice because the woman felt she had a maternal responsibility to protect him despite her own frailty. These cases did present interesting considerations which did not appear to be well understood by practitioners.

As mentioned earlier, safeguarding practitioners tended to describe situations of self-neglecting older alcoholics. Their interventions were more narrow, but consistent with the statutory guidance. In this way they were more tightly bound in terms of

their practice which was acknowledged by them as having limitations. The first requirement in their safeguarding role was to investigate the alleged abuse – a response to an immediate crisis. The investigation focused on the abuse, and as such, was not a holistic assessment of the situation. The older person's capacity to understand the abuse and make decisions was central to the actions taken. Thus, the safeguarding practitioner's involvement in the case was purposively shorter term. The presence of alcohol and its possible consequences was not a particular focus on their work and never a line of enquiry unless it emerged in the referral process.

In light of the above, intervention in the traditional sense was not part of their role. A safeguarding practitioner described a 77 year old man who was drinking excessively for a long time and had a good pension income which enabled him to do so. He was beginning to have memory problems, his health was deteriorating and his partner recently left the shared home. It was when his brother started becoming involved in his financial affairs that the case was reported to safeguarding by a care agency. The safeguarding practitioner did an investigation regarding the man's financial affairs, and when it was recognised he had decision-making capacity and that the brother's intentions were legitimate, they closed the case.

More importantly, carers from a local care agency were visiting three times a week and it was agreed it was their role to “monitor” the situation and notify social services should any other problem arise. Similar scenarios were described by other safeguarding practitioners, and yet they stated concern that home carers did not necessarily have the knowledge or skills to “monitor” complex cases. The alcohol practitioners reinforced this view and one practitioner described the situation of an elderly woman living in sheltered accommodation who had a daughter with substance problems. It was reported that the woman's daughter was stealing some of her mother's medication (to take or sell). The practitioner argued that the scheme manager did not want the “unpleasant conversation” with the older woman and/or her daughter, and “the carer is only paid £7 per hour so they aren't going to get into it”. (713_0025, 38.13)

3.3.3 Recommendations for enhanced responsiveness

All of the practitioners, without exception, stated they were working in an inadequate care system. The overarching problem was the recognition of service

cutbacks within the statutory sector and the lack of stability within the charity sector. It was argued that the consequences had been enormous and limitations within the service sector were now a matter of course. There was also recognition though that work could be done to enhance responsiveness. Their recommendations were similar to those that appear in the literature in relation to both elder abuse and alcohol problems in older age.

Specialty alcohol practitioners responded with a public health/health promotion and prevention approach emphasising the importance of raising awareness regarding alcohol problems over the life course. Their approach, also confirmed at the practitioner seminar, had an alcohol focus rather than an elder abuse one. Similarly, these practitioners recognised that a promotion and prevention approach would address the issue of the stigma and/or discrimination associated with problem drinkers in old age. Finally, they recognised that inter-agency collaboration was in need of considerable improvement to effectively address the range of problems associated with older drinkers.

Safeguarding practitioners, also confirmed at the practitioner seminar, were more concerned about minimising risks for elder abuse and suggested colleagues in their sector and others needed education and training around both elder abuse and alcohol misuse. It seemed there was agreement that their assessments and subsequent interactions with victims of elder abuse were not sufficiently holistic and the current service arrangements contributed to their more narrow approach. This point was also emphasised by their recommendation to critically review what they were doing and for a return to longer term relationship-based care management given the complexity of the cases they were seeing.

DISCUSSION AND CONCLUSION

Knowledge development in the field of elder abuse remains limited and therefore an understanding of risk factors for elder abuse and how to minimise their impact on an older person's circumstances is not well understood. Elder abuse, not unlike the field of alcohol and domestic violence, has also been challenged by the limitations inherent in much of the empirical work where methodological problems have impacted on the nature of the evidence produced. Notwithstanding these critical issues, some headway is being made worldwide to more clearly articulate the nature of the problem and innovative multi-level interventions to tackle it.

Alcohol misuse has long been identified as a risk factor for elder abuse, and yet less is known about its relationship to the older person and the abuse. This study represents a first of its kind in England to begin to expand the elder abuse lens and focus attention alcohol misuse as a risk factor. While we acknowledge some limitations within this work, the outcomes provide worthy insights in relation to alcohol-related elder abuse and reinforce the need for continued investigation.

4.1 Summary of key findings

To discuss the outcomes from this investigation, we return to the study's research questions and address each in turn.

What is the relationship between alcohol misuse and elder abuse and neglect?

We can conclude that the exact nature of the relationship between alcohol misuse and elder abuse and neglect is only partially understood. To some degree this is explained by the fact that both the body and quality of literature on elder abuse and related subject areas is limited. The new data emerging here is also not without its limitations due to the limited scope of this feasibility study; however, we do note that our findings reasonably correspond with existing literature.

In instances of elder abuse where alcohol misuse was identified on case records, we found that alcohol misuse presented itself in various ways: (i) the older victim; (ii) the perpetrator; and (iii) both the victim and perpetrator. With supporting evidence from interviews with practitioners, when the older victim was misusing alcohol, it

appeared that alcohol was a longstanding problem. The alcohol misuse seemed to contribute to increasing the person's vulnerability for abuse from others, self-neglect or a complex combination of these. This vulnerability also seemed to be exacerbated by declining health or other psychosocial problems (e.g., loss, depression). The victim tended to be male and slightly younger than other abused older people. The perpetrator, in these instances, was more likely to be from outside the family system.

In stances where only the perpetrator misused alcohol, s/he was more likely to be a family member. These cases were also complex ones given situation was likely to be compounded by difficult family dynamics. Unfortunately, less is known about perpetrators who misuse alcohol due to the nature of recording in case files and the absence of interventions with perpetrators. Understandings within the domestic violence literature were helpful here, but limited given its lack of attention of older victims.

Self-neglect and other overlapping forms of abuse appeared most relevant in instances where both the victim and perpetrator(s) were misusing alcohol. Self-neglect, not typically within the mandate of safeguarding in England, was more typically managed by others and seemed to require longer term intervention to manage multiple vulnerabilities and/or risks. The literature on self-neglect reinforced a similar assessment (Gibbons et al., 2011).

To what extent does alcohol misuse feature in elder abuse and neglect cases referred to local authority Safeguarding Adults Teams, and what are the key characteristics of such cases?

Not unexpectedly, the quality of the data was based on the nature of the records maintained by the local authority that participated in this investigation. More specifically, we were unable from the recorded data to confidently determine details of the nature of the drinking behaviour for victims or perpetrators. Further to the above though, the review of files for a two year period from one local authority revealed 5% of older victims (N = 975) and 41% of perpetrators (N = 133) misusing alcohol. There were 9 cases where both victim and perpetrator were identified as misusing alcohol. Given the explicit identification of risk factors and characteristics of perpetrators were not required in the case documentation and safeguarding

practitioners' admitting that alcohol misuse was not typically an area of investigation, it was not surprising that both the figures and detailed information were limited.

Characteristics of victims misusing alcohol were available (and described above), but due to the high rate of missing data for perpetrators, few characteristics were identified. This was disappointing to the researchers given less is known about those who abuse older people. Importantly though, alcohol misusing victims were twice as likely to be financially abused. This was similarly acknowledged by both practitioner groups and supports building evidence on this type of abuse and some support for this relationship was found in literature (e.g., Brownell et al., 2000).

Additional narrative data from the files and practitioners identified physical abuse as a problem in the instance of a perpetrator misusing alcohol. Overlapping forms of abuse such as psychological/emotional was also highlighted by practitioners despite not usually documented. Perpetrators in this instance were more likely to be male as well. These findings were consistent with, for example, Hwalet et al. (1996) and Brownell et al. (2000).

How do local authority Safeguarding Adults Teams and specialised alcohol treatment programmes perceive the role of alcohol misuse in relation to the problem of elder abuse and how are they responding to the problem?

The interviews provided detailed information from practitioners on their response to alcohol-related elder abuse that has not been previously documented. The findings support the need for continued training in both abuse and misuse. Safeguarding practitioners did not appear to recognise alcohol misuse as a risk factor for elder abuse. Without exception they stated they were not trained to be aware or sensitive to this factor when conducting an investigation of alleged abuse. Where identified, their role was limited due to statutory regulation. They clearly stated their role was to 'investigate' alleged abuse and intervene, where necessary, to lessen further risk. Their role was to protect those older people who lacked mental capacity only.

Specialty alcohol practitioners, not available in many parts of the country, recognised alcohol misuse as increasing the older person's vulnerability to a host of

areas including elder abuse. Understanding that safeguarding services were not available to people with capacity, these practitioners typically had longer term engagement with older people to first lessen vulnerability to drink and then to address other forms of vulnerability. They collaborated with safeguarding practitioners less frequently than expected.

What other professionals are mobilised by Safeguarding Adults Teams and specialised alcohol treatment programmes when there is alcohol-related elder abuse and neglect, and how do they work together to address the issue (s)?

Both practitioner groups liaised or worked with a number of other community-based professionals in their area of practice. Their key partnerships were with general practitioners and home carers. In some instances, police, hospital, substance abuse and mental health services were engaged. As in the previous question, the findings here supported those in the literature that claim most practitioners were not adequately prepared to deal with abuse and/or misuse (Pillemer et al., 2011).

The main finding, however, was that collaborative working in the instance of alcohol-related elder abuse was not viewed positively. Safeguarding practitioners were limited by their regulated role and tended to close cases promptly, thereby limiting longer term engagement and mobilising community intervention. Specialty alcohol practitioners expressed frustration that the majority of professionals had negative views or misunderstood older people with alcohol-related problems. Thus a review of community-based interventions would appear warranted to identify who, what, when and how partners engage in supporting victims of alcohol-related abuse who have or do not have mental capacity.

4.2 Study limitations and considerations for further research

A key aim of this study was to explore the feasibility of a larger study to more systematically investigate alcohol-related elder abuse. Thus consideration of methods here was relevant in light of this aspiration.

Through the review of case files we were able to abstract a large amount of interesting data on victims of elder abuse. We were limited, though, to understanding the safeguarding role beyond initial investigation rather than longer

term as in a care management scenario. When identified, data specific to perpetrators misusing alcohol was often limited to it simply being noted in an investigative report. Future investigation would need to consider a larger sample of local authorities in various locations across the country and consider carefully what criteria would be used to establish misuse. This would also enable a longer term view of the cases and possibly permit an opportunity to include case controls. In view of theoretical development, this approach would also strengthen an opportunity to engage in further qualitative investigation by interviewing older people, families and perpetrators to explore alcohol-related elder abuse further. The practitioner interviews provided very rich data on the nature of the cases they were working with, styles of intervention and the challenges of delivering community-based care to vulnerable older people. These too could be expanded to different areas across the country (e.g., urban versus rural) and to a sample of other relevant practitioners (e.g., home carers, general practitioners, mental health and other substance abuse services).

Given local authority safeguarding is primarily directed at older people who lack capacity, it would be important to extend consideration to provision provided by other charities, mental health services, substance abuse services, and so forth. An opportunity arose, for example, in relation to AEA that was not taken advantage given this was a small scale study. AEA expressed interest in having their advice line data evaluated and/or including alcohol-related questioning to their advice line protocol (also connected with the new Silver Line helpline). They were also willing to provide access to their 790 plus safeguarding practitioners' network to obtain further frontline views of the problem.

In regards to existing data, a systematic review of the literature would be of value. However, opportunities to exploit existing data sets appear limited.

4.3 Conclusion

This was a feasibility study exploring alcohol-related elder abuse with the view the findings would inform further investigation. Our findings continue to support alcohol-misuse, whether victim or perpetrator, as a risk factor for abuse. Specific characteristics of alcohol-misusing victims and alcohol-misusing perpetrators

identified in this study add to a building body of literature in elder abuse and older drinkers, and enhance our understanding of the complexities of community-based care for an ageing population. We conclude that this study offers an opportunity to expand our empirical understandings of alcohol-related elder abuse through further mixed methods exploration in some of the following areas:

- Further definition and characterisation of alcohol misuse as a risk factor for elder abuse (e.g., constructing explanations for who is misusing, nature of the misuse and abuse, relevance in family care system, self-neglect, relationship with other risk factors);
- Exploration of practitioner assessment tools in relation to alcohol misuse and elder abuse; and
- Developing and testing interdisciplinary social interventions, including education and training for practitioners and older people.

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Appendix 1: Data abstraction tool for review of safeguarding case files

Older victim:	Alleged Perpetrator:
Gender	Gender
Age	Age
Family status	Ethnicity
Ethnicity	Living arrangements
Living arrangements	Relationship to older person
Referral source	Alcohol/drug use
Type (s) of abuse (i.e., physical, sexual, neglect, emotional/psychological, financial, self-neglect)	Other issues (e.g., physical health, mental capacity, learning disability, employment/financial, housing)
Alcohol/drug use	
Other issues (e.g. physical health, mental capacity, learning disability)	
Case Outcomes:	
Length of SA involvement	Services for perpetrator (e.g., monitoring, home supports, counselling, alcohol treatment, respite care, long term care, carer support, education)
Outcome (i.e., substantiated, not substantiated, partially substantiated, inconclusive)	
Partnership involvement (e.g., police, general practitioner, mental health or alcohol services, hospital, etc)	
Services for older person (e.g., monitoring, home supports, counselling, alcohol treatment, respite care, long term care, carer support, education)	

Appendix 2: Semi-structured interview schedule

1. Can you tell me a little about your experience working in [adult safeguarding/specialty alcohol treatment]?
Prompts:
 - Training and professional background
 - Interest and experience in gerontological practice
 - Managing challenges of current work context
2. Can you describe the circumstances around a service user (s) that you were recently involved with where [alcohol abuse/ elder abuse] was a relevant factor in the case?
Prompts:
 - Nature of the problem (i.e. older person or (alleged) perpetrator or both)
 - Type of abuse
 - Associated problems (e.g. mental health)
 - Longstanding issues versus late onset
 - Nature of interventions
3. Can you tell me more about what was significant in this case (s)?
Prompts:
 - Nature of the problem and/or type of abuse
 - Working with older people and their families
 - Interdisciplinary and/or multi-agency working
 - Definition of abuse and use of safeguarding procedures
4. Can you tell me what worked or didn't work in terms of what was done by you or your team?
Prompts:
 - Use of statutory/legal regulations
 - Professional skills/training
 - Interdisciplinary and/or multi-agency working
 - Service user (s) declining support/intervention
 - Mental capacity issues
 - Lack of resources
5. What were the final outcomes for this service user (s)?
Prompts:
 - Effective interventions to protect/reduce alcohol problem
 - Service user (s) declining support/intervention
 - Ongoing risks
 - Home and other supports put in place
 - Death or long term care
6. Can you tell me more about any challenges of working with service users where [alcohol/elder abuse] is present?
Prompts:
 - Use of statutory/legal regulations
 - Professional skills/training
 - Interdisciplinary and/or multi-agency working
 - Service user (s) declining support/intervention
 - Mental capacity issues
 - Lack of resources

Appendix 3: List of Dissemination Activities

41st Annual Conference of the British Society of Gerontology 11-13 July, 2012 Keele University

Use as Abuse: A Feasibility Study of Alcohol-related Elder Abuse and Neglect
Mary Pat Sullivan, Mary Gilhooly, Christina Victor, Sarah Wadd, Nick Ellender

Abstract

The often hidden nature of elder abuse and neglect has meant that current prevalence rates have likely only addressed the tip of the iceberg (Cooper et al., 2009; Tomita, 2006). Alcohol abuse by an older person or a carer is consistently identified as a risk factor for the increased likelihood of abuse. Research in North America has begun to illuminate the impact of alcohol-related elder abuse and neglect and identify strategies for intervention; however, the nature of the problem in the UK remains relatively unexplored. The aim of this feasibility study is to collect substantive pilot data to scope the extent of alcohol-related elder abuse and neglect in the UK, including community-based interventions, and evaluate data sources and research methods to develop a national study of the role of alcohol in cases of elder abuse and neglect. Funded by Alcohol Research UK, this is an 18-month study that began in spring 2012. This poster will be to present current knowledge exploring alcohol abuse as a significant factor in reported cases of elder abuse, the multiple data sources being evaluated to scope the problem in the UK, and preliminary findings. Further research considerations are also presented.

12th Global Conference on Ageing, International Federation of Ageing 4-6 October, 2013 Istanbul, Turkey

Use as Abuse: Findings from a Feasibility Study of Alcohol-related Elder Abuse and Neglect

Mary Pat Sullivan, Mary Gilhooly, Christina Victor, Ken Gilhooly, Sarah Wadd, Nick Ellender

Abstract

The hidden nature of elder abuse and neglect means that current prevalence rates are probably an under-estimate of the extent of the problem (Cooper et al., 2009; Tomita, 2006). Alcohol abuse by an older person or a carer is consistently identified as a risk factor for abuse. Research in North America has begun to illuminate the impact of alcohol-related elder abuse and neglect and identify strategies for intervention but the nature of the problem in the UK remains relatively unexplored. This paper presents substantive findings from a mixed method feasibility study investigating the role of alcohol in elder abuse. We reviewed new referrals to a Safeguarding Vulnerable Adults Team over a 2-year period (n = 1197) and conducted in-depth interviews with safeguarding and specialty alcohol treatment practitioners (n = 12). Multivariate analysis from the case reviews and thematic analysis of the interviews revealed a significant relationship between an older victim's alcohol abuse and financial and physical abuse, and additional sources of vulnerability to abuse including family dysfunction. Our findings also capture other complex sources of vulnerability when substance abuse by a perpetrator is present.

The paper concludes with preliminary considerations for multi-agency interventions and implications for additional research to further scope the nature of the problem in the UK and elsewhere.

Annual Symposium for the Society of the Study of Addictions Conference

7-8 November, 2013

York

Alcohol-related elder abuse: An overlooked problem in practice and research

Mary Pat Sullivan, Mary Gilhooly, Christina Victor, Ken Gilhooly, Sarah Wadd, Nick Ellender

Abstract

Background: Alcohol abuse by an older person or a carer is consistently identified as a risk factor for elder abuse and neglect. Current research on elder abuse, however, tells us remarkably very little about the nature of this problem, strategies for effective health and social care interventions, or key policy implications. The absence of theoretical development in the field of elder abuse also limits our understanding of different forms of abuse, including those where alcohol is present. **Aims:** This paper presents substantive findings from a mixed method feasibility study investigating the role of alcohol in elder abuse.

Design and Setting: We reviewed new referrals to one English Local Authority Safeguarding Vulnerable Adults Team over a 2-year period (n = 1197), and conducted in-depth interviews with safeguarding and specialty alcohol treatment practitioners (n = 12) in various locations.

Findings: 1. Multivariate analysis from the case reviews and thematic analysis of the interviews revealed a significant relationship between an older victim's alcohol abuse and financial and physical abuse, and additional sources of vulnerability for abuse including issues in the family environment. 2. Our findings capture complex sources of vulnerability when alcohol or drug abuse by a perpetrator is present. 3. Inadequate training for practitioners to identify and work with substance problems and elder abuse was also identified.

Practitioner Seminar

18 October, 2013

Brunel University

36 adult safeguarding and specialty alcohol services practitioners (see event flyer below). The event included presentations on alcohol and older people and adult safeguarding, followed by a presentation on this study's key findings. Practitioners were then divided into groups, mixing safeguarding and alcohol practitioners to comment on and discuss study findings in relation to case examples. The seminar was evaluated by attendees and all aspects of the day were highly rated (e.g. environment, delivery from presenters, materials, content, etc). Comments included:

"The practical session was very good."

"I was impressed with the case study and how our group managed to come up with solutions for the case."

"Very well organised. The handouts were very helpful."

"One of the most interesting days I have attended. Good to liaise with other agencies. Can reflect on practise in the workplace, utilising research on practice. Thank you for the hospitality and the day."



Use as Abuse: Alcohol-related Elder Abuse

A knowledge mobilisation event for health and social care practitioners hosted by Brunel Institute for Ageing Studies

Alcohol abuse by an older person or a carer is consistently identified as a risk factor for elder abuse and neglect. Current research on elder abuse, however, tells us remarkably very little about the nature of this problem, strategies for effective health and social care interventions, or key policy implications. The absence of theoretical development in the field of elder abuse also limits our understanding of different forms of abuse, including those where alcohol is present.

This seminar presents substantive findings from a mixed method feasibility study investigating the role of alcohol in elder abuse. We reviewed new referrals to our Safeguarding Vulnerable Adults Team over a 2-year period and conducted in-depth interviews with safeguarding and specialty alcohol treatment practitioners. Multivariate analysis from the case reviews and thematic analysis of the interviews revealed a significant relationship between an older victim's alcohol abuse and financial and physical abuse, and additional sources of vulnerability to abuse including issues in the family environment. Our findings also capture other complex sources of vulnerability when substance abuse by a perpetrator is present. The seminar will feature an interactive discussion to consider: (1) multi-agency interventions; (2) alcohol and elder abuse training for practitioners; and (2) implications for additional research to further understand the nature of the problem in the UK.

Date: Friday 18 October 2013

Time: 10am – 3pm (including lunch)

Location: Darwin Room, Hamilton Centre

Brunel University

For further information or to register: Dr. Mary Pat Sullivan

mary.sullivan@brunel.ac.uk

01895 268846

**This seminar is free and registration is necessary for catering purposes.*

