UK Study of Abuse and Neglect of Older People: Qualitative Findings

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Executive summary

Introduction

This qualitative study forms part of a wider programme of research involving a literature review, focus groups with service-providers and stakeholders, a national survey of over 2000 older people and a feasibility study for researching elder mistreatment in care homes.

The study involved 36 follow-up interviews with older people who had responded to the survey and three interviews with older people accessed through specialist BME organisations. Twenty-two of these involved incidents where the perpetrator was a family member, paid carer or close friend. The remaining cases involved neighbours, acquaintances and, exceptionally, strangers. Three interviews were also carried out with family members who had supported the older person.

Challenges of definition

The definition of elder mistreatment used in this research is widely accepted and is the same or similar to definitions used in previous research. However, in practice, the definition posed particular challenges for analysis and interpretation and highlighted aspects of the definition that are problematic.

A useful definition is one that draws together experiences that are in some way similar and distinguishes them from other types of experience in a way that is meaningful and useful. Evidence from this study suggests that the definition used does not fully meet this criterion for a range of reasons. This research suggests that the definition does not effectively distinguish between elder mistreatment and other forms of conflict and dispute. The definition, for example, captured a range of legal and other disputes as well as cases where the perpetrators were vulnerable dependants and not fully responsible for their actions. The research also pointed to the difficulty of drawing a line between abusive behaviour and 'normal' levels and expressions of conflict and discord in adult relationships.

The definition excludes certain similar experiences as well as some experiences where age is a clear factor in the nature of the experience. For example, cases involving harm caused by service failures were excluded from the definition, although they could involve similar behaviours, produce similar negative impacts and could be more relevant and important to respondents. Similarly, some cases where age was a central factor in the experience were excluded, such as doorstep crime targeted at older people. It would be helpful to place elder mistreatment in the context of the wide range of related difficulties and problems experienced by older people and to clarify the rationale for distinguishing between these different experiences of neglect or difficulty. It seems also that there needs to be clarification of the relevance of age for a definition of elder mistreatment.

The research also highlighted the limitations of using type of perpetrator in the operationalisation of the concept of trust in relationships. There are two difficulties with this approach. Firstly, this study found some perpetrators that could be categorised into different groups, such as an acquaintance who was seen by the respondent to be 'like family', a perpetrator who was variously described as a close friend, lodger and partner, and perpetrators who were described as strangers or acquaintances but could be viewed broadly as neighbours, albeit not next-door neighbours.

Secondly, the people that respondents trusted in practice did not always correspond with that expected in terms of perpetrator groups. Certain characteristics such as living together, frequent contact or a practice of providing help and support seemed to be related to a higher expectation of trust. These were present in some family relationships, but not all and not all family members were trusted by older people in practice. Some neighbours appeared to be more like friends and older people sometimes placed broad trust in friends, neighbours, acquaintances and, sometimes, strangers. Where the perpetrator was vulnerable, not responsible for their actions and cared for by the older person, the nature and directionality of any expectation of trust was also unclear.

This research suggests the need for a clearer theoretical rationale for a definition of elder abuse, with greater clarity about the kinds of distinctions that the definition is either presumed to make or that are required or desired from such a definition. The definition of elder mistreatment used in this study failed to generate clear distinctions and instead gave rise to a sample that was highly diverse. This diversity and lack of 'saturation' of specific forms, types and expressions of mistreatment meant that the substantive findings from the study tend to be high-level and general across the whole sample. Further research would be needed to look at specific forms of mistreatment in more detail and depth.

Types of incident

This study explored a wide variety of different experiences of mistreatment. All five types of mistreatment addressed in the survey (neglect, physical, psychological, financial, sexual) were included. These categories are based upon descriptions of the behaviours of perpetrators. Other categories describing the experience rather than perpetrators' behaviours were found to be better at grouping and distinguishing between cases, particularly where these experiences involved multiple types of abuse. For the cases covered in this study, these categories were: spousal mistreatment, abuse and conflict; family mistreatment, abuse and conflict; mistreatment and abuse experienced in the course of caring for the perpetrator; conflicts and disputes with neighbours and acquaintances; theft, financial exploitation and financial disputes; institutional neglect and service failure; and, sexual harassment and abuse. There was also a broad diversity of cases represented in the sample in terms of the nature, severity and duration of the mistreatment or abuse experienced as well as the contexts within which the incidents occurred.

Reporting abuse and taking action

There were four distinct motivations for taking action: seeking to change the perpetrator's behaviour; placing distance between the respondent and the perpetrator; seeking legal or formal redress; and, seeking emotional support.

One group of barriers to reporting or taking action relates to people's personal circumstances. These are low self-confidence and self-esteem; experience of bereavement; physical frailty; and also a perception that the mistreatment is not serious enough to merit taking action.

Another group of barriers relates to concerns about the consequences of taking action. These are fear of alienating family and friends and of becoming isolated; fear of being seen to be 'making a fuss'; fear of being blamed; embarrassment and shame; concerns for what the consequences could be for their family and significant others if they were to take action; fear of exacerbating the abuse; and, in certain circumstances, concerns about the health and wellbeing of the perpetrator.

A further group of barriers relates to older people's views of the role and remit of services. These are: not knowing where to go for help; not knowing whether it is appropriate to report their experience to the police or other statutory service, sometimes worrying that it may not be seen as serious enough; a perception that services have no or limited ability to take effective action on their behalf; a fear of authorities; and a lack of awareness of their legal rights.

There were two facilitators for reporting or taking action. These were fear for personal safety and encouragement and support from others.

The agencies mentioned by respondents were the police, solicitors, GPs, community nurses, local council and social services and a range of voluntary organisations including Age Concern, Citizens Advice Bureau, and local and/or specialist support groups, including those for minority ethnic groups, people with dementia, and the families of people with alcohol dependency. The role of generic non-statutory agencies appear especially important, providing, or sign-posting to, advice and support for older people who otherwise may have been unsure about which agencies to approach.

Impacts

The impacts of experiences of mistreatment included a raft of psychological impacts, including emotional distress; loss of self-confidence and self-esteem; depression; thoughts of suicide and/or self-harm and, in extreme cases, long-term abuse could result in uncharacteristic and non-premeditated physical retaliation. Respondents could become socially isolated; family and friends could become distant. Where they were not getting the support they needed, respondents could also experience a loss of independence. Also evident were negative impacts on physical health and financial loss.

Impacts described by respondents were often multiple in nature and impacts such as emotional distress, social isolation, depression and loss of self-esteem and self-confidence were typically experienced across a wide range of different cases.

However, some impacts were associated with particular types of experience. Financial abuse, for example, was naturally associated with financial loss, although humiliation, feelings of betrayal and loss of confidence in one's judgement were also prominent in these cases. Where respondents had experienced sexual harassment or abuse, they talked about feeling embarrassed or ashamed and cases of neglect could, understandably, result in a loss of independence and quality of life. In addition, suicide, self-harm and deteriorating physical health tended to be discussed by those experiencing long-term, ongoing and serious abuse.

Some of the incidents experienced which fell outside of the definition of elder mistreatment used in the survey, including conflict with neighbours, fraud and financial exploitation by strangers and service failures, could also have significant impacts on the respondents involved.

Resilience, coping strategies and mediating factors

A range of mediating factors appeared to affect the extent and nature of the impacts of mistreatment, particularly in the long-term.

These covered aspects of the incident or experience itself. The type and severity of the experience played a part, but other aspects that were important were whether the experience was resolved practically and emotionally; the proximity of the perpetrator; the unpredictability of the mistreatment; and whether or not it took place in the context of caring for the perpetrator.

The circumstances and personal characteristics of the respondent were also important in influencing impacts. These were whether the experience challenged deeply felt norms and values about personal and social relationships; the extent of social and community connectedness; having strong religious and spiritual beliefs; living alone, fear of living alone and bereavement; poor health; previous life experiences; personality; and specific tactics such as keeping a diary or deliberately not thinking about it.

The evidence suggests that a positive orientation with regard to these factors can help to protect people from enduring harmful effects, whilst those with a negative orientation are more vulnerable to harmful effects and poor outcomes.

Policy implications

The involvement of a number of different agencies in the life of many respondents and the wide diversity of experience supports the partnership approach that was set out in No Secrets (Department of Health, 2000) and developed further in 'Safeguarding Adults' (ADSS, 2005).

The extent of the health and disability problems experienced by respondents and their references to contact with GPs, community nurses and other healthcare staff suggests that this is likely to be a key interface with services for older people. This raises questions about education and awareness in primary care teams and it may be that more needs to be done to alert GPs and other health care professionals to issues relating to the mistreatment of older people. In turn, health care professionals need information about the availability of the help and support needed and to be clear about the role and remit of adult protection officers.

The research suggests the need for a non-threatening, generic 'first port of call' for older people experiencing problems. Such a facility would provide or signpost older people to relevant services and support regardless of the nature or severity of the problems experienced and would thereby remove anxiety about whether the experience of mistreatment was serious enough or appropriate to report to authorities. This facility might best be provided by the voluntary sector but with close links to Safeguarding Adults partnerships. There may also be a greater role for the primary care health team in directing people to these services.

The findings also point to the importance of the link between Safeguarding Adults and Crime and Disorder Reduction Partnerships.

The research highlights the fact that domestic abuse does not cease in older age. Domestic violence services might helpfully be reviewed for 'ageism' and consideration given as to how they can appropriately help older people suffering from domestic abuse.

The huge diversity and complexity of the mistreatment explored in this study shows that mistreatment should not be chiefly understood in terms of carers mistreating their relatives owing to the stress of the caring role. In fact, the research suggests that more attention may be needed to supporting carers who suffer from aggressive and abusive behaviour in the person they are caring for, notably those suffering from dementia.

This diversity of experience and the broad range of factors affecting resilience and long terms outcomes also suggest that maintaining broad coverage of high quality services (benefits, housing, health, social care, transport) to older people and their families is likely to be one of the most effective ways of responding to elder mistreatment.

1 INTRODUCTION

The programme of research, of which this study forms a part, was commissioned by Comic Relief with co-funding from the Department of Health and undertaken by a team of researchers at the National Centre for Social Research (NatCen) and King's College London (KCL). The research programme comprised four stages of which the third consisted of a series of in-depth follow-up interviews[1]. The importance of this component of the research is in accessing the voices of older people who have experienced mistreatment and hearing directly in their own words about the mistreatment, its impact on them, how they responded and what action they took. Full details of the design and conduct of this study are given in Chapter 2 and in the Appendices. This chapter sets out the context of the research by outlining briefly the contribution that qualitative research can make to the knowledge base about the mistreatment of older people, the relevant literature, and the development of policy in relation to the mistreatment of older people.

It should be noted that the survey report uses the term 'abuse' to refer to all types of abuse involving a positive harmful action or actions (financial, physical, psychological and sexual). This term therefore excludes neglect which involves a lack of action or actions. These are also defined as being perpetrated by a family member, close friend or care-worker. The survey uses the term 'mistreatment' to refer to all five types of mistreatment, again where perpetrated by a family member, close friend or care-worker. This report of the qualitative findings uses the same terminology. However, for simplicity, this report uses these terms to refer to all relevant incidents and experiences of harm discussed by respondents in the in-depth interviews regardless of other factors, including the perpetrator involved.

1.1 Background to the research

Elder mistreatment is increasingly acknowledged as a social problem (Bonnie and Wallace, 2003; House of Commons Health Committee, 2004; Lachs and Pillemer, 2004). There has been a growing momentum internationally with the Toronto Declaration on the Global Prevention of Elder Abuse (World Health Organisation, 2002) and the increasing number of countries participating in the International Network for the Prevention of Elder Abuse. Yet these developments have not been underpinned by comparable developments in research. Outside literature reviews and case studies, there have been few path-breaking studies. The funding of a national prevalence study in the UK is of international importance.

1.2 The potential contribution of qualitative research to understanding the mistreatment of older people

Definition of terms has plagued the topic of abuse and mistreatment of older people (Bonnie and Wallace, 2003; Lachs and Pillemer, 2004). For the purposes of the survey that forms part of the wider programme of research, it was necessary to adopt transparent definitions that placed some parameters around the issue and then to give clear operational meaning to those definitions. In this, international research and consensus guided the team's thinking (See O'Keeffe et al., 2007). However, research that has explored how older people understand the concept of mistreatment or abuse, including preliminary work that we undertook for this study (McCreadie et al., 2006), indicates that older people may have a different understanding from researchers or policy makers (Nandlal and Wood, 1997; Pritchard, 2000; Pritchard, 2002; Erlingsson et al., 2006). A qualitative approach enables older people's own experiences and understandings to be explored and the implications of this for both research and policy to be considered.

[1] See Chapter 2 for greater detail about the wider programme of research of which this study forms a part and about the objectives, design and conduct of this study

It has been widely recognised that mistreatment is *"complex and multi-faceted"* (Ogg and Munn-Giddings, 1993) and that "*the circumstances in which harm and exploitation occur are known to be very diverse"* (Department of Health, 2000, section 1.2). Mistreatment does not occur in isolation, but against a backdrop of an individual's, and their family's, long history of relationships, as well as events that are increasingly common as people age; increasing ill-health or disability, limitations of daily activity, bereavement of partners, family members and friends. There is also a wider context of social, racial and economic differences between older people and the wider 'ageist' attitudes in our society. Older people are, in a general sense, more dependent on adequate public services than younger people in order to manage practical daily life, particularly when disabilities of varying kinds set in. The adequacy of incomes, the suitability of housing, access to health and social care provision all become fundamental to managing life. These issues all constitute the background against which mistreatment occurs and contribute to its nature. A qualitative approach enables these contextual factors to be explored in depth. The result is a greater understanding of how the mistreatment is bound up with an individual's history, personality, relationships or living circumstances, or all or some of these, and how they in turn contribute to the impact of the mistreatment on the individual, and their response.

The qualitative approach may also contribute to the debate about whether the concept of 'elder abuse' is a useful one. It has been called "*an intensely demeaning concept"'* (Macdonald, 1997) and the Australians have debated whether it is helpful to 'lump' the diversity of problems that are brought together under the 'umbrella' of 'elder abuse' or whether it is more helpful to split them into their component parts (McDermott, 1993; McCallum, 1993). McDermott (1993) argues that it is more helpful to categorise different situations; what matters is whether "*professionals operating in different service systems are able to recognise the range of quite different situations in which older people may be vulnerable"*. Kinnear and Graycar (1999) suggest that it is not a question of either/or and that elder abuse remains a useful concept for drawing attention to this range of serious problems.

Much of the research on mistreatment has originated in the understanding of family violence where there is a clear assumption of a perpetrator (who is to blame) and a victim. The appropriateness of this approach to many situations involving older people has however been challenged (Phillips, 1998; Phillipson, 1992; Nandlal and Wood, 1997). Qualitative research such as this study provides the opportunity to examine the nature of abusive situations in depth and understand some of the ways in which age, illness and disability complicate situations.

Finally there are the immensely important issues around whether people seek help and, if not, why not. It has been suggested that there are significant barriers to seeking help (Penhale, 1993; Pittaway and Gallagher, 1995) but there has been little research asking why. Qualitative research can throw light on people's motivations in seeking help and the nature and scope of constructive intervention. This is particularly important given the relatively low prevalence of mistreatment overall, since it is then important to facilitate people's access to services, so that they have a genuine choice about asking for help.

1.3 The relevant literature

The main published research antecedents for this work are the follow-up study to the Canadian national survey (Podnieks, 1992), and research undertaken by Pritchard in the UK involving 12 in-depth interviews with older men (Pritchard, 2002) and 27 with older women (Pritchard, 2000). Although all the four key national surveys that preceded this one have involved follow-up work, those in Boston, USA (Pillemer and Finkelhor, 1989) and The Netherlands (Comijs et al.,1998) adopted quantitative approaches. We understand from contacts that a comparable piece of work to our own is on-going in a follow-up to the Israeli survey. There are one or two other pieces of work such as the small study with four men and four women, all of whom had some experience of elder mistreatment, in Ontario, Canada (Nandlal and Wood, 1997) and a similar study in Sydney, Australia (Sargent and Mears, 2000). However, in general, there has been a paucity of research of this kind. The overwhelming volume of empirical qualitative research has either focused on service providers (doctors, nurses, care workers), has made use of social work or medical records or has spoken with 'carers' of people with dementia.

The study in Canada by Podnieks (1992) involved interviews with 42 older people who had experienced mistreatment, their ages ranging from 67 to 93 years. Twenty-four of the 42 had suffered financial abuse, seven verbal abuse, eight physical abuse and three neglect. The research involved a life-course approach, with the hypothesis being that how the older people dealt with mistreatment in old age would reflect how they had dealt with loss in the years of the Great Depression. The general conclusion from these interviews was that older people who have been mistreated suffer acutely but that they are also resilient; that they 'accepted' their mistreatment as "*part of the much broader problems of their lived experiences"* (Podnieks, 1992, p. 102). Podnieks concluded her research by warning against interventions that are premised on the "*let's rescue the elderly"* approach. Many of her respondents did not want professional intervention and "*definitely do not want criminal charges placed against their abuser*"' (Podnieks, 1992, p103). She urged a straightforward approach to asking people what help they wanted to enable them to maintain their "*greatest wish"*; for self-care and independence. The kinds of intervention recommended as helpful were peer counselling, telephone counselling, alternative living options and a widespread education programme with the aim of preventing elder mistreatment.

Similar recommendations for services were made by Pritchard's respondents, both male and female, who wanted to be able to discuss their past and present experiences, get support and practical advice, for men particularly on finances, and have alternative living options. Many had experienced a life-time of poverty and hardship and, for the women in particular, "*having enough food and living in a warm environment was of paramount importance to them now".* (Pritchard, 2000, p 68-9).

1.4 The development of policy[2]

The overall context of policy addressing the abuse and neglect of older people is the growth of the older population and increasing longevity. These developments have involved concomitant growth in the numbers of people with disabilities, mobility and cognitive problems. Most people, as they age, remain in their own homes and policy aims to support them in this although as people age, particularly after 85, greater proportions move to care homes. There have been substantial and rapid changes in the way social care is provided, involving the growth of independent provision of services and the increased importance of regulation, service commissioning and assessment. The introduction of Fair Access to Care Services (FACS) in 2003 introduced criteria for eligibility for adult social care that aimed to target provision on those assessed to have priority need. At the same time, there has also been substantial growth in the private funding of both domestic help and personal care in people's own homes. The significance of 'partnership working' - between the NHS and social care, between social care and the police and between statutory, voluntary and independent sectors - has been repeatedly emphasised in a wide range of policy documents.

Since the 1960s, there have been intermittent scandals about care in institutional settings, and from the 1970s, the medical profession raised concerns about the abuse of older people in their own homes. In the late 1980s, the Department of Health's Social Services Inspectorate (now part of the Commission for Social Care Inspection) followed this concern up by funding research and seminars and by providing early guidance to local authority social services departments about the abuse of older people in private households.

Rather than focusing on all adults, older people have been regarded as a vulnerable group, along with people with learning disabilities, mental health problems and physical disability, on the assumption that vulnerable adults experience a higher prevalence of abuse and neglect (ADSS, 2005). A 'vulnerable adult' is defined, in line with reports from the Law Commission, as one "*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"* (Department of Health, 2000, para 2.3).

No Secrets is the current Government guidance in England, issued by the Department of Health and the Home Office, addressing the abuse of vulnerable adults, and *In Safe Hands* is the comparable Welsh Guidance. Both were issued in March 2000, and required local authorities, the mandated lead agency, to collaborate with other local bodies, notably the police and the NHS, in drawing up multi-agency responses to elder abuse through policies, procedures, joint training, information sharing and so on.

Abuse was defined in *No Secrets* as:

"*a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of a single or repeated acts. It may be physical, verbal, or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it."* (Department of Health, 2000, para. 2.5. – 2.6.).

The guidance stressed that a vulnerable adult might be abused by a wide range of people, and cited *"relatives, family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit*

[2] Please note that an expanded version of this section can be found in Chapter 1, O'Keefe et al. (2007) UK Study of Abuse and Neglect of Older People: Prevalence Survey Report, NatCen

vulnerable people and strangers". Multi-agency policies, and procedures for addressing elder mistreatment and abuse now exist in all local authorities, but there is considerable diversity in administrative arrangements and in the resources allocated to this work (Mathew et al., 2002).

2 DESIGN AND CONDUCT OF THE RESEARCH

The programme of research, of which this study forms a part, was commissioned by Comic Relief with co-funding from the Department of Health and undertaken by a team of researchers at the National Centre for Social Research (NatCen) and King's College London (KCL). The research programme is comprised of four stages:

- Stage one: literature review and focus groups with practitioners and stakeholders to explore workable definitions of elder abuse for the survey, inform survey question design and explore initial views and perspectives on impacts, coping strategies employed by older people and barriers to reporting[3]
- Stage two: a nationally representative prevalence survey among over 2000 people aged 66 and over throughout the UK, reporting on mistreatment experienced since age 65
- Stage three: a series of in-depth follow-up interviews with people who have experienced or encountered mistreatment in order to explore issues around impact, resilience and coping mechanisms and barriers to reporting
- Stage four: a scoping study to examine and recommend appropriate strategies for obtaining estimates of abuse within care homes

This report presents the findings from stage three of this research programme, involving in-depth interviews with older people and some of their relatives. This chapter sets out the broad aims and design of the study and describes the methodology used in sampling, recruitment, fieldwork, analysis and ethical approach including a description of the sample frame and achieved sample for the study. Please see Appendix A for additional information on study design and methodology including in-depth description of sampling and recruitment processes, fieldwork practice and support offered to respondents, and on the disclosure protocol established for the study.

2.1 Study aims and objectives

The aims of the wider research programme are to establish the national prevalence of abuse and neglect of older people living in private households (including sheltered housing) in the UK and to gather information pertaining to:

- the risk factors for mistreatment
- the impact of mistreatment on older people and their families
- the barriers to reporting mistreatment
- the strategies and coping mechanisms people develop in order to deal with mistreatment
- and to explore how the prevalence of mistreatment in care homes might be reliably established

The qualitative study reported here (stage 3) addressed the following specific research questions:

[3] McCreadie, C; O'Keeffe, M; Manthorpe, J; Tinker, A; Doyle, M; Hills, A; Erens, B and Biggs, S (2006) *First Steps: The UK National Prevalence Study Of The Mistreatment And Abuse Of Older People* Journal of Adult Protection 8 3 4-11

- what is the impact of mistreatment on older people and, where relevant, their families?
- what forms of action do older people take in response to the experience of mistreatment?
- how do older people negotiate taking action, what factors influence their choices and responses and what are the barriers to reporting mistreatment?
- what factors influence how older people experience and cope with mistreatment and what coping strategies do those experiencing mistreatment employ?

2.2 The use of a qualitative approach

This study is based upon 39 in-depth qualitative interviews with men and women age 65 and over (36 from the prevalence survey and 3 from community-based BME organisations) who have experienced mistreatment and also with a small number of their relatives who have been, in some way, involved or affected by the mistreatment of an older relative (although no family members implicated in perpetrating abuse were interviewed).

This study is intended to map range and diversity and to provide a detailed understanding of the experiences, decision-making processes and responses of older people experiencing mistreatment. It aims to facilitate an understanding of the underlying dynamics and processes and to identify and explore how different factors interact. The approach taken is primarily inductive, where analytical concepts and perspectives are derived from the data. Such an approach avoids restricting the investigation to pre-determined concepts or pre-judging the significance of incidents and experiences for respondents. It allows an exploration of the ways in which respondents themselves make sense of their experiences, allows consideration of the issues from respondents' own perspectives and allows unexpected issues and themes to emerge.

It is not the purpose of qualitative research to generate numerical or statistical findings and, for this reason, we do not undertake any numerical or statistical analysis of the qualitative data nor cite the numbers of people expressing particular points of view. These numbers would lack any statistical significance and would not be generalisable in terms of prevalence or be meaningful. Findings from qualitative research such as this take the form of comprehensive mapping and description of relevant phenomena (such as mapping and describing the range of barriers to taking action in the face of mistreatment or abuse) and of exploration and discussion of associations and relationships between phenomena found in the data.

Consequently the findings from this study complement the survey and its findings by exploring the underlying meanings, perceptions and experiences of older people experiencing mistreatment. However, due to the inclusiveness of the definition used in the survey (see below) and the consequent wide diversity of cases in the survey sample, along with high levels of unobtainable respondents and respondents not wishing to take part in an in-depth interview (see Appendix A), the qualitative findings may not reflect the full range and diversity of experiences confronting the older people who responded to the survey. This does not in any way invalidate the qualitative findings; it simply means that there may be additional issues that were uncovered by this study. It should be noted that despite this potential limitation in reading across to the prevalence survey findings, the qualitative study achieved a wide diversity of respondents and contexts, sufficient to generate generalisable concepts and insights into elder mistreatment.

2.3 Sample design

2.3.1 The sample frame

The sample frame for this study (stage 3) was comprised of respondents who took part in the national prevalence survey of older people (stage 2)[4], conducted as part of the wider programme of research. This included cases across England, Scotland, Wales and Northern Ireland. The sample passed to the qualitative team included only those individuals who agreed to being re-contacted and who:

- met the behavioural definitions within the five categories of mistreatment used in the survey – neglect, financial, psychological, physical and sexual - with incidents occurring within the last 12 months (see Table 2.1)
- **or** who met the behavioural definitions but where the experience of mistreatment or abuse occurred at age 65 or over but not within the last 12 months
- **or** who, in the case of neglect and psychological abuse, did not meet the threshold used for the survey of ten incidents in the last twelve months but where the respondent judged the incident(s) to be 'very serious'

In addition, whereas the headline prevalence figure given in the findings from the survey includes only incidents and experiences involving perpetrators who are family members, professional carers and close friends, the sample frame provided to the qualitative team also included cases where the perpetrator was a neighbour or acquaintance and those classified at the time in the survey as 'other' which, it became clear from further analysis, included some strangers. The final sample frame provided by the survey team numbered 141 cases. This number was reduced to 128 when 13 cases were removed from the original sample frame because they involved incidents perpetrated by strangers and acquaintances and appeared to be either disputes and conflict with neighbours (which were already well represented in the sample) or were otherwise considered likely to be of marginal interest to the objectives of the study.

It was recognised early on that the survey may not generate a sampling frame of sufficient size to allow us to achieve the desired sample for the qualitative follow-up research. Indeed, there were relatively low numbers of respondents reporting experiences of mistreatment in the survey, some of whom additionally did not agree to be contacted again for further research and were therefore not included in the sample passed to the qualitative team.

In terms of the comprehensiveness of the sample frame, it was also recognised at the outset that those suffering with bad health or cognitive impairment may have been less likely to have participated in the survey, or that emotions such as guilt, denial or shame or not wishing to dwell further on the experience may have mitigated against people taking part or against full disclosure amongst those who did take part. It is also possible that some people did not take part in the survey for fear of the consequences of participating or because someone close to them blocked their involvement. Hence, it is possible that some people experiencing mistreatment, potentially the most severe forms, were not included in the sample frame for this study. This issue is discussed in greater detail, along with discussion of steps taken to overcome these difficulties, in the report of the survey.[5]

[4] O'Keefe et al. (2007) UK Study of Abuse and Neglect of Older People: Prevalence Survey Report, London: NatCen
[5] Ibid.

2.3.2 Purposive sampling

The older people interviewed for this qualitative study were purposively sampled from the sample frame described above. Purposive sampling employs a different rationale from that of quantitative sampling. Rather than attempting to select a sample that is statistically representative of the wider population, a purposive sample aims to reflect the full range of sub-groups and respondent characteristics. In doing so, it aims to capture the full range and diversity of respondents' experiences, attitudes and perceptions. This approach uses smaller samples than quantitative approaches so that issues can be explored in sufficient depth to allow a full exploration of phenomena and so that relationships and associations can be identified and explored. In addition, due to the lack of respondents in the sample frame from BME communities, three further respondents were accessed through direct approaches to a range of relevant community-based organisations. Three further interviews were conducted with family members identified through the interviews with older people.

2.3.3 Selection criteria

Purposive sampling proceeds by identifying relevant criteria or characteristics against which to ensure an appropriate spread of cases. These criteria should be those that are thought to distinguish cases in terms of the experiences, attitudes, perceptions etc. encountered. By ensuring a spread of cases against each of these criteria, the aim is to map the range of these phenomena (experiences, attitudes, perceptions, etc.) that exist across the target population.

Table 2.1 Behavioural Definitions Used in the Survey

Neglect	10 or more instances of neglect in the last 12 months OR less than 10 instances in the last 12 months but judged by the respondent to be "very serious" Respondent must have stated that they need and receive help with an activity, and that they have difficulty carrying out the activity by themselves. Neglect grouped into three categories: - *Day to day activities (Shopping for groceries or clothes, Preparing meals, Doing routine housework, Travel or transport)* - *Personal care (Getting in and out of bed, Washing or bathing, Dressing or undressing, Eating including cutting up food, Getting to and using toilet)* - *Help with correct dose and timing of medication*
Financial abuse	1 or more instance of financial abuse in the last 12 months - *Stolen money, possessions or property* - *Attempted to steal money, possessions or property* - *Made you give money, possessions or property* - *Tried to make you give money, possessions or property* - *Used fraud to take money, possessions or property* - *Tried to use fraud to take money, possessions or property* - *Taken or kept power of attorney* - *Tried to take or keep power of attorney*
Psychological abuse	10 or more instances of psychological abuse in the last 12 months by the same person - *Insulted you, called you names or sworn at you* - *Threatened you* - *Undermined or belittled what you do* - *Excluded you or repeatedly ignored you* - *Threatened to harm others that you care about* - *Prevented you from seeing others that you care about*
Physical abuse	1 or more instance of physical abuse in the last 12 months - *Slapped you* - *Grabbed, pushed or shoved you* - *Kicked, bit or hit you with a fist* - *Burned or scalded you* - *Threatened you with a knife, gun or other weapon* - *Used a knife, gun or other weapon* - *Done anything violent to you which you have not mentioned* - *Tied you down* - *Locked you in your room* - *Given you drugs or too much medicine in order to control you/ to make you docile* - *Restrained you in any other way*
Sexual harassment / abuse	1 or more instance of sexual harassment or abuse in the last 12 months - *Talked to you in a sexual way that made you feel uncomfortable* - *Touched you in a sexual way against your will* - *Tried to touch you in a sexual way against your will* - *Made you watch pornography against your will* - *Tried to make you watch pornography against your will* - *Had sexual intercourse with you against your will* - *Tried to have sexual intercourse with you against your will*

This study focused on the whole range of types of abuse (neglect, physical, psychological, financial, sexual) and upon experiences involving the full range of perpetrators (family member, carer-worker, close friend, neighbour, acquaintance and stranger). In addition, the research team, drew upon information provided during the survey interview to ensure inclusion of a range of older people. In particular, the team used the following criteria:

- gender (male, female)
- age (three age bands: 65-74; 75-84 and 85 +)
- ethnicity (white British, other)
- country within the UK (England, Wales, Scotland, Northern Ireland)

Minimum targets, reflecting an even spread across these criteria, were set. It was not practical to set specific targets for two criteria – perpetrators and living alone or with others - but the team aimed to include a spread of cases against these criteria and also to include a spread of cases against health status and frequency and intensity of incidents and experiences, as far as could be judged from descriptions of incidents given in the survey.

2.3.4 Number of interviews

In order to ensure that adequate coverage was achieved across these sampling criteria, we aimed to carry out 40 in-depth interviews with older people. This number of interviews is typical for studies of this sort and was designed to provide a manageable number of interviews to conduct and analyse in the necessary depth for meaningful qualitative investigation and, at the same time, to provide adequate coverage of different respondent characteristics. The recruitment and sampling processes, and issues arising, are detailed fully in Appendix A.

2.4 Achieved sample

The final achieved sample of older people for the in-depth interviews totalled 39 interviews. Table 2.3 shows achieved sample against targets for the sampling criteria. Please note that the target numbers do not add up to 40 (the original target number of interviews with older people) because they are minimum targets rather than exact quotas. Also, that no specific targets were set for living arrangements (although this was monitored and a spread sought) or type of perpetrator, since the exact range of perpetrators to be included was determined through discussion with the wider research team and sponsor in the course of recruitment. However, the initial focus was on obtaining a spread across family, paid carers and close friends, extending to include neighbours initially and then to some acquaintances and strangers.

Table 2.3 Achieved Sample of Older People

	Target (min.)	Achieved
Area		
Scotland	6	**9**
Wales	6	**7**
Northern Ireland	6	**3**
England – NW	6	**10**
England – SE	6	**10**
Gender		
M	15	**11**
F	15	**28**
Ethnicity		
White British	30	**36**
Other	6	**3**
Type of abuse (includes respondents who reported multiple incidents)		
Neglect	6	**5**
Financial	6	**11**
Psychological	6	**18**
Physical	6	**11**
Sexual	6	**5**
Age		
65-74	10	**13**
75-84	10	**22**
85+	10	**4**
Perpetrator (includes respondents who referred to multiple perpetrators)		
Spouse/partner		**12**
Other family		**6**
Neighbour		**6**
Professional carer		**6**
Close friend		**4**
Acquaintance		**2**
Stranger		**4**
Living arrangements		
Living alone		**25**
Living with others		**14**

The health of respondents varied greatly. Some described themselves as very fit and independent and, when probed, reported no ailments whatsoever. Most respondents, however, spoke of feeling generally frail and requiring some sort of help or assistance, whether this was provided regularly by professional carers or as needed by relatives, friends or neighbours. Across the sample, older people also mentioned deteriorating sight and hearing though, not surprisingly, this was more pronounced among older respondents. A range of other illnesses and ailments were also mentioned by respondents within the sample. These were: diabetes; cancer; arthritis; angina; cancer; and, a range of mobility difficulties, sometimes the result of hip or knee replacement surgery. Several respondents had also experienced heart attacks and still suffered their effects.

As well as physical ailments, there was also evidence of mental health difficulties among respondents. Some openly acknowledged this and attributed periods of depression to their experience of mistreatment or abuse. In other cases, it was apparent to the researcher conducting the interview that the respondent had difficulties with, for example, concentration, comprehension or expression, yet this was never explicitly disclosed by the older person.

Three interviews with family members were undertaken. This was fewer than the ten originally proposed because in many cases there were no family members who were in any way involved in the incident or experience of mistreatment, they were the perpetrators of the incidents or experiences, respondents were not comfortable passing on information or relatives chose not to opt in to the research. Information was given to respondents to pass to relatives in four cases where the relative did not make contact as a result.

2.5 Fieldwork

The interviews with respondents took place between late July and November 2006. Most were conducted in the respondent's own home. Two of the interviews with BME respondents were conducted at the offices of the organisation through which they were recruited. These respondents, recruited from specialist BME community groups, requested that a worker from the organisation be present. In these cases the worker interpreted at points during the interview where the respondent found it easier to express themselves in a first language.

Interviews followed a topic guide, the development of which was informed by the findings of the survey and the focus groups conducted at an earlier stage of the research programme. The topic guide was developed in close collaboration with the sponsor and an Older Person's Reference Group convened for the study comprising older people with experience and expertise in issues affecting older people. Information about the Older People's Reference Group are included at Appendix C. The topic guides are appended at Appendix D.

The guides covered respondents' general background and circumstances; their perceptions and experiences of mistreatment; perceived impacts of the abuse (short, medium and longer term); strategies and coping mechanisms for dealing with abuse and abusive situations, including sources of support and the nature of any support received; responses to the mistreatment including use of services, any barriers or facilitators to reporting mistreatment and general outlook on life and approaches to problems and difficulties more generally.

The topic guide was used to ensure proper coverage of all key areas of enquiry, but used flexibly, with topics covered in whatever order seemed natural for the respondents and each topic fully probed and explored in the light of the information provided by the respondent.

The same topic guide was adapted to guide and inform interviews with family members. It was used flexibly to explore both the family member's perception of the older person's experience as well as their own perceptions and reactions.

2.6 Analysis

Interviews were transcribed verbatim for analysis. Interview transcripts were stored securely with a respondent code and did not include personal identifiers. Verbatim transcripts of the interviews were then comprehensively and systematically analysed using 'Framework' (Ritchie et al., 2003), a tool for analysis of qualitative data developed at NatCen.

The first stage of analysis involves familiarisation with the data generated by the interviews and identification of key and emerging issues to inform the development of a thematic framework. This is a series of thematic matrices or 'charts' into which interview data is comprehensively summarised. Each matrix or chart represents a particular area of enquiry covered by the study. Within each of these charts the column headings on each of the charts relate to sub-themes within the area of enquiry covered by the chart. The rows on each of the charts relate to individual respondents, with each respondent having his or her own row so that data from the same individual or case can be reviewed together by reading across the row.

Once the charts are established, data for each case is then summarised in the relevant cell. Data from the interviews is comprehensively summarised, so that all of the content of the interview is included, albeit in a précised form. The context of the information is retained and the page of the transcript from which it comes is noted, so that it is possible to return to a transcript to explore a point in more detail or extract text for a verbatim quotation. This approach makes the interview data more accessible to comprehensive and consistent analysis while, at the same time, making sure that links with the verbatim data are retained.

The use of framework enables the views, circumstances and experiences of all respondents to be explored by team members within a common analytical framework which is both grounded in and driven by respondents' accounts. The approach allows for in-depth within case analysis as well as for cases to be compared and contrasted. It also allows for patterns and themes to be identified and explored and for explanations and hypotheses about observed patterns and associations to be generated.

2.7 Ethical approach

It should be clear that this study raised a range of ethical issues, involving as it does potentially vulnerable older adults. The sample selection, recruitment and fieldwork practices described in this chapter and, in greater detail, in Appendix A reflect a concern with the interests and well-being of respondents as well as data quality and the integrity of the research. All of the provisions described were discussed with colleagues at Kings College London, staff at Action on Elder Abuse and were set out in an ethical review submission to the NatCen ethics committee. The committee provided advice and feedback and were available for consultation throughout the duration of the study. The study was also guided by the Research Governance Framework for Health and Social Care (DH, 2005) which covers a range of issues including ethics, research quality, outputs and dissemination, and best use of resources. NatCen operates to the highest standards in terms of ensuring confidentiality and anonymity and subscribes to the Social Research Association's (SRA) Ethical Guidelines. Information covering ethical approach to recruitment, fieldwork, supporting respondents and the protocol on disclosure is set out in detail in Appendix A.

2.8 Report outline

The rest of this report covers the substantive findings from the study. Chapter 3 reflects on the experiences of working with the definition of elder abuse used and raises questions about the usefulness and relevance of the definition and its operationalisation in research. Chapter 4 outlines the types of incidents explored by this study. Chapter 5 discusses the types of action taken by older people in the face of mistreatment and includes a discussion of barriers to reporting and the role of services. Chapter 6 discusses impacts and Chapter 7 explores the role of resilience, coping strategies and other factors in shaping and influencing these impacts. Chapter 8 provides a commentary on the findings and their relevance for research and policy in this area.

3 CHALLENGES OF DEFINITION

This programme of research is one of few conducted on this topic in the UK and the qualitative study presented here represents one of very few attempts within the UK to examine elder abuse in-depth using qualitative methods (see Chapter 1 for discussion of other relevant research). Consequently, this study is highly exploratory in nature and has also highlighted a range of methodological challenges related to sampling, recruitment and conduct of fieldwork. Those relating to the survey are discussed separately in the report of the survey[6] and a number of methodological challenges relating to this study have been discussed, along with how they have been addressed, in Chapter 2.

This chapter, however, focuses on issues concerning the definition of elder abuse which have been raised by the study. The definition of elder abuse used in this research (which is widely accepted and the same or similar to definitions used in previous research) has, in practice, posed particular challenges for analysis and interpretation and, as a consequence, has highlighted aspects of the definition that are problematic and warrant further discussion, debate and development.

3.1 Limitations and restrictions of definition

The strength of the qualitative research was its ability to explore in greater depth the types of incidents and experiences reported in the survey and confirmed and deepened the picture of diversity and complexity presented in the survey. The qualitative research found an extremely wide variation of respondents' experiences, within and across the five 'type of abuse' categories – neglect, psychological, physical, financial and sexual – and within and amongst cases involving different types of perpetrator. The experiences discussed by respondents also varied depending on the apparent intention of the perpetrator, by the apparent severity of both the incident or experience and of the impacts. They also varied in terms of when incidents or experiences took place and their duration and frequency, with the sample including a spectrum of incidents and experiences from one-off incidents to a fifty year long abusive relationship. Experiences varied also as to whether there were multiple types of abuse involved (spousal abuse that involved, for example, psychological, physical and financial abuse) or as to whether there were multiple perpetrators involved. In this, the qualitative research suggested that respondents, who may have reported one type of mistreatment or abuse in the survey, sometimes provided a more complex picture in the qualitative interviews, reporting other types of mistreatment occurring as part of the same overall experience although these may not always have met the criteria for inclusion in the survey's prevalence figures, such as related incidents occurring prior to age 65.

While it is clear that the definition of elder abuse used is intentionally wide-ranging and covers a wide spectrum of different behaviours, a useful definition is one that draws together experiences that are in some way similar and distinguishes them from other types of experience in a way that is meaningful and useful. Evidence from this study suggests that the definition used is not meeting this criterion. There are five specific problems that need further resolution, some relating to the purpose and rationale for a definition of elder mistreatment and others related more to the difficulties of operationalising the definition. These are:

- the need to better distinguish between 'elder abuse' and other forms of conflict and dispute;
- the exclusion of similar and related difficulties, which may be considered more important and severe by older people;

[6] Ibid.

- the limitations of using types of abusive behaviour to classify older people's experiences;
- the difficulties of attempting to operationalise the notion of trust in relationships with reference to perpetrator groups;
- the exclusion of some incidents and experiences where older people are targeted specifically because of their age and, conversely, the inclusion of incidents and experiences which appear unrelated to age.

It may be countered that some of these issues are not, in fact, problems and that the definition is not designed to, for example, identify incidents where older people are targeted because of their age. However, this research suggests that, at the least, there is a need to develop a clearer theoretical rationale for a definition of elder abuse, with greater clarity about the kinds of distinctions that the definition is either presumed to make, which appear to be currently unclear and under-specified, or that are required or desired from such a definition. It should also clarify the relationship of elder abuse to other forms of mistreatment and difficulty experienced by older people. If such a rationale is not identifiable it may be that the definition is inherently unclear and helpful and should be abandoned The following sections discuss these limitations in more detail.

3.1.1 Distinguishing between elder mistreatment and other forms of conflict and dispute

The sample included a wide range of behaviours and experiences, ranging from what would be widely seen as 'abusive' behaviour to a range of other behaviours and situations that, although difficult and upsetting, would not be widely considered to be 'abusive'. This was either because:

- these experiences were characterised by a relatively low level of severity;
- the perpetrators were not fully responsible for their actions (due, for example, to being children with emotional and behavioural difficulties or other adults, sometimes older people themselves, with cognitive impairments or suffering with severe mental illness);
- the perpetrators clearly did not intend harm; or,
- because of the mutuality of the behaviour and the difficulty of drawing a line between 'abusive' behaviour and 'normal' levels and expressions of conflict in adult relationships.

3.1.2 Exclusion of similar and related difficulties, which may be considered as more important or severe by older people

At the same time, there was evidence that, as well as being in some respects overly inclusive, the definition did not include experiences that respondents and other commentators may see as similar or related. These were sometimes significantly more difficult and harmful for respondents. These incidents and experiences predominantly involved difficulties in accessing services or service failures. In the sample, these range from difficulties in being assessed as in need of social services support to, in one case, the repeated failure of a social service department to ensure that a carer attended to a respondent who was unable to get washed and dressed in the morning without such help.

Asking respondents about the incident or experience of mistreatment or abuse reported in the survey could lead to confusion, with respondents feeling that the researchers were failing to understand or were focusing on the wrong things, especially where the experience reported in the survey was less severe compared to other experiences of mistreatment, neglect or difficulty they had experienced, for example with services.

The focus on harm caused by failure to access services and because of service failures also speaks to the importance of placing 'elder abuse', however defined, in the context of the wide range of related difficulties and problems experienced by older people, and of clarifying the rationale for distinguishing between these different experiences of neglect or difficulty. Also, whilst acknowledging the difficulties associated with relying exclusively on respondents' own subjective judgements (for example, respondents down-playing the importance or severity of experiences), it points to the importance of taking account of respondents own experiences and perceptions of severity and of relative harm into account.

3.1.3 The limitations of using types of abusive behaviour to classify respondents' experiences

The five categories of mistreatment (neglect, physical, psychological, financial and sexual abuse) are ways of classifying the specific behaviours of perpetrators rather than people's experiences of mistreatment. It could, in fact, be that individuals were at the receiving end of more than one of these behaviours as part of the same overall experience. For example, spousal abuse may include physical, psychological, financial and sexual abuse. In this example, it may be that classifying the experience as elder abuse involving a series of different types of abusive behaviours may obscure helpful insights that an understanding of the experience as a coherent and singular experience of spousal abuse (in the context of involving older people) would provide.

This study has identified some categories which were useful for distinguishing between the cases included in the sample (see Chapter 4). However, the broad focus of this study and the wide diversity in the data means that it has not been able to generate a comprehensive set of categories, capable of meaningfully distinguishing between respondents' different experiences of mistreatment. This may point to the need for further research aimed at clarifying and exploring distinctions between different forms of incidents and experiences of mistreatment, based on the accounts of, and from the perspective of, older people themselves. However, the diversity and complexity encountered suggests that constructing a sample of such a wide range of incidents and experiences that the definition of elder mistreatment includes so as to provide a manageable sample and still give the necessary 'saturation' and coverage to map and explore a range of dimensions at the level of specific forms of mistreatment may be extremely challenging. There may therefore need to be further thought given to how to focus further empirical research.

3.1.4 The difficulties of attempting to operationalise the notion of trust in relationships with reference to perpetrator groups

The original intention in this qualitative research had been to focus on incidents involving perpetrators who were family members, professional carers or close friends on the basis that these were deemed to be in a relationship of trust to the respondent. However, whilst the decision to broaden out the focus of the study to include cases involving perpetrators who were neighbours, acquaintances and strangers has increased the diversity in the sample, it has also helped to draw attention to the limitations of using type of perpetrator in the operationalisation of the concept of trust in relationships.

The research highlights two difficulties with this approach. Firstly, accurately classifying individual perpetrators and, secondly, the presumption that particular perpetrator groups are inevitably in a relationship of trust with the older person and, equally, that those in other perpetrator groups are not.

Classifying individual perpetrators

Upon closer inspection, it was not always clear to which perpetrator group some perpetrators belonged and some could have accurately fitted into more than one group. For example, in one case a perpetrator was variously described in the survey, the follow-up interview and family interview as a close friend, a partner and lodger. In another case, there was a perpetrator who was defined as an acquaintance in the survey but, in the follow-up interview the respondent explained that the perpetrator had been brought up with a family member and was 'like family'. In cases involving neighbours, the relationship could be one that was conducted over the garden fence whilst in other cases it seemed that the relationship was more one of friendship, where the neighbour and respondent came into each other's houses and socialised together. In another case, local children were described as strangers but given the fact that they lived locally, it may be that they might more accurately be viewed as neighbours.

Equating membership of a perpetrator group with being in a relationship involving trust

The study also highlights difficulties associated with the assumption that being in a particular perpetrator group necessarily involves trust. In particular, the category of family member spanned a wide range of people from close family, who were in regular contact with the respondent, to remote family members, some of whom would not be thought to be in any way in a position of trust towards the respondent. However, the data did suggest that certain characteristics, such as living together, frequent contact or a practice of providing help and support, were related to a higher expectation of trust in relationships. The evidence suggested that these may be present in some family relationships, but certainly not all.

Although none were interviewed for this study, neighbours perpetrating neglect have presumably, by definition, been entrusted with providing certain types of care or support. In cases where the perpetrator was vulnerable and not wholly responsible for their actions, for example where they were suffering from dementia or severe mental illness, or were children, and cared for by the older person the directionality of being in a position of trust is unclear. In such cases the perpetrator is not fully capable of being entrusted in any way and it would seem that, whatever the vulnerabilities of the older person, that it is they who are in the position of trust towards the person that they are caring for.

In other cases, older people placed broad trust in friends, neighbours, acquaintances and, sometimes, strangers and provided them with, for example, access to property and finances.

This points to clear problems of operationalising the concept of trust in this context. However, it also became clear, in the course of reflecting on these difficulties, that there is a need for greater theoretical consideration of exactly what this concept intends to capture and what the importance and relevance of this in terms of older people's experiences of mistreatment. Only with greater clarity about what is intended can the issue of operationalising the concept of trust be addressed more fully.

3.1.5 The exclusion of some incidents and experiences where older people are targeted specifically because of their age and, conversely, the inclusion of incidents and experiences which appear unrelated to age

The fact that certain perpetrator groups were excluded from the definition meant, in effect, that certain incidents and experiences, such as fraud perpetrated by individuals posing as tradesmen where respondents seemed to be actively targeted on account of their age and perceived vulnerability, were excluded from the definition. Similarly, other experiences that were included in the definition appeared to be unrelated to age. Any reconsideration of the definition will need to clarify the relevance of age and, in particular, provide a rationale for prioritising factors such as type of perpetrator over and above the role of age in the occurrence or experience of mistreatment.

3.2 Relevance of these difficulties for analysis and interpretation

A key implication for analysis and interpretation is that, without clear and meaningful distinctions at the level implied by the definition (for example, between those cases that fall within and outside of the definition, or between cases involving different types of perpetrator or different perpetrator behaviours) what is left is a sample that is simply highly inclusive and diverse. This diversity and lack of 'saturation' of specific forms, types and expressions of mistreatment, in turn, means that the sample is not amenable to the exploration and identification of alternative sub-groups or group-based differences. To explore the data in this way would have required huge sample sizes so that there was adequate coverage of the multiple possible sub-groups. In practice, this would be unmanageable in terms of conducting meaningful qualitative research and points to an over-inclusive definition of elder abuse. Hence the substantive findings from this study tend to be generalized across the sample (or are otherwise applicable at a highly specific, even individual, level).

Nonetheless, these findings are valuable and reflect general experiences, reactions and responses to experiences of abuse, mistreatment and other difficulties. The following chapters explore the types of experiences explored in the study and set out findings about the actions taken in response to mistreatment, impacts and the role of resilience factors, coping mechanisms and other mediating factors in affecting how experiences of mistreatment are experienced.

4 INCIDENTS OF ABUSE EXPERIENCED

As explained in Chapter 2, the follow-up qualitative interviews with respondents explored, in depth, the experience of mistreatment reported by respondents in the survey. In the course of these interviews, we heard about a wide range of different experiences. Whilst some of the incidents that we heard about fell within the definition of mistreatment used for this study, others did not. For example, where the perpetrator was a stranger or acquaintance the incident has not been defined as elder mistreatment or abuse in the headline prevalence figure, but where they were a family member or close friend it has and some respondents told us about their experiences of service failure which was not included within the definition.

In the course of describing incidents, reference is made to the severity of incidents. It should be noted that while it was apparent that there was a range of levels of severity of incident or experience present in the sample, direct comparison of cases was problematic and subjective. The diversity of experience meant that one was not often comparing similar experiences, and that what may seem very serious for one person may seem much less so to another. Also, as the report goes on to explore, there is no clear correlation between the perceived severity of the incident experienced and the severity of its impact.

This chapter describes the diversity of incidents that people reported. In addition, it also reflects on the role of age and age-related characteristics in relation to respondents' experiences.

4.1 Types of abuse

All five types of abuse identified as constituting 'elder abuse' were included in the qualitative sample:

- neglect;
- physical abuse;
- psychological abuse;
- financial abuse; and
- sexual harassment and abuse.

Sometimes these occurred in isolation, most commonly in the case of financial abuse or psychological abuse. However, sometimes respondents described experiencing multiple types of abuse. Multiplicity of abuse appears in our sample in several ways. Firstly, there are cases where a respondent has experienced multiple types of abuse from one perpetrator, for example a respondent experiencing physical, psychological and financial abuse at the hands of their partner or spouse in a case of spousal abuse. Secondly, some older people had experienced one type of abuse, typically financial, at the hands of several perpetrators. On the other hand, there were respondents who had two or more experiences of different types of abuse, for example having money stolen as well as experiencing a neighbour dispute.

As we came to analyse the qualitative data, and reflect on multiplicity, it became clear that the types of abuse referred to the behaviour of perpetrators, rather than people's experiences which could commonly involve a range of perpetrator behaviours. Within our sample, several broad categories of experience could be identified that bring together incidents and experiences (sometimes involving multiple 'types of abuse') that are broadly similar in nature. These categories are:

- spousal mistreatment, abuse and conflict;
- family mistreatment, abuse and conflict (other than spousal);
- abuse experienced in the course of caring for the perpetrator;
- harassment, conflicts and disputes with neighbours and acquaintances;
- theft, financial exploitation and financial disputes;
- institutional neglect and service failure; and
- sexual harassment and abuse.

4.1.1 Spousal mistreatment, abuse and conflict

The accounts we heard from people that fall into this group tended to be the most compounded, involving a range of different 'types of abuse' including physical, psychological and financial abuse. They included what could be described as 'classic' domestic abuse cases, where the abuse had been a long-term and ongoing feature of the relationship. For example, respondents described living with partners or spouses who consistently criticised and undermined them, often manifesting threatening behaviour towards the respondents and in some cases beating or hitting them.

Other cases had arisen due to developments in the relationship such as, in one case, where a respondent's ill-health and impotence had caused considerable tension and difficulty, and had resulted in behaviour that met the definition of psychological abuse. In all of these cases, a key feature of the experience of abuse was the proximity of the perpetrator. Not all of the respondents were still in the relationship at the time of interview; some had left the relationship, others had been left by their partner.

This category also included incidents of neglect primarily covering failure to receive support with health-care needs. In the survey all of these incidents had been reported using self-completion, where respondents could report incidents and experiences in confidence without having to do so via an interviewer. During the qualitative interview these respondents tended to concentrate on other related experiences and down-played the relevance or impact of the reported neglect. In one case, for example, the respondent focused instead on psychological abuse from his spouse that was not reported in the survey. In another, although the respondent reported neglect by spouse, the interview focused on the care she provided for her husband who was suffering from Alzheimer's disease. In some cases, the spouse was in the house at the time of the interview although not in the room, and it is possible that this may have discouraged respondents from discussing what they had reported in the survey more fully. In one case, a respondent who reported neglect by his wife was now accessing the support needed through health-care services.

4.1.2 Family mistreatment, abuse and conflict

This category of experiences was highly diverse and includes a range of different situations including harassment, threatening behaviour, legal and other disputes as well as poor and volatile relationships, which could be associated with mental health issues. Whereas the experience of spousal mistreatment, abuse and conflict invariably involved a perpetrator who lived with the respondent (even if at the time of the interview this was no longer the case), respondents did not always live with the family member in cases of wider family mistreatment, abuse and conflict. Family members were also not always blood relations and nor had they always previously lived with the respondent.

Again, incidents and experiences in this category could be compounded, with one type of abuse sometimes preceding and leading to another; for example, financial disputes leading to psychological abuse. In one case, a dispute between a respondent and their immediate family about money led to a breakdown of relationships and resulted in the older person being ignored by her family and locked out of parts of the house. Mental health difficulties could be a feature, especially in cases of mutual and volatile relationships and poor or difficult family relationships could also be dynamic, with periods of better relations then periods of poor relationships between family members.

In other cases, threatening behaviour and harassment from more distant relations was evident. For example, in one case, the children of a respondent's spouse with whom she had previously had little contact had harassed her following the death of her partner, seeking to gain what they perceived as their 'share' of his estate.

In other cases, the behaviour described as meeting the behavioural definitions set out for mistreatment, whilst deeply distressing for the respondent, did not always seem to constitute what might be generally recognised as deliberately abusive behaviour. For example, in one case, the respondent's son started a new relationship and to the respondent's distress, the son's new partner seemed to resent the close relationship between father and son resulting in much less frequent contact between them.

4.1.3 Mistreatment experienced in the course of caring for the perpetrator

Another category was formed of situations where the incidents reported occurred in the context of the respondent caring for the perpetrator of the abuse. Whilst the incidents involved the respondent being hit or struck, the respondent did not necessarily see this as being abusive behaviour and their perceptions and responses were qualitatively different from respondents experiencing other types of incidents. The primary reason for this was because of the lack of abusive intention on the part of the perpetrator and the fact that they were not fully responsible for their actions. This category included respondents caring for spouses with Alzheimer's disease or deteriorating mental illness, or children with emotional and behavioural difficulties.

Incidents as a result of perpetrator's illness

Some of these cases were age-related in the sense that they involved husbands and wives where one partner had become ill with Alzheimer's disease. The other type of incident in this group was a perpetrator with a deteriorating mental health problem that caused her to become violent and aggressive as a result.

For the cases involving Alzheimer's disease, respondents talked about two aspects of the disease which lay behind the incidents of mistreatment reported in the survey. Firstly, they described a particular stage of the illness where people would become aggressive. Secondly, the confusion associated with loss of cognitive function and memory could result in inappropriate or dangerous behaviour such as trying to go for a walk in the middle of the night or wanting to use the kitchen but not being able to do so safely. If a respondent was trying to stop their spouse doing something dangerous, the result could be the spouse hitting out.

Neither of these two scenarios outlined above involve an intention to abuse. However, in terms of severity, there was a marked variation amongst the incidents reported. One man talked about his wife being tiny, '*not able to hurt a fly'*, and he said that when she was aggressive he would just hold her and cuddle her until she had calmed down.

'Well to the best of her ability she'd hit me … she wasn't capable of hurting me … I could just hold her and put my arms round her and say nice things and she would calm down'

On the other hand, one respondent who was caring for her husband who had Alzheimer's disease and who was a large and strong man, had been badly beaten by him and had had to involve the police in order to restrain him. Whilst recognising the lack of abusive intent, the severity of the situation meant that she was more affected by it.

Another dimension to the discussion of elder abuse is the 'stressed carer' syndrome, where the burden of care is so great that the carer becomes unable to cope and lashes out at the person they are caring for. There was evidence of pressure to cope in our sample, with respondents talking about the burden of care. However, these cases did not result in serious incidents although they could still result in considerable anguish for respondents. For example, one man whose wife had been ill with Alzheimer's and had since died, was wracked with guilt and despair about the fact that on one occasion he had lost his patience and shouted at her.

Incidents as a result of fostering children

Abuse at the hands of foster children also featured in the sample. One respondent explained that she had always looked after children whose behaviour was very challenging as a result of extremely distressing experiences of physical and/ or sexual abuse they had suffered. She said it was very common for them to be violent and aggressive towards other people, including their foster carers, and that part and parcel of her role was to manage that sort of behaviour. Whilst she was over 65 and had been hit or struck, she did not consider herself a victim of abuse. However, she did talk about not feeling as fit and healthy as she used to in dealing with the children and expected to 'retire' when her current foster children left home.

4.1.4 Conflicts and disputes with neighbours/acquaintances

None of these incidents fall within the definition of elder abuse used for the headline prevalence figure, forming as they do a distinct group of incidents defined by the fact that they involved neighbours and/or acquaintances. Including them in this study, however, provides us with important data about what these types of incidents can involve and how people are affected by them.

The first set of incidents covers a range of disputes between neighbours, typically about matters affecting both people's property. Some were one-off events, some had been resolved and others were ongoing. These included, for example, disputes about boundaries, trees and the management and upkeep of communal areas. There were accounts of violent and aggressive behaviour in the course of trying to resolve a neighbour dispute which, according to the respondents, was unprovoked. It was at times difficult to be sure of what exactly had happened in these situations, and in some cases there appeared to have been mutual provocation.

Other incidents reported did not involve disputes, but solely aggressive or anti-social behaviour. For example, one situation involved a gang of local youths who were vandalising a respondent's property and intimidating her. In another case, a neighbour had systematically harassed a neighbour, for example by leaving faeces on her doorstep and by hanging around outside her home. In some of these cases the perpetrator was reported to have mental health problems.

These respondents appeared in the sample by virtue of having been sworn at, insulted, threatened or physically attacked. In several cases, the police were involved and in one instance an injunction was issued against a neighbour. As the report goes on to explore, the impacts of such incidents on older people could be significant.

4.1.5 Theft, financial exploitation and financial disputes (actual and attempted)

This group of incidents equates to the category of financial abuse, one of the five 'types of abuse'. It was the type most likely to occur alone, although it could be compounded with other types of abuse such as psychological or physical abuse. It includes a wide range of different experiences, from theft, fraud and deception right through to legal disputes. These incidents and experiences have a very different character depending on who the perpetrator is.

Family/spouse

These cases were very diverse and these could involve significant amounts of money. Examples include where one respondent's partner would not contribute financially to the running of the household whilst another respondent's husband withdrew large amounts of money from their joint bank account without her knowledge. In another case a respondent described an attempt by a relative to gain control, via power of attorney, over her property and in another case there was a dispute, including personal harassment, over the settling of an estate. There was also a dispute over the sale of a property and the proceeds from this, and a respondent whose grandson was stealing money from him in order to fund an addiction to drugs.

Close friends

A group of respondents talked about having had money stolen by friends. In one case this involved sustained and repeated theft of small amounts of money over a long period of time. In other cases there were discrepancies around money taken by a friend to do the respondent's shopping. In these cases the intention to steal was not always evident, although strongly suspected. Others were cases where older people were very clear that possessions or money had been deliberately stolen by friends.

Paid carers

There were cases in our sample where the respondent described a carer stealing from them. A common characteristic of these was that respondents were clear that they had no proof that the carer had stolen something, reflecting the extent of access that carers had to the respondent's property and possessions and, given the respondents ill-health or poor mobility, the difficulty of closely monitoring them while they were in the respondent's home. One respondent explained that a different carer from normal had attended one evening to put her husband to bed. The next day she was unable to find her husband's watch. Although she had not seen the carer take it, she could only assume that this is what had happened. Similarly, another respondent described how she often found her home help looking in places she should not have been such as the respondent's jewellery box, which raised the older person's suspicions.

Strangers/acquaintances

A group of respondents reported having been defrauded by individuals posing as tradesmen. This involved two types of incident. In the first, work was carried out on the older person's property, which was unnecessary, unfinished or grossly overcharged. In the second there were cases of distraction theft, for example, where an individual posed as a water board employee, gained entry to the respondent's property and asked the older person to go upstairs to turn a tap on while he stole the respondent's purse. There was also a case of a dispute relating to the sale of a respondent's property for which the older person claimed to have been underpaid and was pursuing legally. None of these incidents are included in the headline prevalence figure, involving as they do perpetrators who are strangers or acquaintances.

4.1.6 Institutional neglect and service failure

In the course of interviews a number of respondents reported incidents and experiences of service failure and institutional neglect, even though these were not explored in the survey. One group of respondents reported struggling to access support or care they believed they should be receiving. For example, one couple had both had operations at the same time and had been told by the district nurse that they would receive some temporary support from social services to help with shopping. No-one from social services ever contacted them and they were unable to get a reply from the number they had been given to call. There was also an example of a respondent in a dispute with the council about her housing conditions.

There were also more serious cases. For example, one respondent spent some weeks convalescing in a nursing home following a major operation. Whilst a lot of her complaints related to the poor care she saw being given to other patients, she herself was often not given the right medication. Had she not been knowledgeable and able to stand up for herself ensuring that she did receive the correct medicine, she could have been seriously ill as a result. The other example is of a respondent who needed carers to get her washed and dressed in the morning, but who was missed or attended very late on a regular basis. An interesting aspect of this latter group of cases is the fact that it is not clear whether the incidents reported were as a result of poor individual practice or organisational failure.

4.1.7 Sexual harassment and abuse

Of the respondents who had experienced some kind of sexual abuse, the incidents reported included sexual harassment and inappropriate sexual comments from neighbours and acquaintances and one case where a woman was touched inappropriately by an acquaintance at a social club she attended. There was also a case of a respondent who had received a highly obscene and distressing phone call. It is worth noting that the survey did not include any cases of serious sexual assault. These cases commonly lead the respondent to feel embarrassed and/or that their dignity and self-esteem had been undermined, although in one case the respondent described 'laughing' the incident off.

4.2 Role of age

This section explores the role of age in the incidents of mistreatment reported. Not surprisingly, given the wide diversity of cases involved, the relevance of age and the extent to which age can be seen to have influenced the situations experienced also varied widely.

In situations of mistreatment involving spouses and family, there was a range of cases, some where age did not seem to be a contributing factor to the incident, and others where it did. Difficult spousal and family relationships are certainly something that can happen at any age. As discussed above, some of the situations had been problematic for a long period of time.

However, there were also situations where age-related issues did seem to be aggravating factors. For example, in one case, the deteriorating physical health of one partner resulted in a fundamental shift in the dynamic of the marriage, which eventually resulted in psychological abuse. In other examples, respondents spoke about forming relationships with others (in part at least) due to a fear of being alone in old age and, in some cases, found themselves in abusive situations as a result.

Some cases of abuse in the context of caring for the perpetrator have a definite age dimension to them, where the perpetrator was suffering from an age related illness, like dementia. However, there were also cases which involved perpetrators with mental health problems, which could occur at any life stage. The foster carer in the sample talked about the fact that the children she fostered could display aggressive or violent behaviour to anyone they were in contact with, whether at home or at school and regardless of age.

In terms of conflicts and disputes with neighbours, it is hard to gauge in these situations the extent to which the age of the respondent has been a contributing factor due to not being able to know the perpetrators' intentions in these cases. Some people did voice concerns that they thought they were a vulnerable target due to their age. However, one respondent talked about how she thought she was being targeted because of her age, only then to say that it was because she was a woman and that a much younger female single parent was also being victimised by the same gang of boys.

As far as financial issues within families are concerned, there is a clear distinction between those that were part of ongoing difficult relationships and those that related to age and life stage such as disputes over inheritance or control over property in relation to the older person's demise. There was some evidence that financial abuse involving close friends could have an element of exploitation of an older person's vulnerability or confusion, but it is not possible to be sure from the accounts we heard. This seemed particularly likely to be the case in the cases involving men posing as tradesmen in order to defraud. Where financial abuse has been perpetrated by a paid carer, age is an intrinsic factor to the situation in that had it not been for deteriorating health and loss of independence, the help would not have been required in the first place. The same principle applies to the cases of institutional neglect or service failure in the sample.

Interestingly, some cases of sexual harassment and abuse seemed to have a particular angle relating to age in that the perpetrator referred to the fact that the woman was on her own and, considered by the perpetrator, to be lonely. For example:

> *'He probably thinks, 'Well, they've got no fellas', you know'.*

One case involving unwelcome sexual advances from a very close family friend also had an age dimension, in that the man involved had lost his wife and was very lonely, and the respondent said that she thought that he was looking for another wife to 'drive him around'.

4.3 Key findings

This chapter has set out the wide variety of different experiences explored in this study. All five types of abuse addressed in the survey were included in the qualitative research, however it was noted that these constitute descriptions of the types of behaviour of perpetrators and that individuals' experiences may involve multiple types of abuse. So, for example, spousal abuse might involve psychological, physical and financial abuse. There is also a broad diversity of cases represented in terms of the nature, severity and duration of the cases experienced. These include a range of incidents and experiences, such as those in the context of caring for the perpetrator, legal disputes and general family conflict that would not, for a range of reasons, be considered by many people to be abusive. A range of categories were developed that described the broad types of experience and incident that respondents described. These were able to provide some measure of meaningful distinction between different types of case.

There are some cases where age plays a clear role, for example, where the situation concerned has arisen as a result of age-related health problems or the person would appear to have been targeted because of their age. However, there are also accounts where age does not seem to have influenced whether or not an abusive situation has arisen, such as in cases of long-standing family conflict.

5 REPORTING ABUSE AND TAKING ACTION

A key aim of this study was to understand the barriers to identifying and reporting mistreatment. This is important for helping to identify the ways in which older people might be supported to take action in the face of mistreatment or abuse. It is also sometimes an aspect of how people coped with an abusive situation and is likely to affect the way that experiences of mistreatment impact on people.

It became clear during the interviews with older people that 'taking action' was not necessarily a straightforward concept. Their descriptions of action ranged from making a formal complaint about mistreatment or abuse, for example to the police, to confiding in a close friend or relative. The definition is further obscured by the fact that telling someone else could result in action being taken on the older person's behalf. This chapter employs this broader definition of 'taking action' but highlights distinctions between types of action taken where appropriate.

The first section of this chapter outlines the different types of action older people took in reaction to their experience of mistreatment or abuse. The chapter continues by considering the barriers and facilitators to taking action and then looks at perceptions of, and the role played by, agencies and services in the action taken. The chapter concludes by discussing the direct outcomes of action taken.

5.1 Types of action

It was possible to identify different motivations for action from people's accounts of their experiences of mistreatment and these are discussed below. In practice, however, respondents did not always exhibit such clarity of intention around taking action. Whilst in some cases the action and rationale were clear, in others respondents were unable to reflect fully on their decision-making around taking action. It was also clear that people did not always know what the appropriate action to take was. In such cases, they either took no action at all or consulted someone they hoped would have the relevant expertise to help them make the appropriate decision, be that a professional, family member or friend.

Other people also sometimes took action on behalf of the respondent. Sometimes this was explicitly requested. For example, one respondent had told her daughter about the psychological mistreatment she was suffering at the hands of her husband because, she said, she wanted her daughter to make enquiries at the local council about possible alternative accommodation for her if the situation worsened. In other cases, however, whether or not the older person had consented to action being taken on their behalf was unclear. For example, one respondent confided in her son that she had been defrauded by tradesmen and he contacted the police on her behalf.

Respondents also sometimes pursued multiple courses of action. For example, where the first action taken was unsuccessful, respondents sometimes reported trying another. Similarly, a respondent might try both confronting a perpetrator themselves and involving external agencies. Emotional support was also sought alongside taking other action, in particular where the abuse was psychological or where there were psychological impacts for the older person.

Where clear motivations for taking action were evident, these were:

- Seeking to change the perpetrator's behaviour;
- Placing distance between the respondent and the perpetrator;
- Seeking legal/formal redress;
- Seeking emotional support.

Each of these is described in turn below.

5.1.1 Changing the perpetrator's behaviour

This motivation for action was expressed by three different behaviours or actions. The first of these is confrontation whereby the respondent confronted the perpetrator. This tended to be verbal and face-to-face, either at the time of the incident or some time afterwards. Confrontation could also, in extreme cases, be physical. One respondent, for example, hit a family member after a series of verbal altercations. Respondents appeared to hope that confronting the perpetrator would make them understand the distress they were causing, make it clear to them that the respondent would no longer stand for the mistreatment or abuse or, where the confrontation took place in public, shame the perpetrator into stopping their abusive behaviour.

Respondents also described making a formal complaint to authorities about the perpetrator in the hope that this would change their behaviour. Complaints were made to the police, agencies such as social services or another care provider, and solicitors. It was apparent that respondents thought that an authority would have more agency than they did in terms of being able to effect change in the perpetrator's behaviour. It was implied, though not explicitly stated, that the involvement of an authority would be sufficiently intimidating to achieve this.

The third action that sought to change the behaviour of the perpetrator was where the respondent involved the perpetrator's GP, for example where the perpetrator had cognitive or mental health problems. This was only evident where the perpetrator was the older person's partner. Respondents described involving the GP in the hope that diagnosis, medication or other management of the condition would help to change the perpetrator's behaviour and therefore stop the mistreatment or abuse.

> *'We went to the doctor, the pair of us, because I thought if I could get him to the doctor [I could] get to the bottom of what is the problem with him.'*

5.1.2 Seeking distance from the perpetrator

The motivation for action in this case was to minimise contact with the perpetrator or stop it completely. There were different options available to respondents depending on who the perpetrator was. Where the perpetrator and the respondents were partners, the respondent might seek a separation or divorce and either move out of the shared home or request that their partner move out. Where the perpetrator was a friend or acquaintance, respondents talked about trying to avoid them, for example by not attending a regular social event. One respondent described spending time in her home with the curtains drawn and the lights turned off so that her 'friend', the perpetrator, would not know she was at home. Neighbours were harder to avoid altogether although respondents talked about trying to do so and, in one case, took out an injunction against a neighbour. In the cases of paid carers, respondents sometimes made alternative arrangements, either directly or, in one example, by making up an excuse for not being able to have the same carer (being concerned at accusing the carer of theft without having proof).

5.1.3 Seeking legal/formal redress

This motivation for action was based on a perception that an incident merited a response from the relevant authorities or because respondents wanted to see 'due process' being followed, whether this meant punishment for the perpetrator or restitution for themselves. For example, neglect by an individual carer or institution was reported to the management of the care provider or the social services department. Respondents involved the police when they had been the victim of theft or fraud. As well as potentially apprehending the perpetrator, in some cases this could mean that the respondent could obtain a crime number for insurance purposes.

5.1.4 Seeking emotional support

One final motivation for action was not directed at the perpetrator at all but aimed at gaining appropriate personal emotional support in order to cope with the situation. This could sometimes result in action being taken if the person from whom the respondent sought support suggested action or took action on their behalf.

There were examples where, even though respondents took action to affect the perpetrator's behaviour, place distance between themselves and the perpetrator or seek legal or formal redress, they failed to gain appropriate emotional support, which could leave them vulnerable to ongoing emotional impacts even after the abusive situation had been 'resolved'. For example, one of the oldest respondents who had been defrauded of thousands of pounds by men posing as tradesmen, had been offered services from Victim Support by the police. She turned this down on the basis that she felt they would not be able to help 'someone like her' who was apparently coping well with what had happened. However, it was clear that the experience had left her anxious and distrustful of strangers and that she may have benefited from some form of emotional support. Conversely, a respondent who had suffered psychological abuse from her husband for some years, was attending counselling sessions provided by a local support group and she described these as very helpful.

5.2 Barriers to taking action

The decision to take action was not always an easy one for older people and there was a range of factors and barriers that influenced either the type of action taken by respondents and whether they reported the mistreatment or abuse or took any other action at all.

The identified barriers relate to:

- the limitations on taking action placed on the older person by the nature of their personal circumstances and the abusive situation;
- concerns about the potential effect of action taken (on the respondent, the perpetrator, significant others, or in aggravating the abusive situation);
- older people's understanding of the role and remit of agencies and perceptions about their capacity to take effective action on the older person's behalf.

The first and second of these are discussed below. Barriers relating to the involvement of agencies in taking action are dealt with in section 5.4.

5.2.1 Limitations of the older person's circumstances

One set of barriers to reporting or taking action against mistreatment or abuse related to the personal circumstances of the older person. Specifically, these were:

- low self-confidence and self-esteem
- experience of bereavement
- physical frailty
- perception of the seriousness of the mistreatment or abuse.

Low self-confidence and self-esteem

The emotional state of the respondent, their confidence and self-esteem, appeared to be important for whether or not they felt able to take action. This was sometimes itself an impact of the mistreatment or abuse they had experienced. For example, respondents talked about a loss of confidence after making a misjudgement, for example, after having their savings plundered by a partner or befriending someone who stole money from them. These respondents did eventually take action although the decision to do so was not straightforward for them and often required encouragement or guidance from other people, such as family and friends.

Experience of bereavement

Where older people had recently been bereaved, this also affected the extent to which they felt able to take action. Those who had lost their partner described not having anyone with whom to talk through their decision to take action and others were reluctant to add to the stress of bereavement by undertaking action.

Physical frailty

Respondents' physical frailty was a further barrier to reporting mistreatment or abuse and older people were particularly unwilling to invite confrontation if they felt they would be unable to defend themselves. People also referred to specific illness or incapacity at the time of the abuse that prevented them from taking action.

Perception of seriousness

Sometimes respondents felt an incident was insufficiently serious to warrant taking action, or at least taking formal action. One respondent, for example, said he did not inform the police about the theft of money by his grandson because it involved relatively small sums and therefore was not serious enough.

5.2.2 Concerns about the effect of taking action

As well as the limitations placed on older people by the nature of their circumstances, further barriers to taking action were evident that related to their concerns over the potential *impact* of taking action, not only on their own situation but others'. These concerns included:

- fear of isolation
- fear of being seen to be 'making a fuss'
- fear of being blamed
- embarrassment
- the wellbeing of the respondent's family and significant others
- the health and wellbeing of the perpetrator
- fear of exacerbating the abuse.

Fear of isolation

Older people expressed fears that reporting mistreatment or abuse could lead to separation from their partner or estrangement from other family members, and cause them to become isolated. In other cases, respondents were concerned that taking action could alienate others who were close to the perpetrator, for example other members of the respondent's family or friends.

Fear of being seen to be 'making a fuss'

There was also evidence of anxiety among respondents about how they would be seen by others if they did take action. For example, even where the respondent felt affected by the abuse, they feared others would not think it was sufficiently serious to warrant action and described not wanting to '*make a fuss*'.

Concerns about being blamed

Others were worried that they themselves would be blamed for the abusive situation. One respondent, for example, suffered ongoing and serious psychological abuse from her husband but feared involving the council in case she lost the right to live in her home.

Embarrassment

Embarrassment about disclosing their experience could also be a factor in older people's reluctance to take action, especially where the abuse was sexual in nature.

The wellbeing of the respondent's family and significant others

In addition to ensuring their own wellbeing, older people were keen to protect their families and those close to them and this affected both their decision to take action and their approach to doing so. One respondent, for example, did not wish to tell her children too much about problems she was having with other family members in case they were subjected to the same harassment as she had been.

The health and well-being of the perpetrator

Perhaps surprisingly, respondents were also aware of and worried about the effect of taking action on the perpetrator, for example where the perpetrator was ill or temporarily injured. This affected when the respondent felt able to take action though in all cases where this was relevant the older person did eventually report the mistreatment or abuse.

Fear of exacerbating the abuse

Respondents were further concerned that any action taken did not further exacerbate the abusive situation. In some cases this meant the respondent was reluctant to involve other people for fear of making their situation worse. For example, one respondent who was physically abused by a friend, was concerned about involving the police in case it aggravated the situation.

> *'I didn't report it to the police, no, I kept the police out of it…I just didn't want to, I didn't want to cause any more animosity.'*

5.3 Facilitators to taking action

In contrast to the range of barriers presented, there appeared to be two key facilitators to older people seeking support or taking action:

- fear for personal safety; and,
- encouragement and support from others.

Fear for personal safety

Fearing for their personal safety could lead a respondent to take action to stop it. This could be in reaction to the perceived severity of a one-off incident or an escalation in the extent or severity of ongoing abuse. For example, one respondent had lived with a partner who suffered from mental illness over many years and throughout this time experienced both physical and psychological abuse and, as a result, was involved with a wide range of services. Over a period of time, the partner's condition worsened and the respondent described how one day the partner had crossed a '*red line*', causing the respondent to take action that led to the partner being taken into care.

> *'I just felt well if it gets beyond a certain state of intensity well that's it, that's the red line…'.*

In another case, a respondent had been subjected to psychological abuse from her close neighbour for many months. She was prompted to report her to the police when she physically assaulted a close relative of hers during an altercation.

Encouragement and support from others

Encouragement from others was another important factor in helping older people to take action in the face of mistreatment. Such encouragement tended to come from family members, friends or respondents' GPs. It appeared to provide reassurance to respondents about the likely outcomes of taking action and provided moral support. This could be particularly important where people were contacting unfamiliar agencies such as the police. Family members and GPs could also provide practical support in assisting the older person to take action such as contacting agencies on their behalf or, in the case of family or friends, being present when older people confronted perpetrators.

5.4 The role of agencies

A number of agencies were mentioned in older people's accounts of taking action to deal with abuse. They were:

- the police;
- solicitors;
- GPs;
- local council and social services;
- voluntary organisations, for example Age Concern, Citizens Advice Bureaux, and local and/or specialist support groups, including those for ethnic minority groups, people with dementia, and the families of people with alcohol dependency.

Respondents reported approaching different agencies for a range of reasons and with varying degrees of perceived success. We discuss each type of agency and the role they played for older people in taking action briefly below.

A range of barriers were associated with involving agencies related to:

- perceptions about the capacity for agencies to take effective action on respondents' behalf
- older people's understanding of the sources of assistance available to them and the type of help they could offer
- respondents' fear of authorities, and
- older people's lack of awareness of their legal rights.

Each of these barriers is discussed in the context of older people's perceptions and experiences of specific agencies.

5.4.1 The police

There were two perceptions of the role of the police in the context of taking action against mistreatment. Some older people talked about contacting the police as '*the first thing you think of doing*' where an incident seemed sufficiently serious to warrant their involvement. Fraud, theft, violent incidents, and an obscene telephone call fell into this category. Trading Standards were also contacted in cases involving fraud. Sometimes, the relationship with the police was ongoing. In one case, where the respondent's partner suffered from mental illness and physically and psychologically abused the respondent, the respondent had an ongoing relationship with the local police who had monitored the situation.

Other respondents were less willing to contact the police. There was evidence that respondents, especially those who had experienced little previous contact with the police, felt there was a social stigma attached to calling upon them, and this could discourage people from involving them.

> *'Well we didn't really like the idea…I thought I've never had anything to do with police. Well, me and my neighbour we both felt the same thing, you know, we felt it was awful that we had to go and tell people about a neighbour.'*

A further barrier to involving the police was underpinned by respondents' lack of clarity over whether the incident or experience in question was something that was appropriate or serious enough to contact the police about. One respondent, for example, did not report a major doorstep fraud to the police and she said that she felt it had been her fault and that she should not have parted with her money and therefore did not think it was a matter that concerned the police. This lack of certainty about whether it was appropriate to report to the police, was reflected also where respondents were grateful to have reassurance that they had done the right thing in approaching the police.

Respondents also perceived limitations in the capacity of the police to take action, for example, where they had no 'proof' that the incident had happened or where the perpetrator was a stranger and therefore their identity and whereabouts were unknown.

5.4.2 Solicitors

Solicitors appeared to have been used effectively by respondents. For example, one respondent contacted her solicitor to initiate divorce proceedings and protect her remaining assets as soon as she discovered her husband had been withdrawing large amounts of money from their joint bank account without telling her. However, there was also evidence of apparent misunderstandings about what a solicitor would do should an older person employ them. One respondent, for example, was worried about asking a solicitor to act for her in a dispute with a neighbour in case the solicitor sided with her neighbour and acted against her.

5.4.3 GPs

As mentioned above, some respondents approached their own doctors for emotional support and help with psychological impacts of abuse such as depression. They also sometimes involved the perpetrator's GP, where the perpetrator was their partner, for diagnosis, medication and other support. Some respondents found GPs very supportive and emphasised the value of this source of help. Others, however, reported difficulties, for example, in initially getting a diagnosis of Alzheimer's disease for the perpetrator, her husband. In other cases there was a perception that GPs had insufficient time to be able to listen to respondents' problems and to provide adequate support. This had not necessarily acted as a barrier to older people approaching their GPs but had apparently limited the efficacy of the support received.

5.4.4 Local council and social services

Older people sought help from their local authority where incidents involved issues relating to care and housing. Respondents described barriers associated with difficulties navigating automated phone systems or online access. Some respondents could be frustrated and distressed by such systems and could be reluctant to contact agencies, including local authorities, if they thought they might be faced with them.

Social services were generally the first port of call for difficulties involving care provision. People did, however, report mixed experiences of seeking support from social services and it was apparent that respondents had not always received the help they had anticipated; for example, experiencing difficulty in resolving repeated failures by carers to turn up and reporting poor and ineffective responses to complaints. Perceived failures of the services provided by social services were sometimes described as neglect and, even where it had not been the incident or experience reported in the survey, was sometimes presented as a comparable abusive incident in people's accounts.

Housing departments were involved in incidents involving partners living together and in neighbour disputes. For example, respondents had enlisted the help of the council in addressing difficulties with a neighbour who was harassing them and in intervening when one partner had refused the other entry to the home they shared.

5.4.5 Voluntary organisations

Voluntary organisations appeared to play an important role in assisting older people by providing advice, information and support where respondents were otherwise unsure how and where to access help. They commonly reported approaching Age Concern and Citizens Advice Bureaux, for example, with issues related to care provision and responsibility for payment, finances, legal advice and advice on benefits. Even if they did not anticipate that these organisations would be able to assist them directly, they expected they would be able to direct them readily to another that could. This could alleviate an older person's concern about approaching an agency whom they were unsure would be able to help them.

The study recruited three BME respondents from two community-based organisations. These respondents described how help from these organisations was valued. They described using these organisations as a generic first port of call for any difficulties they experienced, including mistreatment. They reported feeling it was otherwise difficult to access support and advice because they were not always aware of the services provided and had limited understanding of the legal system. For example, one respondent had wanted clarification about her legal situation in relation to abuse from her husband. The organisation itself was unsure but staff were able to enlist legal advice on the respondent's behalf. These respondents placed value on the fact that these organisations were able to understand their culture and because some services were offered in their first language.

5.5 Outcomes from action taken

The final section of this chapter aims to map the range of direct outcomes from action taken by older people in response to their experiences of mistreatment. The broader impacts of mistreatment are discussed in detail in Chapter 6.

Direct outcomes from taking action were evident, for example, where partners separated following a divorce or separation, and therefore one or both partners moved home or was re-housed. They were also evident where police or the council intervened to remove respondents and perpetrators and, in one case, where the perpetrator was sectioned. In other cases, people achieved very specific outcomes such as gaining an injunction against a neighbour who was harassing the respondent or a tree-preservation order from the council where it had been the cause of a neighbour dispute. Other outcomes from 'informal' action were evident where respondents had successfully avoided a perpetrator who was a friend or acquaintance.

In some cases, a satisfactory outcome was only achieved after several forms of action were taken and in others the action taken was only partially effective. As described previously, a respondent whose partner suffered from a severe mental illness sought help from his partner's GP and the police to limit and manage the abusive behaviour, before finally cooperating with the authorities to have the partner sectioned. It was only this final action that halted the abuse.

It was not the case however that all actions achieved their aim. The previous section discussed instances where action taken by the police, for example where the perpetrator was a stranger or a neighbour, was ineffective or where some GPs were described as unhelpful or unsupportive in diagnosing and in helping people to manage their own or a partner's health condition. In some cases, respondents described the inability to access services that they felt they needed or described service failures of social services or health services and the lack of effective redress in such cases. Furthermore, in certain cases the action taken had actually worsened the situation of the older person. One respondent, for example, confronted her estranged husband's friends in the hope that they would be able to persuade him to stop his abusive behaviour towards her; however she was, as a result, subjected to physical and psychological abuse from them.

The outcomes of action taken could therefore vary between, at one end, achieving their intended outcome completely, leading to the abuse stopping or, at the other end, effecting no positive change to the situation or even negative change. The effectiveness of the action as it relates to whether the abuse is stopped or not is relatively clear. However, as described earlier, whilst action may have stopped the abusive behaviour, the potential impacts of the abuse may not have been dealt with because of a lack of effective emotional support.

5.6 Key findings

This chapter has highlighted four distinct motivations for taking action: seeking to change the perpetrator's behaviour; placing distance between the respondent and the perpetrator; seeking legal or formal redress; and seeking emotional support. It has also described a wide range of barriers and facilitators to older people taking action. Decisions about taking action, and the type of action to take, appear to be primarily mediated by the motivations, barriers and facilitators described in this chapter and there appears to be no association between whether or not action is taken or the type of action taken, with either the type of mistreatment or abuse experienced or the type of perpetrator involved.

It is clear that agencies can play an important role in the action taken by older people against mistreatment however this appears to be limited by respondents' understanding of them and their willingness to involve them. The role of generic agencies such as community-based organisations or organisations like Age Concern appear especially important. They were seen to provide, or signpost to, advice and support for older people who otherwise may have been unsure about which agencies to approach or uncertain about the appropriateness of approaching statutory agencies such as the police or social services.

Outcomes from taking action are evident. However, the significance of these outcomes and their relationship to the ultimate impacts on the older person, must be understood in the context of resilience and coping mechanisms and other circumstantial factors. These interrelationships are further explored in the following chapters.

6 IMPACTS

This chapter maps and describes the impacts on respondents of having experienced an incident of mistreatment or abuse. A wide range of different impacts can be seen across the sample, with some widespread across different types of mistreatment, whilst others relate more specifically to the particular type of incident experienced.

When considering the impacts on respondents, it is important to bear in mind that there were a range of other factors which mediated the impact of their experience of mistreatment. Analysis revealed that the personal circumstances, resilience and coping strategies of an individual have a significant effect on the extent and manner in which the impact of an experience of mistreatment or abuse is felt by people. The next chapter (Chapter 7) looks at these issues in detail.

6.1 Range of impacts experienced

This section sets out the range of impacts resulting from the abusive incidents and includes the following:

- Psychological impacts
  - Emotional distress
  - Loss of self-confidence/ self-esteem
  - Depression, thoughts of suicide and/ or self-harm
  - Long-term abuse resulting in retaliation by victim
- Social isolation
- Deteriorating physical health
- Loss of independence
- Financial loss
- Impact on family relationships

These are discussed in full below. It should be noted that whilst many of the impacts experienced were negative, they were not always enduring and, in the medium- or long-term, it was possible for respondents to have ended up in very positive situations.

6.1.1 Psychological impacts

The following impacts can be grouped together under the heading of psychological impacts as a result of experiencing mistreatment.

Emotional distress

Participants described a range of emotional responses to the different situations they found themselves in: feeling upset, tearful, fed up, '*awful*', or '*jumpy*'. These impacts spanned the range of different types of abuse experienced. Other responses were related to specific types of abuse. For example, where the abuse had been experienced within a spousal relationship, feeling broken-hearted or feeling betrayed were mentioned. Where there had been an experience of sexual harassment, some talked about the indignity of what they had experienced, and of feeling violated or dirty. Unexpected and unpredictable situations that occurred, for example, with neighbours, strangers coming to the door or obscene phone calls being received could leave people feeling nervous and jumpy.

Loss of self-confidence/ self-esteem

A widespread impact of mistreatment found across the sample was a loss of self-confidence and self-esteem. This could be seen across a range of different incidents and experiences of mistreatment, but was particularly significant for respondents who had been undermined or whose judgement had been called into question. These included respondents who found themselves in situations where they were taken advantage of, for example, by a spouse or by a fraudulent tradesmen. A common response in these cases was for respondents to blame themselves for having been gullible or taken in. In other cases, respondents felt they had been drawn into neighbour disputes against their will and described a feeling of confusion and uncertainty, particularly if they had not experienced these types of conflicts before. Such situations could leave respondents feeling a loss of confidence in their ability to judge and manage these kinds of social relationships.

Depression, thoughts of suicide and/ or self-harm

Some of the participants we interviewed talked about mental health problems resulting from their experiences of mistreatment. Typically, this manifested as depression. In some cases, people had seen a doctor and had been prescribed anti-depressant medication. Some of the respondents who had experienced very serious forms of abuse reported correspondingly serious impacts: either suicidal thoughts or a desire to self-harm. Typically, these respondents had low self-esteem as a result of the abuse they had experienced. These feelings could emerge at different points, either during the experience of abuse or after the abusive behaviour had stopped.

Long-term abuse resulting in retaliation by victim

There was one case in our sample of long-term abuse resulting in retaliation by the victim. This was a case of spousal abuse, involving a respondent who had experienced many years of both physical and psychological abuse at the hands of her husband. She described finding herself one day with a knife in her hand, threatening her husband. This was qualitatively different from cases of mutual abuse, where it was evident from the account given that the abusive behaviour emanated from both parties. What marked this case out was the fact that the respondent had endured abuse for a prolonged period without retaliation, but finally snapped, with potentially extreme consequences.

6.1.2 Social isolation

As a result of the mistreatment experienced, some participants talked about not wanting to go out of their homes or socialise, becoming very withdrawn and isolated and feeling lonely as a result. For example, a group of respondents described not wanting to socialise because of feeling ashamed of their experience of mistreatment, where it had been a result of a friendship or relationship that their friends and/or family had disapproved of. In cases where there were ongoing disputes with neighbours, a respondent could feel scared of going outside their home for fear of confrontation. Also evident in the sample were situations where the perpetrator of the abuse, particularly a spouse, was actively trying to discourage respondents from having contact with their family and friends.

6.1.3 Deteriorating physical health

There was some evidence of impact on respondents' physical health. In some cases, participants were explicit that their experiences had affected their health. These could be seen especially where an experience of mistreatment was long-term, with the impact on physical health being linked to the ongoing worry and stress. For example, one woman talked about the stroke she had suffered being brought on by the mistreatment she had experienced. For other people, the link between their experiences and how it had impacted on their health was not explicitly stated, but could be extrapolated from the description of their changing circumstances over the course of the mistreatment or abuse experienced.

6.1.4 Loss of independence

In some cases, respondents described experiencing a loss of independence and, as a result, a decline in their quality of life. For example, one respondent needed carers to help her get up in the morning, but was often missed off the list and unable to get washed and dressed as a result. She felt that she had lost control of a fundamental element of her independence, which was extremely distressing for her:

> *'I want to know I'm clean and dressed and ready to receive any visitors that come. I don't want people to come and find me in my nightdress and my dressing gown, thinking, 'Poor soul, she's stuck there'. No, I don't want that. It's frustrating.'*

However, in some cases, people became more determined to preserve and/or enjoy their independence as a result of having come through an experience of mistreatment. One woman who had left her husband, for example, described her pleasure at being free to cook herself a meal when she's hungry or watching what she wants on television. In another case, a respondent who had to spend time in a nursing home following major surgery observed poor care of patients whilst she was there, and she herself was not given the right medication. Having had this experience made her even more determined, when she had returned home, to look after herself, keep well and continue to live in her own home for as long as possible.

> *'I felt very, very sorry for them [residents of the nursing home] because a lot of them had sold their houses…they were in that home, there was no return. They said to me 'you're lucky to be in your own home', which was a great lesson in life for me.'*

6.1.5 Financial loss

Where people had been subject to financial abuse, there was a concomitant financial loss experienced by these respondents, to a greater or lesser extent depending on the amount of money stolen or defrauded from them. However, it is worth noting that respondents commonly viewed the financial loss to be less significant than the emotional and psychological impacts. For example, respondents could suffer low self esteem and blame themselves for having 'let' themselves be taken advantage of.

6.1.6 Impact on family relationships

Experiences of mistreatment could affect family relationships in a variety of ways. For example, respondents could find themselves distanced from family members who had disapproved of their relationship with someone who was being abusive, although where the abusive relationship had come to an end, these relationships could improve.

During the course of this study, we spoke to a very small number of family members, who had been involved in supporting or helping their elderly relative through an experience of mistreatment or abuse. What emerged was a clear sense of how worrying it was for families knowing that the older person had experienced some kind of problem or difficulty. The multiple pressures of modern living, including working and running a household along with struggling to find time to support their elderly relative through a difficult period were common themes in relatives' accounts. Relatives varied in how willing they were to manage these pressures, with some feeling resentful and put upon.

Some relatives, especially where an older person had been exploited financially, could be left feeling very concerned about their elderly parent's ability to negotiate business transactions or deal with people coming to the door. Respondents could feel infantilised and resentful that their relative worried about them in this way.

> *'My son still goes on as if I'm a naughty child: 'Now, Mum, you won't let anybody in and you won't answer the door and you won't do this and that.' And the thing is I still feel as sensible as I ever was…believe you me, my mind's as sharp as ever it was.'*

6.2 Key findings

This chapter has identified the range of impacts reported by respondents and has described the different ways in which these impacts were experienced. The impacts included a raft of psychological impacts including emotional distress, loss of self-confidence and self-esteem, depression, thoughts of suicide and/or self harm and, in extreme cases, long-term abuse could result in uncharacteristic and unplanned physical retaliation. Some respondents became socially isolated, others experienced a loss of independence. Also evident were negative impacts on physical health, financial loss, and a change to family relationships.

Respondents would typically experience a combination of different types of impacts, such as emotional distress, social isolation and a loss of self-confidence. Impacts described by respondents were often multiple in nature and those such as emotional distress, social isolation, depression and loss of self-esteem and self-confidence were typically experienced across a wide range of different cases.

However, some impacts were associated with particular types of experience. Financial abuse, for example, was associated with financial loss, although humiliation, feelings of betrayal and loss of confidence in one's judgement were also prominent in these cases. Where respondents had experienced sexual harassment or abuse, they talked about feeling embarrassed or ashamed and cases of neglect could, understandably, result in a loss of independence and quality of life. In addition, suicide, self-harm and deteriorating physical health tended to be discussed by those experiencing long-term, ongoing and serious abuse.

Some of the incidents experienced which fell outside of the definition of elder abuse used in the survey, including conflict with neighbours and fraud and financial exploitation by strangers, could also have significant impacts on the respondents involved.

A key finding from this study was that impacts were affected by a whole raft of mediating factors which influenced the extent and nature of the impacts experienced, particularly in the longer-term. These are discussed in the following chapter (Chapter 7).

7 RESILIENCE, COPING STRATEGIES AND MEDIATING FACTORS

As discussed in the previous chapter, few associations were found between different types of abuse and the resultant impacts, other than at a highly specific level. Instead, we identified a wide range of impacts that were common across a range of different types of experience.

What became clear from analysis of the interview data, is that there was a wide range of factors that mediated the impacts experienced by respondents, both in the short-term and, more noticeably, in the longer-term. Some of these factors relate to the nature and circumstances of the abuse itself, whilst others are about the personality, character and previous life experiences of respondents.

Understanding how older people cope with experiences of abuse is one of the aims of this research. It is not something that people *should* have to cope with. Nonetheless, it is important to understand for two main reasons. First, there may be a link between the way people cope and the likelihood of them taking action; high levels of resilience might enable people to take action or, conversely, it could encourage them to put up with abusive situations. Understanding the factors that promote resilience may be important context for understanding the barriers and facilitators to reporting and taking action. Importantly, understanding resilience factors and coping mechanisms can help to identify the protective factors that help prevent lasting impacts of abuse.

A wide range of factors were found to mediate the impact of an experience of mistreatment and are discussed in this chapter. These factors can be divided into two groups. First there are the issues which relate to the characteristics of the mistreatment. Second are factors relating to the personal circumstance and characteristics of the individual.

7.1 Characteristics of the mistreatment

This section explores different characteristics of the mistreatment which affected the impact of the experience for the respondent. These are:

- type and severity;
- whether the incident is resolved;
- proximity of the perpetrator;
- unpredictability of abuse;
- abuse as a result of caring responsibilities.

7.1.1 Type and severity

As discussed in Chapter 6, a wide diversity of impacts were experienced. Many were general impacts that spanned different types of mistreatment. However, some of these could be related to specific types of abuse. For example, embarrassment and loss of self-esteem and dignity were particularly related to sexual harassment and a destabilising loss of confidence and distress could arise in cases where someone had been significantly betrayed. There was also some evidence that the more severe impacts, such as suicidal thoughts, were related to severe and ongoing abuse and that deteriorating health was related to ongoing and long-term experiences of abuse.

However, what is apparent is that this is only part of the story and that a whole range of factors can mediate these impacts, so that even where experiences have been serious and ongoing, individuals can avoid or experience reduced long term negative consequences. Similarly, for some respondents, even experiences of mistreatment that appear, relatively speaking, less serious can have significant negative impacts.

7.1.2 Whether the incident is 'resolved'

Being able to put a situation behind oneself and find some sort of emotional resolution was found to be an important factor in being able to cope with experiences of mistreatment. Whether this was possible was influenced by the nature of the incident or experience of mistreatment as well people's personal resources. For example, one-off incidents were generally found to be easier to deal with than experiences that were longer-term, ongoing or repeated. In some cases, respondents made explicit efforts to move past an incident of this sort. For example, one respondent reported an incident where she thought a piece of jewellery had been stolen by a carer. Although upset by what had happened, she described how she tried to put the experience behind her.

> *'….you can't let things just worry you to that extent, you've got to get over it and get on with it. It's over and done with, get on with it. It's no good sitting there and worrying, you can't do anything about it, forget it, get on with it.'*

In such cases, external reassurance could make a lot of difference to someone's ability to resolve doubts and put the incident behind them. For example, one respondent felt more able to put the incident she experienced behind her as a result of being assured by the police that she had done the right thing in reporting the incident and that she had not been in any way to blame for what happened, despite the fact they were unable to identify or arrest the perpetrator.

Where specific action had been taken by authorities, and the experiences of mistreatment had stopped, this could clearly enable respondents to feel that the situation had been resolved and there were examples of respondents who were able to quickly resume satisfying lives following a period of ongoing mistreatment. However, even where an experience of mistreatment had ceased, it did not necessarily mean that the respondent had come to terms emotionally with the experience or been able to put it behind them. Where incidents remained unresolved for the individual, with them experiencing ongoing concerns about the meaning or implications of what had happened, feelings of depression and self-doubt were commonly experienced and these findings point to the importance of emotional support in addition to support to practically resolve situations.

Where a situation was ongoing and the respondent felt powerless to change the situation, depression or frustration were commonly experienced. These feelings were accentuated if the ability to 'fix' situations and find solutions to problems were important to that respondent. For example, the case of a man whose close relationship with his son had become increasingly distant as a result of the son's new partner, described feeling very despondent at his inability to improve the situation, particularly given that his career had revolved around problem-solving:

> *'My life has been made up of sort of sorting things out, an awful lot of it is to do with people and yet this is something I haven't managed. I can't sort it out…I shall be six feet under soon and I shall never have sorted it out.'*

7.1.3 Proximity of the perpetrator

Another dimension which affected the impacts experienced was the physical proximity of the respondent to the perpetrator. For example, where the perpetrator was a partner, spouse or other family member in the same home the negative impacts experienced were increased. Similarly, in cases of neighbour disputes it was difficult for the respondent to avoid the perpetrator and this could increase the stress and upset experienced. However, in contrast, some of the incidents reported were one-off incidents and/or involved perpetrators that the respondent was able to create distance from, for example, by avoiding going to places where the respondent was likely to come across the perpetrator.

7.1.4 Unpredictability of the abuse

Much of the abuse discussed by respondents could be described as being unpredictable in nature, but it is possible to see some distinction. Some of the incidents were related to disputes about specific issues, such as building works, and there was some expectation that, at particular times, there was likely to be increased conflict.

On the other hand, there were cases where the incidents were highly unpredictable and unexpected, and in these cases the shock and/or constant sense of being on guard seemed to exacerbate the negative impacts. These included some of the incidents of harassment or anti-social behaviour from neighbours, the sudden discovery of ongoing financial exploitation and some of the one-off incidents, for example, incidents of sexual harassment or physical violence. One respondent who had experienced a series of burglaries and doorstep frauds, describes the shock she felt when something was thrown through her window by local youths totally without warning and the significance of the impact on her:

> *'…it was that last one that shook me up…I don't know whether it was the loud crash, or what it was, but it is something that happened to me at that moment that never happened with the other incidents….and I am still feeling it, because I like to get upstairs and out the way. If I hear a noise I am wondering if one of my windows has gone.'*

7.1.5 Abuse as a result of caring responsibilities

For those respondents who experienced abuse as a result of aggression from someone they were caring for, the impacts of the situation were of a different nature, defined by the fact that the perpetrator was either suffering with dementia, mental illness or was a child with emotional and behavioural difficulties and consequently could not be considered fully responsible for their behaviour. Not that this detracts from the difficult and challenging nature of these situations, but the circumstances meant that respondents were not left with feelings of self-doubt about whether they had done anything to contribute to the situation arising in the first place nor feel personally attacked or targeted.

Another factor in these situations is the extent to which the respondent has chosen and/or embraces the caring role. Where this is the case, there seems to be a level of acceptance amongst respondents that this is the role they have actively decided to take on and that the associated difficulties are part and parcel of that role. However, greater negative impacts are evident amongst respondents who felt they had been thrust into a caring role. More severe impacts were also evident amongst those for whom the mistreatment has been more severe in nature.

7.2 Respondents' personal circumstances and characteristics

The following factors were also identified as playing a role in mediating the impact of an experience of mistreatment. In contrast to the set of circumstances described above relating to the characteristics of the mistreatment experienced, these factors relate to the personal circumstances and characteristics of the respondents themselves.

- Relationship norms and values;
- Social and community connectedness;
- Religious beliefs;
- Living alone, bereavement and fear of being alone;
- Health;
- Previous life experiences;
- Personality and personal qualities;
- Specific tactics.

7.2.1 Relationship norms and values

Respondents' norms and expectations about their personal and social relationships could mediate their experiences of mistreatment, such that where the experience of mistreatment challenged or undermined their strongly held expectations of others the negative impacts could be more significant. As already discussed, respondents could be very distressed and undermined where they had been betrayed by those they had placed trust in and these feelings could be very enduring:

> *'I didn't want to meet people because – especially [friend's name], when she said, 'You know, I didn't expect that [relationship] to last.' And I couldn't understand why other people could see it and I couldn't… It took me a long time to get over it…even now sometimes I…perhaps I go and do something and I think, 'Well whatever possessed me?''*

A similar case involved a respondent who made friends with someone only to find that this friend was stealing from her. Eventually, the respondent confronted her friend and told her she didn't want to continue the friendship. However, she describes how this experience left her *'shattered'*.

Impacts of financial abuse by fraudulent tradesmen were keenly felt where people had clear expectations of being able to trust other people, and there was some evidence of a cohort effect with this expectation of being able to trust people in one's community possibly being more common amongst this older generation.

> *'Well I'm Honest Joe! I just thought everybody would be honest and wouldn't tell me some such things and er… I'm a pensioner, a widow.'*

In another example, one respondent was unable to come to terms with the break up of her marriage, despite the fact that her husband had been abusive towards her, because it was against her religious and cultural beliefs for a husband and wife to split up and she was finding it impossible to reconcile herself to this.

In the case of respondents caring for husbands or wives with dementia, the situation was more complex. For some, loyalty to their spouse came across as being of immense importance to them, despite the fact that they sometimes found themselves being struck or hit. In these circumstances, doing a good job of caring was critical for that respondent's sense of self. If they felt that they had failed in their duty of care, as was the case with a respondent who had on one occasion lost his patience and shouted at his wife who was suffering from dementia, the impact could be significant; this man could not stop crying when talking about this incident. Conversely, where the sense of duty to care was not felt so keenly, the associated expectations of self were not so demanding and impacts were less.

7.2.2 Social and community connectedness

One factor affecting a respondent's ability to cope is whether or not respondents have an effective social support system in place. This could include having close relationships with family and/or friends, being part of a neighbourhood community or being part of a support group. Having people around to talk to about a situation can in itself be a way of coping with an experience of mistreatment, as well as having the added protective benefits of enhancing someone's sense of self-esteem, belonging and connectedness.

The sort of social contact people had varied. Some lived very near, or with, other family members: often their adult children, sometimes siblings. These relationships could be very close, and in these circumstances, it was clear from the accounts given that these relationships provided respondents with a sense of security. Even when the older person lived further away from their family, there could still be a close, supportive relationship, with frequent phone calls, regular visits and an understanding that the older person's relative was ready and willing to be called upon in case of difficulty.

Several respondents also talked about having a network of friends, people that they might go shopping with, visit, or speak to on the phone. Although there were older people in conflict with their neighbours, there were also respondents who enjoyed good relationships with their neighbours. This might involve, for example, social contact such as conversations, having tea together, or helping each other out by, for example, looking after each other's houses if either went away. Although these friendships might not have been very close, having people around to call on if necessary seemed to be reassuring for people and, again, enhanced their sense of security and wellbeing.

Across the sample, there were also people who were involved in a wide variety of local clubs, groups, classes and other local community or church activities. Some were volunteering at hospitals or in one case at a local credit union. This could create a sense of belonging and forge a range of local connections and friendships. The following quotation describes one respondent's experience of attending art classes at the local college:

> *'I go to classes and get on wonderfully with everybody. I mean everybody is lovely and we help each other and the lady round the corner that I take says, 'I don't know what I'd do without you'.'*

There was a tendency towards greater social engagement amongst the younger age group (65-69 years); including, for example, taking computer courses, looking after grandchildren regularly, and attending art classes. There were, however, also people in the older age groups, including the oldest age group (80 years and over), who retained a high degree of community engagement, for example by attending church and other local activities, despite sometimes experiencing health problems.

Conversely, some people were quite socially isolated and found this difficult. They experienced loneliness and felt more vulnerable, making it harder for them to cope with problems and difficulties. But there were some older people who were very used to living on their own and had little social contact yet who did not express feelings of isolation or loneliness.

7.2.3 Religious beliefs

It was noticeable that several people talked about religion as being an important source of support. For some, this involved actually attending church, and may also have included a raft of associated social activities and engagements, which provided the benefits of social support described above. However, others described their religion as a more private, internal set of beliefs that could nevertheless help them deal with difficult situations, as the following quote exemplifies:

> *'I've got deep religious beliefs and I think I fall back on that... there's nothing happened without God's planning it and that's the way I feel.'*

7.2.4 Living alone, bereavement and fear of being alone

Some respondents had lost their husbands or wives recently. There were also those who had lost spouses at a much younger age. Clearly, bereavement can happen to people at any point in their lives, although may be more common in later stages of life. However, what looked different in the cases of people who were older is the extent to which they were left socially isolated as a result. They had lost the company, friendship and love of having a lifelong partner, who was also typically the person they would share problems or difficulties with. In contrast, the respondents bereaved at a younger age typically had small families they were bringing up, and/or were working, so tended to be much more engaged with some form of social network and less vulnerable to isolation and loneliness.

A common theme in interviews was a fear of being left alone, or of being more vulnerable by living alone. Some, in an apparent bid to avoid loneliness in old age, befriended or got involved with members of the opposite sex, sometimes against their better judgement. For example, one respondent who said that she had been scared of being alone, remarried despite the fact that friends and family were concerned about the new partner, and went on to suffer abuse at the hands of her new spouse.

7.2.5 Health

As you might expect amongst an older population, there was a broad spread of age-related illnesses across the sample, including diabetes, arthritis, cancer and coronary heart disease. There is also a group of respondents caring for relatives with dementia. Whilst there was considerable variation and diversity across the sample, a comparison of the sample by two age groups, 80 years and over at the time of interview and under 70 years, did reveal that poor health was more evident in the older age group with more frailty and loss of independence as a result of deteriorating health conditions. There was also more evidence of carers being around and respondents living in sheltered accommodation. Some respondents spoke of keeping physically active to avoid or allay poor health in the future. The key difference is that those in poorer health were likely to be more physically dependent, and potentially more vulnerable to abuse and neglect by informal and professional carers as well as more vulnerable to service failures of social and health services.

Some respondents also talked about the importance of retaining their mental acuity. Some respondents talked explicitly about making a concerted effort to stay engaged and alert, referring for example to the benefits of doing crosswords or sudoku puzzles or reading newspapers. Others talked about writing their memoirs or using the internet. These steps were described as important in retaining independence and quality of life.

7.2.6 Previous life experiences

When asking respondents about the effect the abusive situation experienced had had on them, the number of people who reflected on the incident in context of previous life experiences was striking. Looking at their current experience in light of other, often very serious, events they had lived through seemed to enable respondents to attain a stabilising sense of perspective on what they were going through. For example, respondents talked about the death of family members. A woman who had lost her husband and son spoke of finding an inner strength and determination to carry on despite her recent bereavements that she had not previously known she possessed.

> *'…you realise that you have to survive. At times it can just seem as if you can't cope but then you go on, you have to. There's no other way so you have to so...'*

There was also evidence of a cohort effect associated with this age group having lived through the Second World War and, for the respondents from Northern Ireland, living through the political and social difficulties experienced there. For example, one respondent talked about the way she dealt with an experience of sexual abuse:

> *'I suppose you do take it day by day. Like I lived through the blitz in London for eight years and then I've lived through the 'troubles' here for whatever length of time it was. You know, you learn to cope.'*

However, there were also respondents whose previous life experiences left them *more* vulnerable in the face of the abusive incident; situations where the incident resonated and brought back a previously traumatic experience. For example, one respondent described how she felt as a result of threatening behaviour from step-children following the death of her spouse. She said she felt constantly frightened, although she was not sure why, and could not stop crying. She went on to talk about feeling just like this when she had been with her first husband, who was an alcoholic. Years of attending Alcoholics Anonymous had helped her to overcome these feelings, and she was determined that her stepfamily were not going to put her back in that negative place, but it clearly took huge amounts of courage and determination for this woman to resist falling back to the psychological place she had been in her first marriage.

7.2.7 Personality and personal qualities

In contrast to the stereotype of an older person as frail and vulnerable, amongst the sample of older people interviewed for this study were some respondents that had very strong characters, which enhanced their resilience to the abusive situations they were experiencing.

There were different dimensions to this aspect of being able to cope. For some respondents, there was an explicit link with previous life experiences having made people very resilient and psychologically able to withstand difficult situations. Others simply had strong characters, regardless of previous life experiences, and demonstrated high levels of self-confidence and determination.

In some cases, this strength of character impacted directly on the nature of the abuse experienced. For example a woman who spent some time in a nursing home following major surgery was repeatedly given incorrect medication. It took determination on her part to insist on being given the medicine she knew she should be receiving:

> *'[relaying a conversation with the nursing home supervisor] 'I said to her, I came in here to get better but if I'm not getting the medication that I think I need…I'm not staying'…I said, 'Well, ring up the [name of hospital] and they will take the responsibility...I told her the ward I was in, I told her who was in charge in that ward and who would be there…So she did ring the [name of hospital], I got my medication after a lot of arguing but I had to do that.'*

Another way in which some respondents countered the abusive experiences they were going through was with a sense of humour. These people tended to laugh off the situation. Whilst this could be seen as an avoidance tactic, a way of playing down the importance of what had happened, it also appears to be a useful way for some respondents to keep the incident in perspective.

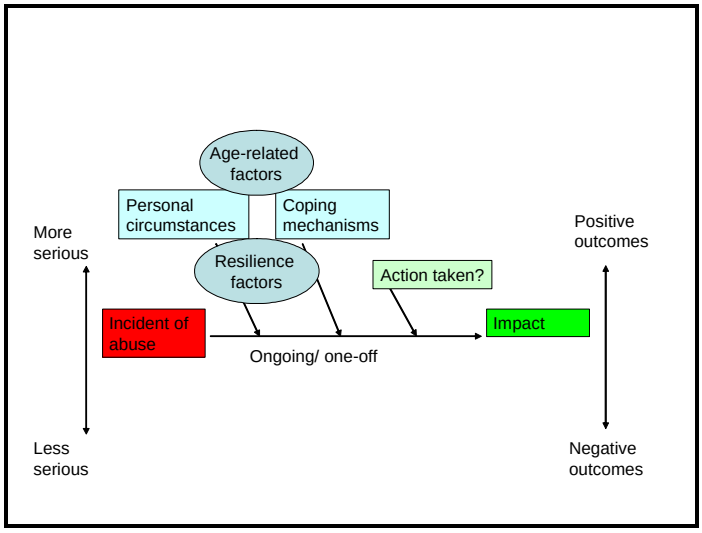
7.2.8 Specific tactics

There were some respondents who employed specific tactics to cope with the situations of abuse they found themselves in. One respondent talked about keeping a diary of events as a way of dealing with the situation he was experiencing. Another described how they tried to push all thoughts of the mistreatment experienced from their mind in order to try and get on with their lives.

7.3 Inter-relationship between abuse, personal circumstances and impact

The diagram below graphically represents the dynamic and multi-faceted nature of a person's journey through and following an experience of abuse or mistreatment.

Figure 7.1 Inter-relationship between abuse, personal circumstances, coping mechanisms, resilience factors, interventions and action taken and impact



The diagram highlights the number of factors which come into play between an incident of abuse and what the impacts of that abuse are for a respondent in both in the shorter- and longer-term, and the eventual outcomes and circumstances the older person finds themselves in. The following examples illustrate the importance of these mediating factors. These describe respondents in the sample who had had similar types of experiences but ended up in very different circumstances.

Example 1

Two women had both recently left long-term relationships where they had been subject to persistent psychological and physical abuse. One was in a very distressed state and had low self-esteem. In contrast, the other woman talked about positive aspects of having got out of the marriage, like being able to cook something for herself when she's hungry or watch television when she wants to. Both women had supportive families and were being formally supported by the police, social services and support groups. The critical issue for the former respondent was the fact that it was against her religious and cultural beliefs for a husband and wife to split up and she was finding it impossible to reconcile herself to this.

Example 2

In another case, there were two respondents who had both experienced an estrangement with their children. In one case, the respondent had been living with her daughter but, following a dispute over finances, had been ostracised by her daughter and her husband and had eventually left her daughter's home.

The other respondent had been very close to his daughter, they shared a lot of common interests and had done lots of things together. However, when his daughter started seeing a new partner, his relationship with her grew more distant.

A very different reaction could be seen in these two situations. The first respondent now had no contact with her daughter. She said that she did not feel depressed about what had happened. She had a clear conscience and took the view that:

> *'I have done my duty as a mother, one hundred percent'*

In contrast, the man estranged from his daughter had quite a different experience. He felt very depressed about what had happened, was lonely, missed the company of his daughter and felt terribly sad about the fact that he could not, despite many attempts, do anything to improve his relationship with his daughter and her new partner.

Several differences could be identified between these two respondents in terms of their coping mechanisms and how these impacted on where they ended up. The woman had a very strong personality. Having lost her husband at a young age, she had had to focus on bringing up her family on her own and talked about this having made her strong and able to cope in difficult circumstances. The other respondent was struggling with bereavement, having recently lost his wife, and the relationship with his daughter was possibly more central to him, having few other social connections, making it harder for him to deal with.

Example 3

A third example relates to two respondents, each of whom were looking after a spouse who was suffering from Alzheimer's. In the first case, the husband wanted very much to be looking after his wife, but was himself diagnosed with cancer which resulted in his wife being looked after in a nursing home because he was unable to manage. Although he had expected this to happen eventually, he had hoped to have longer at home with his wife. The abuse in this case related to when the respondent's wife became confused, wanted to go out and would hit out in order to try and get past her husband. However, he said she was tiny and '*not capable of hurting me*'.

The second situation was quite different. The respondent in this case was a woman who was finding it very difficult to cope with looking after her husband and was suffering from depression for which she was receiving treatment. She was used to being very active and sociable, but was no longer able to do all the things she wanted as a result of the time needed to look after her husband and the fact that he couldn't be left on his own. When her husband got confused as a result of his illness, this respondent had on occasion been badly hurt as a result of him lashing out at her.

An obvious difference between these two cases relates to the severity of the mistreatment experienced. However, it was the contrast between their attitudes to looking after a sick spouse that was the most striking feature in terms of how they were coping overall with their situations. Whilst the former respondent was devastated at no longer being able to look after his wife at home, the latter was depressed about the loss of freedom and independence as a result of having to care for her husband.

7.4 Key findings

A range of factors were identified in this chapter, all of which had a mediating influence on the impacts felt by respondents as a result of experiencing some kind of mistreatment or abuse. One group of factors is comprised of characteristics of the experience: its type and severity; whether the incident was resolved or ongoing, both in terms of whether the abuse had stopped and whether emotional resolution was possible; the proximity of the respondent to the perpetrator; the extent to which there was an element of unpredictability to the mistreatment; and, whether it occurred in the context of caring for someone.

The other factors which affected the impacts on respondents related to the characteristics of the individuals involved as opposed to the characteristics of the experience of mistreatment. These can be seen as the components of a person's ability to cope and represent the extent of their resilience to deal with difficult situations they might find themselves in. These include the extent to which the incident undermined norms held about relationships and about trusting others. These also include the level of a respondent's social and community connectedness. Some respondents, for example, were involved in different kinds of clubs, groups or activities or had close relationships with family and/or friends. Religious belief could also be a source of comfort and support to respondents.

Not all respondents we spoke to had this kind of social support or involvement. However, their absence did not necessarily seem to mean that someone was lonely. Some described having been alone and not having much social contact for a long time and being used to it. However, there were others who were lonely or who were fearful of being alone, and those who felt they were more vulnerable because of living alone. There were also those who had been recently bereaved and were having to adjust to life on their own as well as try and cope with the grief of having lost a life partner.

Considerable variation and diversity was evident across the sample in terms of respondents' health. Whilst some were enjoying good health, poor health was evident across the three different age groups although had more prominence amongst the oldest group of respondents. Some respondents were making a significant effort to maintain their health by keeping themselves physically active and mentally alert.

Previous life experiences could also be seen to affect the nature of impacts from experiences of mistreatment. A cohort effect as a result of having lived through the Second World War was evident. A similar effect was noticeable amongst respondents in Northern Ireland, who spoke of their experiences in the context of having lived through the political troubles there. A group of respondents said that they had become more resilient as a result of these experiences of war and political conflict. In other cases, previous events, especially personal experiences of prior loss or trauma, could actually increase the negative impacts of experiences.

Finally, there was a range of personal qualities that affected the way in which respondents dealt with different situations, with some respondents displaying high levels of self-confidence and determination. Others adopted specific tactics in dealing with an abusive situation, like keeping a diary or actively avoiding thinking about it.

In the context of this discussion, it should be borne in mind that this sample may not include the most vulnerable older people, such as those too unwell to participate in an interview either through physical or mental illness, cognitive impairment or other factors. However, the evidence suggests that a positive orientation with regard to these factors can help to protect people from enduring harmful effects, whilst those with a negative orientation are especially vulnerable to harmful effects and poor outcomes.

8 CONCLUDING COMMENTS

This chapter draws on the findings reported in Chapters 4 to 7, comments on them in the light of the points made in Chapter 1, and suggests what some of the implications may be for policy and further research.

8.1 Links to prevalence survey

As explained in detail in Chapter 2, approximately half the respondents who were interviewed for this stage of the research featured in the prevalence estimate of 2.6 per cent, and around three quarters in the broader estimate of 4 per cent. The remaining quarter were excluded, for definitional reasons, from the prevalence estimates entirely. Cases that are illustrative of some of the mistreatment reported in the prevalence estimate of 2.6 per cent include caring for someone with a behaviour problem, spousal and other kinds of family abuse and conflict and alleged theft by family, friends and care-workers. Incidents involving a wider range of perpetrators, as outlined in Chapter 2, enabled various scenarios to be explored, such as conflicts with neighbours and harassment, doorstep fraud, and various forms of sexual harassment, that in terms of the type of behaviour and the impact on the respondent were often very comparable and were certainly cases that could have been picked up in Adult Protection work. In general, the conclusions from the survey and the qualitative work are consistent, but the qualitative work throws light on how older people deal with neglect and abusive situations with corresponding implications for how the problem may best be addressed.

8.2 The diversity and complexity of mistreatment

Chapter 4 highlighted the substantial diversity of the abusive situations (echoing comments made in the focus groups conducted for stage one) and pointed to the fact there was no such thing as a typical case. The cases in this study are differentiated not only by the different capacities and resources of the individuals involved but by widely varying differences in context. This may relate to family relationships or to history or to socio-economic status or to the neighbourhood they are living in. Only some cases can be seen as a straightforward issue of 'victim' and 'perpetrator' and often the situation is more complex. In instances involving the care of someone with behavioural problems (arising from dementia or mental illness, for example) respondents did not blame the perpetrator but saw the behaviour as part of their illness or condition. These findings confirm those from other research and challenge the validity of the family violence approach.

The nature of the cases explored led to a categorisation of types of abusive experience or situation (Chapter 4) that was seen to group the cases in this study more effectively. While this may prove challenging for the definitions of mistreatment used in the survey (see discussion in Chapter 3), it is in many respects more in line with policy and practice. Adult protection policies, for example, do not restrict their concerns to harms committed to older people by specific types of perpetrator not to those perpetrators who are in a relationship involving an 'expectation of trust'. This is because their focus is on the vulnerability of certain groups and on harm caused regardless of the particular relationship between the older person and the perpetrator. The findings of the qualitative study, showing commonalities across these different experiences of mistreatment, generally support this broad focus.

A group of respondents in the study could be described as vulnerable in these terms because of factors such as physical and mental disabilities and health problems. However, other factors that appeared to increase vulnerability included social isolation; volatile family dynamics, sometimes associated with mental health issues; living arrangements (either living with someone with a problem or living alone); being a woman living alone; and having

awkward, difficult and sometimes harassing or violent neighbours. These factors provided the context for the abusive situations explored in the study.

8.3 The involvement of services and action taken by respondents

Many respondents were in contact with various services already and some had specifically sought help with their situation. Chapter 5 highlighted reasons why people took action about the mistreatment. They hoped to change the perpetrator's behaviour; they wanted to place distance between themselves and the perpetrator; they wanted legal or formal redress; and they looked for emotional support. Three barriers inhibited them from taking action. First, the limitations placed on them by their circumstances and the abusive situation. Second, their concerns about the consequences of taking action, echoing remarks made in the early focus groups. Third, their understanding of the role and remit of agencies and their capacity to help, also raised in the focus groups. Two factors facilitated action; the respondent's fear for their personal safety, once again raised in the early focus groups; and the encouragement and support given by other people. These findings imply that it is important to make it both easy and non-threatening for people to access help, either on their own or on others' behalf.

8.4 The impact of mistreatment

Chapter 6 examined the impact of mistreatment on respondents. In general, respondents reported a range of sometimes serious effects on their health, well-being and quality of life, reflecting views expressed in the focus groups. They described how they had lost their self-confidence and were depressed or anxious, how they were nervous about leaving their house, and respondents could feel that their physical health had been affected. However the research shows clearly that physical frailty or dependency does not, and must not, be equated with loss of autonomy or a lack of robust views about a situation and how to deal with it (Chapter 7). What clearly emerges from the interviews is that adversity does not mean collapse and capitulation. Although there were certainly a range of negative impacts and experiences, and some respondents found it less easy to cope, the resilience of other respondents was one of the most striking features to emerge from the data. This resilience could exist in the face of sometimes profound disabilities, serious health problems, adversity in personal relationships and so on. Respondents, like those in Podnieks' research (1998) linked their reactions to their previous life experiences, including in this study the Second World War and the troubles in Northern Ireland. What also emerged in both Podnieks' and Pritchard's research, was a picture of older people with views and opinions about what would help them, even if they were sometimes uncertain about what help was available or the likely response of agencies to them and their problems. Therefore a key message from this part of the research is not to treat victims of mistreatment as dependent in relation to personal decision making.

8.5 Some thoughts on policy implications

The involvement of a number of different agencies in the life of many respondents supports the partnership approach that was set out in No Secrets (Department of Health, 2000) and developed further in Safeguarding Adults (ADSS, 2005).

The extent of the health and disability problems experienced by respondents and their references to contact with GPs, community nurses and other healthcare staff suggests that this is likely to be a key interface with services for older people. This raises questions about education and awareness in primary care teams and it may be that more needs to be done to alert GPs and other health care professionals to issues relating to the mistreatment of older people. In turn, health care professionals need information about the availability of the help and support needed and to be clear about the role and remit of adult protection officers.

It was also notable that respondents had concerns about knowing where to go with a problem, about whether it was appropriate to approach statutory services with a problem and about the consequences of reporting. The research suggests the need for a non-threatening, generic 'first port of call' for older people experiencing a wide range of problems. Such a facility would provide or signpost older people to relevant services and support and would remove anxiety about whether the experience of mistreatment or abuse was serious enough or appropriate to report to authorities. This facility might best be provided by the voluntary sector but with close links to Safeguarding Adults partnerships. There may also be a greater role for the primary care health team in routing people to these services. Eastman and Harris (2004) have suggested a *'partnership of agencies, local communities and older people, underpinned by resources and by performance measures that evidence the approach to secure 'citizenship' for all'*.

The findings also point to the importance of the link between Safeguarding Adults and Crime and Disorder Reduction Partnerships. In this study, the police were evidently involved in a range of cases including conflict with neighbours and harassment, alleged thefts, fraudulent doorstep tradesmen, as well as those where respondents were caring for someone with extremely challenging behaviour.

The research also highlights the fact that domestic abuse does not cease in older age. Domestic violence services should be reviewed for 'ageism' and consideration given as to how they can appropriately help older people suffering from domestic abuse, who may have different concerns to younger people, for example, about how they will cope living alone or about financial matters.

The huge diversity and complexity of the mistreatment explored in this study show that mistreatment should not be chiefly understood in terms of carers mistreating their relatives owing to the stress of the caring role. In fact, the research suggests that more attention may be needed to support carers who suffer aggressive and abusive behaviour from the person they are caring for, notably those suffering from dementia.

The diversity of experience and the broad range of personal and social factors affecting resilience and long term outcomes also suggest that maintaining broad coverage of high quality services to older people (benefits, housing, health, social care, transport) and their families is likely to be one of the most effective ways of responding to mistreatment.

The qualitative research reported here, undertaken as part of the wider programme of research into the mistreatment of older people, has provided valuable insight into experiences from the perspective of older people themselves. It has also helped to explore and understand aspects such as the impacts of mistreatment experienced by older people, the processes and decision-making involved in taking action and responding to mistreatment, and the ways that people cope and recover from such experiences.

APPENDIX A STUDY DESIGN AND METHODOLOGY

Recruitment processes

Older people

The recruitment of older people was carried out in several stages. This was done for three reasons. Firstly, the fieldwork for the survey was still in progress when selection and recruitment for the qualitative study began and eligible cases from the survey were supplied to the qualitative team in waves. Secondly, all the interviews were conducted by the team of three researchers and it was therefore necessary to stage the fieldwork, so that it was manageable for the researchers and to ensure that respondents were telephoned and interviewed as soon as possible after receiving the initial letter. It was also to allow a managed and iterative approach to achieving targets for the various sampling criteria.

The recruitment process at each stage involved initially sending a letter to an eligible sub-set of the sample frame. The letter is appended at Appendix B. It is deliberately unspecific about the precise nature of the proposed interview content, focusing on health, well-being and difficulties experienced by older people so as to preserve confidentiality if other household members were to see the letter. The letter, however, is clear that the aim was to follow-up the survey and explore, in more depth, issues identified by the respondent during the survey. The letter provided a free-phone number that respondents could call to ask questions about the research or in order to opt out at this stage. The letter also made clear that not everyone receiving a letter would be contacted.

After the opt-out period, a researcher called all respondents who did not opt out until sampling criteria targets were achieved. During this telephone call, the researcher explained in more detail the purpose of the follow-up interview, being more specific about the incidents of mistreatment raised in the survey that would be followed up. This was vital for gaining properly informed consent. However, whilst making it clear what they wanted to interview the respondent about, researchers did not go into detail about the incident or experience on the phone since this may have been distressing for the respondent. The call also provided an opportunity for the respondent to ask questions and for the researcher to explain what participation would involve. These recruitment telephone calls were directed by a ‘guide’ developed for the purpose and appended at Appendix B. The guide is not a script but is designed to be used flexibly to ensure that all key issues are covered and that all important information is explained.

If respondents declined to participate in the study their decision was noted, and they were told that they would not be pressured to participate but that it would be helpful for us to know why they had refused. This information was recorded where provided.

If respondents agreed to take part, an interview was either provisionally arranged and then confirmed between a week and ten days later, or the interview was arranged at the second telephone call. Evidence has shown the importance of allowing potential respondents time to reflect upon participation, particularly in a study of a potentially sensitive nature. This allows the respondent to consider more fully whether they want to take part or to think of and raise further questions with the researchers about the process. In this way, the team were able to have confidence that respondents had given fully informed consent.

Researchers made explicit assurances about confidentiality and about preserving anonymity in final reports and it was made clear to the respondent that NatCen do not, under any circumstances, share personal details or transcripts with anyone outside of the immediate research team. These reassurances were made when recruiting respondents and again at the outset of interviews.

It was also made clear during recruitment and again at the beginning of the interview that the respondent would be free to stop the interview at any time or to choose not to answer particular questions. It was agreed that interviews would be conducted in a private setting and the subject matter of the interview would never be divulged to, or discussed with, other family or household members.

Respondents were told, that under exceptional circumstances, NatCen may have to inform authorities, most likely the police or social services, about things they have told us. However, it was explained that this was extremely rare and only something that would happen if we were told about something life threatening to respondents or others, where the person affected was unable to act for their self in order to seek help. In practice, this situation did not arise.

A confirmation letter was sent to the respondent after an interview was arranged which re-iterated the free-phone telephone number for any further queries the respondent had and confirmed the name of the researcher who would visit them. All recruitment documents are appended at Appendix B.

Relatives

A network sampling approach was taken to recruiting family members, gaining onward referrals from older people interviewed for the study who referred to family members in their interviews. These were relatives who had advocated for them or supported them in some way or who had been affected by the incidents in question. It was not the intention to recruit family members who had been the perpetrators of mistreatment or abuse.

The researcher discussed with the respondent whether they would be comfortable if we were to speak to a particular family member they had referred to in their interview. In these cases researchers provided the respondent with written information about the study to pass on to the family member. This included a form for them to enter their contact details and a freepost envelope for the family member to send us their contact details if they were willing to discuss taking part in an interview. A copy of this information and the contact details sheet are appended at Appendix B.

Sampling

Approaches taken to reduce non-participation and selection bias

Given the relatively small number of eligible respondents and need for a spread of cases across the range of identified sampling criteria, the team were mindful of the need to maximise participation, both to obtain overall interview numbers and to avoid any further selection bias (whereby certain sub-groups are inadvertently excluded or under-represented in the achieved sample).

Working to meet targets against sampling criteria was an iterative process, involving continual review of the available sample and completed recruitment. At each stage, sub-groups that were deemed under-represented were prioritised for the next stage of recruitment.

Significant effort was put into ensuring that the survey respondents that we were re-contacting were approached sensitively, that they were given the fullest opportunity to provide informed consent and were not put under any undue pressure to take part in the study. Within these constraints, steps were taken to maximise participation. These included:

- sending a letter in advance of telephoning, with a free-phone telephone number for respondents to call at a time convenient to them to find out more about the study;
- aiming to speak to respondents on more than one occasion to explain the study fully, address concerns and answer any questions about what participation would involve;
- providing comprehensive reassurances about interview conduct, confidentiality and anonymity;
- using senior researchers to make recruitment phone calls, who were experienced at recruiting from hard to reach and vulnerable populations;
- using a recruitment guide to ensure full coverage of all relevant information in a way that is straight-forward and easy to understand.

Unobtainables and refusals

Despite taking these steps, the team experienced a high incidence of unobtainable respondents (25 unobtainable respondents despite each respondent being telephoned on at least 3 occasions) and high refusal rates (67 refusals overall). Respondents who refused to take part in the research were asked to give a reason. Not all chose to do so, and for those who did, it needs to be borne in mind that people do not always provide a genuine or accurate reason, especially in the case of researching difficult topics. For example, even though reassurances were given that the researcher would not try to persuade them to take part following their refusal, respondents may have provided a reason for refusal that they perceived to be less likely to invite the recruiter to persuade them to participate or, despite reassurances of confidentiality, may have been unwilling to discuss the incident or experience with the recruiter. The reasons given for refusal are set out below (Table 2.2).

Table 2: Reasons for refusing participation in the qualitative work

No reason given	30
Respondent maintained that they were unable to remember incident or that no incident of abuse took place	12
Respondent unwell	6
Respondent too busy/couldn't arrange interview within fieldwork period	6
Respondent didn't want to re-live incident	4
Respondent taken part in previous research/feels repetitious	4
Respondent felt incident not relevant/ serious enough	4
Deceased	1
Total	*67*

High refusal rates are always a concern and can be related to selection bias, whereby there may be something different about those who participated from those who did not resulting in certain sub-groups being effectively excluded from the research.

In this study, analysis of reasons for refusal (where given) and of information obtained from the survey for respondents who refused to take part in the qualitative follow up interviews does not suggest that those who refused to participate were in any way distinctive from those who agreed to take part in a follow-up qualitative interview (for instance, in terms of the nature or apparent severity of the mistreatment or abuse they experienced, or personal characteristics such as their age).

Nonetheless, although there was is no evidence of selection bias, some caution must be observed since it remains possible that those who refused to participate were different to those who did participate and that some dimensions of older people's experiences were not captured as a result.

Extension of sample to include wider range of perpetrators

As a consequence of these difficulties, the cases in the sample frame where the perpetrators of mistreatment were family members, professional carers or close friends were eventually exhausted.

The number of respondents who fell within this category and took part in an in-depth interview was 22. These included 15 respondents who were included in the headline prevalence figure (from a total 53 survey respondents), six who differed only in that they had experienced the mistreatment or abuse since age 65 but not within the last 12 months and one further respondent who did not meet the frequency threshold set for psychological abuse but reported the incident concerned as having been 'very serious'.

In order to meet the target of 40 interviews a decision was made, in consultation with the sponsor, to extend the criteria for inclusion to include those meeting the behavioural definition but involving perpetrators who were neighbours, acquaintances and, exceptionally, strangers where the incident appeared to be targeted at older people. Although prompted by concerns about sample numbers, discussions between the team and with the sponsor also identified substantive interest in exploring the nature of these experiences and incidents of mistreatment involving, as they do, similar behaviours and harms but perpetrated by alternative categories of perpetrators. A further 17 interviews were obtained at this stage.

However, the survey sample was highly heterogeneous and extending the range of incidents and experiences to include a wider range of perpetrators had the effect of increasing the already significant diversity in the sample. A key impact was that it added to the difficulty of gaining adequate coverage and 'saturation' (where one can be confident that one has mapped the full range of experiences, perceptions, responses, barriers, etc.) at the level of specific types, forms and expressions of mistreatment.

However, as noted above, the decision to extend the sample to include incidents and experiences involving this wider group of perpetrators was also seen as a positive opportunity, since it allowed comparison of experiences fitting the same or similar behavioural definitions but differing in terms of the perpetrator. This proved to be productive in highlighting some definitional issues (discussed in Chapter 3) and in mapping and exploring impacts, barriers to taking action and reporting mistreatment, as well as factors affecting resilience and coping mechanisms across a wide range of difficult circumstances experienced by older people.

Inclusion of respondents from black and minority ethnic (BME) groups

A further challenge faced was that the sample frame did not include any respondents from BME backgrounds. A decision was taken to identify respondents from BME groups through specialist community-based organisations identified in liaison with Action on Elder Abuse and the sponsor. Three such interviews were obtained through two organisations. These organisations are not named here in order to protect the anonymity of respondents. Recruitment for these interviews involved providing information to staff within these organisations to pass to clients who they knew to meet the behavioural definitions of elder mistreatment. If these individuals agreed, their contact details were passed to the research team and the recruitment would follow the same steps as for respondents being followed up from the survey. However, in two cases, interviews with respondents were arranged through staff because of the difficulties of making arrangements over the telephone where the respondent's first language was not English.

Interview conduct and support offered to respondents

Carrying out depth interviews with older people on the subject of mistreatment requires a sensitive and flexible approach to interviewing. The design and conduct of interviews carried out for this study reflected a concern with ethical practice as well as data quality and the integrity of the research.

At the outset of interviews, respondents were reminded of their right to change their mind about participating in the research at any time and that they were not obliged to answer any questions they did not wish to. They were reminded about confidentiality assurances given during recruitment. Researchers also agreed with the respondent at the outset of the interview, that where interviews were interrupted (for example, by a family member entering the room), the researcher would shift away from discussion of mistreatment and talk about something neutral until the interruption had passed. Interviews generally lasted for around an hour, sometimes for longer. They were recorded, with participants' consent.

The structure of the topic guide was such that respondents began by talking about themselves, their daily activities and their current living situation to get them used to, and ensure they felt comfortable with, the interview context and the researcher. Researchers then invited respondents to talk about their experiences of mistreatment before the interview moved on to discuss their reaction to that mistreatment and its impact on them. The time spent on different topics and the course of the discussion varied between interviews although all interviews covered the same broad areas of enquiry. Care was taken to end on a more positive note with broad questions about advice they would give to others and the kinds of support they think would be useful.

In conducting interviews, researchers were sensitive to how respondents appeared to be coping with the interview and, where they appeared upset, researchers checked with respondents whether or not they wished to continue and, if so, whether they wanted to take a break and if they wanted the recording to be switched off. Interviews were resumed only when respondents said they were happy to continue. Researchers were also alert to whether respondents were finding the interview tiring and, in all cases, regularly checked with the respondent about their need to take a break, with prompts for this included in the topic guide.

The team of researchers conducting the interviews are all experienced in conducting interviews on sensitive topics and with potentially vulnerable respondent groups. In addition, they were given additional specialist training and coaching to prepare them for interviewing on this specific subject from colleagues at King's College London and staff at Action on Elder Abuse.

Provisions were made for researchers to receive post-interview support. Ongoing support to researchers was provided within the team, in particular the Research Director for the project who had frequent discussions with team members about the interviews and led regular team 'de-briefs'. Researchers were also able to discuss their experiences of conducting interviews on this study confidentially with a fieldwork specialist located within the QRU, with counsellors available through the organisation's employment assistance programme and with a member of staff from Action on Elder Abuse who was 'on-call' to the team.

At the end of all the interviews with older people, the researcher spent some time guiding respondents through information cards that were left with respondents at the end of interviews (this is appended at Appendix D). These cards signposted people to a range of organisations which could be of benefit to them. The services provided by these organisations were explained, with special care taken to discuss the services provided by Action on Elder Abuse (AEA) and its telephone help-line. This was important as the card contained only the acronym AEA to avoid drawing the attention of any other household members to the fact that any part of the interview might have covered the topic of elder abuse.

If an older person did not want to make a call to a service him or herself but wanted the researcher to contact AEA or another service listed on the card on their behalf, the researcher was able to do so. In addition, at each interview, researchers had the phone numbers of the local adult protection co-ordinator (who had been informed that a member of the team would be interviewing in the area on a specific day) in the event that the respondent wanted us to facilitate contact with social services. Such provisions were not, however, requested in any of the cases encountered during this study.

The research team ranged from being in their late twenties to mid forties. Whilst the research team conducted all interviews, provision had been made for interviewers in their fifties and sixties to conduct some of the interviews or for interviews to be carried out by a male researcher if this was requested, if the respondents had expressed any concerns about the age or gender of the interviewer during recruitment or otherwise seemed particularly appropriate. Neither provision was utilised.

The team were also able to arrange for translation or for the interview to be conducted in a language other than English. Again, this was not necessary although two of the three interviews with BME respondents were conducted, at the request of the respondent, in the presence of a worker from the organisation through which they were recruited who was able to translate at points during the interview where the respondent found it easier to express something in their first language.

All respondents were given a gift of £20 as a thank you for their time.

Disclosure protocol

Part of the ethical framework for the project (set out in the ethical review submission) was having a clear protocol on disclosure. This took account of the fact that the research was specifically aimed at discussing harmful and abusive situations and balanced this against the need to provide appropriate support and protection where circumstances merited it. Researchers were advised to refer cases in which respondents were judged to be in life-threatening situations and/ or unable to act for themselves to seek support. These cases would be discussed, in the first instance, with the research director for the project and the director of the Qualitative Research Unit (QRU), where the team is situated. Were a case to have arisen where potential disclosure to authorities needed to be considered, it was agreed that the next step would be to convene an emergency sitting of the NatCen Ethics Committee or a sub-group thereof for a decision to be made about what action to take. The disclosure protocol for the study required that, in these cases, respondents would not have been made aware that the researcher considered that an issue had been encountered of such a serious nature that the researcher was going to implement the disclosure protocol, since this may have put the researcher in a vulnerable situation and caused distress to the respondent. Instead the protocol required that the researcher would complete the interview as soon as they could without ending it abruptly. The researcher would then talk the respondent through sources of help available to them, as with other interviews. This meant that in the event that NatCen decided not to disclose to any authority, the respondent would still have the information needed in order that they could seek appropriate help for themselves.

APPENDIX B RECRUITMENT DOCUMENTS

Introductory letter to respondents

(Note: this letter was provided to respondents in 14pt text, double-spaced)

Dear

Growing Older: Life Experiences & Wellbeing

You recently took part in a survey interview about older people's life experiences and well-being. This survey was carried out by The National Centre for Social Research (NatCen). When you completed the survey, you said that you were happy to be re-contacted about other research projects. I am writing to you now about some further research that we are doing into older people's life experiences and well-being to find out if you would be interested in taking part. Like the survey, this is being carried out with Department of Health and charitable funding.

We are working with the team who conducted the survey, following up on the work that they did. Our study addresses some issues similar to those covered in the survey, such as general health, use of care services and relationships that might be supportive or difficult. However, instead of asking you to give answers to specific questions as we did in the survey, this time we are asking you to participate in an in-depth interview, which is more like having a conversation. A researcher will ask you about a range of issues and will be interested in hearing your views and experiences in your own words. This follow-up study is being carried out by a small team of researchers at NatCen. They are myself (Alice Mowlam), Ros Tennant and Josie Dixon.

Because we only need to carry out interviews with a limited number of people, we may not call everyone that we have written to. However, if we do call you, this will be to tell you more about the research, answer any questions you might have and ask if you would like to take part.

If you do not want us to call you, please let us know by calling the freephone number 0800 652 9935 before insert date. Please make sure you leave your name if you reach the answerphone. You can also call this number if you have further questions about the research. Taking part in the interview is voluntary so you do not have to agree to take part. If you do agree, you can change your mind at any time. No-one will try to persuade you to take part if you do not want to.

If we do call you and, after finding out more about the research, you decide you do wish to take part, we will arrange an appointment for either me, Ros or Josie to come and interview you. The interview will last about an hour to an hour and a half and we can come at a time convenient for you, either to where you live or somewhere else if you prefer. Everyone who takes part will be given £20 as a thank you for giving up their time to talk to us.

Everything that is discussed in the interview remains confidential. As with all our research, confidentiality would only ever be broken where people are in situations of extreme and immediate harm or are being harmed and are unable to act to protect themselves. At the end of the study, we will write a report about the sorts of issues raised by people in the interviews, but without identifying any individuals.

Please do not hesitate to get in touch with me, Ros or Josie on the freephone number 0800 652 9935 if you have any questions about this study.

Yours sincerely,

Alice Mowlam
Senior Researcher

Recruitment 'guide'

Please note: this is intended to be used as an aid during recruitment, not as a verbatim script.

Introduction:

- *We need to speak to the respondent themselves, if there are gatekeeping issues with getting through to respondent, keep information about purpose of call general: following up on letter sent about research study*
- *Once speaking to respondent, need to cover the following:*

- My name's xxxx, I'm calling from The National Centre for Social Research. I sent you a letter about a research project that we're working on. As it said in the letter, I'm calling to follow up the letter, to talk to you about this study and find out whether you might be interested in taking part or not. Is now a convenient time to talk to you about this, or would it be better if I called back another time?

- As it said in the letter, we are working with the team who conducted the survey that you took part in in xxxx. We are following up some of the people who took part, like yourself.

- As you probably recall, part of the survey was to find out about difficulties or problems being experienced by older people. There has been very little research done in this area, so (that is why) we are following up on some people like yourself to find out in more detail what their experiences have been and try and look for ways that these problems might be avoided in the future.

- What we will be exploring with people are their experiences of any mistreatment or difficulties they have faced. This covers a wide range of topics, for example, disagreements about money, personal care neglected or difficult family relationships.

- This would be a very different kind of interview from the one you took part in last time. Instead of the interviewer asking you questions, to which you choose an answer from a list or give a short reply, this will be much more like a conversation. What we are really interested in finding out about are your thoughts, experiences and views.

- For example, if you said in the survey that something affected you a lot, or a little, we would want to hear more about what you meant by that. For example the ways you were affected and why, whether the way you feel about it has changed over time, what help you had or what might have been useful to you and so on. There are no right or wrong answers. What we are really interested in finding out is what you think and what your experiences have been.

- It's really important to emphasise that whether you take part or not is completely voluntary. We are aware that talking about experiences that were difficult or upsetting is not an easy thing to do, and if you would rather not, that is absolutely fine.

- If you did want to take part, I would be the person who would be coming to see you. I could come at any time convenient for you and we could either do it at your home or somewhere else that suited you. Because what we want to talk to you about is quite sensitive, we really need to be able to do the interview somewhere where no one else who might be in the house/flat will be able to hear, so in a private place.

- All the interviews that NatCen conducts are confidential, and carried out in accordance with the Data Protection Act. What this means is that your name, personal details or anything else that could identify you will not be shared with anyone outside of the research team. We will be writing a report based on the sorts of things people tell us about in the interviews, but without identifying any individuals. For example, if lots of the older people we talk to have had difficulties in a particular area, we would write about what sorts of problems those have been, without ever identifying the individuals who said these things. So confidentiality is maintained in the report at all times.

- However, in all of the research that NatCen carries out, there are some exceptional and rare circumstances where that confidentiality might be broken. These are occasions where a researcher visits a respondent and finds someone in extreme and immediate harm, or someone who is in difficulty and not able to get help themselves. For example, if a child or an older person with severe dementia is being seriously hurt. In these circumstances, the interviewer may have to tell the police or social services in order to stop someone who is very vulnerable being abused. These are the only sorts of circumstances under which we would break our promise of confidentiality to our respondents, and as I said, these situations are extremely rare.

- With your permission, we would like to record the interview. This is so that we can concentrate on what you are saying rather than trying to take notes. Also, it means that we have an accurate record of your experiences, and avoids the danger of us not remembering something accurately. I would like to reassure you that the recording stays completely confidential within the research team (in accordance with the Data Protection Act) and will be destroyed a year after the research report is published.

- *Even if the respondent is happy to participate: say that you will call back once they've had a chance to digest the information to confirm the interview*
- *Invite any questions; check respondent has contact details from approach letter to call if they have any queries or want to get in touch with researcher for any reason*

Letter to confirm interview

(Note: this letter was provided to respondents in 14pt text, double-spaced)

Dear

Growing Older: Life Experiences and Well-being

Thank you for agreeing to participate in this study of older people's life experiences and well-being. Further to our telephone conversation, I am writing to confirm the details of the interview as discussed.

Your interview will take place at: TIME **on** DATE **at** LOCATION**.**

The NatCen interviewer will be RESEARCHER**.**

You will receive a £20 payment as a thank you for your participation and to compensate you for your time. The interview will last approximately one hour to one-and-a-half hours and will be recorded with your permission.

Everything that is discussed in the interview remains confidential. As with all our research, confidentiality would only ever be broken where people are in situations of extreme and immediate harm or are being harmed and are unable to act to protect themselves. At the end of the study, we will write a report about the sorts of issues raised by people in the interviews, but without identifying any individuals.

The interviewer will be carrying NatCen photographic identification with them. They will show you this when you first meet them.

Please do not hesitate to get in touch with us on the freephone number 0800 652 9935 if you have any questions about this study.

Yours sincerely

RESEARCHER NAME

Letter to family members

Our ref: P6153

Growing older: life experiences and wellbeing

Research with family members
We are currently carrying out a research study about older people's life experiences and wellbeing. You will be aware that we recently interviewed your relative as part of this research. Following the interview, they agreed to pass this letter on to you on our behalf.

The reason we asked them to pass this letter on to you is that, as well as speaking to older people themselves, we would also like to interview members of their family. We want to find out how family members feel about their relative's experiences of growing older. The research covers a range of issues to do with growing older such as general health, use of care services and relationships that might be supportive or difficult.

Taking part in the interview is voluntary so you do not have to agree to take part. And if you do agree to take part, you can change your mind at any time. The interview will last about an hour to an hour and a half and we can come at a time convenient for you, either to where you live or somewhere else if you prefer. Everyone who takes part will be given £20 as a thank you for giving up their time to talk to us.

Everything that is discussed in the interview remains confidential. As with all our research confidentiality would only ever be broken in the case of extreme and immediate harm or where somebody can't act to protect them-self. At the end of the study, we will write a report about the sorts of issues raised by people in the interviews, but without identifying any individuals.

NatCen (the National Centre for Social Research) is an independent research organisation, established as an educational charity. We carry out social research studies on a range of different topics, mostly for central government but also for other public bodies. This study has been undertaken with Department of Health and charitable funding.

If you are interested in taking part in the study or would like us to contact you to tell you more about it, please complete the form with your contact details and return it to us in the pre-paid envelope provided. Or please feel free to call me, **Ros Tennant,** at NatCen on **Freephone 0800 652 9935** or to email me at **r.tennant@natcen.ac.uk**.

Contact details sheet for family members

Our ref: P6153

Growing older: life experiences and wellbeing

Research with family members
If you would be interested in taking part or in hearing more about the study, please let us have your contact details and we'll get in touch.

Your full name:

Your full address, including postcode:
Your telephone number, including full code:

Please tick when we can use this number:
morning ☐
afternoon ☐
evening ☐

Or, if you prefer, your email address:

Thank you very much!

Please return the form, in the pre-paid envelope, to:
Ros Tennant, NatCen, 35 Northampton Square, London EC1V 0AX

If you would like any more information about the study before sending us the form, please contact Ros Tennant at NatCen on freephone 0800 652 9935.

Letter for respondents contacted via BME organisations

(Note: this letter was provided in 14pt text, double-spaced)

Our ref: P6153

Growing older: life experiences and wellbeing

I am writing to you about a research study into older people's life experiences and wellbeing that we are carrying out here at The National Centre for Social Research (NatCen). NatCen is the UK's largest independent social research organisation. We design, carry out and analyse research studies in the field of social and public policy.

The study covers a range of issues to do with growing older such as general health, use of care services and relationships that might be supportive or difficult. Part of the research involves conducting 40 face to face interviews with older people (65yrs and over) who have experienced some kind of abuse. Very little research has been done in this area. It is important to gather evidence about the experiences of older people in order to devise policies and strategies for helping and supporting those who are being abused. It is with this in mind that we have been asked to carry out this study by the Department of Health and other charitable funding.

We are looking at the following types of mistreatment and abuse:

- Physical
- Psychological (verbal)
- Neglect
- Financial
- Sexual

Most of the people that we are interviewing have already taken part in a survey, which is also part of this project. However, there are low numbers of potential respondents from black and minority ethnic groups. I am writing to you in the hope that you may be able to help us identify some older people from amongst your BME service users, who have experienced some form of abuse and who might be willing to take part in these research interviews.

This is a challenging study. The issues around recruiting people are very sensitive: clarifying the content of the interview, gaining informed consent and setting up the interview safely. If you thought you were able to help, we have an information sheet for you to talk through with potential participants. However, there are a couple of points worth mentioning now. Firstly, taking part is voluntary. If someone agrees to take part, they can change their mind at any time. The interviews last about an hour to an hour and a half and are conducted in private at a time and place convenient for the respondent. Everyone who takes part is given £20 as a thank you for giving up their time to talk to us. We are able to conduct interviews in languages other than English, using a professional interpreter. We are a team of three working on this study and are all experienced research interviewers.

Everything that is discussed in the interview remains confidential. As with all our research confidentiality would only ever be broken in the case of extreme and immediate harm or where somebody can't act to protect themselves. At the end of the study, we will write a report about the sorts of issues raised by people in the interviews, but without identifying any individuals.

I hope it will be possible for us to discuss this in more detail. My contact details are above.

Information for BME respondents

(Note: this information was provided to respondents in 14pt text, double-spaced)

Growing Older: Life Experiences & Wellbeing

We have been asked to talk to you about a research study looking at older people's life experiences and well-being. It is being carried out by The National Centre for Social Research (NatCen), the UK's largest independent social research organisation who design, carry out and analyse research studies in the field of social and public policy.

The study they are doing covers a range of issues to do with growing older such as general health, use of care services and relationships that might be supportive or difficult. One part of the research involves interviewing older people (65 years or more) who have experienced some kind of problem or difficulty. This could include problems with family, friends or other people – for example, disagreements, arguments or fights. It could be financial problems, for example, where an older person has had money stolen by someone who's doing their shopping. Alternatively, it could be problems experienced because of people not doing things they were supposed to or said they would, like helping someone bath or get dressed. Some people also experience unwelcome sexual advances or comments.

NatCen has asked us to talk to you on their behalf about your experience. ***Please discuss the incidence of abuse experienced that we would want to talk to them about***. They are looking for people to take part in an interview, which would involve talking to one of their researchers about what happened to you and would take about an hour to an hour and a half (a bit longer if through an interpreter). The interviews are carried out in a private place so no one else can hear and are done at a time and place convenient for you. The researcher will want to hear about your experience in your own words: your thoughts, feelings and views about what happened. Everyone who takes part is given £20 as a thank you for giving up their time.

Everything that is discussed in the interview remains confidential. As with all NatCen's research, confidentiality would only ever be broken where people are in situations of extreme and immediate harm or are being harmed and are unable to act to protect themselves. At the end of the study, a report will be written about the sorts of issues raised by people in the interviews, but without identifying any individuals.

NatCen has been asked to carry out this study by the Department of Health and charities. Very little research has been done into what kinds of difficulties or problems face older people from black and minority ethnic groups in particular. It is important to gather evidence about the experiences of older people in order to devise policies and strategies for helping and supporting those who are being abused.

Taking part in the interview is voluntary so you do not have to agree to take part. If you do agree, you can change your mind at any time. No-one will try to persuade you to take part if you do not want to. If you think you might be interested, we will ask one of the research team to contact you and talk to you directly (through an interpreter if necessary) about what is involved, and you can then think about whether you want to do it or not.

APPENDIX C OLDER PEOPLE'S REFERENCE GROUP INFORMATION

Invitation letter to members of Older People's Reference Group

Dear

We are writing to invite you to join a reference group for a research project on the mistreatment or neglect of older people. King's College London and the National Centre for Social Research (NatCen) have been awarded a grant by the Charity Comic Relief to study the national prevalence of elder abuse. The Department of Health have contributed to Comic Relief as part of this. The research is challenging but we are very committed to improving knowledge, and through knowledge, services, to address this social problem.

We are asking you to help us in this task by joining an Older People's Reference Group. This will be a group of older people (not academics or professionals) who have broad experiences and interests and would be willing to help us by acting as a sounding board for the project – looking at interview questions, helping us to think about the responses we get and helping us to make our findings accessible and useful. The group will meet four times during the course of the study (August 2005 – Spring 2007). Outside the meetings we hope members of the group will comment and advise on specific issues but this will not be onerous.

We will meet reasonable travel expenses and will pay you a fee of £75 for coming to each meeting. You will be able to contact us by email or Freepost address. We hope that members of the group will volunteer to chair the group, perhaps on a rotating basis.

This project covers the UK and so this will be a group from a variety of locations! We hope that we can make meeting times convenient and will plan these well in advance. While we do not think London is a superior venue, we think it may be easier for everyone but if other places would be preferred please let us know.

We plan to hold the first meeting on 6th October at King's College London (Waterloo) and will circulate advance details of the proposed research. If you would like to join us in this exciting new project we would warmly welcome your interest. Please complete the attached form so we have your details and please let us know if the proposed first date is convenient. And, if you have any queries or comments please do not hesitate to contact me.

National Elder Abuse Study
Older People's Reference Group
Terms of Reference

The Role of the Reference Group:

The role of the reference group is regarded as an active partnership between the group members and researchers throughout the study. The group provides an opportunity for older people with varied experience to contribute to and influence the research through:

- Bringing together the views and opinions of people with different experiences who encounter (or may encounter) possible abuse of older people.
- Highlighting and advocating any issues that older people may identify which may relate to gender, ethnicity, culture, sexual orientation or age.
- Offering advice on the proposed research methods from the older people's expertise by experience.
- Sharing ideas and information while ensuring the confidentiality of the research and any other information shared by the researchers or other members of the group.
- Commenting on any findings and outputs, and making suggestions about the dissemination of the research.

The research team will ensure the following:

- Research questions, methodology, analysis and findings are explained and summarised in a clear, jargon-free and concise manner.
- Information will be written in an accessible format.
- Members of the group to be kept up to date with progress of the research and provided with summary documents if possible.
- Members' views and suggestions will be valued.

Members of the group

Older people have been invited to join the advisory group and they reflect a variety of experiences, locations and interests.

- Alan Mitchell
- Christiana P. Wilcock
- Dorothy Runnicles
- Jenny Thomas
- Mair Evans
- Mr Mohamed
- Alsam Khan Lodhi
- Noreen E. Haselden
- Pauline Weinstein
- Peggy Redfern
- Phillip Rapaport
- Tony Beresford
- Wesley Dowridge

Frequency and duration of meetings

The group will meet four times and each meeting will usually last for around three hours. After consulting the group members the majority agreed that meeting in London is more accessible. Meetings are arranged by the Social Care Workforce Research Unit, King's College London on behalf of the research team.

For further information please contact:
Janet Robinson
Administrator
Social Care Workforce Research Unit
King's College London
Franklin Wilkins Building
150 Stamford Street
London SE1 9NH

Tel: 020 7848 3752
Fax: 020 7848 3700
Email: janet.j.robinson@kcl.ac.uk

APPENDIX D TOPIC GUIDES

Topic guide for older people

Growing Older: Life Experiences & Wellbeing

Research Objectives

The purpose of the overall research study, of which these qualitative interviews form one part, is to measure the prevalence of abuse experienced by people aged 65 and above, and explore in depth what the experiences of people in these abusive situations have been.

These depth interviews are the element of the study which explore the experiences of older people who have been abused in one of the following five ways: physically; psychologically; financially; sexually or through neglect.

There are three key research objectives: to explore,

- the impact of the abuse
- barriers and facilitators to taking action, (e.g. telling someone)
- strategies and coping mechanisms in the face of abuse

NB: Researchers to be sensitive to respondents' needs throughout. The topic guide is structured to allow for regular breaks. The final section aims to move respondents away from specific incidents and impacts to more general material in order to achieve appropriate closure. In addition, time will be spent with the respondent after the interview providing information about different forms of support.
Given the sensitive and personal nature of the topics being discussed, if interrupted, the researcher will pause the interview and explain the importance of interviews being confidential and conducted with only the researcher and respondent present. The researcher will resume the interview once they are alone again with the respondent.

1. Introduction and consent

***Aim**: to introduce the research, clarify the content of the interview, explain confidentiality and gain verbal consent. In discussing the interview content, researchers should not use the phrase 'elder abuse', but rather talk specifically about the experiences reported by the respondent (e.g.: being shouted at etc). This section reiterates the information provided to the respondent during recruitment.*

Introduction

- Introduce self, NatCen
- Introduce research
- Participation is voluntary: respondent can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances *(confidential unless individual faces extreme and immediate harm or is being harmed and unable to act for self)*
- Recording *(to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)*
- Length (*about an hour with breaks – however breaks and timings are flexible*)
- Nature of discussion (*conversational in style with specific topics to be addressed, following up information given in survey*)
- Place of interview (*need for private space to conduct the interview*)

- Interruptions (*due to the personal nature of the topics covered in the interview)*
- Reporting and data storage issues *(no-one identified in report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets; don't have people's names on them, not shared with anyone outside of team)*
- Address any questions

Consent

Turn on digital recorder and explain need to get their verbal consent on tape as a record. E.g.: 'I need to briefly repeat the information I have just given as a record that you are happy to take part in this research. Can you just confirm that:

- I've explained the content and purpose of the study, how long it will last, what issues I'll be talking to you about and confidentiality arrangements.
- Do you have any questions about any of that?
- Are you happy to take part and continue with the interview?'

- this research is about older people's well-being and life experiences and, in particular, we plan to talk about the incidents that you raised in the survey interview about XXXX;
- the interview will be about an hour or so long but we can stop or take a break any time you like;
- we will record the interview so that we know exactly what you said and don't have to remember or take notes, but only the research team will listen to it;
- findings will be reported in a way that maintains confidentiality with no individual being identified in the report;
- only if you are at risk of extreme and immediate harm or are being harmed and can't act to protect yourself would we consider telling someone anything you have told us, otherwise everything is completely confidential;
- we have to conduct the interview in a private place and if we are interrupted by anyone we will pause the interview and explain that we can't continue the interview with another person present;
- Do you have any questions about any of that?
- *Are you happy to take part and continue with the interview?'*

2. <u>Current circumstances</u>

<u>Aim</u>*: to gain background information about the respondent's life, exploring their living circumstances and family as well as wider social networks. NB acknowledge this was covered in survey but really useful to get overview/bit more detail/check accuracy*

- Age
- Living arrangements
  - where living and whether alone or with others (*explore any recent changes to living arrangements)*
  - housing tenure (*own home, supported housing, etc.*)
  - how long lived there
  - where lived before
- Relationship status: (*married, single, widowed, divorced)*

- Wider family: if have relatives
  - where living
  - level of contact
  - any caring responsibilities for family (*children/grandchildren; spouse, others)*
- Social activities: *explore nature and frequency of attendance/ contact*
  - hobbies and activities (*organisation / club / community involvement)*
  - anyone else seen regularly / in contact with (*e.g.: friendship networks)*
- Day to day living
  - how often do they go out
  - receipt of any care at home (*carer, district nurse, relative)*
  - details of care received
  - shopping & cleaning *(do they do it themselves, do others help, where do they go, how do they manage the financial side: if others help/if on small budget)*
- Health
  - general perception (*including any recent changes to health status)*
  - medication *(current medication; any issues with taking meds e.g. forgetting, side effects; how they manage repeat prescriptions*)
  - any recent hospital admissions and whether/how this might have affected:
    - finances (*e.g. bills unpaid, someone else collecting pension)*
    - health (*e.g. weight loss, bedsore*)
  - history of mental health problems (*respondent or family)*
  - history of higher than average alcohol consumption *(respondent or family)*

CHECK WITH PARTICIPANT WHETHER NEED TO TAKE A BREAK

3. <u>Experience of abuse</u>

<u>Aim</u>*: to explore and map what abuse respondent has experienced, circumstances surrounding this abuse, understandings of how and why it happened as well as how it made the respondent feel (which is followed up in more depth in following section).*

- Explore experiences of abuse (reported in survey)

  E.g.: 'During the survey, you talked about some difficulties you'd had in your relationship with your husband/wife, when s/he shouted at you/wasn't helping you get dressed. Can you tell me about that?'

  For each experience, probe to find out:

  - What happened
  - When
  - Where
  - Who was involved
  - Was it one-off or ongoing (*if ongoing - when did it start*)
  - Respondent's view of why this abuse happened (e.g., perpetrator motivation. Also, explore dynamics of relationship between perpetrator and respondent as appropriate)
  - How this experience made the respondent feel

- Explore whether respondent has experienced any other kind of abuse since they were 65

  E.g.: 'Are there any other experiences (that have happened since you were 65), that you perhaps didn't mention when interviewed before that you would like to talk about now or that you think are relevant to what we are discussing?'

  Prompt, if appropriate: E.g. : 'Other participants have talked about problems they've had with:

  - people taking money from them
  - people shouting at them/ threatening them
  - people hitting or striking them
  - shopping not done
  - medication not given or over-medication
  - personal care needs ignored
  - people have also told us about having been touched or felt inappropriately in a sexual way, or have been victims of serious sexual assault'.

If other experiences of abuse mentioned, in each case probe to find out:

- What happened
- When
- Where
- Who was involved
- Was it one-off or ongoing *(if ongoing – when did it start)*
- Respondent's view of why this abuse happened
- How this experience made the respondent feel

NB: if respondent has had multiple experiences of abuse, the need to obtain adequate depth may preclude covering all incidents mentioned. In such circumstances, the researcher will need to be led primarily by the respondent as to which experiences it will be appropriate to focus on. In deciding on how many and which incidents to focus on, the researcher will also need to consider how the respondent is coping with the interview as well as wider concerns such as ensuring coverage of different types of abuse across the sample.

CHECK WITH PARTICIPANT WHETHER NEED TO TAKE A BREAK

4. Dealing with abuse

Aim*: explore what happened subsequent to the abuse experienced: details of whether respondent told anyone or took any other action, exploring reasons for doing so/ not doing so and feelings about this.*

- How respondent coped/dealt with situation (psychological/emotional)
  E.g.*, 'How did you cope/deal with that?'*
  - whether coping strategies were built up over lifetime

  e.g. 'Did your life experiences up to that point help you cope?'

  - OR: did respondent feel ill equipped to deal with situation

- Whether respondent did something about the situation (practical)
  - did they tell anyone
  - did they do anything else *(e.g., avoid a particular place, move house, change their financial management arrangements, arrange to have new carer attend them)*

If told someone/ other action taken, explore:

- What action taken
- When

How decision to tell someone/ take other action was made, including any trigger(s)/prompts for acting at that point: *(e.g.: situation getting worse, comment from someone; article in media)*

- Who did respondent tell and why did they tell that person(s)
- Expectations of telling someone/ taking other action
- Outcomes of action
  - what happened as a result (*did situation improve or not)*
  - views of outcomes (*was response appropriate)*
  - any knowledge of what happened to perpetrator and views and feelings about this
  - extent to which these met with expectations
  - what went well/ less well
  - explore any advantages/ disadvantages to actions taken
  - anything which, looking back, could have helped the respondent at that time

If not told anyone/ no other action taken:

- Why respondent did not tell anyone/ take other action
- Any experience of barriers to not taking action (*e.g.: fear, not wanting to upset anyone, lose contact, thinking it was their fault)*
- Explore whether respondent considered telling someone/taking action at any point
  - probe for details of what action was considered & why
  - reasons for not acting

- Reflection on not telling anyone or doing anything else about the abuse: would they do anything differently if something similar happened again or not, exploring reasons fully
- Explore any perceived advantages/ disadvantages of not telling anyone/ taking other action

CHECK WITH PARTICIPANT WHETHER NEED TO TAKE A BREAK

5. <u>Impacts</u>

<u>Aim</u>: explore respondent's perception of the impact of the abuse on different aspects of their lives, both tangible/measurable impacts as well as psychological or emotional. NB: abuse may have been happening over long period, tailor questions accordingly

- Respondent's perception of impact of abuse experienced

  E.g.*: 'What effect has this had on you….?'*

  Give respondent opportunity to respond to open question about impacts before going on to probe as necessary. Throughout this section, acknowledge response given to survey questions on impacts & use as prompts as appropriate.

- Probe for impacts on respondent's:
  - Health
  - Self esteem and self image
    E.g.*: 'Do you feel differently about yourself in any way since xxx?'*
  - Social and family relationships/ networks (*e.g.*, *relationships with family/spouse; friends; neighbours; carers/professionals)*
  - Perception of/attitude to relatives and/or services
  - Social activities
  - Level of independence
  - Ability to cope
  - Perception of/attitude towards independence
  - Any change to respondent's ability to perform activities of daily living before and after the abuse (*eg: going shopping, travelling on public transport)*
  - Financial circumstances
  - Feelings about/ trust in service providers
  - Feelings about/ trust in other people

  For each of the above, explore:
  - the nature of the impact
  - extent to which respondent views the impact as significant or not and reasons why
  - any change over time in the way these impacts have been experienced: *(improvement/worsening/no change)* and reasons why

5a) <u>Comparing different experiences of abuse if appropriate</u>

♦ If respondent has had experience of ***multiple*** forms of abuse at same/similar time of life after 65, explore:
  - any difference in dealing/coping with the different types of abuse

E.g. 'You talked about having had problems with your husband at the same time as your grandson was taking money from you. Did/do you feel differently about these two experiences?' Prompt if necessary:

- *more/less serious/upsetting;*
- *whether one had bigger impact on than other(s)*

  - if so, reasons why
  - if not, explore why not

♦ If respondent has experienced ***different types of abuse*** at ***different life stages***, *e.g. physically abused at age 65/ financially abused aged 75*, explore:
  - any change in the way they dealt with these experiences

E.g. 'Did you react/feel differently when you had these different experiences?'

  - if so: reasons why
  - if not, explore why not
  - whether difference in age has made these experiences easier or more difficult to deal with and why/why not

E.g. 'Do you think being younger when *[xxxxxxxxx the first experience]* happened made it easier or harder to cope with than the second? Why/why not?'

- If respondent has experienced ***same type of abuse*** at ***different life stages***, *e.g. sexually abused in twenties then again in seventies,* explore:
  - any difference in how they felt about these different experiences and reasons why
  - whether difference in age has made this experience easier or more difficult to deal with and why

    E.g. 'Do you think being younger when [xxxxxxxxx the first experience] happened made it easier or harder to cope with than the second? Why/why not?*'*

6. Advice and support

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Aim*: it will be important to end the interview having moved away from specific incidents and impacts experienced by the respondent to more general material in order to achieve an appropriate closure. Also, to explore views of sources of potential support.*

- Advice respondent would give to someone in similar situation (*including things they should do and things to be wary of,*)

- Explore what (advice/support) would be available in an ideal world

- Explore whether there is help or support that respondent thinks could help people in these situations.
  Probe (covering both practical and emotional forms of help):
  - someone to talk to:
  - confidential phone line
  - social worker, nurse, GP, carer
  - relative/friend
  - information/support to manage finances *(following change of circumstances, eg: death of spouse)*
  - respite or day care
- Any other suggestions of support/advice

- Any other comments, questions

End of interview. Thank respondent and close interview.

Following the interview, researchers will go through the contact card with respondents explaining what the different organisations do and how they might be able to help. Researchers to initiate contact with organisations if respondent requests assistance.

Tell respondent that they are welcome to contact members of the research team to ask questions about the research at a later date if they wish.

Seek permission to re-contact

Leave respondent with the following *NB: some might not want any contact details left, check with respondent*:

- **Incentive payment;**
- **Contact card for local services and support organisations; and**
- **Contact details for researchers.**

APPENDIX E INFORMATION CARDS

England

NatCen
National Centre for Social Research

Growing Older: Life Experiences and Wellbeing

Some useful numbers:

NHS Direct: 0845 46 47
Help The Aged: 0808 800 6565
Age Concern: 0800 00 99 66
AEA Helpline: 0808 808 8141

Pension Service: 0845 60 60 265
Nuisance call advice: 0800 661 441
Carers Line: 0808 808 7777
Lifelong Learning: 0870 757 7890

NatCen
National Centre for Social Research

The National Centre for Social Research
35 Northampton Square
London EC1V 0AX
Website: www.natcen.ac.uk

Scotland

Scottish Centre for Social Research

Growing Older: Life Experiences and Wellbeing

Some useful numbers:

NHS Direct: 08454 24 24 24
Help The Aged: 0808 800 6565
Age Concern: 0800 00 99 66
AEA Helpline: 0808 808 8141

Pension Service: 0845 60 60 265
Nuisance call advice: 0800 661 441
Carers Line: 0808 808 7777
Lifelong Learning: 0870 757 7890

Scottish Centre for Social Research

The Scottish Centre for Social Research
5 Leamington Terrace
Edinburgh EH10 4JW
Website: www.scotcen.org.uk

Wales

NatCen
National Centre for Social Research

Growing Older: Life Experiences and Wellbeing

Some useful numbers:

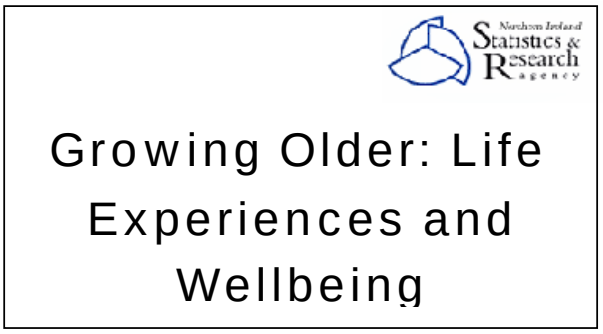
NHS Direct: 0845 46 47
Help The Aged: 0808 800 6565
Age Concern: 0800 00 99 66
AEA Helpline: 0808 808 8141

Pension Service: 0845 60 60 275
Nuisance call advice: 0800 661 441
Carers Line: 0808 808 7777
Lifelong Learning: 0870 757 7890

NatCen
National Centre for Social Research

The National Centre for Social Research
35 Northampton Square
London EC1V 0AX
Website: www.natcen.ac.uk

Northern Ireland



Some useful numbers:

Help The Aged: 0808 808 75 75
Age Concern: 0800 00 99 66
Shelterline: 0808 800 4444
AEA Helpline: 0808 808 8141

Pension Service: 0845 60 60 265
Nuisance call advice: 0800 661 441
Carers Line: 0808 808 7777
Lifelong Learning: 0870 757 7890

Central Survey Unit
Northern Ireland Statistics & Research Agency
McAuley House, 2-14 Castle Street
Belfast BT1 1SY
Website: www.csu.nisra.gov.uk

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