School of Nursing

Articulating and ameliorating elder abuse in Australia

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ABSTRACT

The abuse of older people is a largely unrecognised and under acknowledged social problem in Australia. My major objective in undertaking the work, which is represented by the original published articles that comprise the thesis, was to make a scholarly and practical contribution toward the minimisation of elder abuse. This objective was achieved with the development and implementation of a series of studies that articulated and ameliorated elder abuse in Australia.

The thesis provides an erudite synthesis of these studies, which fall into four themes that illustrate the nature and scope of my theoretical and professional work in elder abuse. Much of the work was guided by a conceptual framework of ways of knowing in nursing, and was underpinned by the principles and practice of community development and participatory community-based action processes.

The outcomes of these studies include work with three stakeholder groups: professionals who deal with elder abuse, older people who are victims or potential victims of abuse, and those who perpetrate abuse on an older person. The work, illustrated in the four themes, includes

- the articulation of elder abuse issues with West Australian aged care workers
- the development of elder abuse protocols, policy guidelines and ethical principles, to guide professional practice in abuse prevention and intervention
- the design and implementation of participative community programs to empower older people, and their carers, to resist being abused or abusing and to assist perpetrators stop their abuse
- the amelioration of abuse of nursing home residents by staff

The thesis situates my conceptual and clinical effort within the wider corpus of Australian knowledge and practice on elder abuse and contributes to addressing the social problem of elder abuse within the context of Australian aged care.

ACKNOWLEDGEMENTS

FIGURE

CHAPTER ONE

INTRODUCTION

Elder abuse has probably been a social issue since our earliest forebears reached old age. There are certainly records of ageism, intergenerational conflict and negative behaviours toward older people throughout history, especially in western nations during the post industrial centuries (Stearns, 1986). During the latter half of the twentieth century reports and early research studies of elder abuse were published, mainly in western industrial countries such as the United States (US), the United Kingdom (UK) and Canada. However, elder abuse is not confined to these nations and a review of abuse around the world concluded there is a growing awareness that elder abuse is not isolated to any particular area of the globe but is a significant issue in most countries (Kosberg & Garcia, 1995a).

This thesis provides a scholarly synthesis of a series of original published works that deal with articulating and ameliorating the abuse of older people in Australia. It describes innovations undertaken systematically to deal with elder abuse through prevention and intervention strategies in community and residential aged care. The body of published work has contributed significantly to both conceptual development and professional practice in the field of elder abuse throughout Western Australia and Australia. The work has been recognised by an Anzac Fellowship to study aged care and elder abuse in New Zealand, the Aged Care Australia National Meritorious Service Individual Award for work in elder abuse, a National Government Violence Prevention Award, and a Nurses Board of Western Australia Motivation and Innovation Award. Awards have been received for work that includes a significant component of elder abuse, such as the Best Practice in Local Government Innovation Award for our Health and Wellness Program conducted with the City of Subiaco, and a Curtin Alumni Medal that included recognition for community work with older people and elder abuse.

The Abuse of Older People

The thesis concerns the abuse of older people and a first step to allowing discussion of the topic requires the clarification and definition of the concept of elder abuse. Complex concepts such as abuse defy simple definition yet it is necessary to establish what is being referred to in the thesis. With multiple contributing factors and manifestations of abuse, it is difficult to identify causes or to set the parameters of exactly what constitutes abuse (McDermott, 1993). The same difficulties of definition also apply to the concept of elder abuse (Kingsley, 2001a). Nevertheless elder abuse is generally accepted to involve some form of harm caused to an older person by someone they know and with whom they share a relationship that involves a level of trust (Australian Network for the Prevention of Elder Abuse, 1999; Kingsley, 1993, 2000a). This is the general meaning of elder abuse that will be used throughout the thesis.

However, there are more specific connotations of what constitutes elder abuse and the term has been used to describe a variety of actions and outcomes that include the following

- inadequate, inappropriate, inhuman or abnormal expression of caring
- the misperformance of caring or occupational responsibilities
- active or passive mistreatment (poor care) or maltreatment (bad treatment)
- behaviour that harms or is likely to harm an older person, which results in
- physical, sexual, psychological, social, spiritual, financial harm or neglect
- where the older person's needs for physical and emotional support are either increased or ignored

(Hogstel & Cox Curry, 1999; Hudson, 1989; Kingsley, 1993, 2000a; LaRocco, 1985; Meddaugh, 1993; Payne & Cikovic, 1995; Pillemer & Moore, 1990; Watson, Cesario, Ziemba & McGovern, 1993).

Much elder abuse occurs in the domestic setting where older people live and are harmed by someone with whom they have an ongoing relationship. However, a

small but significant number of older people living in a nursing home also experience resident abuse which is a form of elder abuse that occurs in a distinct place and under particular circumstances (Kingsley, 2000b). In the debate on resident abuse there are also variations in the definition of what constitutes abuse (McCreadie, 1996; Pillemer, 1988), although the term has been used to describe harm caused to a resident by a staff member from whom they have every right to expect safe care (Kingsley). More detailed discussion of the abuse of older people will follow in the review of the literature on elder abuse in Chapter Four.

Early interest in, and a number of the original public reports of elder abuse, arose from the medical profession (Burston, 1975; Eastman, 1984) where the abuse of older people was seen as a medical issue with emphasis on the symptoms of abuse, the frailty of the victim and the pathology of the abuser. This early medicalisation of elder abuse was similar to what happened in the beginning days of recognising child abuse whereas domestic violence has always been seen as a social issue (Bennett, Kingston & Penhale, 1997). Despite its medical origins elder abuse has more recently been identified as a social problem that requires urgent attention (McCallum, 1993a), and most of the activities to deal with abuse have moved from the doctor's surgery to the arena of community and nursing home staff who deal with people where they live and are generally abused.

Part of the reason for elder abuse being accepted as a social problem more than a medical ailment or gerontological syndrome, revolves around a shift in understanding that now includes societal as well as individual pathological causes for abuse. It is also valid to consider an issue like elder abuse as a social problem on the grounds that it affects a significant number of older people and has the potential to affect more as aged populations increase (Wolf & Pillemer, 1989). With any move to see elder abuse as a social problem there is need for a corresponding shift in emphasis from concentration on the individual characteristics and pathology of victims and abusers to consideration of the interrelational, environmental and socio structural factors that influence abuse.

It is recognised that as knowledge and practice complement each other, the development of new understandings and shifts in patterns of knowing about abuse will, in turn, influence practice initiatives in dealing with elder abuse.

Patterns of Knowing about Elder Abuse

In elder abuse work it is important to acknowledge that this topic encompasses multiple forms of knowledge and patterns of knowing (Kingsley, 2002). Empirical knowledge alone is insufficient to explain or to drive preventive practice in elder abuse, as recognition of the affective and valuing components of knowledge is also necessary. Because elder abuse is an issue that discourages observation and compels involvement, some broader conceptual framework to guide knowledge development and its accompanying professional practice is essential. A seminal nursing framework that has allowed a variety of patterns of knowing in both practice and scholarly work is that provided by Carper (1978).

Carper (1978) identified four patterns of knowing; 'empirics', the science of nursing; 'aesthetics', the art of nursing; the component of 'personal knowledge'; and 'ethics', the moral component of knowledge. Carper's patterns of knowing can be applied to aspects of knowledge and professional work in any field of practice. Her patterns have allowed me to situate my learning experiences and knowledge development within a conceptual framework of ways of knowing.

The field of inquiry in elder abuse must involve not only scholarly knowledge in the traditional empirical sense but also knowledge that stems from ethical, personal and practical understanding and wisdom. Carper argues that the body of knowledge that serves as the rationale for practice "has patterns, forms and structure that serve as horizons of expectations and exemplify characteristic ways of thinking about phenomena" (1978, p. 13). Analysis of the different kinds of knowing by elder abuse practitioners will give them increased understanding of their work and its contribution to abuse prevention and intervention.

No one pattern will be sufficient to deal with elder abuse, nor are the patterns mutually exclusive, rather they are interrelated and interdependent. At the same time all are essential if knowledge and practice are to be situated in reality. If professional practice is to meet the needs of elder abuse victims and perpetrators, it will need to incorporate each of these ways of knowing in dynamic patterns that are arranged and played out according to individual client needs and the context within which the abusive relationship occurs (Kingsley, 2002).

'Empirical knowledge', Carper's (1978) first pattern that arises from scientific inquiry is important because it has the potential to provide systematic explanation and understanding of the empirical world. Empirical inquiry has given a clear understanding that elder abuse is a significant social issue. However, even though current research has not yet allowed the prediction nor the control of abuse, early steps are being made to base conceptual frameworks and models on empirical evidence that can be applied to the theoretical understanding of abuse.

'Aesthetics', which incorporates the more abstract and expressive art form of a discipline, comprises Carper's (1978) second pattern that implies there is much known about abuse that is not necessarily verified by empirical methods. Aesthetic meaning goes beyond scientific explanation to the place where we look past victim or abuser behaviour to perceive what needs or issues are reflected in that behaviour. An outcome of this empathetic interaction is a deeper understanding of the complexity of abusive relationships, which gives rise to creative intervention options that can be implemented to address the abuse.

An essential way of knowing that enables understanding of the meaning and experience of abuse to clients is Carper's (1978) third pattern, 'personal knowledge'. She talks of the 'therapeutic use of self' as a means of viewing both self and the client within a therapeutic relationship of shared interaction and trust. As we strive to know ourselves we will better understand the perceptions and experiences of the other, that is of the elder abuse victim or abuser. Through

reflection and self examination, aged care workers become more sensitive to their client's lived experience of abuse and gain an increased understanding and acceptance of the client's values, needs and expectations. This enhanced awareness allows a more personal relationship with a client and more acceptance of them as unique people who require individual assistance and support.

Moral rights and wrongs form an integral part of Carper's (1978) fourth pattern of knowing, 'ethical knowledge'. With maturity practitioners become more aware of the difficult decisions involved in assessing the motivation and intent of abusers, and in determining whether complex or ambiguous situations actually constitute abuse. In recognising the complex causes and circumstances of elder abuse, professionals can face ethical dilemmas when determining the most appropriate interventions that will address those causes and bring optimal benefit to all involved. Gaining this understanding of what is right for a client gives the practitioner an insight into what ought to be done in a particular case of abuse.

The original application of this approach to knowing to the field of elder abuse is demonstrated throughout the thesis and illustrates that Carper's (1978) patterns of knowing are a legitimate source of knowledge in elder abuse. By working through and reflecting on how these patterns apply to elder abuse practice, it is argued that scholars and practitioners alike will develop a deeper understanding of abuse and an enhanced ability to relate knowledge to practice.

Summary of the Components of the Body of Work

The body of work submitted in the thesis consists of twelve components, ten of which are separated into sections that illustrate four thematic areas of theoretical and clinical work in elder abuse. The first theme revolves around the articulation of the issues of elder abuse in Western Australia; the second includes responses to elder abuse through the development of protocols to guide professional practice, the ethical issues that arise when responding to abuse and an overview

of the professional education that is represented in the submitted articles. The third theme considers community responses to abuse through empowering community education and a perpetrator program to minimise elder abuse. The final theme relates to the issues of institutional care and resident abuse. These themes are briefly outlined below and the scholarly and professional practice related to the works is discussed in further detail in Chapter Two.

A basic philosophy that has underpinned much of the developmental and professional work in dealing with elder abuse is based on the values, process and practice of community development. Community development is a conceptual framework of positive social change that is applicable to work in minimising elder abuse. This chapter from an edited text is included in the thesis to articulate the values of community development that have guided work in elder abuse.

Kingsley, B. (1994). Community development: The challenge of change. In C. Cooney (Ed.), *Primary health care: The way ahead* (pp. 37-60). Melbourne: Prentice Hall.

The body of work has also been influenced and guided by the application of Carper's (1978) framework of knowing to work in elder abuse. The following article briefly illustrates how aspects of the four patterns of knowing can be applied and can contribute to scholarly and clinical work in dealing with abuse.

Kingsley, B. (2002). Patterns of knowing in professional practice in dealing with elder abuse. *Contemporary Nurse, 12*(2), 136-143.

Theme 1. Articulating Elder Abuse in Western Australia

The edited volume *Dealing with elder abuse* reports the first statewide initiative to articulate elder abuse in Western Australia, a state conference for aged care workers involved in elder abuse. My contribution included editing the volume and writing three substantive sections of the proceedings. These comprise a keynote paper on the issues of abuse identification and assessment; the

proceedings of small group activities on dealing with abuse; and the outcomes, conclusions and recommendations for future directions that were developed from the conference. The two latter contributions are submitted as part of the thesis.

From this conference it became clear that elder abuse was considered by aged care workers to be a significant problem that they encountered in their work and which they felt needed to be addressed. The two articles set the scene for early work in this area of practice. The conclusions and recommendations that were developed from the conference had a significant influence in setting the direction of the future activities on elder abuse work within the state of Western Australia.

Kingsley, B. (1992a). Proceedings from small group workshops. In B. Kingsley (Ed.), *Dealing with elder abuse* (pp. 44-55). Perth: Council on the Ageing.

Kingsley, B. (1992b). Conclusions and recommendations. In B. Kingsley (Ed.), *Dealing with elder abuse* (pp. 85-90). Perth: Council on the Ageing.

Theme 2.   *Response to Elder Abuse: Principles and Guidelines for Professional Practice*

One outcome of the state conference was that aged care professionals recognised elder abuse as a significant social and professional issue and they wanted guiding principles and direction to help them identify and intervene in abuse cases. No documents that met their needs could be found in the Australian literature, so the development of the first published Australian protocol on elder abuse fulfilled these initial practitioner requirements for help in intervening in cases of abuse.

Some years later, the residential care industry also recognised the need for similar principles and practice guidelines to assist them in dealing with resident abuse. As a result, a second protocol was developed which contained additional principles, procedures and policy guidelines for preventing and responding to abuse in both community and residential care settings.

Kingsley, B. (Ed.). (1993). *Responding to elder abuse: A protocol for non-government agencies*. Perth: Council on the Ageing.

Kingsley, B. (2000a). Elder abuse: *Protocol and policy guidelines to prevent the abuse of older people in community and residential care*. Perth: Curtin University, Centre for Research into Aged Care Services.

Whilst working with aged care professionals involved in elder abuse, one issue that was constantly raised concerned the ethical decisions and dilemmas they faced when involved in difficult cases. Limited ethical guidelines that related to responding to elder abuse were available in the literature, and to help remedy this situation a series of articles, workshops and conference papers were developed and presented. Submitted are a chapter from an edited text that introduces nurses to the ethical issues related to dealing with cases of suspected elder abuse, and a more recent journal article that raises the awareness of aged care workers to some of the ethical challenges they might encounter when responding to abuse.

Kingsley, B. (1997a). The older client. In G. Hawley (Ed.), *Ethics workbook for nurses* (pp. 181-192). Wentworth Falls, NSW: Social Science Press.

Kingsley, B. (2001b). Elder abuse: Ethical issues in professional practice. *Geriaction, 19*(4), 5-9.

Theme 3. *Response to Elder Abuse: Community Participation and Empowerment*

In response to the recognition of abuse against older people in the community, a series of empowering, learner centred education forums were held throughout Perth. The target audience for these forums included older community members, incorporating those who were possible or actual victims of elder abuse plus carers who were potential or actual abusers. The forums used drama, showing a series of abuse scenarios, to support abusive carers to resist abusing and to empower older people to reduce their vulnerability to being abused. The conceptual frameworks that drove the development of the forums included health promotion, community development, psychodrama and action based learning for problem solving.

Kingsley, B. (in press-a). Community empowerment: Promoting the safety and minimising the abuse of older people. *Journal of Primary Health.*

Kingsley, B. (in press-b). Community education to reduce elder abuse and promote quality of life. *Journal of the Australasian Rehabilitation Nurses Association.*

Community education and empowerment may raise awareness of elder abuse, but the abuse of older people still occurs. To address elder abuse in the community, a unique response program was developed to work directly with perpetrators and two articles are included which examine this program. The first outlines the model that was developed specifically to support and empower abusers to terminate their abuse. The second article reviews the application of the model in the clinical setting and considers some of the lessons learned from the implementation of the program. The outcomes of this program demonstrate that many cases of abuse can be successfully stopped and that the victim and abuser can learn how to build a more harmonious and non abusive relationship.

Kingsley, B., & Johnson, S. (1993a). Resolution through confrontation: Working with the perpetrators of elder abuse. *Australian Journal on Ageing, 12*(4), 20-23.

Kingsley, B., & Johnson, S. (1995a). Resolving elder abuse: Issues arising from a perpetrator program. *Australian Journal on Ageing, 13*(4), 168-171.

Theme 4.   Institutional Care and Resident Abuse

The original scholarly and clinical work in dealing with elder abuse was directed toward issues of community elder abuse. However more recent contributions to the field have raised issues concerning the abuse of nursing home residents by staff members. Over recent years there has been a growing awareness that resident abuse occurs and that a small but significant number of residents are harmed by staff who have a responsibility to ensure the safety of their residents. The work in elder abuse, which has always included nursing homes, was consolidated with the development of these articles and the inclusion of resident

abuse in the second protocol. The conceptual bases that underpin work on both community and residential abuse bear a marked resemblance; they both consider the causes of abuse and the principles that underlie intervention in cases of abuse.

Mott, S., & Kingsley, B. (1999). Challenging behaviours: The issues of quality care. In R. Nay & S. Garratt (Eds.), *Nursing older people: Issues and innovations* (pp. 212-232). Sydney: MacMillan & Petty.

Kingsley, B. (2001a). Resident abuse: An unacceptable reality. *Geriaction, 19*(1), 21-25.

Use of the First Person in the Thesis

The second chapter of the thesis contains an exegesis, which places my contribution to the work on elder abuse within a context of what was happening in Western Australia and Australia during the period covered by the published articles. Because this exegesis, and other segments throughout the thesis, tell of a personal journey in working with elder abuse the 'first person' has been used when referring to personal conceptualisation, learning, work and reflection.

It is "acceptable to write in the first person when giving a personal opinion or when one has played a crucial role in shaping the data or ideas presented" (Webb, 1992, p. 747). Webb suggests that use of the third person is appropriate "when referring to a generally accepted body of knowledge or thinking, and when reviewing a subject in the light of available evidence" (p. 748). However, because the neutral passive voice distances the researcher / writer from their topic and mystifies the personal and social elements of the work, Webb advocates the use of the first person when a personal contribution is being described and evaluated. Similarly, the American Psychological Association says that using third person terms such as 'the experimenter' when the term "refers to yourself is ambiguous and may give the impression that you did not take part in your own research" (1994, p. 29). For these reasons I have used personal terms in this thesis.

Organisation of the Thesis

The thesis comprises this introductory chapter, a background chapter that introduces early Australian and West Australian work on elder abuse and outlines my part in that work, plus a literature review and the submitted body of work.

A brief introduction to the topic of elder abuse is given in Chapter One, which previews the body of work submitted in the thesis. In Chapter Two I introduce the concept of elder abuse and outline the early Australian and West Australian initiatives to address this issue. An exegesis of the components of the body of work conceptually situates my involvement in the development and implementation of elder abuse work, and outlines the contribution this work has made to elder abuse practice at a state and national level. Each of these areas of work is represented by the studies submitted in a subsequent chapter.

In Chapter Three, I highlight the context in which most elder abuse takes place and demonstrate the need to consider contextual and societal issues when considering elder abuse. The chapter reviews the context of Australian aged care since colonisation and especially since World War II. Literature about the history, trends and current directions in aged care that have an impact on older people and their safety and wellbeing is analysed. There is also a critique of the concepts of community, community care and some of the issues of those who give care, plus a discussion of nursing home care, the issue of quality in residential care and issues relating to the staff who give intimate day to day care to residents.

Chapter Four contains the literature review of the abuse of older people. It reports debates about some of the difficulties involved in defining what constitutes abuse and discusses the nature, categories and extent of community and residential abuse. The causative factors that potentiate abuse in the community and residential care settings are compared, and the chapter concludes with a discussion of important elements of elder abuse intervention.

Chapter Five, which is located in the second volume of the thesis, contains the studies that comprise the body of work. Each theme is prefaced by an introduction that outlines the development of the submitted work. Conclusions from the published works are drawn in Chapter Six and recommendations for future scholarly and professional work in elder abuse are made. Finally, the Appendix gives details of the principles and rationale for the participative community based methodology used throughout the development and implementation of the works that comprise the thesis.

Glossary of Terms

Carer: An unpaid person who gives ongoing care to an older person. This term is used throughout the thesis to distinguish a carer from paid agency staff or professional workers who provide care or service to older people

Elder: A neutral or positive term to describe a senior or older person who shares the same citizenship, human, and civil rights as the rest of the adult population and yet who may have special personal and health needs or requirements. In considering elder abuse, the term elder does not signify a specific age group as this could exclude mature people who experience situations such as chronic disease, physical or psychological disability or premature ageing.

Elder Abuse: harm caused to an older person by someone with whom they have an ongoing relationship that implies a level of trust. Also referred to as the abuse of older people or, in some American literature, elder mistreatment. Includes deliberate or unintentional acts that arise from benign or malevolent motives that cause physical, sexual, psychological, social, spiritual, financial harm or neglect.

Home and Community Care: Combined Federal / State program that funds agencies to deliver community care and assist vulnerable people to remain in their own home with optimal levels of independence, dignity and wellbeing.

Nursing Home: A residential care institution that delivers high level personal and health care to residents. Also known as an aged care facility.

Perpetrator: Abuser. One who abuses an older person with whom they share an ongoing relationship or for whom they have a responsibility to give safe care.

Protocol: A set of guidelines, usually based on some conceptual framework and usually includes a set of guiding principles to direct policy formation and clinical practice.

Resident Abuse: A generic term for a form of elder abuse that occurs in a distinct place and under particular circumstances. Describes harm caused to a nursing home resident by a staff member who is mandated to give quality care, and from whom the resident has every right to expect safe care.

Social Problem: A situation or issue that is seen as distressing and requiring action to change the social milieu or causative factors related to the existence of the phenomena.

Staff Abuse: Abuse or harm caused to a staff member by an older person such as a nursing home resident.

Victim: An older person who experiences harm from someone with whom they have an ongoing relationship of trust.

Abbreviations

ABS: Australian Bureau of Statistics

ACAT: Aged Care Assessment Team

AGPS: Australian Government Printing Service

CBAR: Community-based action research

COTA: Council on the Ageing

HACC: Home and Community Care

HDWA: Health Department of Western Australia

NSW: New South Wales

OSI: Office of Seniors Interests

SECDC: South East Community Development Council

UK: United Kingdom

UKCC: United Kingdom Central Council for Nursing, Midwifery and Health Visiting

US: United States

CHAPTER TWO

CONCEPTUAL POSITIONING OF THE BODY OF WORK

The purpose of this chapter is to situate my contribution to elder abuse work at a state and national level in Australia. The chapter introduces some of the early Australian and West Australian initiatives that raised public and professional awareness of elder abuse and which made beginning steps to address this issue. As the chapter unfolds, it will become apparent that there have been a number of parallel streams of development in both my thinking and experience in working with elder abuse. These streams are reflected in the development of elder abuse programs and the direction that activities have taken in this state.

Elder Abuse in Australia

In order to position the body of work, it is necessary to consider elder abuse in Australia, its construction as a social problem and the early steps taken to raise awareness of the issues of elder abuse.

During the 1980s when Australians were writing about the social construction of old age; elder abuse was one of the issues identified in relation to the maturing of the population (Dunn, 1995). A decade or so earlier as the first articles on elder abuse were emerging in the US, Tallman and McGee (1971) suggested that, when deciding whether a social issue was indeed a social problem, there was a need to consider not only the magnitude of the issue but also the interest and passion of those who work with the issue. In Australia, although the magnitude of abuse was unknown, health and social welfare professionals, criminologists and academics "staked a claim on elder abuse" and were passionate about placing the issue, as a social problem, on the agenda for public and government action (Dunn, p. 26).

It must be noted that even though elder abuse issues were raised by aged care professionals and academics rather than by older people, this early professional work has had a major impact on the safety of older people by bringing elder abuse to government and public awareness. In a problem as complex and taboo as elder abuse there was a definite need for professional workers to raise the issue in the public and government arenas thereby giving older people the freedom to speak out, to disclose abuse and to expect support to deal with that abuse.

For example, it was a NSW Welfare Action Group who conducted a 'phone in' on elder abuse, which received a majority of calls about resident abuse and 6% of calls about community abuse that raised awareness of abuse and highlighted the need for action. This type of activity plus a review of how hostel and nursing home residents' rights were ignored, neglected and abused (Ronalds, 1988), inspired governments to address the rights of older people. One example of government's response to protecting the rights and safety of vulnerable older people was the Commonwealth Government Charter of Resident's Rights and Responsibilities (Department of Community Services and Health, 1989).

Similarly, an article by Ferguson (1985), that reviewed the US literature and made recommendations for work to be done in Australia, was a trigger to prompt the Victorian Office of the Public Advocate in 1986 to conduct a one day elder abuse seminar in Melbourne. This seminar led the Victorian Office to take a rare government initiative of carrying out a study of elder abuse and subsequently reporting on the issue (Barron, Cran, Flitcroft, McDermott & Montague, 1990).

In his critical review of the development of elder abuse as an 'innovation' in Australia, Dunn suggests that in the early 1990s Australia followed other countries, especially the US's late 1970s efforts to identify "new social issues" (1995, p. 13). These included the fear of crime, victimization of older people and the abuse of residents in institutions. Dunn found that despite positive initiatives such as protocols and the best efforts of aged care professionals, attempts to raise

awareness of elder abuse were largely ignored by governments. This situation echoes that of the UK where little social or political notice has been taken of early reports that elder abuse is an emerging concern (Bennett et al., 1997).

Significant Early Australian Initiatives in Elder Abuse

When the Victorian Public Advocate's study of the abuse of community older people, *No Innocent Bystanders* (Barron et al., 1990), was published the results were heralded as significant. They also supported the results of a South Australian National Centre for Epidemiology and Population Health and Office for the Commissioner on Ageing study that examined the range of local service providers' experience with elder abuse (McCallum, Matiasz & Graycar, 1990). The third early Australian study that raised the profile of elder abuse involved a retrospective audit of the abuse of clients of an Aged Care Assessment Team (ACAT) at Hornsby Ku-ring-gai's Geriatric and Rehabilitation Service (Kurrle, Sadler & Cameron, 1991).

These three studies were widely reported and helped define the Australian situation with regard to elder abuse. Given that this early research originated from credible government, epidemiological and medical agencies, their conclusions that elder abuse was a significant social problem were accepted and raised government, public and professional awareness of elder abuse in Australia.

During the early 1990s, aged care workers, policy makers, academics and health workers around Australia frequently raised the issue of elder abuse. Community and government service agencies and senior's organisations in Western Australia, New South Wales (NSW), Queensland, South Australia and Victoria, began to develop programs, protocols and policies to address elder abuse. Meanwhile the Federal Government concentrated on what it called its aged care reforms and chose to absorb elder abuse within existing structures and policies rather than develop specific new structures to deal with elder abuse (Dunn, 1995).

Significant Early West Australian Initiatives in Elder Abuse

Many of the initiatives on the eastern seaboard were also significant for the local situation and this section outlines West Australian initiatives to address elder abuse. These initiatives are recounted to illustrate professional activities and to trace the cognitive development and theoretical underpinning of my approach to elder abuse. This work has had a particular impact on the direction of efforts to address the issues relating to elder abuse in Western Australia. The work includes interventions to deal with actual cases of abuse and an important component of prevention. Prevention to minimise abuse is an ideal strategy to enhance personal safety and to reduce vulnerability to being abused (Washington Criminal Justice Services Department, n.d.). Prevention includes developing policies and protocols to deal with abuse (McCallum, 1992), programs with abusers to terminate their abuse (Gibb, 1998) and professional and community education for workers, older people and carers (Capezuti & Siegler, 1996; Tonks & Bennett, 1999).

The next section includes examples of the above preventive strategies including the development of two protocols (Kingsley, 1993, 2000a), the development of a model for a perpetrator program, (Kingsley & Johnson, 1993a, 1995a), and professional education programs on abuse (Kingsley, 1992a, 1992b, 1992c). Prevention also included empowering community education to raise awareness of and minimise the incidence of elder abuse (Kingsley, in press-a, in press-b). The first recorded formal professional activities related to dealing with elder abuse in Western Australia commenced in the late 1980s and early 1990s, a period when the first research studies were being undertaken in other states.

Early Beginnings

Over a period of more than ten years there has been both theoretical and practical involvement in the early direction setting activities in elder abuse throughout Australia. This journey commenced with local activities in Perth during the early 1990s and then moved to a wider context of involvement and influence within

this state and around Australia. As patterns of knowing developed and evolved, professional involvement in the field also evolved and underwent considerable development and expansion in not only clinical practice but also in the areas of empirical, aesthetic, personal and ethical knowledge (Carper, 1978).

While no research studies were reported in Western Australia during the 1980s, anecdotal evidence of elder abuse was emerging. Some of us who worked with older people were seeing cases of abuse first hand. However, few had the skills or knowledge to correctly identify all the complex causes of these cases, nor were the necessary resources to deal with each case available. Others were becoming interested in elder abuse and it was raised as an issue in 1988-9 at the South East Community Development Council (SECDC) of which I was chairperson, and in SECDC's Committee for Aged and Disabled, of which I was also chairperson.

At this time a small number of community workers had become aware of the potential for abuse in many home situations. Whether abuse was on the increase or whether, with the increased provision of community care, more workers were entering people's homes and observing abuse that may have always been present was not clear. Nevertheless, some of us joined forces in an attempt to tackle this problem by acting to promote the safety and wellbeing of these clients.

There was little Australian literature on violence against older people at this time but much on domestic violence with which elder abuse shares some similarities. Domestic violence counsellor Ian Macdonald said many Australian professionals were caught in a "complex pattern of denial which surrounds the issue. We do not ask the right questions or pick up the classic signs" (1988, p. 1). I felt a similar pattern applied to the recognition of elder abuse. If we do not ask the confronting questions, if we deny that elder abuse occurs or we refuse to accept that some behaviours are abusive, there is a risk that we will underestimate the significance of the problem and fail to see how much harm is being perpetrated on older clients.

On occasions I had suspected that a client experienced abuse in one or more of their relationships, but from ignorance had either done nothing or had responded with actions that were not always the most appropriate to the situation, the victim or the abuser. When we do not know how to handle a difficult situation it is easy to say that it is someone else's responsibility to deal with it. However, if we deny or ill define our responsibility to confront abuse and expect others to respond to cases, then there is a grave risk that much abuse will be ignored. It was astounding to read where the Washington Criminal Justice Services Department (n.d.) found only 20% of abuse cases received professional treatment, an alarming figure that demonstrated the hidden nature of elder abuse and showed the dangers of waiting for someone else to deal with the issue. I certainly did not want this situation to occur in my practice even though I felt I was doing the best possible work with limited time, resources and skills in dealing with elder abuse.

Basically, what I was doing during this period of practice and reflection was developing personal knowing (Carper, 1978) by confronting my own values about ageing, aged care, and elder abuse. Working with older people had made me confront my own mortality, now I had to confront my real feelings about working with old people, about who should be responsible for their care, about what is acceptable behaviour and what is abuse and what ought to be done about elder abuse. If this work was to be effective I had to accept a moral responsibility that I could not be a passive observer but had an obligation to make the hard decisions and to confront the difficult and often unpleasant tasks involved with elder abuse. Each practitioner will have to work through some similar process of reflection and development of personal and ethical ways of knowing if they are to become fully committed to working in this area of practice.

During 1989-1990 members of the SECDC received a small grant, developed an *Elder Abuse Workshop Kit* (SECDC, 1989) and we conducted programs for community and aged care workers. The professional workshops were hosted by the Aged and Community Services Department of the City of Gosnells and

implementing the concept of community participation and participatory research through consultative work with older people on the issue of elder abuse. Also, for those of us who had the ideas of how to commence tackling this issue but did not have the organisational support to do so, belonging to an organisation with an existing supportive and administrative infrastructure seemed to be a logical idea.

From these early beginnings, conceptual and practical work in dealing with elder abuse continued to grow and develop. The following section examines the body of published work, submitted as part of the thesis, which gives some details of my ongoing contribution toward initiatives to address the abuse of older people.

Themes of the Body of Work

The major outcome of early elder abuse activities was to highlight the need for consolidated scholarly work and innovative professional practice in dealing with elder abuse. The issue had been accepted as a significant social problem that required action and these early beginnings helped set the agenda and direct further action on this issue within Western Australia. Ten of the twleve components of the body of work submitted in the thesis are subsumed within four broad themes that relate to various areas and phases of the work in elder abuse. Each theme represents an area of both conceptual and clinical work and details the contribution made to this specialist area of professional practice.

Theme 1.   Articulating Elder Abuse in Western Australia

When the COTA Steering Committee first convened two factors were quickly recognised; first, elder abuse was a significant issue that required action and second, there was little information and few resources to help workers respond to abuse. It seemed logical that any first steps should include the theoretical and practical education of those who would be working with victims and abusers when responding to cases of abuse. The first major task carried out by the Steering Committee was to conduct a statewide conference on elder abuse in

1992. Conference participants included aged care professionals in the non government and government community service and institutional care sectors, in acute hospitals, government departments and peak organisations around the state.

This conference was working on a number of levels. First, it aimed to articulate how participants perceived elder abuse and whether they experienced abuse in their practice as a significant issue or a rare occurrence. Analysis of conference proceedings and outcomes endorsed this first level of activity and demonstrated that participants did recognise elder abuse as a significant issue in their work. I was aware of the literature (e.g. Bookin & Dunkle, 1985), which accused professionals of not understanding the parameters of elder abuse and of being unwilling or unable to identify or confront abuse and abusers. It seemed important to establish whether or not these front line workers would acknowledge elder abuse as an issue and a significant problem in their work. Most people will only be prepared to spend valuable time and intellectual energy to participate and learn about an issue and how to deal with it, if they see the issue as 'real' and of significant value to warrant their attention.

Second, was the educative and conceptual level of raising professional awareness of the issues of elder abuse and enunciating what it is, why it happens and what can be done about the issue. It was accepted that workers fail to identify or act on abuse because they are confused or misunderstand what abuse is; they judge what constitutes abuse according to the cultural influences that operate in their own family, social or professional systems, systems which often accept force as a legitimate means of punishment, control or conflict resolution (Bookin & Dunkle, 1985). At the second level, the conference addressed this situation; presenters gave accurate current information about elder abuse and attempted to confront some of issues relating to professional attitudes towards older people and abuse.

The third level was a practical level of finding out what local aged care workers needed to help them deal with abuse. Before any philosophical base or model of

action for working with elder abuse could be developed, it was important to know both how the workers who would be responding to cases perceived the issue, and to establish any practical requirements they had for dealing with the problem. Through analysing their stated needs I began to consolidate and strengthen my own understanding of the issues surrounding abuse and how individual cases could be identified and interventions planned and implemented. My editorial role in compiling the proceedings from the small group workshops (Kingsley, 1992a), in drawing conclusions from the conference and in proposing future recommendations (Kingsley, 1992b) was subsequently pivotal in identifying the key concepts of elder abuse for West Australian conditions.

The conference conclusions and recommendations had a significant influence on elder abuse activities in this state. Around this time, Meddaugh (1993) suggested that when agencies have no prevention or intervention protocols it is timely to identify how to help staff recognise and prevent elder abuse. The third level of conference activity validated Meddaugh's comments, few agencies had protocols and practitioners wanted help in dealing with abuse, so the development of guidelines was an important next step for action. The conceptualisation and the practical outcomes of this conference had a major influence on the understanding of abuse and the subsequent direction of professional work in Western Australia.

Theme 2. *Response to Elder Abuse: Principles and Guidelines for Professional Practice*

Once elder abuse was recognised as a significant issue worthy of concentrated attention, it was important to conceptualise and develop response principles and guidelines to help workers deal with the issue. One response that seemed to be immediately required involved giving aged care workers some professional guidelines on how to identify, assess and intervene in cases of abuse. This first step, as requested by community practitioners, constituted the development of an elder abuse protocol to guide professional practice with assessment, response and intervention strategies to either prevent or terminate cases of elder abuse.

Elder abuse protocols for responding to elder abuse

The importance of giving agencies practical guidelines to help staff recognise and prevent elder abuse (Meddaugh, 1993) was kept in mind when planning the elder abuse protocol *Responding to elder abuse: A protocol for non government agencies* (Kingsley, 1993). In developing this protocol the emphasis was on the abuse of older people in the community. Even though many abuse reports arose from the residential care sector (Downing, 1986; Pillemer, 1988), the first local calls for assistance had arisen from the community sector and so a protocol was developed, under the auspice of the COTA Steering Committee on Elder Abuse, to work with community elder abuse. Although many of the principles and strategies in this document applied to resident abuse, my early emphasis was on community abuse. Similarly, although the protocol was also relevant to workers in government agencies (Department of Human Services and Health, 1994), it was directed mainly at the non government sector of community aged care.

The development of the first protocol explicitly reflected my professional framework for dealing with elder abuse in the areas of the

- identification of principles that underpin how elder abuse is conceptualised and responded to
- development of professional awareness, skill and willingness to confront and respond to elder abuse
- recognition and identification of abuse
- case assessment, planning and intervention plus evaluation of the process and outcomes of professional intervention in cases of abuse
- framing of ethical questions and issues in responding to elder abuse
- outlining of proactive interventions to empower older people to reduce their vulnerability to elder abuse.

Even though this protocol met many needs of community practitioners there was little available that met the specific needs of the residential sector of aged care. Over the years there had been a growing awareness that resident abuse was also

an issue that needed to be acknowledged and addressed. With extensive experience in nursing home work, and following conferences and meetings with nursing home personnel there was a move to raise the issues of resident abuse. During this time, as many in residential care had become more aware of resident abuse, managers began to request help to either address this issue in their home or to work with staff to help their home become or remain abuse free. These changing attitudes contributed to the conceptualisation of the second elder abuse protocol that included the issues of abuse in both community and residential care.

The second protocol *Elder abuse: Protocol and policy guidelines to prevent the abuse of older people in community and residential care* (Kingsley, 2000a) reflected developing professional knowing about abuse. The original document included material about the issues surrounding abuse for an audience with a self confessed lack of knowledge on the topic. Acknowledgement of the development of professional understanding of and experience with elder abuse in the intervening years is evident in this document. The expectations and requirements of practitioners had developed over time and these were addressed in the protocol that gave guidelines to assist agencies to develop and implement their own policies and procedures for abuse prevention and intervention.

As each case of abuse is unique, it was recognised that each agency will have unique requirements for policy and procedural guidelines. These may differ according to the nature of services provided by the agency, the type of clients and the location of the agency, whether it is in an urban, rural or remote area. To test the protocol's application in a variety of settings, a draft was sent to agencies around the state who trialled the protocol and used the policy guidelines to develop and implement their own agency policies. It was rewarding that a great deal of positive feedback regarding the utility of the protocol was received. To deal with the possible differences in organisational requirements, the protocol gave a series of generic suggestions each agency was invited to take and adapt to meet their own needs.

Comparison of the two protocols shows my personal and professional growth in conceptual thinking and analysis of elder abuse. Ongoing study, casework and interaction with others involved in elder abuse work deepened my understanding of abuse and widened my comprehension of the issues surrounding abuse. Ongoing experience heightened my awareness of the myriad of social, contextual and interpersonal factors that can influence abusive relationships and behaviours. It also made me more aware of the numerous societal, environmental, client and abuser factors and the practical, ethical and social issues that must be taken into account when any worker or agency is planning case assessment and intervention.

One significant difference between the two protocols was that the first was requested by community workers but was driven by community professionals from non government agencies, government departments and peak bodies. The second protocol however, was requested, driven, critiqued and trialled by practitioners who were directly involved in aged care (Kingsley, 2001c).

The guiding principles and preventive interventions in both protocols have assisted practitioners and agencies in Western Australia and throughout Australia to respond to and intervene in cases of elder abuse. Reflection on the process and outcomes of casework will allow the development of personal knowledge (Carper, 1978) of both abusers and their victims. Similarly, the implementation of creative and appropriate professional interventions reflect Carper's aesthetic pattern of knowing and will help minimise the incidence of abuse.

There have been significant outcomes from both protocols which are recognised as forming part of the "valuable resources available to assist in the identification of abuse and the development of organisational policies, procedures and practices" (Brophy, 2001, p. 81). A review of the second protocol called it "an excellent publication", "essential reading" for all involved in aged care, and "an ideal reference book" to help agencies develop their own protocols and procedures for preventing and responding to abuse (Candlin, 2001, pp. 31-32).

As the first of their kind in Australia, each of these protocols has stimulated the conceptualisation and implementation of considerable professional education on abuse that has had the effect of strengthening knowing and understanding of the issue and enhancing professional intervention in dealing with elder abuse.

Ethical issues in responding to elder abuse

From education programs, case work and work with other practitioners, it became clear that there were difficult situations and decisions that confronted workers (Kingsley, 1997a). These difficulties, which centred on the problematic decisions that practitioners faced, related to Carper's moral component of knowing. Ethical patterns of knowing relate to the moral questions, obligations and choices of right and wrong that have to be made in times of "ambiguity and uncertainty, where the consequences of one's actions are difficult to predict and traditional principles and ethical codes offer no help or seem to result in contradiction" (1978, p. 20).

It was perceived that ethical clinical practice in working with elder abuse required application of Carper's (1978) ethical pattern of knowing; a clear understanding of ethical frameworks, codes and philosophical positions regarding what was good or right; plus a commitment to honour professional values for what ought to be done. Ensuring the appropriate interpretation of and adherence to these rights and values involved Carper's reflection, personal knowledge of the older person and their situation plus creative ways of implementing elder abuse interventions.

It was when the veracity of suspected abuse was unclear or when there were conflicting ideas on interventions, that practitioners faced ethical dilemmas where "the balance between respect for the autonomy of the victim and the desire to act in a beneficent manner often-times results in disagreement and tension" (Simmons & O'Brien, 1999, p. 33). In dealing with abuse, morals embodied 'obligations' and 'oughts' where choices were made and actions chosen according to the professional's understanding of the victim's or abuser's lived experience of abuse, plus their own professional judgements of right and wrong.

The moral codes of professions involved in elder abuse included concepts such as obligations to give quality service, to respect client rights and to promote the safety and wellbeing of the client group. It was important, therefore, to reinforce that the greater the practitioner's potential to influence a vulnerable client's decisions or behaviours or to cause harm to a damaged victim, the greater was their obligation to ensure actions did not cause further harm (Kingsley, 2001b).

Workers faced difficult decisions when faced with elder abuse. Questions would arise as to why some victims would not disclose abuse or give consent for intervention when the experience of being abused was causing obvious distress. Freedom of choice is inherent in client autonomy but there were times when client choices were limited by personal circumstances or external constraints which meant that choices could only be made when the freedom to do so was available (Keenan, 1999) or when freedom of choice did not adversely affect the rights of others (Kerridge, Lowe & McPhee, 1998). A competent older person who experienced abuse had every right to not disclose abuse, or to decline consent for intervention. Yet their situation could reach a point where the professional team felt obliged to intervene, even against the client's wishes, in order to ensure client safety (Kingsley, 1997a). In these situations it was vital that practitioners honoured their responsibility to ensure that beneficence and non maleficence, advocacy and justice, plus the honouring of client rights and the ethical 'oughts' of professional practice, were evident in all their interventions.

The issues of ethical decisions in elder abuse work have become an integral part of education programs and, to further discussion on this topic, workshops and papers have been presented (Kingsley, 1996, 1998a; Kingsley & Johnson, 1993b, 1993c). A chapter in an edited nursing text introduced nurses to some of the ethical ideals related to responding to cases of suspected elder abuse (Kingsley, 1997a). More recently, as they became increasingly involved in working with complex abuse cases, practitioners talked of the difficulties they faced in their

practice. With some of these discussions in mind a recent article was developed to consider the ethical pitfalls of working with elder abuse (Kingsley, 2001b).

Professional education on responding to elder abuse

Tied to professional and ethical responses was a need for professional education on abuse. With protocols distributed and the initial education of professional workers begun, the intervening years were a time of developing, implementing and evaluating the frameworks on which programs with community, hospital and residential care agencies in metropolitan and rural areas were based.

If practitioners were to be sensitised to the needs of victims and abusers and taught the principles of case management, professional education was needed to reach and teach workers. The Australian Society for Geriatric Medicine statement on elder abuse agrees that "all health professionals dealing with the elderly need appropriate education and training programs to enable them to identify cases of elder abuse", similarly, "policies and procedures need to be developed by these agencies for management of these cases, ... and it is therefore recommended that adequate support and counselling be available to these workers" (Kurrle, 1995, p. 172). Education programs are necessary to prepare and support practitioners to recognise and respond appropriately to suspected cases of abuse in community and residential care (Daichman, Wolf, Bennett, Penhale & Podnieks, 1997).

As an educator I have always believed in the power of learner centred problem based experiences where learners are active participants in their own education. To encourage transformative learning, a significant component of professional education has included the empowerment of learners to increase their knowledge, skills and strategies in preventing and intervening in cases of elder abuse.

In the early nineties during the beginning days of professional education a small minority of workers did not feel ethically bound to respond to cases, either because they did not see it as their responsibility to become involved or because

they did not have the agency resources such as time, manpower or support to respond. While these latter factors might have some validity, my observations were consistent with Bookin and Dunkle who observed that many professionals refused to 'see' elder abuse, which they often "couched in fear, denial and secrecy" (1985, p. 11). The decision not to see elder abuse seemed to signify an unwillingness or fear of becoming involved in this difficult and unsupported area of practice. These were moral decisions of what 'ought' to be done about abuse and they reflected the ethical component of knowing as it applies to elder abuse (Carper, 1978). Understanding the motives of these workers was an important factor in conceptualising and designing appropriate education programs.

More recent professional education has introduced interactive drama to add depth to case study presentations and problem solving discussions. The process involved improvisational drama where the director could periodically halt the action, allow the professional audience to discuss the action so far and give directions for the actors to resolve the abuse. This activity allowed audiences to take an active part in their own and each other's learning so that each participant generated and practised new ways of thinking and acting (Brodie, 2001). The dramatisation of abuse scenarios similar to those practitioners confronted in their work allowed them to conceptualise the types and causes of elder abuse, and facilitated new and creative problem solving methods for responding to complex and difficult cases.

However, professional education on elder abuse alone was insufficient, as it was also necessary to educate the next generation of nursing and community aged care practitioners. In one study it was found that less than 10% of sampled Registered Nurses had received any education on elder abuse and only 2 of 173 respondents had had elder abuse included in their nursing education (Pettee, 1997). Programs have been developed and integrated into undergraduate nursing, social work and technical and further education aged care curricula. The development of course materials has accompanied the educational interventions.

However, not only nurses deal with elder abuse and an extension of the work was to conduct multidisciplinary programs to expose other professionals to the issues relating to elder abuse. Through clinical work it also became apparent that abuse was often an extension of long term family conflict and that the topic should be considered when domestic violence was discussed. This issue was addressed at a National Domestic Violence Conference (Kingsley & Johnson, 1996a). Similarly, to raise awareness of violence against seniors, the paradox of power in youth violence against older people was addressed at an Australian Institute of Criminology National Conference (Kingsley & Johnson, 2000).

An overarching aim for professional education has been to promote the safety and wellbeing of older people (Hargrove & Derstine, 2001). Health promotion is "care directed toward high level wellness through processes that encourage alteration of personal habits or the environment in which people live" (Grasser & Craft, 1984, p. 208). This early definition suggested a mix of environmental and personal strategies to achieve client wellbeing, the same strategies professionals were taught and encouraged to use. More recently Pender (1996) reinforced this view that promoting health implies action to enhance personal quality of life in the interaction between the individual and their environment. Again, this idea applies to the prevention of abuse where older people are supported to modify not only their individual behaviour but also any abusive relationships, contexts or environments in order to maintain and promote health and safety.

To further extend professional education on this topic all articles submitted in the thesis illustrate the nature and scope of scholarly work that has contributed to the professional education of practitioners who deal with elder abuse.

Theme 3. ***Response to Elder Abuse: Community Participation and Empowerment***

Empowering community education: A response to prevent elder abuse

During 1994-1995, following the initial professional education that arose from the first protocol, a next step was to consider empowering community education as a further response to abuse. The COTA Steering Committee agreed to hold a series of public forums to raise the awareness of older people, carers and the community to the issues of elder abuse. The underlying philosophy for the forums derived from my professional background and personal belief in the principles of community development (Kingsley, 1994). Although unaware of community-based action research (CBAR) (Stringer, 1996) at the time, in looking back it is evident this program also applied many of the principles of CBAR.

It was believed that participation and empowerment were fundamental aspects of community development (Kingsley, 1994) which, in the case of abuse, result in individual behaviour change to resist abuse, plus community action to prevent abuse and community rejection of abuse as acceptable in society. Community education is one of the most appropriate interventions in dealing with elder abuse (MacLean, 1995) and it was seen as an ideal methodology to incorporate the principles of community participation and empowerment.

The participatory education framework of Paolo Freire (1972) informed the development of these forums. Freire, eminent sociologist and educationalist, saw participative education and problem centred learning as powerful methods of liberating vulnerable people from oppressive and disempowering situations. The forums applied this philosophy to empower vulnerable groups of older people who were at risk of elder abuse. Through empowering community education processes and reality based dramatic experiences, competent participants gained the skills to confront negative situations, and the confidence to either transform their negative environment or to remove themselves from that problem situation.

Throughout the planning stage, focus groups with seniors added to my personal knowledge (Carper, 1978) of older people, their perceptions of elder abuse and the lived experience some had with abuse. The forums, which were largely an outcome of these discussions, were based on a principle of participation where participants were empowered with the skills to recognise and confront oppressive realities and abuse relationships. Empowerment was believed to alter the nature of a senior's relationship with their abuser, and empowerment programs were assumed to support older people to resist the imposition of power by an abuser and so reduce their risk of abuse. These forums aimed to raise community awareness of elder abuse, to support carers to stop their abusing and to empower seniors to reduce their vulnerability to abuse (Kingsley, in press-a, in press-b).

With colleague Susan Johnson a drama format was developed to raise abuse issues and give participants an opportunity to tell their stories and face the reality of abuse. Because drama involves thinking, feelings and actions, it helps people learn creative responses to situations and how to translate learning into action in their relationships (Brodie, 2001). As a process of action learning that reflects real life situations, the drama allowed participants to observe the outcomes of abusive behaviours and encouraged them to use existing life skills or to develop new skills to confront and respond to abuse (Kingsley & Johnson, 1996b).

The conceptual pattern of knowing behind this methodology was the aesthetic concept of art, creative meaning and innovative intervention (Carper, 1978) and the educational philosophy for the drama was action based learning and problem solving (Stringer, 1996). Getting the message across on a sensitive and painful topic like abuse is not easy. However, program evaluations suggested we were successful because we were prepared to talk about a taboo topic, we showed abuse as it happens and offered a safe environment for participants to discuss the issue and to explore new ways of dealing with it. There was an average of four disclosures, either by a victim or abuser at each forum. These figures are representative of Australian figures for elder abuse (Sadler & Kurrle, 1993).

Besides increasing community awareness of elder abuse, these forums also empowered older people and their carers to act in ways that minimise the risk and incidence of elder abuse (Kingsley, in press-a) and so improve their quality of life (Kingsley, in press-b). With participant consent, the dramas from one forum were videoed by an independent television producer and aired on national and state television. Since the forums, community education has continued through community projects, appearances on radio and television and in newspaper articles. The philosophical base that underpinned the forum planning and the dramatic format used to portray the reality of elder abuse offers a successful prototype of community development, education and empowerment that can be adapted to a wide variety of social issues, community audiences and settings.

Elder Abuse Perpetrator Program: A response to terminate elder abuse

Some carers cause harm to the older person with whom they have an ongoing trust relationship, and it was recognised that there were few strategies that dealt directly with perpetrators. To fill this gap another step in responding to elder abuse was taken when Susan Johnson and I developed the Elder Abuse Perpetrator Program. Abusers were often carers, and although not all carers were abusers, some did harm the older person for whose care they bore some responsibility. Evidence suggested much abuse was associated more with the problems of the abuser than of the victim (McCreadie & Tinker, 1993), a suggestion that had implications for elder abuse intervention programs.

The emphasis on victim frailty and carer stress has been a convenient argument that saved professionals from having to confront and deal with the abuse and abusers (Wolf, 1994). Validating Wolf's accusations, previous to the Elder Abuse Perpetrator Program most programs concentrated on the plight of victims and stressed carers (Kingsley & Johnson, 1993a). In contrast, this program dealt directly with abusers. Based on the principle of confrontation and utilising cognitive behavioural techniques the program applied to cases that had not achieved abuser self resolution with supportive community educative measures.

Breckman and Adelman (1988) suggested five interventions were appropriate with abusers; counselling and treatment, respite and assistance, education, law enforcement and courts, and living arrangements. The perpetrator program applied the counselling, treatment and education components and has, on occasions, led perpetrators into the courts. Assistance with respite and living arrangements were addressed where necessary, but they had often been attended to by community service agencies prior to referral into the program.

This perpetrator program was designed to work with abusers. The strategy of confrontation was central to the program that aimed to empower clients with the skills and determination to terminate their abuse. Cognitive behavioural activities were used to guide perpetrators to confront and acknowledge their abusive behaviour. Within a supportive counselling framework clients learned to implement non abusive behaviours and to resolve the causes of their abuse. This program had perpetrators talking about the context of their abusive relationship, about their feelings and emotions and their abusive behaviours; it involved recognition that their actions were abusive and caused harm to the older person.

Once they recognised and admitted their abuse there was an element of recovery in the program, similar to the principles of other programs such as those dealing with people with alcohol problems which educated and supported participants to terminate their undesirable, unacceptable or harmful behaviours (Lithwick, Beaulieu, Gravel & Straka, 1999). With support, clients unlearned abusive behaviours and learned to restructure their cognitive and emotive systems to effect behaviour change, they then learned how to substitute abuse with non harmful behaviours. Finally they were encouraged to identify and work to resolve the underlying causes of their abuse (Kingsley & Johnson, 1993a).

A number of basic principles, which are outlined in the submitted articles, underpinned the development of the theoretical framework for the model that guided the program. This cognitive behavioural model went beyond the typical

behavioural focus of changing observable behaviour whilst disregarding non observable elements such as emotions. It was also important to focus on emotions where abusers confronted their feelings about past and current experiences and relationships, so they could begin to recognise how these experiences were related to their abuse. Similarly, to bring their abuse into focus, it was sometimes necessary to be blunt and ask hard questions like 'he abused you as a child, so how do you feel now the boot is on the other foot?' (Kingsley & Johnson, 1994).

Over time the program outcomes have been evaluated and, on reflection, a variety of issues had a significant effect on its conduct. These issues included intra and inter personal factors relating to the client and methodological factors concerning the practical conduct of the program. Experience and regular post program follow up over a minimum of twelve months demonstrated a positive outcome for this program. The program has a strong potential to reduce the incidence of abuse where a majority of clients stop abusing and demonstrate ongoing positive behaviour change and improved relationships (Kingsley & Johnson, 1995a).

In referring to the impact of the Elder Abuse Perpetrator Program, Gibb (1998) highlighted the importance of specialist programs that address the issues of abusers and that confront the reality of abuse and abusers. Gibb suggested that programs such as the perpetrator program are a pivotal part of abuse prevention.

Papers on the program have been presented at state and national conferences (Kingsley & Johnson, 1994). More recently I presented a paper on the program and the lessons we have learned from it at the International Federation Ageing Conference in Montreal, Canada (Kingsley, 1999a). Currently, the Australian Institute of Criminology is forming a register of award winning Australian Crime Prevention Programs. All the elder abuse work to this date was incorporated in the COTA sponsored award winning National Violence Prevention Program, and these programs will form part of this register.

Theme 4.   Institutional Care and Resident Abuse

During the 1990s residential care was affected by government thinking that was firmly based on economic rationalism or 'neo-liberalism', which was "a mean-spirited and ill-directed policy program that has infected both the public and private sectors" (Kenyon, 2000, p. 304). Kenyon said "economic rationalists are in the ascendancy and the consequences are often neither efficient nor equitable, despite the promise" (p. 304). He noted various potential outcomes of economic rationalism, the increase in public and private sector charges for services that were once free and the economic uncertainty of income maintenance, two negatives that could affect older people. The possibility of some lower prices, wider access to imported goods and cheaper technology, telecommunications and travel (Kenyon) were some of the potential benefits for older people.

However, it was the negative outcomes of economic rationalism that would affect and have the greatest impact on older people, and it was the rationalist push that promoted privatisation and competition (Kenyon, 2000). In aged care, where vulnerable older people with limited incomes could not compete equally for access to services or commodities, they were less certain of a liveable income and many incurred higher ingoings and fees when they entered residential care. It was within the context of this market economy that the incumbent conservative Liberal Government introduced the current 'residential aged care reforms'.

The Government's reforms spelt out in the 1997 Aged Care Act hoped to improve the quality of nursing home care by rationalising the number of beds and introducing user pay principles to nursing home care (George & Davis, 1998). However, as a consequence of limited funding and a shortage of nursing home places there were long waiting lists for beds, serious staff shortages and insufficient moneys to employ qualified staff to give quality care (National Aged Care Alliance, 2001). As a consequence much residential aged care was delivered by untrained, unlicensed workers (Uren, 1996).

Uren (1996) had questioned what value was placed on frail or dependent older Australians when their care was left in the hands of unlicensed workers. She suggested there was a notion that nursing and personal care could be separated and that it was the expedient imaginings of economic rationalists that conceived such a separation as a means of cutting costs. Uren rejected this notion and questioned the quality of care that was delivered by unregulated workers. Experience suggests that it was in these conditions that unskilled care had the potential to include elements of poor quality care, resident neglect and abuse. The recent introduction of Certificate courses for care aides is attempting to redress this situation.

Australia had instigated aged care reforms to ensure quality of life and quality health care for its older people (Pearson, 1998). However, there was still little research or information about specific resident needs or the level of quality care, poor care, or abuse they received. An UK 'British Action on Elder Abuse' project in 1997 found 27.5% of aged abuse occurred in residential settings (Griffin & Aitken). These authors lamented the lack of research and data on the incidence of resident abuse and the UK government's lack of "incentive to invest in such research, as the privatisation of care has been one of its ways of dealing with the increasing needs for care in our population" (1999, p. 31). At the turn of this century the Australian situation was not dissimilar.

With emphasis on quality of care, there had been a concentration on issues of assessment and accreditation to ensure quality care for nursing home residents (Braithwaite, 1998). However, in more recent years as Simmons and O'Brien suggest, "ironically, efforts to protect older patients may result in further harm" (1999, p. 43) and policy and systemic changes to ensure quality have not always been successful or had the desired outcomes (Braithwaite, 1998).

It was during this period of change and accreditation, of limited funding and staffing shortages that many Directors of Nursing had begun to openly

acknowledge that staff abuse of residents was taking place. Like the UK there was limited research on the incidence of resident abuse in Australia, nevertheless reports, anecdotal evidence and personal experience in dealing with cases suggested it was a significant if not huge problem in residential aged care.

At the invitation of a Geriaction and West Australian Directors of Nursing Association Conference (Kingsley, 1998b), I presented the issue of resident abuse for discussion. Out of this conference came the impetus and support to develop a second protocol to guide residential aged care organisations in their prevention and intervention activities with resident abuse. Based on my nursing home experiences, I have also developed a number of articles and conference presentations (Kingsley, 1997b, 1997c, 1997d, 1997e, 1998b, 1999b, 1999c, 2000c), and professional education programs to raise and address this issue. I have also developed articles on resident abuse (Kingsley, 2000b, 2001a; Mott & Kingsley, 1999) plus the publication of the second protocol (Kingsley, 2000a). These works joined a small number of published Australian articles on resident abuse and feedback, a review of the protocol (Candlin, 2001) and requests for assistance to deal with cases suggest they are beginning to have a significant influence on the thinking about and response to resident abuse.

Conclusion

The collection of published works outlined above is representative of the professional and theoretical work undertaken in the area of elder abuse.

This chapter has positioned my body of work within the context of early and more recent initiatives to recognise and address elder abuse in Australia. The four themes, under which the submitted articles are subsumed, have been described together with the conceptual frameworks that have formed an integral part of my personal and professional development in elder abuse work.

CHAPTER THREE

THE CONTEXT OF AGED CARE IN AUSTRALIA

The purpose of the literature review is twofold. First it situates the studies that comprise the thesis within the wider corpus of knowledge relating to elder abuse. With respect to scholarly knowledge and practice, the review locates my endeavours within the local, national and international practice in this field of work. Second, in the first part of the review in Chapter Three I analyse the history and context of aged care in Australia to set the scene for a review in Chapter Four, of elder abuse its definitions, categories, extent, causes and interventions.

Before any review of the abuse of older people can take place it is necessary to examine some of the social and structural influences on aged care policy and practice. This analysis gives a background understanding to the historical trends in aged care, especially the post World War II trends that have led to the current situation in Australia. It is followed by a critical analysis of the current concepts and practice of aged care in community and residential care settings, in order to differentiate between the espoused and the actual practices of eldercare.

The purpose of this analysis is to allow understanding of the historical trends and past directions of Australian aged care that have had far reaching repercussions for older people and which continue to influence aged care practice. It also attempts to determine recent government and economic trends and policy changes, plus the pressures that drive older people toward community care. All of these factors have very personal implications for the life quality and wellbeing of the current and forthcoming cohorts of older people and those who care for them. Analysis of the realities of community aged care opens up and considers what lies beneath the concept of community care in order to uncover the actual processes involved in aged care. The review also considers residential care and analyses

measures to ensure the quality of care received by nursing home residents. The analysis critiques the impact of aged care on carers and nursing home staff, the very ones who give 'hands on care' to older people and who, in many cases, are the abusers of those for whom they have a responsibility to give safe quality care.

The main thrust of the literature review that relates more directly to the submitted studies comes later, in the following chapter. Chapter Four briefly considers the rights of older people then moves on to consider elder abuse, what it is, why it happens and to discuss interventions to deal with the abuse of older people.

The Changing Demographics of Ageing

By world standards, Australia is one of the younger industrialised societies. Nevertheless, there is no doubt that the population is rapidly ageing with increasing numbers of people over 65 years of age (HDWA, 2000). From the days of early settlement the number of older people increased from 1% in 1861 and 4% at the beginning of this century (Borowski & Hugo, 1997), to 12% in 1988 (ABS, 1998). Although there was a decline in ageing during the mid 1960s to early 1970s, this overall increase accelerated between 1984 and 1997 where the expected life span increased from 72.5 to 75 years for men and from 79 to 80.9 years for women (ABS, 1996). During the late 1990s and early 2000s there has again been a slow down in ageing (Borowski & Hugo, 1997). Nevertheless, when ageing rates pick up again as the 'baby boomers' retire, it is anticipated that people over the age of 65 years will comprise 22% of the population by 2021 (OSI, 1999) and between 24-26% of the population by 2052 (ABS, 1998).

These figures have strong implications for future planners, because the seniors of the future will have had vastly different life experiences and different expectations for future care than those who are old now. The next cohorts of people approaching old age are increasingly well informed and will demand individualised care to meet their personal needs (Francis & Humphreys, 1998).

The baby boomers have been called a selfish generation and few expect them to 'put up' with the conditions that the aged, who have lived through migration, depression and two world wars, currently tolerate. The baby boomers will "not only expect but demand" and much creative thinking and a shift in values will need to occur when their future care is planned (Flett, 2002, p. 27).

One of the fastest growing population groups is that of older people, especially women over 75 years of age (OSI, 1999). One half of those who were over 65 years of age in 1994, were estimated to be over 75 years of age by 2000 (National Health and Medical Research Council, 1994). This rise in the aged population reflects past increases in longevity, improved lifestyle, developments in health promotion and illness treatment, past migration patterns and the ageing of the baby boomer generation (HDWA, 2000). On the other hand this rise in longevity will have implications for future demands for income support, housing, health, welfare and supportive services for an increasing number of older people.

As the peoples of the world age, changing demographics will have implications for family patterns of care and formal aged care (Kosberg & Garcia, 1995b). Although illness is not an automatic part of old age, longevity is nevertheless associated with chronic illness, disability and frailty (HDWA, 2000; Ruler, 1998) yet only 3.5% of those over 65 years of age require help with their acts of daily living (Kinnear, 2001). It is estimated that one third of people over 65 years of age suffer a physical disability that is sufficient to affect their life. Despite this, most of these people (64% in a 1995 National Health Survey) rate their health as good, very good or excellent and they live independent lives (Palmer & Short, 2000). Many of those who experience a significant disability or impairment also manage to act as a carer for their frail or dependent spouse or relative. Eleven percent of the aged are counted as being severely handicapped and of these 6% still manage to live at home (Rowland, 1983). Similarly, the risks of dementia and organic brain diseases increase with age and again most of these people live in the community (Argyle, Jestice & Brook, 1985).

Older people with debilitating health problems are a small minority: most seniors are independent, resourceful and a burden to no one where they "contribute more to their families and communities than they receive in assistance" (Palmer & Short, 2000, p. 296). Although many older Australians rely on a pension for most or all of their income, self funded retirees incur little if any government expenditure. A majority of older people, including those with health problems, make a positive contribution to their community (Jones, 2001) by giving practical and financial support to their families, by being volunteers to help others or by retaining a link with the paid work force (Kinnear, 2001). The fact that compulsory retirement has largely been removed speaks to the skills, the values and the economic contribution that older people make to society (Encel, 1997).

Australian health costs might have increased by 2.8% between 1983 and 1995 but only 0.6% of that increase was attributable to the 'cost' of ageing (Kinnear, 2001) nevertheless, as people age it is likely there will be increased demands for health care and income maintenance. Although Kinnear may not agree, others suggest these demands could be from two to four times that required for the young, an increase that forms part of an anticipated growth in total health care expenditure from $28.7 billion in 1990 to $106 billion by 2041 (Borowski & Hugo, 1997).

However, Palmer & Short hesitate to accept that older people are an economic burden on society. They note that perceived "increasing costs associated with older people are linked more closely with social and political changes than with physiological ageing as such" (2000, p. 296). These social changes included increased pension payments, which were associated with the introduction of enforced retirement, and the political changes included decisions that increased financial support to nursing homes. Even though these changes might be social and political in nature, the bottom line for policy makers and the aged care industry is that an increase in the aged population of around 10% by 2015 will create issues for nursing and nursing care (Bergener, Jirovec, Murrell & Barton, 1992). The increasing incidence and prevalence of disability and chronic illness

will require higher levels of health care with older people needing more periods of hospitalisation, and additional community and medical services if they are to be maintained at home (National Health and Medical Research Council, 1994).

The recent interest in the ageing of Australia is not only because of the increased numbers of older people but also from "population ageing having captured increased public attention as its social and economic consequences (or at least perceived consequences) began to be more acutely felt" (Borowski & Hugo, 1997, p. 19). Media coverage of the aged rarely encourages positive views of older people. One article about ageing West Australians was headed "Ageing WA to burden the young" and contained comments like "West Australians are living longer than ever - but today's baby boomers are about to saddle their children with hefty bills" and "the 'me generation's' chickens will soon come home to roost, adding substantially to their children's tax bills" (Thornhill, 2001, p. 50).

Borowski and Hugo suggest the "construction of population ageing as a problem in large measure has its source in the great public costs that ageing is expected to generate" (1997, p. 45). However, after evaluating the burdens and costs that older people will place on the economy, these authors see the burden of labour force dependency of older people remaining fairly constant over the next decades. This means "the total support burden that will have to be borne by the labour force will be lower in the future than experienced in the past" (pp. 48-9). Borowski and Hugo conclude that although the costs of ageing will increase future public expenditure, these increases will be modest, sustainable, and easily covered by future economic growth; in fact projections predict an increase in aggregate welfare expenditure of only 1.5% between 1990 and 2041.

The increase in the aged population is an important topic for many reasons, including the obvious policy areas of income maintenance, housing, health and welfare. However, it is also important to each older person who must rely on public support to be able to live a life of quality, dignity and safety. For many

older people the rhetoric about them being an economic and social burden on society causes distress and makes some feel obliged to struggle on with limited resources rather than to seek the care and support that is their due as citizens.

Similarly, the increase in vulnerable older people living at home with limited community resources to meet their needs has a significant impact on an ageing population. With more frail old people being cared for at home by family carers, often with insufficient support, there is an increasing risk of carer burden and burnout. It is not easy to care for a frail and dependent person twenty four hours a day seven days a week and the physical, emotional and financial costs of caring can be high. For many, once they accept the responsibility of caring, their role will continue until either they wear out or their caree becomes too frail to stay at home and one, or both of them are admitted to residential care (Kingsley, 1992c).

The literature review now considers issues that have arisen and changes that have occurred during past and current aged care and welfare activities in Australia. In this section I show how and why community and institutional aged care have evolved over recent decades; and demonstrate the pressures placed on governments to drive older people and their carers towards community care.

Aged Care and Welfare in Australia

In order to put the current aged care conditions into some context, it is necessary first to consider the historical and social development of aged care in Australia. In his much quoted history of Australian welfare Dickey (1981) describes social welfare as the provision of benefits for those who, for a variety of reasons, cannot avail themselves of mainstream services. Older people and their carers are two groups who may require the support of social welfare benefits. Dickey cited and used Peter Townsend's (1976) model of social responses to poverty and disadvantage to place Australia's welfare into a historical perspective. Dickey talks of three modes of reacting to social welfare needs.

Dickey's (1981) first mode of social welfare, which applied to most of the nineteenth century, is one of 'conditional welfare for the few' where benefits are dispensed according to the recipient's moral worth. The second mode of 'minimal but universal rights', tends to exist in free enterprise societies and emphasises limited universal benefits. The third mode refers to socialist principles of 'distributed justice for all', where resources are distributed on the basis of need rather than power. Dickey suggests early Australian welfare demonstrated the first mode where benefits were conditional on the applicant's worth and morality.

With the end of transportation governments wanted to reduce their welfare responsibilities, so they handed some funding and many of the 'welfare' administrative responsibilities over to the benevolent and non government societies. The voluntary and not for profit sector then shouldered much of the responsibility for meeting the needs of the old and the poor (Dickey, 1981).

By the early 1900s economic expansion and free trade had given way to high levels of inflation and an ageing population who needed help to survive. Early institutional care for older people developed during this period with the provision of selective charity for those who had no one else to provide for their needs. This group, many of whom were also aged, included those destitute, deserted and homeless people who were 'deserving' of public support (Minichiello, 1995).

Over time both sides of politics moved towards universalism, even though both still thought that recipients should prove their eligibility for benefits such as aged pensions. The Labor Party, with their more socialist philosophy, moved further toward Dickey's (1981) second and third modes of welfare than did the Liberals who still favoured free enterprise and self care (Markey, 1982). Later, during the depression and post World War II years, welfare money was limited and welfare policies were based on political ideology and economic expediency. As a result, the needs of an ageing population were again increasingly handed over to be met by the voluntary sector and not for profit community organisations (Dickey).

Social welfare, which during the early eras had largely benefited the aged and poor, was now directed more broadly and was extended to meet the needs of many other groups in society (Dickey, 1981). As welfare services became more universal they extended from the aged and poor to include the middle classes and the wealthy, and although capitalism benefited many it did little for older people. Inequality and poverty remained entrenched, and in the 1960s Dickey notes that the aged were one of the poorest groups in Australia. This situation continued into the 1970s when the plight of the aged poor in the community and the need for social justice began to receive political attention. Subsequently, in the early 1970s, Dickey observes that with a Labor Government there was a refreshing increase in social justice measures when universal health care was introduced in concert with increased funding for a growing community based welfare system.

However, economic rationalism was making its presence felt and, in the mid 1970s, a new conservative Liberal Government said the economy could no longer afford growth in welfare spending and they made significant funding cuts. The aged and disabled trying to manage at home with limited supports were amongst those who suffered from these cuts. A report to the West Australian Community Services Board described how the lack of rational welfare policies resulted in ad hoc funding and little coherent planning or direction for the non government welfare sector (Tonkin, 1985). Aged care services were called a hotchpotch of separately funded and administered programs which were uncoordinated, inadequate and mismatched to the needs of the aged (Hemer, 1983).

During the 1960s the nursing home industry had begun to boom. This growth occurred when long term hospital and mental illness patients were discharged from acute care to nursing home care (Palmer & Short, 2000). Following the 1960's introduction of bed subsidies, the provision of nursing home care grew to such an extent that Australia had one of the highest rates of institutional care for older people in the world (Parker, 1987). By the end of the 1970s Commonwealth expenditure on nursing home benefits had trebled, thus leading to a search for an

alternative and less expensive method of aged care. Consequently a variety of reports were commissioned and the results "stressed the desirability of community based non-institutional care" (Palmer & Short, p. 118).

As a result of these activities the Home and Community Care (HACC) Act was passed in 1985, and the HACC program was developed to expand services and support for the aged in the community (Saunders, 1988). Institutional nursing home care received ten times the funding allocated to community care, and yet only 6% of older people lived in an institution (Grimes, 1987). While there had been increased spending on community aged care, from $32 million in 1976-1977 to $101 million in 1986-1987, in the same period there have been even greater increases in institutional spending from $96 million in 1973 to over $1,000 million in 1986 (Minichiello, 1989). Economically, it was time for a change.

The 1970s was a period of change in aged care, and one outcome of the changes was the Federal / State Government HACC program which combined a number of separate aged care services. The HACC program funded services to keep the aged and other vulnerable groups at home with optimal independence and quality of life and to prevent inappropriate admission to a nursing home (Department of Community Services and Health, 1987). Many HACC funded programs struggled in the early days, and a Social Policy Research study of the first eighteen months of one Sydney program concluded there was "inadequate overall funding and problems with coordination in both the planning and provision of community support services" (Fine, 1992, cited in Palmer & Short, 2000, p. 297).

Even though most home nursing programs were subsumed under HACC it was "not primarily part of the health care services but it shares some of the objectives of the Community Health Care Program, notably the maintenance of people in their own home" (Palmer & Short, 2000, p. 125). This complex mingling of health and welfare services (George & Davis, 1998) had ambitious objectives but limited resources. Only around 5% of recurrent health spending was earmarked

for community services, including public health and health promotion (Palmer & Short), which left few resources to support carers looking after frail dependent older people. In times of economic rationalist policy where governments concentrate on economies of scale and cost saving, health and welfare including the care of the aged are traditional areas that are targeted for cuts.

Palmer and Short (2000) suggest the limited development of community services showed the difficulty of diverting resources away from the nursing home sector. Federal governments have traditionally spent many times more on institutional than community care (Minichiello, 1995) and nursing home interests are far "more successful in resisting expenditure cuts or the redistribution of funds than the community health groups are likely to be in securing the benefits of the change" (Palmer & Short, 2000, p. 121). The outcome of this position was that more older people were being cared for in the community, but with fewer resources to support carers give that care.

To limit nursing home costs, controls were set on bed numbers and ratios per 1000 of population were reduced from 67.2 in 1985 to 58.5 in 1990 and 52.6 in 1996 (Minichiello, 1995). Nursing home care is one of the most controversial areas of aged policy (Howe, 1990) and the industry has long been fraught with controversy. The Nursing Homes and Hostel Review (Department of Community Services, 1986) was one report that highlighted difficulties in the funding, administration, operational efficiencies, standards and quality of care in Australia (Lindenmayer, 1987). The industry has also had a history of differences in opinion about the ideal split between federal and state funding, and public and private responsibility and control of residential care (Palmer & Short, 2000).

With the dawning of the 1990s more reports were commissioned to consider the various service and care aggregated funding models, plus the quality issues of nursing home care. One 1996 report, by the National Commission of Audit, predicted that with large increases in the aged population, unless radical financial

reforms were implemented the Commonwealth would face huge increases in aged spending. The report recommended means testing nursing home fees and a variety of increased user charges to help defray costs (Palmer & Short, 2000).

Again, Palmer and Short see a fallacy in using projected increases in the aged population to predict health care costs. They suggest it is naïve to predict "doom and gloom" for health services and government budgets, and erroneous to automatically associate advanced age and increased health care expenditure for the incoming cohort of older people (2000, p. 345). Costs in the period approaching death are invariably high for any age group, but increased life expectancy will not necessarily involve increased health care costs during all the extended years of life; in fact health costs for older people may decrease overall. Palmer and Short conclude that ageing populations are little more than a convenient argument to justify reducing public sector expenditure and placing greater responsibility on individuals and the private sector to provide aged care.

With the election of the conservative Liberal Government in the mid 1990s, the promise of short term money saving in residential aged care was too great a temptation for the Liberals. The threat of increased aged care spending and the potential for short term monetary gain led to the controversial reforms of 1997 where costs were increased with the introduction of means testing, increased daily fees and entry contributions or accommodation bonds (Palmer & Short, 2000). Palmer and Short suggest this "abortive attempt to introduce an accommodation bond for nursing home residents to support capital expenditure in the nursing home sector is the latest example of health care policy making based on limited evidence and dubious assumptions" (p. 120).

During the 1990s, increased funding for hostels reinforced Federal Government intentions to move from high cost nursing home care to less expensive hostel services for those who required less intensive care (Minichiello, 1995). Between 1989-1990 and 1995-1996 there was a 41% increase in hostel beds compared to

an increase of only 3% for nursing home beds (Australian Institute of Health and Welfare, 1998). Yet in 1996-1997 the total recurrent spending on nursing homes was still estimated to be $3148 million (Palmer & Short, 2000).

Since the early days of selective charity when recipients had to justify why they should receive help, Australia has remained fairly entrenched in Dickey's (1981) second mode of welfare. However Dickey claims the answer to welfare needs lies with the third mode of social justice. Pensions and welfare benefits for older people which were once seen as a privilege that had to be earned, have only more recently been considered a right for all older Australians. However, as always economic and political factors influence social policy and in the controversial and financially pressed post recession days of the 1990s these factors were very evident as they dominated the scope and future direction of Australian aged care.

From the above it can be seen that Australian welfare has had a changing and turbulent history, not all of which has benefited older people or those who care for them. Many on the left of politics might idealise Dickey's (1981) third mode of 'distributed justice for all' while those on the right say that benefits should be reduced to increase independence and reduce reliance on government (Gokhale, 1984). An educated guess suggests the future will probably remain somewhere in the middle ground, though Gokhale suggests a second likely option could herald a conservative retreat to Dickey's first mode of welfare where limited benefits are selectively dispensed at the beck and call of the market or the government.

Given even a brief glance at the aged care and welfare activities over Australia's past allows us to place the current issues of first community and then residential aged care into some social and economic context. In order to consider elder abuse as social phenomena, it is first necessary to consider the contexts within which abuse takes place. Similarly, it is important to look at the issues of those who give care, for in many cases they are the guardians of safe care for older people and in other cases they are the perpetrators of elder abuse.

The following section reports on the realities and changes in community based care over recent decades and highlights the impact of government policies on family members who accept the responsibility for caring for an aged relative. It is important to consider older people and their carers who live in the community, because the domestic setting is where the greatest growth in the numbers of older people will occur and it is also the setting in which much elder abuse occurs.

Older People Living in the Community and Community Care

Post World War II moves in Australian aged care, especially those in the 1970s and early 1980s, included reforms that aimed to achieve a balance between community and residential care (Stevens & Herbert, 1997). However, these moves never redressed that imbalance and though spending on community care did increase, spending on residential care for approximately 6% of older people increased many times more to such a point that in 1983-1984 for every $10 spent on nursing home care only $1 was spent on community care (Minichiello, 1995). Even though these moves toward community care were not ageist in motive or intent the reality was that the outcome did not auger well for older people in the community, especially for the carers of old people many of whom were themselves old and required community support.

During the 1970s-1980s, the policy shift that prompted a move from institutional to community care was based on the 1960's concept of 'normalisation' which involved the use of "culturally valued means" to maintain experiences and behaviours that were considered normative (Graycar, Dorsch & Mykyta, 1986, p. 26). With rising costs institutional care, which had been culturally normative and valued in the 1960s-1970s, was no longer so valued in the 1980s.

The option of community care became the normative and valued option for aged care. This philosophy suggested that community care, which coincidentally was also the cheaper option, could be all things to all people. However, not all had the

same faith in the philosophy of normalisation via community care. For example Jones, Brown and Bradshaw stated that to

> the politician, community care is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant, it is a cheap alternative to institutional care which can be passed to the local authorities for action - or inaction; to the visionary, it is a dream of the new society in which people really do care; to social service departments, it is a nightmare of heightened public expectations and inadequate resources to meet them. We are just beginning to find out what it means to the old, the chronic sick and the handicapped. (1978, p. 114)

Over the years political views have differed on what constitutes community care, who should provide it and who should receive it. Community care today does not mean care by the government for people in the community (Henderson, 1985). The rhetoric about community care suggested it would

> improve the quality of life for aged and disabled carers through a comprehensive range of integrated home care and comprehensive based services in each locality, thereby providing a realistic level of support for those people who prefer to remain living in their own homes. (Department of Community Services, 1986, pp. 4-5)

However, even in its early days HACC was no 'panacea' for older people, and it never met all their needs nor those of their carers (Hicks, 1986). Hicks went so far as to question what the concept of 'community' really meant. In an astounding admission, the Office of the Minister for the Aged (1985) said that the term 'community care' was a euphemism for family care and governments were slow to provide appropriate support services for the families who provided that care. The Office further suggested family care was invariably caring by women who most often reduced themselves to a dependent state in order to provide that care.

The HACC program funded community services in an attempt to meet the needs of target groups and to keep as many vulnerable people at home for as long as possible. Just after the introduction of HACC, Hicks (1986) questioned who community care did help and suggested that fulltime caregivng increased rather than decreased the burden of care for the wives and daughters of the frail aged. He also asked who worried about the aged before the advent of the health professional, and wondered why the aged had been largely ignored by the social systems and indeed why older people had allowed this situation to exist.

One year after Hicks's (1986) comments, recession hit Australia and community care reverted to Dickey's (1981) ideology of selective welfare (Minichiello, 1989). Government programs retreated and much of the responsibility for community welfare was transferred to wives and daughters and to the volunteer sector (Wiles, 1988). A concern for many community practitioners during this period of economic recession was that while community service funding decreased there was no corresponding decrease in the demand for services.

Economists might foresee increases in aged care spending of 50% between 2001-2021 (Minichiello, 1995) and argue that aged services are too generous and contribute to the nation's economic problems. Nevertheless, although critics suggest welfare costs must reduce, there is no evidence that cutting social spending leads to long term economic growth (Saunders, 1987). Governments continue to push for community care over residential care and 92.2% of people over 70 years of age, 84% of men and 75% of women over 80 years of age, plus over 70% of older people with moderate to profound or severe disability, still live in the community rather than an institution (ABS, 1996; HDWA, 2000).

From the preceding discussions it is evident that just how effective these services are in providing the level and quality of care necessary to maintain older people at home is a matter for debate and the various arguments will depend on whether the protagonists are economists and politicians or older people and their carers.

Carer Issues in Community Care

It is all very well to consider the wider social and economic implications of public policy and funding arrangements for aged care, but it is also necessary to consider what impact these measures have on the individuals who give care. When the rhetoric is stripped away community care is not the range of domiciliary services the term implies, rather it is usually care given by wives, daughters, and the volunteers who help them look after frail relatives (Jorm, 1988). For many the reality of community care has never measured up to the grand predictions of government press releases. Walker (1989) goes so far as to suggest the rhetoric about increased quality of life for older people who receive community care is more about political expediency than humanitarian concern.

Nevertheless, family care of frail older relatives is "alive and well" (Braithwaite, 1990, p. 3). Most family members give care willingly to a relative who has cared for them in earlier years or to one with whom they had a long happy relationship. However, the family is not always a sanctuary for safe loving care. There are families who have never been loving or happy and families with a long history of dysfunction, conflict and abuse. It is in these situations where family members, often wives and daughters, feel obliged to become carers for a previously abusive relative, that caregiving can become problematic (Kingsley & Johnson, 1996a).

Because most carers are female the reality for many women is that they will provide substantial long term personal care for an older person with an illness or disability, care that is essential if the older person is to be able to remain at home (Department of Community Services and Health, 1991). Currently, women make up 70% of the carers for people with a disability (ABS, 1999) and 40% of the carers of dependent older Australians are wives (Department of Health, Housing and Community Services, 1991). While 91% of men have their wife as their primary carer only 60% of women are cared for by their husbands (Dunn, 1995).

Similarly, 16% of dependent seniors are cared for by their daughters (Department of Health, Housing and Community Services, 1991) who tend to adopt an increasingly heavy caring role as their parents become more frail and infirm (Australian Institute of Health, 1990). Aged care is predominantly women's work and it is suggested that, with increased longevity, many women can expect to spend more years caring for an aged relative than they did for a dependent child (House of Representatives Standing Committee for Long Term Strategies, 1992).

For many carers looking after an older person especially one who is frail, handicapped or dependent can lead to feelings of stress, cost and burden (Parsons, 1997). While most carers find the experience one of meaning and purpose (Bowers, 1987), others will feel a loss of health and wellbeing (Sayles-Cross, 1993). If an older person is dependent on others for many of their daily needs the carer may have little time for self or to meet personal or family needs (Travers, 1996). There may be a physical burden of giving consistent hands on care, a psychological burden of dealing with difficult behaviours, an emotional burden of seeing past relationships fall apart as a loved one deteriorates in health and capacity. There can be a social burden that comes with being constantly 'on call' to give care and losing contact with outside social and support networks and then there can be the financial burden of all the costs involved in giving care.

However, these burdens are not evident in all cases nor is it all a one way load. In many cases it is the carer who depends on the older person for somewhere to live, for company and emotional support, for money, for childcare or for a general contribution to the domestic duties around the home. In many situations older people contribute far more towards their own care than they ever receive from their carer or the community (Bennett, 1990; Pillemer, 1986; Wolf, 1996).

Different people will experience almost any situation in different ways as each participant assesses and responds to the circumstances in light of their own feelings and perceptions. Whether or not a carer experiences caregiving as a

burden depends on a number of factors in their past and present life and experiences. The concept of 'burden' in relationship to caring can be an emotive one where it implies stress, overload and hardship for a carer. Even so the term is deliberately used as it one that is used in the literature (Braithwaite, 1990; O'Connor & Kingsley, 1991). However a burden need not imply problems or feelings of liability where the carer sees their relative as a millstone around their neck, rather they may see their burden in the more positive light of its less emotive meanings of duty and responsibility. Caring is also talked about in terms of the cost to the carer (Gibson, 1998; Kingsley, 1992c). Again the concept 'cost' can be used objectively in discussing the costs of time, energy or money that are implicit in the caring role; or the concept may be used to infer the costs of sacrifice, loss and detriment, that can be experienced by the burdened carer.

Regardless of the language, it is evident that caregiving can cause stress. In her study of Canberra carers, Braithwaite's 'burdened carer' was one who "perceives him or herself as having too little time to do things, sole responsibility for care, minor psychiatric symptoms, a breaking point in relation to future care, much to learn about caregiving, and a care receiver with emotionally or cognitively impaired behaviour" (1990, p. 121). These carees may have had Alzheimer's disease but the study results suggest it was the personal issues, a lack of time and having to do everything alone, or not receiving enough support or tuition in how to care for someone with difficult behaviours that brought the carer to breaking point. It seems that it was less the actual tasks and more the context and the personal, emotional and social difficulties of giving care that were burdensome.

For some carers the burden is ongoing and doesn't end when the older person is admitted to residential care. It could be expected that their stress levels would decrease with the relief from the twenty four hour caring duties. However, this is rarely the case where the nursing home entry of a loved one becomes a significant life event, and many carers experience feelings of guilt, anger, distress, despair and a sense of loss (Douglas & Davis, 1994; Nay, 1996).

In closing this section on community care it must be said that politically, Australia has rarely looked ahead in social welfare and there is a need for planning that is theoretically sound, practical and affordable (Mendelsohn, 1982). History suggests that, unless all involved in aged care including family and community carers accept the challenge to determine future directions, decisions will be left in the hands of the traditional power brokers such as the powerful, the politicians, the rich and the economic rationalists (Minichiello, 1995). Australian social policy revolves around who is powerful and what social changes are acceptable to these groups. In aged care, the 'who' is the government and the health care industry, and the 'what' is economic rationalism and the medical model of care (Minichiello). Minichiello says aged care is based on a dependency model, where decisions are made by 'other people' and are based on tools that often override the wishes of the older person, such as the decision by an ACAT to admit an older person into nursing home care - against their wishes.

The above review of community initiatives over recent decades suggests the future is uncertain for older Australians. If they are to be ensured of safe quality care, then a major issue in community care must be the quality and adequacy of that care. However, in reviewing the community literature, little talked of evaluating community services to see just how much help older people and their carers felt they received from community care. Nor was there an abundance of literature that evaluated the quality of the process of service delivery by community carers. It is interesting to note that while duty of care and the regulated responsibility to give safe quality care are clearly set out for community workers and nursing home staff (Hamilton, 1997), there is no corresponding duty of care for the family carer. It seems we just hope and trust they have adequate caring skills and the willingness to give safe care to their relative.

The review so far has given some background to the nursing home situation. However, it does not explain why, when there is such "profound ambivalence surrounding the role of institutional care" (Biggs, Phillipson & Kingston, 1995, p.

78), when placement into a nursing home is frowned upon by society (Dellasega, 1991) and when most older Australians wish to stay at home, there is a constant demand for nursing home beds. Nor does it explain why governments continue to spend so much time and money on nursing homes when only 3-4% of the population live in them (Minichiello, 1995). Maybe future reforms and research about nursing home life, as residents experience it, will give some answers.

In contrast to the previous section the discussion now raises issues of nursing home regulation and the quality of resident care. It describes how older people experience institutionalisation, and how the environment and climate of the home influence the quality of care residents receive, and also considers the staff who give personal intimate resident care.

Older People in Residential Care and Quality of Care

With increasing age and infirmity, older people who can no longer manage in the community tend to be admitted to a hostel (3.9%) or a nursing home (3.9%) (HDWA, 2000). Those who require nursing home care might be a small minority but they are a vulnerable group who have significant personal and health needs which require skilled physical, psychological, social and emotional care (ABS, 1992; Ruler, 1998).

Australia is one of many countries, which have instigated aged care reports and reforms to ensure quality of life and quality health care for its older people (Pearson, 1998). One of these reports, the 1986 Report of the Nursing Homes and Hostels Review, strongly criticised Australia's heavy emphasis on institutional care for older people and identified inadequacies in assessment procedures and poor coordination of funding and services (Beattie, 1999).

These reports prompted changes to the residential sector in the 1980s. Changes included new funding arrangements for staffing and running nursing homes plus

the introduction of Geriatric Assessment Teams, and later ACATs, to assess an individual's need for nursing home admission. The introduction of ACATs and their more stringent requirements for nursing home admission led to a reduction in the number of older people entering a home and a corresponding increase in the admissions to hostels (Minichiello, 1995).

For years there had been increases in nursing home expenditure for a small percentage of the aged population, yet until the late 1980s there was still very little information about the quality of nursing home care. Much was heard about the expenditure but little was written about the nature and needs of residents except for some general information about the distinctions between residents requiring ordinary care and extensive care. This information was more forthcoming after the introduction of the Resident Classification Scale in 1997.

The espoused goal of the new Liberal Government's reforms was evident in their Aged Care Act of 1997 which aimed to improve the quality of resident care through reducing the number of nursing home beds and increasing user pay services (George & Davis, 1998). However, Australian researchers who studied the previous Standards Monitoring Process, which ran from 1988 until the new accreditation process was introduced, suggest the need for change was questionable. They say the previous quality assurance process was

> a success compared to the regulatory regimes we have studied in other countries and compared to other areas of regulation in Australia. Perhaps this is why the nursing home industry successfully lobbied the Howard Government (which came to power in 1996) to abolish it; it will be replaced by an accreditation regime in which industry has a stronger voice. (Braithwaite, 1998, p. 172)

Braithwaite suggests a key variable identified "in the success and failure of nursing home regulation is the quality of the regulation dialogue. Often enough Australian nursing home regulation not only fails to improve quality of care but

actually makes it worse" (1998, p. 172). One of the reasons why there has been little improvement in the quality of nursing home care, even with many reports and reforms is that the guidelines do not seem to be accompanied by appropriate and plausible intervention technologies that will allow homes to realistically meet the standards for care (Schnelle, Ouslander & Cruise, 1997).

The quality of nursing home care has been a research and discussion topic in gerontology for some decades and much research has concentrated on the macro organisational issues that influence the quality of care. However, there is little empirical evidence that organisational characteristics, such as the size of home or home ownership, account for very much of the variance in resident care (Sheridan, White & Fairchild, 1992). From their research, Sheridan et al. suggest that structural variables may measure the capacity of the home to give quality care but they do not always measure whether or not that capacity is used and whether residents actually receive quality care. They reason that macro organisational factors give little information or "little insight into the management of resident care practices within the nursing homes" (p. 334).

In their study of 25 nursing homes, Sheridan et al. (1992) found it was the environmental milieu or climate of the home and the human resources management policies and procedures, rather than the macro organisation of the home, which were significant factors in the quality of resident care. They found that homes assessed by monitoring bodies as providing adequate care were higher on human relations (administrators working to improve the wellbeing of staff, and staff relationships) and task orientation (administrators giving clear guidelines of staff responsibilities and their expectations for employee development, and giving positive feedback and rewards based on personal accomplishment). These authors suggest that personal dynamics and work management practices were the underlying factors that influenced the nature and quality of the lived environment and the quality of resident care.

Sheridan et al. (1992) concluded that poor care was less a consequence of macro organisational factors or of inadequate or inappropriate staff leadership and supervision. Rather they found that quality care was a consequence of a positive organisational climate. Failed homes in this study demonstrated significantly less attention to staff motivation, showed less planning, provided fewer resources for staff to give quality care and showed disdain for lower level workers. Staff in failed homes also demonstrated significantly lower cohesion, they tended to see residents as difficult to understand and felt residents needed close monitoring and should be discouraged from being involved in social and personal care activities. What is evident here is that the quality of resident care depends on a number of factors. The climate in which care is given has a significant influence on resident wellbeing and life quality, and the atmosphere in which residents live is influenced by the quality of the day to day management of home activities and of the staff who work there.

It would be evident to all in aged care that a principal role of nursing homes is to provide quality care in a home like environment for those older people who require specialised institutional care. Recounting how Goffman and others in the 1960s-1980s wrote of the difficulties of entering an institution and the detrimental effects of living in an institution, Fiveash (1998) tells how nursing homes have become increasingly regulated with stringent monitoring activities to try and ensure a positive life quality for those who require nursing home care.

When older people enter a nursing home few have much say in the decisions concerning admission which are mainly made by children and other kin or by physicians and health workers. When left by their families at the nursing home many new residents feel dejected and lost in a strange place that has no memories of the past, but numerous reminders that they have become just "one of many patients": few ever get over the shock of "being 'cut off' from the community and confined behind the walls of the nursing home" (Minichiello, 1996, p. 167).

Moving to a nursing home often follows a period of illness, a health crisis or the loss of a carer where the older person can no longer manage at home. Mitchell (1997) suggests few factors predisposing admission are positive and that decisions are often made for the person under less than ideal conditions and on the basis of speed and expediency. Admission to a nursing home is a significant life event about which few older people have any real choice. Yet on admission, they are expected to adapt and fit into home routines even though they experience a loss of choice even in little things such as when to get up, shower, eat or go to bed. For many, nursing home admission is a major transition that is accompanied by feelings of fear and loss of control, choice and autonomy (Mitchell).

Transition to institutional life can harm new residents (Pillemer, 1988). Many feel abandoned and helpless (Pritchard, 1995), depersonalised and separated from familiar environments (Mitchell, 1997), a loss of control over established routines (Ryden et al., 1998) and a dislocation of social networks, which can lead to loneliness and depression (Bromberg & Cassel, 1983). Pillemer suggests however, that alienation and helplessness also come from negative staff patient relationships or resident abuse where maltreatment may have a more direct negative effect on a resident's quality of life than the effect of institutionalisation.

Aged care facilities are charged with a responsibility to provide quality care within a home like environment (Kingsley, 1997a). Facility employers and managers also have an obligation to respect the rights of staff and to provide adequate support, supervision and quality education to assist staff to give safe, high quality care (La Rocco, 1985).

Staff Issues in Residential Care

Just as was relevant to consider the issues of community carers, so it is relevant to consider issues of the staff who are responsible for direct hands on nursing home care. The staff who give direct resident care in Australian nursing homes are Registered Nurses, Enrolled Nurses and care aides, or care assistants. A great

deal of the intimate personal resident care is given by untrained, unlicensed care aides who operate under the supervision of licensed staff (Uren, 1996).

Staff attitudes and behaviours undoubtedly affect the quality of nursing home life and what residents seem to appreciate and value most is what they call 'good staff' who show the human qualities of being courteous, polite, friendly, cheerful, pleasant and respectful (Tellis-Nayak & Tellis-Nayak, 1989). These authors suggest that as "advancing age strips elderly individuals of their symbols of independence and authority and shrinks their social world, nurse's aides assume a larger-than-life role in the life of residents in the nursing home" (p. 307).

In community care most carers give quality care, so in residential care most staff like and have empathy with their clients and take their responsibilities seriously (Courtney & Spencer, 2000). Nevertheless, similar to the community where some carers do not like caregiving or their caree, there are some nursing home staff who do not like their work or their clients (Pillemer & Bachman-Prehn, 1991). Yet some stay on the job because they need the money or they like the hours, the location or the convenience of the job (Pillemer & Moore, 1989). Evidence suggests Registered Nurses have more empathy with residents than do care aides (Pillemer & Bachman-Prehn), but many trained staff still have neutral attitudes or hold negative stereotypes of older people (Treharne, 1990). No matter how staff try to hide their feelings about residents, ageist feelings and a lack of empathy invariably have negative implications for the care that staff members deliver.

How staff deal with residents is influenced by the mix between the social culture in which they live and the professional culture in which they work. Few would ever say that nursing home work is easy and many staff experience high levels of stress and burnout (Mott & Kingsley, 1999; Pillemer & Moore, 1990). There are many stresses on staff with having too much to do in too little time, dealing with difficult behaviours and aggressive residents who hit out at or abuse staff, seeing clients deteriorate and die, receiving little support or education for their role,

feeling powerless to change things they do not like, being unappreciated and inadequately rewarded for giving quality care (Goodridge, Johnston & Thomson, 1996; Kingsley, 2001a; Meddaugh, 1993), and sometimes bringing stresses and cares from home to work (Tellis-Nayak & Tellis-Nayak, 1989).

When the outside culture of the care aide enters the work milieu within the nursing home there is a profound effect on the performance and quality of resident care (Tellis-Nayak & Tellis-Nayak, 1989). The following comments by Tellis-Nayak and Tellis-Nayak agree with Sheridan et al.'s (1992) conclusions about the impact of the climate or culture of the nursing home, when they say that

> in too many nursing homes the institutional culture prevails. Within it aides are only hired hands, no one provides for their affective needs nor cares if it alienates them. And being in constant company of dependent elderly residents, the aides too, begin to individualize their problems. They make their wards a ready target of their discontent and resentment.

> And that completes the vicious cycle. Two parties both powerless, little respected, and hardly recognized by society are made to face each other in a difficult setting not of their own making. They are bound in an intimate association, but enjoy little intimacy. Neither party controls the institutional environment in which they exist, neither can break the negative cycle, and so the problem feeds on itself. (p. 312)

The above review suggests it is not only the residents and staff who influence the quality of nursing home care, but it is also the climate and the lived environment in which staff give that care. The more distant exogenous factors of government funding and legislation also have a significant though maybe less direct impact on resident care and they are discussed elsewhere in the review. However, discussion of quality of care raises the question of what people have a right to expect as they age and may become vulnerable and reliant on others for care.

Conclusion

In the first part of this chapter I demonstrated that the political and economic history of Australia, especially since the end of World War II has had a profound influence on the direction of aged care. This influence is evident in the past and current trends of moving away from expensive nursing home to less expensive community care, plus the more recent 'aged care reforms' that are having a major impact on both community and residential care.

Most older people live in the community and the issues of 'community' and 'community care' have been analysed to show it is family carers who bear the greatest burden of eldercare. Some of the issues of family carers have also been analysed. For the small percentage of older people who require skilled institutional care, the issues of quality care are paramount. The review identified how these quality issues have dominated the activities and monitoring of residential care, yet the impact they have had on resident satisfaction and quality of life is still largely unknown. This chapter concluded with an analysis of some of the issues experienced by nursing home staff, who are held accountable for giving safe quality care while often working with inadequate skills and insufficient support to give the required quality of care.

The first part of the literature review has set the scene of aged care in Australia and has identified the social context within which most older people live and in which much elder abuse occurs. The next chapter includes the remainder of the literature review, which considers the issues relating to elder abuse.

CHAPTER FOUR

DIMENSIONS OF ELDER ABUSE: A REVIEW OF THE LITERATURE

This chapter forms the second part of the literature review. In it I briefly consider the basic rights to which all older people are entitled and then move on to the topic of elder abuse. Articulating and ameliorating the abuse of older people is the topic of the work submitted in this thesis and one purpose of the review is to give a contextual setting of existing knowledge on the topic, within which my scholarly and professional work has been developed and undertaken. It is also within the general timeframe of much of the literature cited in this chapter that my work is situated. The development of elder abuse work in Australia lies over a decade behind the work in the US and is more closely aligned with developments in Canada and the UK. It has been during the last twelve to fifteen years that the majority of work on elder abuse has taken place in Australia and my formal involvement in work on this topic spans the period from 1989 to the present time.

A further purpose of this part of the literature review is to consider factors related to the social problem of elder abuse. In order to understand the complexities of elder abuse it is important to first define what is meant by the term. The review analyses some of the difficult issues of definition and identifies how and why there is little agreement on exactly what constitutes elder abuse. Due to limited research and a lack of consistency in defining what to measure and how to measure it, there is also limited agreement on the extent of abuse. However, from the restricted evidence available it is advocated that the abuse of older people is a problem worthy of considerable practical and theoretical attention.

In this chapter I also consider factors that underlie elder abuse in the community setting. A conceptual framework of patient maltreatment (Pillemer, 1988) is utilised to translate and illustrate that the major causative factors of community

abuse can be extended into residential care. As part of Carper's empiric way of knowing (1978), it is recognised that knowledge is generated by the transference of knowledge from one area to a new area of practice. The purpose of this exercise is to generate transferred knowledge of causative factors of elder abuse from the community into the nursing home by demonstrating how categories of causes of domestic elder abuse also apply to resident abuse.

When the definitions, extent and causes of a social problem have been identified it is relevant to move on and consider interventions to address the problem. Many of the causes of elder abuse lie outside the domain of individual practitioners, and extensive discussion of socio structural interventions to reduce social and organisational abuse offer little utility to field workers who come face to face with interpersonal abuse. For this reason the discussion of interventions considers principles to guide workers as they plan interventions to deal with elder abuse.

It is within this interpersonal arena of community and nursing home work that my practical and theoretical practice is situated. Most of this work is directed toward those who are in an abusive relationship, either as victim or abuser, and toward the professionals who work to prevent and deal with abusive relationships.

The final purpose of this part of the literature review is to share my perceptions on the abuse of older people. The choice of articles and the analysis undertaken within the review will reflect these personal views, which have over the years had a significant influence on both my conceptual and clinical work in elder abuse.

The Rights of Older People

In the early 1980s it was at last accepted that seniors were not a homogenous group and that policies and services should consider the specific rights and needs of older people (Graycar & Kinnear, 1981). Human rights laws give legal expression to shared community values as a means of protecting and promoting

fundamental human rights and freedoms to which all Australians are entitled (Sidoti, 1996). Sidoti, then Human Rights Commissioner, identifies the International Covenant on Civil and Political Rights that include the right to life and personal security, to freedom from inhuman or degrading treatment, arbitrary detention or interference with privacy, family, home and correspondence plus the right to equal treatment by the law. Sidoti also talks of the Covenant on Economic, Social and Cultural Rights such as the right to a decent standard of living, including food and nutrition, clothing and housing plus a right to social security and medical care. Each of these rights apply equally to all citizens regardless of their age or state of health, and to deny these rights to any section of the community would be discriminatory (McCallum, 1997).

In similar vein, the United Nations' *Principles for Older Persons* (1982) uphold that seniors have the right to live with dignity, independence and safety, free of ageism and abuse. Unfortunately some do experience ageism (Rowland, 1991), which negates their independence and safety and reduces their ability to claim their rights. A society that sees older people as dependent and valueless reflects these attitudes in ageist policies that equate age with dependency and decline (George & Davis, 1998). It is when changing demography and difficult economic conditions are tied to ageist attitudes, decreased resources and increased societal violence, that elder abuse is a significant issue (Kosberg & Garcia, 1995a). When rights are dishonoured, it is then that older people are at risk of elder abuse.

Besides civil and social rights older people have ethical rights. To be able to meet the needs of abuse victims, health professionals require an understanding of and competence in dealing with ethical issues and honouring ethical ideals (Burke & Laramie, 2000). There are principles that guide practice in responding to elder abuse. These include the ideals of self determination, autonomy and informed consent; of beneficence and the obligation to do good; and justice, or the older person's right to fair and equal treatment (Rini, 2001). Working with victims and perpetrators of abuse requires competence in implementing each of these ideals.

Conceptual ethical principles do not translate easily into practice guidelines and though social and professional standards offer guidance it is the professional's personal ethics that determine how they act when faced with difficult choices. It is in confronting difficult issues that ethical dilemmas arise where the practitioner must address questions of right and wrong, duty and obligation, rights and the moral responsibility to do good and prevent harm (Hawley, 1997).

In dealing with elder abuse the practitioner's first responsibility is to the client and to ensure their own personal and professional attitudes toward older people are positive and their interventions honour client rights and choices. The greater the potential to influence a vulnerable client's decisions or behaviours or to cause harm to an already damaged client, the greater is the obligation to ensure interventions do not cause further harm. (Kingsley, 2001b).

The Abuse of Older People

The discussion of aged care issues in the previous chapter concentrated on the way socio economic, structural and power issues have affected aged care in Australia. Of course each older person will be affected by these wider issues according to their individual situation, relationships and needs. Discussing the general impact of wider social issues is in no way meant to diminish the importance of looking at the needs and rights of individual older persons and how each experiences the impact of socioeconomic policy on their life. A similar pattern will emerge as the review moves on to consider the abuse of older people. In the main the review concentrates on general definitions, categories, incidence and causes of abuse; again this is not meant to detract in any way from the personal experience of those who are harmed by abuse.

Abuse against older persons includes conventional crime (Kingsley & Johnson, 2000) and societal or organisational abuse by a system that devalues older people and allows aged stereotypes and discrimination (Kingsley, 1992c). This thesis

however, centres on elder abuse where an older person experiences harm at the hands of someone they know (Australian Network for the Prevention of Elder Abuse, 1999; Kingsley, 1993) who could be an informal carer, family member, friend or volunteer who gives care to an older person. For convenience, the term carer is used throughout the thesis to distinguish them from paid agency staff or professional workers who give care or service to older people (Biggs et al., 1995).

Other terms that require clarification before beginning the discussion of elder abuse include those of older person, senior or elder. These terms are descriptive and give neutral or positive connotations to older citizens who have the same human and civil rights as the rest of the adult population (Biggs et al., 1995). Biggs et al. suggest these terms convey the special status of older people and denote the fact that they may have special needs or requirements. They avoid using the term 'the elderly' because it reinforces the view of older people as a homogeneous group, which is both depersonalising and an inaccurate description of older people. I agree with these authors and would also hesitate to use the term 'the aged' for the same reasons.

In the Australian context common terms in use are older people, seniors and elders though for some, such as Aboriginal groups, 'an elder' has specific cultural connotations that make me hesitate to talk about an elder when talking about abuse. In discussion with groups of Aboriginal leaders the use of the term elder abuse is accepted even if it is not their preferred term. Nevertheless, the term 'elder abuse' is widely accepted and is a preferred term in the literature. The term elder abuse is often used interchangeably with 'the abuse of older people'

The use of terms such as senior or older person are generally accepted to include those over the age of 65 years of age, a figure used in writing or giving statistics about older Australians (ABS, 1999; Borowski & Hugo, 1997). However, few practitioners apply an exact age limit when responding to elder abuse as they

could exclude victims who experience situations such as chronic disease, physical or psychological disability or premature ageing (Kingsley, 1993).

Some authors have drawn comparisons between elder abuse and domestic violence. McDermott (1993) is one who sees elder abuse as a form of family violence and does not want to see artificial boundaries set purely on the basis of age. Others (Pillemer & Finkelhor, 1988) including myself disagree. Much elder abuse is neither spousal where children or other family members harm older relatives, nor typical of domestic violence when it is not committed by a family member at all. There can also be differences between the power play of domestic violence and elder abuse where both victim and abuser might be victims. It may not be a case of power and punishment but rather dementia and disability when two frail and powerless older people harm each other through neglect because they are unable rather than unwilling to give care (Kingsley & Johnson, 1996a).

There are similarities between domestic violence and elder abuse but there are enough differences to warrant separate consideration from other types of family violence (Kingsley & Johnson, 1996a). Bennett et al. considered whether abuse should be seen as a form of domestic violence and decided elder abuse is "a problem with its own distinctive characteristics that set it apart from family violence". They saw elder abuse as "similar to and yet different from other types of family violence and the differences suggest it must be considered separate to but not in isolation from other forms of family conflict" (1997, pp. 51-2).

It is also important to identify from whose perspective elder abuse is defined. Much of the literature cites professional opinions and observations rather than the perceived reality and experiences of the older person. That is it is 'observer oriented', where abuse is identified and defined from the perspective of the observer who makes "negative judgements" about behaviours that have "jeopardized the wellbeing or safety of the elderly individual" (Phillips, 1983, p. 382). Most descriptions come from observers, which diminishes the personal

definitions of abuse as experienced by older people. To the worker abuse might be described as denial of dignity or poor hygiene. However, the older person involved might bemoan the fact that after being taken to the toilet they feel dirty and abused when they are never given an opportunity to wash their hands, especially when they go to the toilet before a meal. Both parties evaluate this social problem but from different positions and in very different language.

If elder abuse is a social problem (Dunn, 1995; Kingston & Penhale, 1995) then before action is taken to address this problem, definitions must be agreed upon. In this section of the review I show there is little agreement on how to define elder abuse. "The conceptualization of any new social problem is always fraught with difficulties and elder mistreatment is no exception to this rule" (Biggs et al., 1995, p. 46). It is easy to tell abuse stories, but as an issue with many contributing factors it is difficult to set the parameters on just what constitutes abuse.

Definitional Issues: What is Elder Abuse?

From the days of talking about elder abuse in the derogatory terms of granny battering (Burston, 1975) or bashing (Eastman & Sutton, 1982) the phenomena is known in Australia as elder abuse. The Americans, British and Canadians use this term though some American literature subsumes elder abuse and neglect under the umbrella of 'elder mistreatment' (Johnson, 1991). Bennett et al. suggest 'elder abuse' is the accepted term as it "has stood the test of time" (1997, p. 24).

Definitions of elder abuse have evolved as understanding of the complexities of abuse has emerged (Baumhover & Beall, 1996). Although the term 'elder abuse' might seem self explanatory, the literature concludes there is little agreement as to its exact meanings (Hudson, 1989; Payne, Berg & Byars, 1999). When discussing any problem, definitions are important as they act as "pointers towards the social problem in question, they guide the enquirer towards a clear understanding of what the issue involves." In other words they focus attention on an issue and distinguish it from other issues (Biggs et al., 1995, p. 35).

Hudson (1989) undertook a concept analysis of the perceived meanings of elder mistreatment, abuse and neglect. She concluded that the literature contains no clear definition but that most descriptions talk of mistreatment of an adult over 65 years who is abused and / or neglected by a family member or informal caregiver. Hudson identified a need to analyse these concepts before any foundation could be built, by which we can evaluate behaviours and decide which are abusive.

How any concept is defined is "clearly crucial to what is discovered about it" (McCreadie, 1991, p. 24). McCreadie (1993) notes a variety of definitions and suggests most point to general areas of concern and activity, "once an issue has been defined in a specific way, the methods of investigation and the possible solutions are encapsulated within that original definition" (Dobash & Dobash, cited in McCreadie, 1993, p.24). To begin, we need definitions, no matter how imprecise, to help clarify understanding of the topic (Baumhover & Beall, 1996).

Many early definitions concentrated on interpersonal behaviours and focussed on victim and abuser characteristics, as if these were the defining characteristics of elder abuse. Callahan (1988) criticises this practice as it concentrates on individual causes and players and ignores social and institutional abuse. Nevertheless, even though defining specific behaviours as abusive may not encompass the wider forms or causes of abuse these definitions do offer guidance to the practitioner who is confronted with a case of domestic or resident abuse.

In their 1987 review of nine US definitions of elder abuse, the American Medical Association found little agreement of what should form part of a definition. Some describe abuse as "collective harm" or "unnecessary suffering", useful concepts because they tell what abuse is rather than "becoming prematurely entangled in who, which, why, how, and where" (Johnson, 1989, p. 16). Again in a general vein McCreadie (1993) cites Johns, who sees elder abuse as a threat to or actual violation (whether legitimate or illegitimate) of an older person's identity, their boundaries and basic needs for safety, independence, meaning and belonging.

Most commonly definitions give more detail of the abuse or they separate the harm done to the older person into categories, for example a working definition used frequently in UK policy guidelines that describes abuse "as physical, sexual, psychological or financial. It may be intentional or unintentional or the result of neglect. It causes harm to the older person, either temporarily or over a period of time" (Bennett, et al., 1997, p. 27).

Some definitions describe the act of abuse and also identify the perpetrator such as one that refers to injury, mistreatment or neglect in the physical, psychological and sociological domains that is inflicted by caregivers (Coyne, Reichman & Berbig, 1993). Another describes the systematic physical, emotional or financial abuse of an older person by a caregiving relative (Eastman, 1984) and Australians McCallum et al. talk of "a pattern of behaviour by a person that results in physical or psychological harm to an older person" (1990, p. 11).

More definitions however, include the outcomes of the abuse such as "human-originated acts of commission and omission and human created or tolerated conditions that inhibit or preclude unfolding and development of the inherent potential of elders" (Kingston & Penhale, 1995, p. 6). Another speaks of acts "of commission or omission by a caregiver in a formal or informal setting which results in physical or mental harm, neglect or violation of the rights of the elderly person" (Ottawa-Carleton COTA, cited in Hutchison & Schulman, 1989, p. 12). One definition that seems to include all of the above factors talks of

> destructive behaviour that is directed toward an older adult, occurs within the context of a relationship connoting trust, and is of sufficient intensity and/or frequency to produce harmful physical, psychological, social, and/or financial effects of unnecessary suffering, injury, pain, loss, and/or violation of human rights and poorer quality of life for the older adult. (Hudson, Armachain, Beasley & Carlson, 1998, p. 539)

A UK 'Action on Elder Abuse' 1995 definition followed the general intent of most of the working definitions already developed in Australia. It talks of abuse as "a single or repeated act, or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (Bennett, et al., 1997, p. 27).

Although there has been considerable development and change in my experience and conceptualisation of elder abuse, there has been little significant change in how the concept has been described in my working documents and articles. The recent protocol talks generally of elder abuse as "the wilful or unintentional acts that harm an older person and which occur within a relationship that implies a level of trust" (Kingsley, 2000a, p. 3). Other Australian definitions are similar in that they also tend to be practical working descriptions that are given to help workers recognise and identify abuse, rather than the philosophical statements of some definitions (Barron et al., 1990; NSW Task Force on Abuse of Older People, 1992; Office of the Commissioner for the Ageing, 1992).

Each of the above definitions has similarities, they include notions of frequency, acts of commission or omission, an ongoing relationship between the parties that involves some level of trust, plus an outcome of harm to the older person. Because these definitions talk of abuse occurring within an ongoing relationship they tend to exclude self neglect or harm caused to an older person by an unknown assailant (Kingsley, 1993). This is not to say that these are not abusive acts toward older people, they are, but they require different means of prevention and intervention than does abuse that occurs within a continuing relationship.

Ongoing experience in dealing with abuse, future research, analysis, intervention and reflection, and new understandings may well challenge the existing dogma on abuse and lead to new terms and definitions that may be even more useful for those involved in dealing with elder abuse (Biggs et al., 1995).

Definitional Issues: What is Resident Abuse?

Resident abuse is really one form of elder abuse and though many of the definitional factors of elder abuse also apply to nursing homes, the debate on resident abuse has similar variations in definitions (McCreadie, 1996: Pillemer, 1988). Like the concept of elder abuse, resident abuse is also a broad generic term used to describe harm to a resident that is an outcome of government, organisational, interpersonal or individual acts of omission or commission. In this thesis however, the term is used to describe harm caused to a resident by a staff member from whom they have every right to expect safe care (Kingsley, 2000b).

There are two general types of care delivered to residents in the nursing home, technical and interpersonal care (Donabedian, 1985). Donabedian sees technical care as the more scientific and technological care applied by doctors, nurses and other health specialties whereas interpersonal care includes the more social and interpersonal interactions between staff and residents. Ideally interpersonal care will meet with resident expectations and comply with the social norms, values and expectations for interpersonal relationships plus the ethical standards of the health professions. Pillemer agrees that the quality of the interpersonal relationship between staff and residents "can be measured by the degree of conformity to these values, norms and expectations" (1988, p. 228).

In setting a research agenda for resident abuse Pillemer sees abuse as fitting within the process aspect of how care is provided. He defines patient maltreatment as "a deviation from expected standards for high quality care ... a deviation from socially accepted standards for the interpersonal process between staff and patients" (1988, p. 228). Continuing in the same vein in a later article, Pillemer and Moore (1990) also talk about resident abuse as inadequate or inappropriate staff practices, inappropriate patient management and inhumane care in the course of patient care. These descriptions again imply that, in resident abuse, the norms and expectations of quality care are not being met.

Pillemer (1988) suggests many definitions of resident abuse are vague, confusing and lack specifics. However, some seem more comprehensive rather than vague, such as Meddaugh who talks of "the abnormal expression of the caretaking role in which the needs of a person for physical and emotional support are increased or ignored" (1993, p. 21). Over the Atlantic, the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) also see resident abuse in general terms. They see resident abuse as "the result of the misuse of power or betrayal of trust, respect or intimacy between the practitioner and the client, which the practitioner should know would cause physical or emotional harm to the client" (1999, p. 5).

Overall these definitions suggest that resident abuse implies the norms and values of care are not met in the interpersonal relationships between residents and those who give care. The result is unsafe, inhumane or inappropriate care or neglect of care that causes harm to a resident. Tied to definitions of abuse are the categories of behaviour that describe the types of harm experienced by older people.

Categories of Abuse Against Older Persons

To explain and describe elder abuse it is necessary to identify and differentiate between the various categories of abuse (Gilliland & Jimenez, 1996; Wolf, 1992). Similarly, to be able to identify and intervene in cases of elder abuse, knowledge of the types of abuse being experienced by older people is required.

Murder, rape, or major theft is shocking and dramatic (Foner, 1994), but elder abuse also involves subtle categories of 'overt' or 'covert' harm (Meddaugh, 1993; Podnieks, 1990). It includes harm by 'omission' where the older person's needs are neglected and not fulfilled, or by 'commission' which includes careless destructive, improper or indecent behaviours (Hudson, 1989). Other categories include 'active' and 'passive' abuse (McCallum et al., 1990), 'intentional' and 'unintentional' abuse (Bennett, et al., 1997), plus the unlikely categories of 'legitimate' and 'illegitimate' abuse (Johns, 1991, cited in McCreadie, 1993).

However, many working documents include a more descriptive element of the categories of abuse rather than just noting whether the abuse is passive, deliberate or legitimate. These categories generally include physical, sexual, psychological, financial or material abuse and the neglect of an older person though authors may add other categories that they have identified in their work or research (Kingsley, 1993; McCreadie, 1991; Wolf & Pillemer, 1989). From work with older people and with other professional workers in the field, I also include the categories of social and spiritual abuse in more recent work (Kingsley, 2000a).

From a review of the literature Lachs and Pillemer (1995) found all discussions on abuse include physical harm, most include psychological or emotional abuse and many include material abuse or exploitation. However, other descriptions of abuse categories such as my own include sexual abuse as a separate category rather than including it as a part of physical abuse (Kingsley, 1993, 2000a; NSW Task force on Abuse of Older People, 1992; OSI, 1997).

Sexual abuse can include sexual harassment, denial of the right to have relationships or denial of the dignity and privacy for intimate or personal expressions of an older person's sexuality. Although these abuses are sexual they may not include any physical contact or harm. The outcomes of sexual and physical abuse can also differ, where sexual abuse may cause physical damage but will often leave more mental and emotional scars than a hit or burn. Similarly the interventions for violent sexual assault or even denial of sexual rights can be vastly different than for many forms of physical abuse.

Evidence suggests community and nursing home victims may experience the same general categories of abuse (Pillemer, 1988). However because of the environment in which care is given and the relationships between management, staff and residents, the nature and descriptors of resident abuse and neglect may differ (Goodridge et al., 1996; Kingsley, 2001a).

A number of practical categories of abuse have emerged over time, which have been useful for workers in their identification of abuse. These are reproduced below (Kingsley, 2000a, p. 4).

Physical Abuse

e.g. physical coercion, pain or injury; substandard or very poor quality living conditions, food or physical care; denial of choice of diet, hygiene care or physical activity; overmedication or refusal of medication; inappropriate use of physical or chemical restraint.

Sexual Abuse

e.g. sexually abusive or exploitive behaviour such as rape, indecent assault or sexual harassment; denial of the older person's right for an intimate relationship or opportunity to express their sexuality or personhood.

Psychological Abuse

e.g. threat, intimidation or coercion that leads to feelings of indignity, powerlessness or fear; labelling or treating older people as children; disregard for dignity and personal needs; disrespect for an older person's wisdom, culture or customs.

Social Abuse

e.g. social isolation; exclusion from activities or forced inclusion or participation in social activities.

Spiritual Abuse

e.g. disregard of spiritual beliefs or values; denial of the older person's right to partake in religious or spiritual customs or practice.

Financial Abuse

e.g. illegal, improper, uninvited use or inappropriate sharing of the older person's finances or possessions; denying access to, or control over personal affairs; forced changes to a will or other documents.

Neglect

e.g. failure to provide service or care to meet personal needs; lack of appropriate physical, mental, spiritual, social or cultural stimulation; making decisions for competent older people; delay or non compliance with medical or nursing orders.

The Extent of Elder Abuse

It has been asked whether elder abuse is on the increase or have new awareness and expectations of standards of care redefined and extended the understanding of what constitutes abuse (Stearns, 1986). There may have been new awareness and recognition of abuse but it is suggested that, with an increasing aged population, abuse will be on the increase. If efforts are to be made to address any social problem some estimates of its extent and significance are necessary.

It is appropriate to ask if elder abuse is a significant issue. Because it is often hidden, the incidence is unknown. Kinnear and Graycar (1999) suggest it is hard to measure elder abuse because there are different definitions of what abuse is, different research methodologies for measuring abuse, it often occurs behind closed doors in the private arena and older people may not regard the abuse as a crime or serious enough to warrant disclosure and intervention. There is also high underreporting, either because there may be no one to report to or because there are few health and justice systems to deal with abuse (Kinnear & Graycar). Because many older people are either unwilling or unable to disclose abuse, this underreporting is a distinct barrier to the detection of abuse (Kurrle, 2001).

In discussing the extent of elder abuse epidemiologist McCallum (1993b) talks of maximisers and minimisers. Maximisers suggest we only see the tip of the iceberg of a hidden, under reported problem. Minimisers on the other hand suggest the incidence of abuse is over estimated and it is not an issue for alarm. However, there appear to be more maximisers than minimisers when authors claim that "abuse and mistreatment of the elderly by family and other caregivers are now recognized as problems of staggering proportions" (Pettee, 1997, p. 7). The US National Center of Elder Abuse figures showed a 206% increase in reporting of abuse between 1987-1994 (Wolf, 1996). Similarly, in Ireland two reports show parental abuse by adult children is increasing at an alarming rate with the number of calls from victims doubling during 1998 (Birchard, 1999).

There are similar claims that resident abuse by nursing assistants is prevalent (Pillemer & Moore, 1989). Similarly, in the UK there is a "shocking amount of abuse" by staff (Lipley, 2000, p. 6), which is on the increase (Castledine, 1994). The UKCC says "we are seeing the sort of abuse and poor practice that was common in large institutions in the 70s" and if similar behaviour was seen in a hospital it would lead to an inquiry, but in "small nursing homes it tends not to create the amount of concern nationally that it should do" (Eaton, 1993, p. 16).

Extent of Community Elder Abuse

There has been increased awareness of elder abuse over recent decades with studies in the US (Pillemer & Finkelhor, 1988), the UK (Ogg & Bennett, 1992), Canada (Podnieks, 1990) and Australia. (Kurrle et al., 1991).

A US random survey found a prevalence of 32:1000 for physical, psychological / verbal abuse and neglect (Pillemer & Finkelhor, 1988). The Canadian prevalence was 45:1000 (Podnieks, 1990) and British rates were 15.2:1,000 for physical abuse, 53.9:1,000 for verbal abuse and 15.2:1,000 for financial abuse (McCreadie, 1996). In Australia a retrospective audit of clients of a NSW, ACAT found that 4.6% experienced physical abuse or neglect (Kurrle et al., 1991). The full extent of the problem is unknown, however figures suggest the Australian prevalence rate is similar to that in other countries (Sadler & Kurrle, 1993).

None of these studies have been exhaustive in scope, few used consistent methodologies or sampled the same type of populations, nor did they measure identical categories of abuse. These methodological factors limit data collection and make the comparison of figures difficult. However, although the defining characteristics of elder abuse and the research tools suggest there is little consistency in measuring abuse, there are nevertheless some similarities in the limited estimates of abuse. These results, which suggest between 3.2% (Pillemer & Finkelhor, 1988) and 10% (Lau & Kosberg, 1979) of older people experience some form of abuse, are still seen as current (Hogstel & Cox Curry, 1999).

Australian figures suggest 4.6% of ACAT clients (Kurrle et al., 1991) and up to 7% of people with mental incompetence (OSI, 1996) experience abuse. It is also a problem for people of Aboriginal (Morrison, 1994) and culturally diverse backgrounds (City of Canning, personal communication (letter) Chief Executive, 1992, August 13; NSW Taskforce on Abuse of Older People, 1992). Few conclusions about prevalence for abuse amongst ACAT clients can be generalised to the total aged population (Kurrle, Sadler, Lockwood & Cameron, 1997), and these figures only include the cases identified by health workers. Extensive research is needed to show whether these figures indicate the real extent of aged abuse or whether they are just the tip of the iceberg (McCallum, 1993a).

Elder abuse is a sensitive emotional and often taboo topic for older people, and more victims will not disclose their abuse than will make up tales of abuse (Tomita, 1982). This nondisclosure makes it difficult to gain any exact count of cases. It has also been suggested that the more frail and those without the cognitive ability to recognise what is happening to them may be the people who are most at risk of abuse, who underreport their abuse and who are underreported in the research (Biggs et al., 1995).

Extent of Resident Abuse

It is suggested that how the severity and extent of resident abuse is perceived will be determined by the type of abuse, and the role the observer occupies in aged care. A 1990 US Office of the Inspector General survey found nursing home administrators and industry personnel believe the problem is only minor while the majority of resident advocates and respondents from state oversight agencies see the problem is either moderate or severe. (Paton, Huber & Netting, 1994). It is yet to be identified just how extensive residents perceive the problem to be.

From a review of early abuse literature, Paton et al. conclude that resident care "has been categorized by negativity, and at times, has even been damned for outright neglect and abuse leading to injury, debility and death" (1994, p, 98). It

is difficult to gain accurate estimates of the nature or extent of resident abuse for a number of reasons. While there are variations in definitions and methodologies, research is likely to underestimate the extent of abuse (Hudson, 1989; Payne et al., 1999). Another difficulty in gaining an accurate measure of resident abuse is tied to the hidden nature of abuse. Rarely will staff admit they cause harm to a resident and it is not easy to observe many forms of abuse, because as soon as another staff member or a researcher appears the abuse is likely to stop (Kinglsey, 2000b). There are also legal and ethical issues related to identifying and measuring abuse, entrapment is rarely acceptable and there are ethical issues in using hidden devices such as microphones or cameras or using undercover staff to gain evidence of suspected resident abuse (Speaks, 1996).

There are few available data on resident abuse. No national prevalence studies have been documented in the US (Lachs & Pillemer, 1995), the UK or around Europe (Tonks & Bennett, 1999). However, some estimates indicate that resident abuse is a problem that requires attention (Paton et al., 1994). A UK 'British Action on Elder Abuse' project found 27.5% of elder abuse occurred in residential settings (Griffin & Aitken, 1999) and the national figures of the American Administration of Aging showed 70% of complaints were against nursing homes (Paton et al.). A US study of three nursing homes also suggested abuse is prevalent when they found that 92.5% of aides had "seen or heard of a resident being mistreated" (Mercer, Heacock & Beck, 1993, p. 106).

A review of 51 US Ombudsman Programs found complaints of physical harm outnumbered psychological abuse by more than 5:1 and neglect by 2:1 (Paton et al., 1994). In their study Watson et al. (1993) found that assault-battery (33.5%) and neglect (30.4%) were the two most often cited forms of abuse, followed by fiduciary or material abuse (9.4%) and verbal abuse (5.8%). By contrast Pillemer and Moore (1989) found psychological (81%) and physical (36%) abuse were the most common forms of abuse seen by staff. Evidence also suggests that resident abuse is a problem on the increase (Hogstel & Cox-Curry, 1999).

To date there are no Australian prevalence rates for resident abuse but it has been accepted as a problem from the time of Ronald's (1988) review of nursing home and hostel care.

The Causes of Elder Abuse

The causes of elder abuse are diverse and there is little agreement on the major risk factors of abuse. In a situation of diverse understanding of the reasons why one person will harm another, there is a need for some organising framework to help researchers and practitioners discern the causal factors related to the abuse of older people (Harbison, 1999). Simplistic explanations of this complex problem, especially those which separate the players from the social and structural context in which abusive relationships occur, will rarely explain the complex causes of elder abuse.

McCreadie was asked by the UK Department of Health to clarify what was known about abuse in the UK. "The study examined American and Canadian research findings, as well as the very modest United Kingdom contributions and concurred with recent thinking that elder abuse is a more complex and multi-dimensional issue than has often been recognized" (1993, p. 19). Different types of abuse occur for different reasons (Homer & Gilleard, 1990), and no one explanation can clarify how such an enmeshment of causes and categories can be manifested in so many different abusive relationships. The development and use of theoretical explanations of elder abuse that look past the characteristics and behaviours of the older person and their abuser to include the issues of the broader contextual framework in which the abusive relationship occurs, will aid understanding of the causes of abuse (Kosberg & Nahmiash, 1996).

Bennett et al. summarise this view and suggest that how the discrimination, routine devaluation and lowered status of older people in an ageist society; the poverty, oppression and marginalisation faced by many older people; mixed with

mental or physical pathology of the victim or perpetrator; and a general lack of resources to prevent or deal with abuse, will exacerbate the problem. Any one of these factors may not be enough to cause abuse, but it is the "potential interplay of individual, structural and societal circumstances that leads to the pervasive and somewhat intractable nature of many of the abusive situations experienced by individuals in whatever setting the abuse occurs" (1997, p. 51).

Bennett et al. talk of a taxonomy that they found helpful for "deconstructing the different forms of abuse", where they consider elder abuse by type and align each type with a structural micro, meso or macro level of abuse (1997, p. 9). Their micro level of abuse is the abuse between individuals, meso level abuse comprises institutional abuse, and macro level abuse is the wider form of political abuse of older people. These authors agree that locating the types of abuse within some framework can suggest causes of the different levels of abuse.

Social ecological models of family and social behaviours utilise similar levels or subsystems that are also useful to the discussion of the causes of elder abuse (Schiamberg & Gans, 1999; Seligman & Darling, 1997). Seligman and Darling talk of the microsystem or patterns of roles, functions and interpersonal relationships, the mesosystem or the range of environments and settings where members actively function and interact. They also include the ecosystem or outside systems in which members might not be actively involved but which still affect the operation of the group or relationships, and the macrosystem that reflects the values of the wider social, economic, cultural or political institutions. These concepts suggest that changes in any part of the system will have an effect on the other parts or subsystems. For example, any positive or negative changes in the macro or ecosystems that influence community support and services for older people, will have a corresponding effect on the more personal meso and micro systems of older people and the delivery of their care. This classification system can also give some indication of types and causes of abuse.

There are many causes of elder abuse and it is fruitless to try and isolate one cause (Barron et al., 1990). During the 1990s talk of an ageing population causing increased costs and burdens to society became "stigmatising and discriminatory"; few recognised the wisdom and contribution of older people but talked of an "apocalyptic scenario of increasing numbers of older people" (McCallum et al., 1990, p. 15). Little has changed since then, and ageism and sexism are still two strong but negative social values in Australia that contribute to the "broader social causes for the victimization of vulnerable persons" (Dunn, 1995, p. 21).

It is unlikely that any one cause or theory will explain all aspects of abuse, nor will one sociological framework explain why one person harms another. Theories about the role of power (Haralambos, 1980), social interaction and social exchange (Phillips, 1986); theories regarding the influence of reasoned action (Ajzen & Fishbein, 1980), stress (Selye, 1956), crisis (Parad, 1965) and learned behaviours (Bandura, 1977) can all be used to try and explain elder abuse. Even though each of these frameworks may make some contribution to the explanation of elder abuse it is suggested none would explain all aspects of abuse.

Causative Factors for Community Elder Abuse

Professional practice in elder abuse has led me to speculate about four categories of risk factors that seem to relate to elder abuse. These include

- *victim characteristics,* that do not cause abuse but may potentiate abuse
- *abuser attitudes, behaviours and characteristics,* that influence quality of care
- *the context in which care is given,* including the general and interpersonal environment within which the abusive relationship takes place
- *the wider socio structural issues of aged care,* that have a profound influence on society's attitudes toward and treatment of older people, and also on the nature, scope and quality of care available to older people and their carers.

Each of these four categories will be discussed, first from the perspective of community abuse and then in relation to resident abuse.

Older people as the victims of elder abuse

Not all old people are abused and no precise relationships between the victim's characteristics and their maltreatment exists, nevertheless victim characteristics do seem to potentiate abuse. Community victims are mostly female (Clarke & Ogg, 1994; Kleinschmidt, 1997), usually over 75 years of age (Bennett, 1990; McCreadie, 1996) and often poor (Lachs, Williams, O'Brien, Hurst & Horwitz, 1997). Many victims are physically well and capable (Wolf, 1989) but others, who are frail or functionally impaired, experience poor physical and mental health (Biggs et al., 1995) and depend on their carer for care (Lachs & Pillemer, 1995; Podnieks, 1990). Of those who experience cognitive confusion, depression or functional impairment, a few are bedridden, half need mobility devices and many have difficulty with acts of daily living (Bennett, 1990; Fulmer, 2000).

Homer and Gilleard (1990) saw no relationship between abuse and dementia or mental illness though they found a relationship between poor communication skills and physical abuse, and between disruptive behaviours and verbal abuse. Lachs and Pillemer (1995) found no relationship between victim poor health, functional impairment and abuse yet they suggest physical frailty may increase an older person's vulnerability to abuse in the presence of other risk factors such as cognitive impairment, a history of family conflict or living with their abuser.

Victims are likely to live with their abuser (Biggs et al., 1995; Humphries Lynch, 1997) with a general exception of those who experience financial abuse (Podnieks, 1990). Victims of financial abuse tend to be unmarried, live alone with limited social networks and have relative(s) who are financially dependent on them (Humphries Lynch, 1997; Wolf, 1989). Many victims, regardless of where they live, have limited social networks (Wolf, 1996), the social contacts they do have are often less than satisfactory (Biggs et al., 1995) and many experience social isolation (Greenberg, McKibben & Raymond, 1993). Again there is no agreement on this factor with Homer and Gilleard (1990) not finding social isolation to be a significant risk factor for elder abuse.

Victim 'dependency' is another debated factor and while some victims are dependent on their carer for care (Humphries Lynch, 1997), there is little direct relationship between excessive dependency and abuse (Lachs & Pillemer, 1995). Some may be dependent but many are also obstinate and will reject available help (Sadler & Kurrle, 1993). On the other hand, Biggs et al. (1995) found abused seniors were no more dependent than 'non abused' seniors.

These data illustrate some of the victim factors that may influence abuse, though the evidence for their power as risk factors is not certain from the literature. As discussed in Chapter Three some carers feel burdened by their caring responsibilities and become stressed when they must continually cope with demanding or disruptive behaviour (Braithwaite, 1990). Nevertheless, although these victim factors may give some understanding of why abuse might happen, victim issues do not excuse or vindicate the harming of one person by another.

The perpetrators of elder abuse

Though many abuse issues relate to the older person, the ultimate responsibility for safe care comes back to those who deliver that care and abuse is associated more with the problems and characteristics of the abuser than the victim (McCreadie & Tinker, 1993; Wolf, 1994).

As not all older people experience abuse, neither will all those who give care or have a relationship of trust with an older person abuse. There is no clear picture of the abuser but a number of characteristics do appear to be associated with abuse. Abusers are likely to be male (Penhale, 1999), a spouse, adult child especially a son, or relative who is a carer (Birchard, 1999; Lithwick et al., 1999; Roberts, 1993). The age of perpetrators range from young to old and most appear to be from a non English speaking background (Lachs et al., 1997). A high percentage of abusers are either retired or unemployed, though it is unclear whether their lack of employment relates to unemployment or their being a full time carer (Brownell, Berman & Salamone, 1999; Pritchard, 1993).

Breckman and Adelman (1988) divide abusers into two categories; those with caregiving stress and those with malevolent motives. A third category could include abusers who have problems with their mental status and mental health.

With regard to Breckman and Adelman's (1988) first category of abusers, some feel stressed and burdened from being a carer (Hogstel & Cox Curry, 1999; McCreadie & Tinker, 1993) and some become stressed when they have inadequate options for care (Kinnear & Graycar, 1999) or when they feel forced to make all the decisions about the older person's care (Douglas & Davis, 1994). Under these circumstances, caring can become a source of continuing stress from social isolation (Bendik, 1992) though some suggest carer stress is less of a factor than first thought and, when it is a factor, it is usually associated with dependency or other mediating factors (Kinnear & Graycar). Nevertheless, it is interesting to note that community workers still consider carer stress, victim dependency and social isolation as the major causes of abuse (McLaughlin & Lavery, 1999).

Breckman and Adelman's (1988) second category of abusers includes those who perpetrate from malevolent intent such as revenge for abuse as a child (Hogstel & Cox Curry, 1999) or from greed and selfishness (Sadler & Kurrle, 1993). These people may experience severe financial problems from the use of drugs and alcohol or from a gambling habit, and they abuse or defraud the older person in order to feed their dependency (Pritchard, 1993; Wolf, 1994). A number of abusers have had contact with the criminal justice system (Brownell et al., 1999) and some, in order to feel more powerful, vent their frustration and anger on the closest most vulnerable person (Garcia & Kosberg, 1992).

I would add a third category of possible causes, which includes the abuser's mental status. Mental health issues related to abuse include psychopathology and cognitive impairment (Sadler & Kurrle, 1993), developmental disability (Greenberg et al., 1993) and mental illness (Brownell et al., 1999). These abusers often have a history of poor relationships (McCreadie & Tinker, 1993), low self

esteem (Pillemer & Suitor, 1992), uncontrolled anger (Garcia & Kosberg, 1992), emotional problems and psychotic conditions (Pillemer & Finkelhor, 1988) or a recent decline in mental status (Wolf & Pillemer, 1989). However, abusers with no specific mental illness may have problems with chemical dependence on drugs or alcohol that affect mental health and behaviour (Birchard, 1999; Greenberg et al., 1993), and which may be at the root of their abuse (Pritchard, 1993).

Although some general perpetrator characteristics do relate to elder abuse, more evidence is required before any claims about the 'typical abuser' can be made. It seems more likely that research on the changing contextual environment within which most care is given will give useful information about the causative factors of elder abuse.

The context of care in which elder abuse occurs

Few behaviours can be judged without regard to the socio ecological factors and environmental context in which they occur, and elder abuse is no exception (Kingsley, 1992c; Seligman & Darling, 1997). There is a need to move from the strictly two actor view of elder abuse and to consider the wider environmental issues that influence relationships (Bennett, et al., 1997).

Some abuse is played out in an atmosphere of ageism where people hold negative and discriminatory attitudes that devalue older people and their rights (McKimmie, 1992). Some carers are more conscript than volunteer who do not want to be in a caring relationship with the older person, especially when taking on the caring role thwarts their own plans or goals (Bennett, et al., 1997). Many in an abusive relationship have increased, sometimes unreal, expectations of the other (Bennett, 1990) and some have difficulty communicating with one another, which suggests a context of faulty communication rather than "faulty people" (Seligman & Darling, 1997, p. 10). Nevertheless, living in such an environment is not conducive to safe care and suggests a context of ongoing or recurring abuse (Washington Criminal Justice Services Department, n.d.).

Violence is a matter of relationship rather than function, which suggests we should look at the context of abusive relationships as well as the role and function of those involved (Johnson, 1989). To understand the relational aspects of abuse it is necessary to look back and consider past abusive relationships, past experiences of pathological family dynamics and interpersonal processes that give rise to a highly charged abusive environment (Homer & Gilleard, 1990; Sadler & Kurrle, 1993). For example, intergenerational violence occurs where a once abused child now caring for a previously abusive parent will, in retribution, harm their now dependent parent (Biggs et al., 1995). There are also examples of where long standing spousal abuse continues into old age, but in some instances it now takes the form of reverse or inverted abuse where a previously harmed wife takes revenge on her now dependent spouse (Biggs et al.).

Abusive relationships often exist within a context of unequally distributed power (Haramblos, 1980). Violence may be an outcome of perceived powerlessness, when carers abuse to compensate for their perceived lack of power over the relationship or resources (Finkelhor, 1984; Kingsley & Johnson, 2000). Much abuse also occurs within a context of reverse dependence where the abuser relies on their victim for sustenance. Although some victims depend on their carer, there are many cases of reverse dependence where abusers rely on their victim for emotional, practical and financial support (Biggs et al., 1995; Franco, Gray, Gregware & Meyer, 1999), such as when they move in and live in their victim's home (Korbin, Anetzberger, Thomasson and Austin, 1991). A significant number of victims find that even in old age they are expected to support their children with somewhere to live, with money, by providing child minding services and by performing domestic chores (Bennett, 1990; Pillemer, 1986; Wolf, 1994). That is, they live in a context where they make a major contribution to the relationship but exert little power and receive little in return.

There are other cases of abuse that occur within a context of mutual powerlessness and dependence. For example, where both abuser and victim have

mental or physical problems and are either unable or unwilling to give care and attention, there is a grave risk of neglect (Kingsley & Johnson, 1996a). It is in this context of mutual dependence and inability to care that many sad cases of abuse are seen. It may not be a case of intentional harm, but more a case of incapacity to meet the needs of the self and the other. This situation often relates to circumstances where there are insufficient family or outside services or supports coming into the home, regardless of whether this deficiency arises from a lack of support (Wolf, 1996) or a lack of knowledge about available services (Sadler & Kurrle, 1993). Bennett et al. (1997) note that isolated older people and carers with limited access to family, friends or outside support are less insulated from abuse and are at higher risk of violence.

A number of studies suggest older victims and abusers have few contacts outside the home (Pillemer, 1986), or options for care or alternative care arrangements (Kinnear & Graycar, 1999; Podnieks, 1992; Wolf, 1996). As a consequence they may have no one to turn to for help should they feel threatened and experience abuse or wish to seek help to prevent or stop their abuse (Biggs et al., 1995).

Each individual influences the context in which they live, and each is influenced by the context of recurring interactions within the group or family. Individuals within a family are members of a social system where their actions are influenced by the past and present characteristics of the overall system. Similarly, families exist within the context of the group and, because the behaviours of one member will affect other members, no one functions in isolation (Seligman & Darling, 1997). In elder abuse this means the contextual causes of abuse are dynamic and change as the caring relationship changes and develops, and especially as the context of care and the more external environment changes over time.

Socio structural factors and elder abuse

In the early conceptualisation of elder abuse the societal factors related to abuse were largely discounted, and causal explanations were based in the psychological

disorders and mental health problems of victims and their abusers (Bennett, et al., 1997). However, it is now recognised that much abuse is related to wider social and structural factors of the society within which the abusive relationship occurs. Abuse tends to flourish within a culture which allows it to be acceptable (McCreadie, 1996) and the social attitudes and structural factors that influence the life quality of older people must be considered in order to understand the complexity of elder abuse (Kinnear & Graycar, 1999; McCreadie, 1996).

In the early 1990s the growing number of older Australians was tied to increasing ageist and sexist attitudes (Dunn, 1995), which were set against a need for increased resources to meet the needs of this growing group (Rowland, 1991). The political and economic culture has never adequately resourced aged care (Wolf, 1994), their health care is rationed (Bennett, et al., 1997) and they receive insufficient support and respite services. The economic culture also fails to recognise the input of carers or to recompense them for their caregiving, care that would otherwise become the responsibility of governments and bureaucracies (Hicks, 1986; Walker, 1989). There is no Australian legislation that specifically protects older people from domestic abuse or neglect (James, 1994), and though community programs have changed some attitudes toward the abuse of older people (Kingsley & Johnson, 1996b), elder abuse still seems to be accepted by many as a private family affair that is not the concern of the greater society.

Seligman and Darling (1997) suggest a basic tenet of the socio ecological paradigm is that any changes in the wider ecological system affect the subparts of that system; to change behaviours there is a need to change the environment within which those behaviours are acted out. This means events that occur in the wider society such as changes to economic, social, health or aged care policies and practices on a state or national level, will have an influence on the individual players and stakeholders in aged care. It is essential to consider the macro level of elder abuse if we are to ever place the meso and micro levels of abuse within some sort of sociological framework (Bennett, et al., 1997).

In considering historical and contemporary, social, cultural, political and economic factors it will soon become apparent that these factors affect older people, their carers and the various risk factors for elder abuse. History tells mixed stories of the "death-accelerating behaviours" inflicted on older people by society (Biggs et al., 1995, p. 20) and these authors cite Minois's (1989) historic factors that have influenced the status and plight of older people in the past and which they suggest are re-emerging with a vengeance in the postmodern world.

Minois's factors (cited in Biggs et al., 1995) suggest that in societies with no age protection, weak old people are worse off than in societies where the weak are protected. Similarly, in cultures that worship youth and beauty, older people with illness or physical deterioration are denigrated and unacceptable. In technological times the skills of older people become obsolete and they lose the status their previous 'wisdom' and ability to act as a link between the generations gave them. Finally, in cultures of nuclear families there are few extended families to give care to older people who are incapable of working and supporting themselves. These changes suggest the diminished status and role of older people, their poverty and the financial dependence of their adult children, their weakened kinship systems, their perceived loss of wisdom and value in the face of technology and progress, and the handover of leadership from older people to middle aged adults all act as risk factors for elder abuse (Hudson et al., 1998).

This section of the review has considered four categories of risk factors that relate to elder abuse in the community setting. None of these factors alone will explain why elder abuse happens, but together they give some indication of the likely causes of abuse and some of the conditions under which abuse might occur.

Causative Factors for Resident Abuse

"The experience of reading numbers of reports about scandalous care is profound. 'Instead of being hardened, I have become punch drunk: angry, helpless, dejected and with a feeling of revolt in my stomach'" (Clough, 1999, pp. 13-14). Clough

cites his own words from his 1988 review of institutional abuse for the British Wagner Report. Although he sees the problem as one of scandal he also notes that drawing attention to residential practice is problematic because of the difficulties in highlighting the scale and causes of abuse and in positioning the abuse within the totality of resident care. However, he advocates there "is nothing to be gained by sweeping the dirt under the carpet" (p. 14) and so it is necessary to consider the risk factors for resident abuse.

This section of the review considers resident abuse. I build on the four risk factors for community elder abuse and apply them to an existing model of resident abuse. In the review I explore parallel relationships to see whether the proposed causes of community abuse are comparable to the causes that US researcher Karl Pillemer (1988) suggests apply to abuse in residential care. From personal experience it seems evident that elements of the causes of community abuse are consistent with the predictor variables of Pillemer's model of patient maltreatment that, in Australia, would be called resident abuse. In extending my perception of community abuse to Pillemer's nursing home model it will be shown that these factors demonstrate similar relationships and issues in residential care as in the community. Consideration of the community variables, and their similarity to the predictor variables of nursing home abuse will provide a potentially helpful framework for explaining and responding to elder abuse.

Extension of Community Elder Abuse to Pillemer's Model of Patient Maltreatment

Pillemer's theoretical model of patient maltreatment in the nursing home

Pillemer (1988), one of the early authors and researchers into elder abuse, has had a significant influence on the work and research on this topic (McCreadie, 1996). In his overview of the maltreatment of nursing home patients, Pillemer offers a theoretical model (see Figure 1), which he proposes should drive the agenda for future work on resident abuse. Pillemer models maltreatment as an outcome of

patient and staff characteristics that are influenced by aspects of the environment in which care is given, and by certain exogenous factors over which the parties have little or no control but which influence the caring relationship. To explain maltreatment he proposes the investigation of these four 'predictor variables', which he believes are associated with resident abuse.

NURSING HOME ENVIRONMENT

PATIENT CHARACTERISTICS

EXOGENOUS FACTORS

PATIENT MALTREATMENT

STAFF CHARACTERISTICS

Figure 1. Theoretical Model of Patient Maltreatment

In extending my community perceptions to Pillemer's (1988) nursing home model it is necessary to change the terminology in a way that allows the intent of the variables to be maintained but which translates them to incorporate the factors that Pillemer suggests apply in the nursing home.

Community Application		Nursing Home Application
Older Person	*translation of*	Patient / Resident
Perpetrators	*terminology*	Staff
Context of Care	*applied to the*	Nursing Home Environment
Socio Structural Factors	*nursing home*	Exogenous Factors.

The question of whether previously discussed community risk factors can be applied to the abuse of nursing home residents is addressed by research and sociological writings that corroborate the identified categories of causality. My analysis of causality now considers residents who are victims of abuse and the subset of staff who perpetrate abuse, I also consider the influence of the nursing

home environment on safe care and the exogenous societal issues that have an influence on abuse within the nursing home setting.

Obviously not all residents will be abused, nor will all nursing home care staff commit abuse. This part of the review largely ignores the quality care given to older people and concentrates on the causes of harm to residents.

Patient characteristics and resident abuse

Only a small percentage of older people live in nursing homes but they are a vulnerable group with significant physical and mental impairments who require skilled specialist care (Ruler, 1998). Abused residents tend to be older with an average age of over 80 years (Watson et al., 1993). Their gender however is debatable, Payne and Cikovic (1995) found more male victims though Saveman, Astrom, Bucht and Norberg (1999) found two thirds of victims were women.

Dealing with high care or cognitively impaired residents can be difficult stressful work and it is these residents who are at high risk of abuse (Chappell & Novak, 1992; Goodridge et al., 1996). In the nursing home, where staff work with severely handicapped older people, those with dementia and mental illness and those who can not understand logic or reason, dealing with difficult behaviours becomes a significant factor in the delivery of care (Goodridge et al.). It is the aggressive residents who are unpopular and at high risk of abuse (Downing, 1986; Meddaugh, 1993; Mott & Kingsley, 1999).

Few would suggest working with dependent or emotionally volatile residents is easy. Most nursing home staff have been hit, bitten, sworn at or had something thrown at them, often by aggressive residents with cognitive difficulties (Mercer et al., 1993; Pillemer & Moore, 1990), and it takes skill and experience to deal with volatile behaviours and resident aggression (Goodridge et al., 1996). One factor not mentioned in Pillemer's (1988) model that seems to be associated with resident abuse is this abuse of staff by residents, especially by residents who have

some level of dementia. With between 62.5% and 90% of staff reporting physical or verbal abuse by residents (Coyne et al., 1993; Mercer et al.), this is a significant contributing factor that requires further examination.

Staff abuse increases the risk of resident abuse where workers who have been abused by a resident may isolate residents, deny them food or shout at them (Goodridge et al., 1996). However, if staff are assaulted more than once they are often assaulted by the same resident which can indicate a problematic relationship rather than a difficult resident (Whittington & Wykes, 1994).

Pillemer's characteristics of age, gender and diminished power relate to similar community factors though nursing homes residents are likely to be older, more physically and mentally frail and dependent, and require more intensive care than many older people in the community. The characteristics of residents might potentiate abuse but, to gain insight into why resident abuse occurs, we also need to consider the attitudes, characteristics and behaviours of those who give care.

Staff characteristics and resident abuse

Though resident issues are important, the responsibility for care lies with management and the staff who give care (McCreadie & Tinker, 1993). Pillemer's model suggests a potential relationship between staff age, gender, position, education or experience and maltreatment. These characteristics relate to similar community perpetrator issues except that, community carers are often old themselves, and even though society expects family carers to give safe quality care, few receive education in caregiving and they are not bound by the legislated 'duty of care' that applies to nursing home staff.

Abuse and harsh treatment may be sensational but they do not obscure that fact that despite frustrations and demands, most staff are kind helpful people who are motivated to give safe sympathetic care (Foner, 1994). Even though many staff find the work somewhat exhausting and stressful, many also feel rewarded by

that work (Pearson, Hocking, Mott & Riggs, 1993a). Overall staff are motivated more by humanitarian concerns and a wish to help others than by the material aspects of the job (Biggs et al., 1995). Nevertheless resident abuse does occur.

Personal characteristics of nursing home staff such as lower social class, being young, inexperienced and of an ethnic background, having a low education level, having negative attitudes towards older people and having limited skills in the delivery of aged care, have regularly been associated with resident abuse (Chappell & Novak, 1992; Payne & Cikovic, 1995; Pillemer & Moore, 1990; Tellis-Nayak & Tellis-Nayak, 1989). Gender is also a contributing factor and, in nursing homes with a largely female population of residents and staff, resident abuse has been called "the abuse of women by women" (Griffin & Aitken, 1999, p. 32). However, there is still a greater proportion of male perpetrators than female, which means that males are underrepresented in the nursing home workforce but over represented as abusers (Payne & Cikovic).

There is evidence that some staff do not like their work or their clients (Pillemer & Bachman-Prehn, 1991) and while more Enrolled Nurses find the work boring, stressful and exhausting (Pearson et al., 1993a), more Registered Nurses have empathy with residents than do care aides (Pillemer & Bachman-Prehn). Many trained staff however, still have neutral or negative stereotypes and attitudes towards older people (Treharne, 1990). Invariably ageist feelings will have a negative impact on the quality of care these staff members deliver (Courtney, Tong & Walsh, 2000), and more aides than nurses have been associated with resident abuse (Pillemer & Moore, 1990). For example, in one UK resident abuse survey "unregistered care workers were implicated in half the calls concerning paid workers, while licensed nurses were reported as abusers in just under 15 percent" (Lipley, 2000, p. 6). However, Payne and Cikovic (1995) note that although assistants are accused of abuse more than other workers, this does not necessarily mean assistants commit more abuse. It may just mean they have more personal contact with residents or that most research involves only assistants.

Many staff work in a context of illness and suffering where relationships can become volatile and affect both caregivers and the quality of their care (Dallender, Nolan, Soares, Thomsen & Arnetz, 1999). It can be distressing to work with and become fond of residents who have increasing acuity levels and who inevitably experience decline, deterioration and death, with the result that staff may experience continual loss and bereavement at work (Kingsley, 2001a; Meddaugh, 1993). Dallender et al. suggest that where staff are in constant contact with severe illness and death and are expected to alleviate distressing situations, they are exposed to intense physical and emotional suffering and can experience both affective and hostile transference reactions which can become abusive.

Some nursing home staff who have difficult home lives and poor stress management skills, bring these problems to work and hit out when faced with conflict or stress or when they feel overworked and under appreciated (Pillemer & Moore, 1989; Tellis-Nayak & Tellis-Nayak, 1989). However, staff also hit out because they have low self esteem or emotional stability, from malevolent intent, because they experience high levels of stress, they feel aggressive or lose their temper or when they want to 'hurt' (Saveman et al., 1999; Thomsen, Arnetz, Nolan, Soares & Dallender, 1999). These people may also abuse when they are unhappy and depressed or dissatisfied at work, when they have a perceived lack of power in their work or when they are at risk of burnout and want to quit (Biggs et al., 1995; Coyne et al., 1993; Meddaugh, 1993; Mott & Kingsley, 1999).

Staff patient conflict and staff burnout are the variables most related to resident abuse (Pillemer & Moore, 1990). As workers become overwhelmed by multiple stressors and approach burnout, many become physically, mentally or spiritually exhausted. As a result some infantilise or dehumanise residents and their care needs, ignore their need for privacy, confidentiality and decision making, use too much restraint, are physically or verbally abusive or at the other end of the scale do not touch or talk to residents (Heine, 1986; Novak & Chappell, 1994).

One early study found insufficient staff numbers were a factor when a Registered Nurse in a 40 bed home, after attending to required administrative and paper work, had just four minutes per resident per day to give care. The conclusion was that staff had insufficient time to give quality care and that staff to resident ratios "were such that staff members were badly overworked and suffered bodily dysfunctions due to fatigue and stress" (Harrington, 1984, pp. 103-4). It is in these times that staff neglect those parts of their role which they feel they can not handle, and so partially or totally neglect resident care (Mercer et al., 1993).

Mercer et al. suggest qualified staff

> tend to avoid nursing homes and thereby the aged. Many nurses share society's negative attitudes towards older people and it could be that only those nurses who can't get work elsewhere are willing to work in aged care ... not only do nursing homes often lack a sufficient quantity of nurses, they also lack a sufficient quality. ((1993, pp.102-3)

Mercer at al. also identified

> a noxious aura surrounding those who care for the elderly, which causes the dedicated caretakers to be classed with the abusers, and the competent with the incompetent. This sets up a cycle of demoralization from which the competent caretaker cannot escape without also abandoning the aged. (p.103)

From over 1000 hours of research in four homes Mercer et al. describe a "sense of humiliation and degradation experienced in the nursing home by both patients and staff." (1993, p. 103). Although not all staff will share these feelings, it is still a depressing picture of working and living in a nursing home.

The nursing home environment and resident abuse

Pillemer talks of environment in preference to organisation when discussing patient maltreatment, because the concept of environment includes more than just the organisation of the nursing home. Although few studies considered the

environment as a factor of abuse, some found no correlation between organisation factors and quality care indicators (Newcomer, Preston & Roderick, 1995) while others have correlated environmental factors to quality of care (Sheridan et al., 1992). Pillemer proposes that organisational factors of the setting, staffing and running of the home, plus environmental factors of the nature, range, availability and costs of resources, services, and the degree of choice available to residents, will correlate to care quality and maltreatment. These factors correspond to many contextual factors of home and community service provision in community care.

Nursing home admission can have detrimental effects on new residents where they are stripped of the identity, lifestyle, possessions and sense of control that many enjoyed in the community. In moving to a nursing home "the social conditions of individuality, autonomy and self determination, connectedness, social identity and choice, and privacy and dignity can be dramatically altered by the institutionalisation" (Jilek, 2000, p. 19). These changes to the resident's social condition have devastating and disabling effects of "disempowerment, excessive passivity, loss of dignity and personal identity, social isolation, assumption of the chronic sick role, stigmatisation, and an overall functional decline" (Jilek, p. 19). Pillemer (1988) agrees that nursing home admission can harm new residents, but he suggests that a variety of negative effects on residents come more directly from resident abuse than from the effects of admission to a nursing home alone.

The milieu of the nursing home also influences care quality. The home's size, the standard of buildings and equipment, management's' philosophy, profit motives and attitudes toward residents, relatives and staff plus their staffing and education practices all affect the living environment, the quality of care and resident satisfaction with that care (Kingsley, 2001b; Pearson, Hocking, Mott & Riggs, 1993b). Small, ill kept, ill equipped homes with unsafe uninviting environments and no resident protection policies, or homes where staff are forced to work in an unsupportive high conflict environment, will increase the risks for abuse (Nay, 1996; Paton et al., 1994; Pillemer & Bachman-Prehn, 1991; Watson et al., 1993).

Conversely, well maintained homes with resident protection policies and supportive work practices, homes that retain staff and offer job security with staff training and support will actually promote staff satisfaction and reduce abuse (LaRocco, 1985; Mott & Kingsley, 1999; Pillemer & Bachman-Prehn, 1991). These outcomes are important in a service industry where profits are closely tied to labour costs and where managers rely on the good attitudes of staff to achieve efficient cost effective care (Tully, 1986).

Overall it is the home's day to day management and administration that directly impact on abuse and safe care (Sheridan et al., 1992). There are three major enemies of autonomy; routine, regulation and restricted opportunity that are associated with regimented rules and administration (Smith, 1996). This is where resident behaviours are controlled; and they are given little self determination, autonomy or choice (Hall & Bocksnick, 1995). It is when management allows impaired residents to be objectified, victimised or "acted upon without explanation or recourse to redress", that they live and are abused in a context where staff have the power and freedom to abuse (Griffin & Aitken, 1999, p. 37).

Biggs et al. suggest "institutions by their very nature abuse residents and brutalize staff" (1995, p. 78). The home's social climate or culture will influence the care residents receive (Dallender et al., 1999) and a culture that condones abusive behaviour, such as management abuse of staff, will increase the likelihood of resident abuse (Tellis-Nayak & Tellis-Nayak, 1989). It is also when staff are embarrassed, insulted or humiliated in front of residents or other workers (Harrington, 1984), are harassed and bullied by older or more senior staff members (Quine, 1999) or where management treats staff as low status workers and pays low salaries, that homes have higher levels of abuse (Biggs et al.). For example, it is when staff are poorly treated and paid that some may be motivated "to supplement their pay through theft" (Harris & Benson, 1999, p. 76).

On the other hand a supportive environment, where the norms of daily administration and work encourage new ideas and information sharing amongst staff, where management and workers support each other and staff help each other to complete tasks, will result in improved teamwork and quality care (Thorsness & Sayers, 1995). From their study of workplace environments, Thomsen, Dallender, Soares, Nolan and Arnetz (1998) suggest that factors such as reasonable workloads, positive leadership, support to deal with work problems and being able to participate in the organisation seemed to almost act like a vaccine against work related exhaustion and problems.

A statement by Biggs et al. sums up the previous categories of causative factors.

> The reduction of stress, increased job security, participation in positive decision making and conflict resolution plus regular and meaningful training would support those most positive motivations that staff report for entering the caring endeavour. Positive attitudes to elders would increase and the likelihood of abuse diminish. The above evidence would suggest that institutional abuse cannot be reduced to individual evil acts. The working environment and the relations that emerge between residents and staff are intimately related, and to change one without changing the other would be a fruitless exercise. (1995, p. 86)

Exogenous factors and resident abuse

Pillemer (1988) suggests that factors external to the caring relationship, but which influence the environment, the staff and patients, will influence behaviours such as resident maltreatment. These risk factors include approval for nursing home beds, unemployment rates and difficulties in recruiting and retaining staff. In community care, Pillemer's exogenous factors translate to political and economic factors that influence the funding of community care and the recruitment, reimbursement, support and retention of family carers. It would also include the lack of legislative and political safeguards for older people and their carers.

As in family care where personal relationships are mediated by outside social forces (Seligman & Darling, 1997), so aged care legislation and policies that occur outside the facility will affect not only nursing home funding and management, but also those who live and work inside each home. For example, one goal of the aged care reforms of 1997 was to decrease the number of nursing home beds (George & Davis, 1998). These decreases in funding and nursing home bed licenses have both had a significant influence on the nature of residents, with nursing home admission being restricted to those who require high levels of care (Minichiello, 1995; Ruler, 1998). This acuity of resident problems requires a high level of skilled nursing if safe quality care is to be delivered.

Kendrick and Taylor (2000) describe a model of institutional abuse of children and 'systems abuse' which comes from the damaging effect of a system that is stretched beyond its limits and which lacks the resources to meet client needs. The same issues apply to the over stretched and under resourced age care system. Structural explanations for the under resourcing of aged care relate in part to issues of the low status of older people, the low esteem in which they are held by society, and society's acceptance of the insufficient provision of services to meet their needs (Clough, 1999). One reason why older people and aged care are devalued could be because it is largely care for women by women and "women and women's work is habitually devalued" (Griffin & Aitken, 1999, p. 33). Devaluing older people and apathy about their wellbeing is reflected in the community's acceptance of ageist legislation and funding that rations money for residential staffing and care services, and undervalues older people when their care is placed largely in the hands of untrained, unlicensed workers (Uren, 1996).

Uren raises the issue of unlicensed unregulated workers and asks

> what are we saying about the value we place on sick, elderly and disabled people if, as the expression goes, a person can walk in off the street and get a job performing nursing work? What are we saying about these

workers and the work they are expected to do? Worse still, what are we saying about the people who are being cared for? (1996, p.3)

There is a notion that nursing and personal care can be separated, which Uren (1996) suggests is the product of the agile and expedient imaginings of economic rationalists who see this separation as a way of cutting costs by using cheap labour. This issue involves more than economics, it also impinges on the amount of skilled care available to nursing home residents. Licensed Nurses are held accountable for their practice under duty of care but the "same mechanisms are not available for redressing poor practice by unregulated health-care workers" (Hamilton, 1997, p. 3).

There is a shortage of nurses willing to work with older people (Mallabone, 2001) and a shortage of beds with around 1600 West Australians waiting for residential care (Casellas, 2001a). With an annual shortfall of $159 million, the National Aged Care Alliance identified a crisis in residential care (Mallabone). Many blame privatisation and competition for the decreases in funding and suggest there is an urgent need for a $1 billion boost if the residential industry is to provide the beds and quality services required by older people (Capp, 2001).

As 'for profit' homes predict home closures and 'not for profit' organisations report heavy losses of money and staff, they are "under pressure as the lack of money begins to bite" (Casellas, 2001b, p. 1). Flett lamented the negative changes, and lack of forward thinking in aged care, when she said that

> ten years ago people were building 30-bed facilities and they were viable. Now a 60-bed facility is questionable. The government wants old people in home-like facilities yet we're being forced to build 90-bed institutions. Our system of dealing with the elderly hasn't changed in 100 years. We have demeaned the elderly and removed their dignity. (Casellas, 2001c, p. 6)

However, despite all the evidence to the contrary, Aged Care Minister Bronwyn Bishop refused to acknowledge any problems and "has dismissed the concerns of WA providers declaring that Australia's aged care industry is one of the world's best". "She rejected any suggestions that nursing homes and hostels were understaffed and on the brink of crisis" (Mallabone & Clery, 2001, p. 9).

This section of the review, in which I compared the causality of abuse in the community and nursing home settings, suggests the major causative factors of elder abuse in the community parallel similar causes in the nursing home. These similarities offer a fertile ground for future research, and the potential to make comparison between the causes of elder abuse in the community and nursing home has been shown In the review I have also illustrated that victim characteristics, though not directly causative do influence abuse. The causative factors relating to abusers, the context in which the abuse occurs and the wider social factors that influence the quality of care received by older people show similarities, regardless of where the abuse occurs.

Elder Abuse Interventions

Having considered the literature that informs about elder abuse and its causes the review moves to issues of intervention. Elder abuse is a social problem and it is when the problem is defined and areas of concern are identified that potential solutions to abuse arise and become evident (McCreadie, 1996). No case is one dimensional (Simmons & O'Brien, 1999), and practitioners need to be aware of the complexity of abuse (Lithwick et al., 1999) and the wider causative factors of abuse (Bennett, et al., 1997). However, regardless of the definitions, categories or causes of elder abuse one thing common to all cases is that harm is caused to an older person, and directly or indirectly interventions need to address this fact.

Both societal and individual intervention strategies are important in tackling elder abuse (McCreadie, 1991). From her study of international research McCreadie

concludes that different types of abuse "in different contexts will have different explanations and require different kinds of interventions" (p. 57). For example, different interventions are necessary for unintentional neglect by an aged spouse than for a case where a staff member is stealing from a nursing home resident.

Elder abuse may have been legitimised as a social problem, nevertheless on a state and national level there is little government recognition of elder abuse and social policy on the topic has not been forthcoming (Leroux & Petrunik, 1990). On the broadest level workers must plan interventions that will influence the policies, funding and legislation that affect the wellbeing and safety of older people. However, on a more local level, social theories conceptual frameworks and socio structural explanations are of little use to the practitioner who is confronted with dealing with an individual case of elder abuse. To a greater extent it is the individual agencies and workers who respond to abuse in the course of their work that undertake the bulk of abuse prevention and intervention.

Much of the early Australian work on elder abuse was based on US ideas and interventions (McCallum, 1993a). The American literature laid greater stress on individual causes and interventions of abuse whereas UK and Australian professionals looked more at wider social and systemic issues when considering abuse. Yet we still seem to follow the Americans in their concentration on individual issues and the pathology of victims and abusers when considering assessment and intervention. The rationale for this individualistic emphasis may be somewhat limiting, but it has practical connotations for the casework practitioner who has to confront and work with individual instances of abuse.

It is not my intention in this review to consider a list of specific or individual prevention interventions. Rather, I propose some principles and raise issues that will influence and guide the development of both societal and individual interventions, so they can be designed to address the particular circumstances, relationships and needs of all who are involved in abuse.

Intervention Principles

A number of principles, which ideally uphold the rights and wellbeing of all parties involved in abuse, will be needed to guide response and interventions strategies to prevent or terminate elder abuse. In this section I consider some of the issues that influence the decisions and choices that practitioners make when planning and implementing interventions to address the abuse of older people.

Response principles to guide case assessment and intervention include the following (Kingsley, 2000a, p. 6)

- mutual trust, respect and positive communication between all parties are essential for the effective identification and resolution of elder abuse

- the safety, rights and wellbeing of the client are always a priority; nevertheless, the person suspected of perpetrating abuse also has rights that are respected

- the older persons, relatives and / or staff members who disclose or give evidence about abuse are believed unless proven otherwise

- the confidentiality of information or evidence is safeguarded in accordance with social and professional ethics, organisational policy and legal obligations

- self determination is encouraged: even if they cannot make fully competent decisions, older people will have relevant information, their views and requests are taken into account and their advocate (of choice where possible) is involved in planning and intervention

- where abuser self resolution does not occur the least punitive intervention that stops the abuse and yields the best result for the older person is implemented: interventions range from supportive education and counselling to restrictive discipline or legal action

- some abuse is illegal and is reported to the appropriate authority for action, criminal proceedings may result should the abuse of an older person constitute a crime.

Issues Influencing Elder Abuse Interventions

Independence versus protection

As well as following these basic principles there are important questions to be asked when planning interventions. Is it on the older person's suggestion that interventions are planned, do they or their advocate want the intervention or is the professional imposing their 'expert' values and beliefs in what 'they see' would be the most therapeutic response to the situation (Harbison, 1999)? As discussed when considering aesthetic, ethical and personal ways of knowing (Carper, 1978), a sound understanding of the victim's wishes, their perceived reality and their ownership of their problem is paramount when planning interventions.

Practitioners have a duty of care and an ethical responsibility to honour a client's rights and wishes and, unless specific conditions apply, a cognitively capable client has the right to decline intervention in their case. Bennett et al. (1997) sum this situation up when they suggest workers must find a balance between protecting the individual, which risks paternalism, and allowing them self determination. Where "legislation governs interventions professionals receive formal designation to intervene" (Harbison, 1999, p. 66), however, professionals are still obligated to ensure that wherever possible the impetus for intervention is determined in partnership with the client and not by the professional alone.

It has long been my belief that where a victim can understand what is happening to them, is not at risk of extreme or irreversible harm and is aware of the potential outcomes of declining intervention, then they have the right of 'dignity of risk', that is the right to decline intervention and to choose independence over protection, or placement in a safe environment. Maximum control over interventions should stay in the hands of the older person because

> the elderly are not children and in many cases they are not dependent. We cannot continue to remove them from their chosen environment, against their will, and place them in one we have chosen for them. To do so is not

our right for unlike the children we analogize these adult victims to, the older person has the right to make his or her own choices. (Bolton & Bolton, 1987, p. 240)

Both individualised and community education and empowerment programs will help give competent older people the skills and the strength to make their own decisions and be fully involved with any intervention in their situation or abuse (Kingsley, in press-b).

Confronting the abuse and the abuser

Another question that must be asked is whether the planned interventions are valid, that is do they address the causes of the abuse? Some ageist workers will turn "a blind eye to the problem either through lack of awareness, a tendency to blame victims, or reluctance to believe victims" and they will not be prepared to confront the abuse or the abuser (Phillips, 2000, p. 191). Conversely, those who see abuse but regard a 'caring' abuser "sympathetically rather than punitively" (McCallum, 1993b, p. 7) may not be able to resolve its underlying causes. Some workers feel compelled to do something to help, and so they offer interventions that may not even be related to the cause of the abuse (Homer & Gilleard, 1990). If greed and dependent behaviours such as alcoholism lie behind the abuse, the victim will gain little if interventions flood the home with community supports aimed at relieving a stressed carer. Workers have a responsibility to ensure interventions address the assessed causes of abuse otherwise they might provide "an inappropriate resource in order to feel absolved of any possible feelings of guilt about not being able to resolve the situation or to feel that they have at least provided a solution, even if it is not ideal" (Bennett et al., 1997, p. 159).

It is essential to see abuse as it really is and to accept that the causes lie more with the abuser than the victim (Harbison, 1999; McCreadie & Tinker, 1993). It also needs to be acknowledged that much abuse arises from malevolent motives and mental health problems and that some abuse is criminal and must be referred to

the police. Some programs advocate a 'no blame' rather than an adversarial approach to dealing with elder abuse (Farr, 1993) and in some cases this is fine. However, in other cases responsibility and blame for actions must be accepted and an adversarial approach may be the only course of action. It is often easier to assign stress rather than culpable motives to abuse and it is invariably a more comfortable option to refer for community services than to confront the abuser (Kingsley & Johnson, 1995b). Practitioners will often have to face the discomforting task of focussing interventions on the abusiveness and not just concentrate on caregiving (Bookin & Dunkle, 1985; Kingsley & Johnson). The Elder Abuse Perpetrator Program is based on the principles of confronting both the abuse and the abuser (Kingsley & Johnson, 1993a).

In resident abuse, if there is an environment of frustration, silence or collusion and staff receive no support to deal with abuse, few workers will be prepared to confront and intervene or to whistle blow on abusive colleagues because they fear they will lose their job (Griffin & Aitken, 1999). Griffin and Aitken outline a phenomena of worker 'learned helplessness' that arises when cases are complex, intervention resources are limited and there is no legislative support to act on abuse, with the result that workers feel unable to confront and intervene in abuse.

The nature and context of elder abuse

Because there are "distinct scenarios of elder abuse, which relate both to the type of abuse and the context in which it is occurring", McCreadie (1996, p. 83) says there will be different interventions for each situation. Although we need to focus on the victim, the nature of abuse and the context within which it occurs help determine the intervention for each cultural or social situation (McDermott, 1993; Tatara, 1999). This means victims living alone, those in a shared domestic relationship or those in a nursing home will require different interventions. Similarly, whether the abuse is intentional or unintentional, a case of sexual assault or financial abuse, a continuation of domestic violence or a new phenomenon will all influence what interventions are implemented.

The social context in which abuse occurs also calls for intervention, such as empowering social policy to prevent and alleviate abuse, including policy interventions to provide adequate aged care services and the legal protection of older people as required. These policies would also promote positive community attitudes and reduce negative stereotypes about old people (Tomlin, 1989).

In the context of social abuse there is no Australian legislation that protects older people or prevents elder abuse or neglect (James, 1994). Many government departments deal with older people and a small number deal specifically with seniors. There is the West Australian Government protocol to guide assessment and intervention (OSI, 1997), yet there are no collective policies for departments to identify and respond to abuse. Legislation and policy interventions to safeguard older people are also lacking and there are few special provisions to maintain the safety of vulnerable groups who live with severe disability or cognitive impairment, or for Aboriginals and other culturally diverse groups where mainstream services and programs are not appropriate (Tatara, 1999).

Mandatory reporting

Reference was made above to the criminality of some abuse, which raises the question of police involvement and mandatory reporting as possible interventions. Personal experience has shown that a minority of cases require direct police involvement and the general principle of initiating the least restrictive intervention wherever possible has underpinned all scholarly and professional work. The question of mandatory reporting is a vexed one. The US has largely embraced mandatory reporting (Becker, 1997) but Australia has yet made no move in this direction. In fact most Australian commentators oppose its introduction (Kurrle, 1995; McCallum, 1993b; NSW Taskforce on Abuse of Older People, 1992). Dunn (1995) sees a general opposition to mandatory reporting and notes a government preference for modifying and updating relevant legislation that affects older people rather than enacting legislation to deal exclusively with elder abuse.

In the early elder abuse work Faulkner (1982) talked of mandatory reporting as being an ageist intervention that would 'infantilise' and remove the decision making capacity from older people who are capable of making decisions about their own affairs. Experience suggests little has changed where reporting can "needlessly injure the autonomy and privacy of older adults and their carers" (McCallum, 1993b, p. 5). It is also suggested that mandatory reporting causes problems for those professionals who may have to dishonour victim trust and confidentiality when they report abuse (Brewer & Jones, 1989). Medical compliance with mandatory reporting is variable with some doctors not reporting if their patient objects (Rodriguez, McLoughlin, Bauer, Paredes & Grumbach, 1999). Similarly, discussion with community workers suggests few see any benefit in mandatory reporting and they would not report abuse should they feel the action would have little benefit for the victim or where they were not sure that abuse was actually taking place. This is not an unlikely scenario as McCallum (1993a) reports that up to one in seven cases of abuse reported under mandatory reporting may be incorrectly identified and in fact not be an actual case of abuse.

My disagreement with mandatory reporting is based on all of the above factors plus the fact that the problem lies less in identifying abuse and more in having inadequate legislation, government bodies and resources to respond to abuse, little community awareness or outrage against abuse and insufficient skilled workers to deal with cases. While we have more trouble in finding resources to deal with abuse than in identifying cases, and when "mandatory reporting statutes may actually worsen the situation they were designed to improve" (Daniels, Baumhover & Clark-Daniels, 1989, p. 326), we have to question the value of mandatory reporting.

Frameworks for intervention

It is suggested that interventions to deal with the social problem of elder abuse need to "be guided by a framework of some kind, one which sets out what kind of risks create and sustain particular forms of abuse" (Biggs et al., 1995, p. 46). No

one theoretical model for abuse intervention has yet been identified so there is a need to look outside the elder abuse literature for an intervention framework (Lithwick et al., 1999). The framework of primary, secondary and tertiary intervention levels is useful in elder abuse work (Hogstel & Cox Curry, 1999; Windham, 2000). This framework, which has been largely adopted in nursing, primary health care and community health, has the goal of facilitating optimal client wellbeing and can be used to apply these three levels of intervention to problems such as abuse (Ballantyne & Lange, 1996).

Ballantyne and Lange (1996) talk of primary interventions, which would include the identification of factors that potentiate abuse, preventive activities to empower older people to stay safe by reducing their risk of being abused and interventions to support potential abusers reduce their likelihood of abusing. Secondary interventions would involve care which is given in direct response to abuse and which aims to stop the abusive behaviour and minimise any harm or damage that could be caused by the abuse. Tertiary interventions would include activities for readaptation and the rebuilding of non abusive relationships, empowering victims to minimise their vulnerability to abuse and working with perpetrators to put a permanent stop to their abuse. Of course in a cyclical framework of intervention each of these levels can be active at any one time.

In terms of my personal elder abuse work, primary prevention relates to the community education forums that were aimed at empowering older people to resist being abused, and perpetrators to resist the impulse to abuse. Secondary interventions include the development and utilisation of protocols, professional education programs and ethical principles to guide workers as they respond actual cases and intervene to terminate abuse. Tertiary interventions relate to ongoing support of victims to reduce the impact of past abuse, and the Elder Abuse Perpetrator Program to support perpetrators to stop their abuse.

Urgency of interventions

Not all abuse requires urgent or emergency intervention (McCreadie, 1993), and a first step in responding to elder abuse is to determine the urgency of the case. Some situations constitute an emergency where the older person is in immediate danger and needs police or emergency services. Some cases will demand urgent action where help is required to ensure the safety of the older person, and other cases may be non urgent where referral and support are needed to prevent or stop elder abuse (Kingsley, 1993). Interventions will be made according to the nature, severity and the assessed urgency of each case.

Levels of intervention

Phillips (2000) talks of two levels of intervention. First are the 'community' level interventions that include political and policy activities, or community awareness programs such as the education and empowerment forums. Second are the 'individual' level interventions that include the support of older people and referral for services, plus individualised programs such as the Elder Abuse Perpetrator Program that works with perpetrators to stop their abuse.

Levels of intervention can also range from self resolution by an abuser who receives support but no legal sanctions, to criminal intervention with full legal sanctions (McCallum, 1992). Although some cases have required legal interventions many cases of elder abuse do cease with the least restrictive level of community support. Most cases would fit in with the idea that support and community services "promote caring and support interdependency" and work to prevent abuse (McCallum, p. 12). In the Elder Abuse Perpetrator Program (Kingsley & Johnson, 1993a), clients who have not stopped abusing with community support, sit somewhere within McCallum's level of "self resolution by abuser because of bad conscience" (p.12). Through the phases of the program, many perpetrators feel shame and regret at their abuse, they stop abusing and enter an experience of reintegration. A few however, will not be prepared to stop abusing and will risk social stigma and 'out-casting' as 'an abuser' (McCallum).

Intervention Strategies

Although there are many interventions that prevent and terminate abuse in community and residential care, it has not been the purpose of this review to discuss individual strategies but rather to consider principles and guidelines that can direct intervention, regardless of where the abuse occurs. Both elder abuse protocols offered intervention principles and strategies for responding to abuse. The second protocol also included sections on policy guidelines and response strategies to allow community and residential care agencies to develop and implement strategies that are applicable to their function, their client base and the nature of the abuse they encounter (Kingsley, 1993, 2000a).

In planning specific intervention strategies, professionals have a duty to assess and verify the social congruence of planned actions, and to ask whether they are actually congruent with the social expectations of elder abuse interventions (Fawcett, 1984). There is a need to consider whether planned interventions honour both professional values and the needs and expectations of the client. There is also a need to determine that interventions have social significance and will actually make a difference to the problem and the people involved, and that the chosen strategies have adequate social utility to prompt and guide educational, administrative and research practice (Kosier, Erb, Blais & Wilkinson, 1995).

Strategies based on the community development principles of empowerment and participation, a personal knowledge of the client's experience of abuse and the 'agreed needs' of older people, will increase the social congruence and utility of interventions. Such strategies will also be more likely to actually meet the needs of older people and address the underlying interpersonal, contextual and socio structural causes of elder abuse (Kingsley, in press-a).

Conclusion

The review has concentrated on the issues surrounding the definitions, categories, extent, causes and interventions related to elder abuse. Extensive time has been devoted to the causes of elder abuse for a number of reasons. First, the diversity of research results and differences in understanding about the causes of abuse, signify that research and theoretical explanation on this topic are in relatively formative days of understanding. Second, many of the differences in proposed causes for elder abuse are explained by factors such as a lack of common definitions of abuse and a lack of consistent research methodology and empirical referents. However, it may also relate to the fact that each case of abuse involves individuals who experience a unique relationship within a unique context. The fact that each case is influenced by the particular characteristics of the persons involved and the context within which the abusive relationship takes place could account for many of the differences in perceived causative factors for abuse.

A key issue arising from this literature review of elder abuse is the similarity of the proposed categories of causal factors for elder abuse in the community and nursing home settings. Another key issue is the diversity of unique factors that will influence each case regardless of where it occurs. This suggests the need for further research, and emphasises the need for practitioners to undertake careful assessment and consideration of all factors involved in every case they confront.

Similarly, in the discussion of interventions there will be differences in what is perceived as the 'best' intervention for each situation. Again, considerable time has been given to the discussion of intervention principles and guidelines, rather than to suggest specific interventions for different categories or causes of abuse. If practitioners abide by a set of principles, develop a conceptual framework to guide their practice, and consider a variety of generic intervention strategies they will develop a stronger arsenal of weapons against elder abuse than if they simply attempt to follow a given set of rules on abuse intervention.

CHAPTER FIVE

BODY OF WORK IN SUPPORT OF THE THESIS

This chapter contains the papers that form the body of work submitted in support of the thesis. The published articles illustrate the range of theoretical and professional work that has been developed over time and that has contributed to understanding and practice in elder abuse throughout Australia over a timespan in excess of a decade. A brief explanatory preface introduces each of the articles, which have been positioned within the four themes of the body of work.

Beginning Steps

Over a period in excess of ten years there has been professional interest and involvement in the early direction setting activities in elder abuse work throughout Australia. My journey commenced in the mid 1980s when, as a hospital based 'extended care' community nurse, I was involved in working with frail older people in the community. This role included seeing many older clients who were in hospital for some acute condition, an acute on chronic episode or who were admitted for respite care. In preparation for their discharge from hospital to home referrals were made, the home was prepared for their arrival and services were developed to allow the client as seamless as possible a transition from hospital to home care. In the process of extending the time, location and realm of post discharge care I saw and heard evidence that, in a small but seemingly significant number of cases, older people lived in either fear of being harmed or they actually experienced neglect or abuse.

Some of these clients would suffer in silence and not disclose what was happening to them but others asked for help, help I was not always capable of giving. These very early experiences were so disturbing that it was apparent

something needed to be done but I was unaware of how best to address the situation, nor of where to gain support in dealing with these cases. Little information or research data on the topic was forthcoming from the Australian nursing, health or community literature and few people in the health services were aware of or willing to accept that the abuse of older people was a significant issue worthy of attention. In discovering that little specific help was available it became obvious that this issue could not be ignored and that it was necessary to take steps to support these victims and abusers. Having seen abuse and having been asked by stakeholders in this issue for help, upon reflection it was recognised little outside help was forthcoming and that some beginning action was necessary to address the issue of elder abuse.

A significant shift in perspective occurred in the period between being an interested but distant observer of abused older people and becoming actively involved in elder abuse. Like others, I saw aged care as largely a family matter and the control or discipline of 'difficult' older people as an unfortunate issue but one with which it was not my role, as a community nurse, to become involved. However, my change in perspective came from a realisation that elder abuse was not a private or family matter any more than other types of abuse or crime; it was a social issue which needed urgent public and professional acknowledgment and action if it was to be resolved. The major outcome of these early activities was my recognition of the need for consolidated scholarly work and innovative professional practice to address the issues related to elder abuse.

Two basic constructs have underpinned most of my thinking and work on elder abuse; these comprise the practice toward social change through community development and the application of Carper's (1978) patterns of knowing in scholarly and clinical work in elder abuse. The first two articles reflect these guiding constructs.

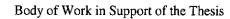**Community Development: A Basis for the Body of Work**

From the first SECDC workshops and activities with the COTA Steering Committee on Elder Abuse, my conceptual and clinical work has been based on the principles of community development. Community development incorporates the values and activities of empowerment and participation and is allied to the concepts of CBAR, the methodology on which much of my work was based.

Community development, as a process of positive social change applies to abuse work on a number of levels. These include working with communities to change the attitudes of policy makers and legislators about the safety needs of older people and to change disinterested community acceptance of abuse as a private family matter and not a public concern. It includes helping abusers change their behaviours to stop their abuse, and facilitating changed behaviours by seniors to resist being abused. This article sees community development as integral to the dynamic of change and articulates the values that underpin my elder abuse work.

Patterns of Knowing:- Guiding the Development of the Body of Work

In dealing with elder abuse I felt a conceptual framework would help guide thinking and action on this topic. Carper's (1978) patterns of knowing has been a useful framework that has encouraged me to gain empirical knowledge of elder abuse, personal knowledge of both the victim and myself, plus knowledge of aesthetic and moral ways of responding to abuse.

I saw that no one pattern of knowing was adequate to deal with the complexities of elder abuse, rather each has contributed to the development of my elder abuse work. The application of knowing to abuse is demonstrated in the submitted article and throughout the thesis; it illustrates my belief that Carper's (1978) patterns have legitimacy in elder abuse work. By applying these patterns to practice, it is argued that scholars and practitioners will develop a deeper understanding of abuse and an enhanced ability to relate knowledge to practice.

Kingsley, B. (1994). Community development: The challenge of change. In
C. Cooney (Ed.), *Primary health care: The way ahead* (pp. 37-60).
Melbourne: Prentice Hall.

CHAPTER 3

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COMMUNITY DEVELOPMENT: THE CHALLENGE OF CHANGE

— E. Kingsley

CONTENTS

INTRODUCTION

This chapter considers the meaning of community development and, within the context of health care, suggests how the development process can bring about positive social change.

Community development is a construct that describes the actions intended to change the aspects of the environment which promote ill-health, inequity, poverty and powerlessness. It is a complex process whereby people work together and use their combined social power to gain control over both the decision making processes and the community resources which affect their lives.

Like health, community development is tied to the political and economic power structures within society. It aims to achieve social justice where both power and resources are distributed fairly and equitably throughout society. Currently, some groups are excluded from the decision making systems that control their health and they have little or no power over the distribution of local community resources or services. Community development aims to redress these deficiencies.

There are two fundamental principles of community development: community participation and empowerment. Participation means more than the tacit compliance of people with the decisions made by the bureaucracy, and more than their participation in services provided by the health system; rather it means that the community jointly makes its own decisions and works together to meet its own needs. With regard to empowerment, there are three major strategies of empowering the community with the skills and strategies to identify and change those aspects of the health care system which adversely affect them. These include education for social change, involving the community in the decisions which affect their lives, and eliminating any discrimination which might cause inequity or oppression in society.

This chapter emphasises the vital role of health professionals who work with groups to identify and solve their own community problems as a means of meeting community needs.

WHAT IS COMMUNITY DEVELOPMENT?

Community development is about change. Based on the democratic principles of equity and the freedom to participate, it aims for social change to meet the needs of the community (Anyanwu 1988). More specifically, with regard to the health of the community, development is based on a social model which involves practical strategies to achieve positive change. It includes

interventions to change those aspects of the environment which are promoting ill-health, rather than continue to deal with illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles, when the environment in which they live and work gives them little choice or support for making such changes (South Australian Health Commission 1988).

There are various descriptions of the development process, but it may be helpful at the outset to place it within the context of health and primary health care.

Community development has been described as one of three basic approaches to health. Each approach implies a specific view of the definition of health, the involvement of the community in health matters and the amount of control the community has over health resources (Rifkin 1985).

First, the medical science approach, which is based on the medical model, equates health with the absence of disease and suggests that any improvement in health depends on medical technology and public compliance with doctors' orders. Second, the health planning approach sees health in the World Health Organization's (WHO) terms of physical, social and mental well-being. With this approach, improvement in health occurs when there is adequate provision of health services. Third, Rifkin describes the community development approach which views health as a human condition rather than a service. In this approach, a healthy community exists when the public has authority and control over its own health resources.

Programs aimed at improving health will not only consist of direct health care and services. They will also include activities which have a more indirect impact on health, such as the provision of affordable housing, agricultural improvements or literacy programs. Similarly, these activities will not involve only one health discipline, but teams composed of practitioners involved in health and welfare in the community. To achieve health through these wider activities, teams must first gain an overall picture of the shape and structure of that community. They need to distinguish how its structural components are organised, identify which people have the power over resources, determine the roles of the various power players and, possibly most importantly, discover the basis of their power. This activity extends beyond the confines of direct health care and involves health professionals in those wider structures of society which might impinge on the health or well-being of the community.

Although community development is associated with the promotion of well-being, on a practical level it is more often involved with solving the problems of people so they may achieve well-being. Current health systems are shaped by the larger political systems within which they function. Similarly, the health of the community is shaped by the political, economic

and social systems of society. If health practitioners are to fulfil their role in community development, they need to be cognisant of the social structures within which they operate. Karpik (1990) highlights this social approach to health care when she suggests practitioners involved in community development have a responsibility to:

> View society from a social relations perspective so that health is understood in terms of social and environmental issues rather than disease and illness;
>
> Focus on the social processes which affect health and well-being, especially those associated with power and powerlessness;
>
> Be concerned with social disadvantage and social justice, and aim to address inequality in society.

Community development is a complex process. Because it involves people working in harmony to gain control over community resources, and because it often results in disharmony with those who hold power, it is based on the concepts of both consensus and conflict. Successful development requires some level of consensus among citizens and workers who combine in an atmosphere of mutual support to resolve their common problems (Raysmith 1975a). However, problem solving activities often result in conflict between the community and the power structures. By its very nature, community development generates criticism of bureaucratic attitudes, policies and programs. It also stirs up conflict and minor revolution when groups begin to demand public control over health care resources (Scott 1983).

Community development has been described as the participation of people to improve conditions in the community. Indeed the UNESCO definition suggests that development occurs when the people work in harmony with the Government to contribute fully to the life of the nation and so improve their economic, social and cultural conditions. UNESCO says the development process contains two essential elements: the participation of the people, and the provision of services and technology to encourage community self-help and mutual aid. Jakubowicz (1974) of the University of New South Wales, the Government Social Welfare Commission and a noted exponent of community development reviewed a number of authors' comments on UNESCO's definition. He concluded that it is not community development; rather it is little more than a process of manipulating people into accepting responsibility for their own welfare, and thereby relieving governments of that responsibility.

In contrast, Jakubowicz states that 'community development is about change, but it is about change in the distribution of power in society'. It occurs when groups of people recognise their interests are not being met, and where they become convinced that by working together and utilising the force of their combined power their ends can be achieved. He further

suggests that community development involves the 'implicit understanding that the present structure of society has caused their plight, and that any action will necessitate conflict with existing interests'. This is the point at which development moves beyond the consensus of a communal self-help activity to meet group needs and becomes social action with the potential to challenge and condemn the nature of power distribution and the control of resources in society.

Jakubowicz goes on to say that any analysis of community development without due recognition of 'the fundamental power elements involved and without clear acceptance of the conflict likely to emerge, is fated to irrelevance and impotence'. He suggests that others might see community development as activities to get services to the people who need them, but he believes that if power was equitably redistributed, then social justice would prevail and services would be available to the people who need them. If the existing power structures are to be challenged and if social change is ever to occur, there must be programs aimed at empowering communities to participate and work together to achieve structural change.

Raysmith (1975b), a contemporary of Jakubowicz and a noted proponent of community development during the halcyon days of the Australian Assistance Plan, held similar views. Raysmith said community development is concerned with society's decision making systems and the way they exclude some groups from community resources. Development activities, according to Raysmith, aim to empower the community to remove any constraints against freedom of choice, to reduce economic scarcity, to end the maldistribution of wealth, and to prevent vested interests from controlling the economy. That is, it is an ongoing process, which operates in the local community or on a larger national scale and which is concerned with social justice and working together to transform society.

Not all current social commentators or practitioners would agree that community development should be so concerned with power structures and social change (Dixon 1989). Nevertheless, though they might not agree on the extent of community development, most agree that two of its fundamental principles are community participation and empowerment (Fiske et al. 1989; McWaters et al. 1989; Tomlins 1990). The remainder of this chapter will consider these components of community development and their relevance to the role of the health worker in the community.

COMMUNITY PARTICIPATION

The Declaration of Alma Ata states that 'the people have a right and duty to participate individually and collectively in the planning and implementation of their health care' (World Health Organization 1978). Idealistically, community participation is not only one of the goals of community

development, it is also an integral part of the development process (Midgley 1986).

Rifkin (1985), who categorised the three approaches to health, similarly applied them to the manner in which different health systems implement the concept of community participation. In the previously described medical science approach, participation occurs when the people assist the professional by compliantly using the services and technology provided by the health system. Health planners who equate health with increased services involve the community in 'top down' activities to increase the provision of health services. In contrast the 'bottom up' developmental approach sees participation as a means for the community to learn to 'change existing systems of health care which adversely affect them and to take control of policy which affects their daily lives'.

Active participation of the Australian community in its own affairs saw a dramatic increase during the 1960s when decentralisation gave many people the opportunity to become involved in neighbourhood and government activities. Recent decades have seen an upsurge in the number of community forums, advisory councils, area health boards, and community action groups which give people the opportunity to participate in local services.

Who then initiates the process of community participation? Initiatives will vary with specific issues and within different communities. Kelly and Sewell (1988) suggest the first move may be made by the authorities who set up programs to address problems that arise from inadequacies in the social system. They suggest 'the system' recognises it is failing to meet community needs; it then restructures its activities to allocate some level of control over resources to the people, and works with them to develop programs to meet their own needs. This concept implies that the system acknowledges the legitimacy of, and responds to, community demands. In turn the people participate by restructuring their relationship with existing structures, and this participation will proceed, for some time at least, in an atmosphere of consensus between the community and the system. Unfortunately, if the system can allocate control over resources to the community it can, and usually does, eventually reclaim that control, thus limiting any community development which might take place. The underlying objective of development in this model is to restructure inadequate systems rather than to change or remove those systems which do not meet the needs of the community.

Community workers often initiate participation when they perform community assessments and work with the people to develop programs to address identified problems (O'Brien & Johnson 1988). A basic principle of development is that the community's 'own felt needs' form the central point of the development process (Downing 1969). This information gives them a starting point for combined action to address the problems most

commonly identified in the community, such as the problems of isolation, alienation, ignorance and powerlessness as well as health and illness within the community (McWaters et al. 1989; Fiske et al. 1989).

Alternatively, participation might occur when people unite to solve some identified problem or undertake a community project in the local area (Richardson 1983; Caird 1989). Community action often begins when groups reach a consensus about the nature of their problems and about how they can work together towards a solution (Kickett et al. 1987; McWaters et al. 1989). Bureaucrats and community professionals invariably portray themselves as the vanguard of community development activities. However, it may be more precise to say that bureaucrats have in the past recognised the worth of community actions which they have then adopted and developed as their own. For example, some of the 1960s worker and union demands for health services to become part of a social wage resulted in the introduction of Medibank when the Government adopted and developed the principle of a health component to a social wage. This was a case of 'bottom-up' action, begun by the community and taken up and developed by the professionals and bureaucrats.

Regardless of who initiates them, most development activities begin with locally based community programs. Participation in neighbourhood affairs can build a sense of community identity; it reduces feelings of powerlessness and anomie and gives the community a sense of negotiated partnership in the conduct of local affairs (Raysmith & Einfeld 1975; Dixon 1989; Fiske et al. 1989). The emphasis at this level of involvement is on the right of people to participate in the immediate decisions which affect their lives and well-being. Parochial participation is not necessarily about changing the world at large; rather it often relates to small but significant social change in the local community (O'Brien & Johnson 1988; Crawford 1988).

Dixon (1989) suggests that some claims made for community development are exorbitant. She says it is not undefined 'social change' where societies are radically altered; it is more often change to individuals and groups which allows them to achieve some power over local issues. In fact Dixon suggests that community development's strength of parochial responsiveness to local needs is also a weakness which limits its potential for more radical change. She maintains that community development is not social change, but it can be a precursor to social action when people recognise that greater change is possible. Local action can raise community consciousness about the causes of social problems and lead people on to more widespread activity. Similarly, success in local action can give communities the confidence and vision to attempt greater change.

An example of the health worker's role in participation occurred when a community health nurse became aware of the needs of an ageing population. Although domiciliary nursing and meals on wheels were

available, with current economic constraints there was little likelihood that governments would ever provide all the services to meet their demands. Using a developmental approach, the nurse and a small number of interested citizens called a public meeting. From that meeting a committee of community members was formed to develop a volunteer agency to provide home help to aged and disabled people. The agency has grown during the last few years and the current committee of community members employs a co-ordinator, office staff, a handyman driver, a respite worker and a team of more than ninety volunteers. The community is successfully using government funding and its own resources to service the needs of more than nine hundred people per year in the local community.

The health practitioner used a developmental approach when she acted as an initiator to motivate and support the local community to participate and meet the needs of its citizens. Although she maintains a professional liaison with the agency, she no longer has direct involvement with the group. The community, not the bureaucracy, developed this service as a resource for the local area, and participating citizens control the general conduct and direction of agency activities.

This type of participation might not have a major impact on the structures which cause the problems of the elderly. Nevertheless it gives the community and the elderly the opportunity to define their own needs, to demand they be met and to participate in meeting them. Although it makes a powerful contribution to the community, this program alone does little to question why the elderly have these problems, nor does it challenge the forces that cause them to be in this situation of need. However, these actions were a positive starting point. The health practitioner's role, as part of the community development team, is to enable others to act rather than to do everything personally. In this instance, the practitioner helped initiate a process which others have taken over and developed.

Changes can be small and they can be local, but as long as they are aimed at the structures which promote inequity or ill-health they contribute to community development (South Australian Health Commission 1988). The key is that these small changes should be co-ordinated into a long-term strategy for greater structural change. The crucial element in community development is that people must change the present structures to gain control and authority over their own health resources (Tomlins 1990). Health professionals will be more successful in facilitating these changes when they adopt a developmental approach to community work (Benn 1981). In describing this approach, Benn suggests the health team must concentrate on three major areas.

First, social change can only be achieved by a group if they have four types of power: power over resources, power over relationships, power over information and power over decision making. Second, the techniques to

obtain these powers should include participant strategies, self-help mechanisms and deprofessionalisation where professionals relinquish some of their traditional authority in favour of the group or community. Third, the community development approach must be directed towards changing society's institutions rather than teaching individuals to adapt to fit in with existing institutions; it must lead to self-actualisation rather than stigmatisation of the individual, be a means of social change rather than of social control, ensure life choices are made by individuals and not imposed by professionals, and make professional workers accountable to consumers and not only to their peers or employers.

Benn is implying that the development approach uses community participation to move beyond changes to individuals and groups to wider social change. However, this broadening of vision does not always occur. For those community workers who do not think beyond their local boundaries, there is a risk that words like 'community' and 'participation' will become the goals, rather than the means, of community work. Bryson and Mowbray (1981) suggest that the concept of community was the 'spray-on' solution for the ills of the 1970s. They also suggest that 'communitarianism' is a conservative approach which encourages community consciousness, neighbourliness and mutual support. Unfortunately this approach can also be misused to divert attention from the political nature of society and from the underlying causes of social problems. Practitioners working in the community must recognise that people are at risk of being manipulated by the dominant power groups when participation is used as if it were the goal of development.

The social model recognises that health is greatly influenced by power structures and social factors such as distribution of community resources, economic conditions, employment a..d housing factors which form part of the social context in which people live (Raeburn 1986). To work within this model, health workers must look beyond the problems of their immediate community and be aware of the social structures which determine employment, housing, the economy or the control and distribution of resources. It is heartening to see health professionals recognising that they must not be caught up in the urgency of illness to the extent that they give less attention to the broader social determinants of health (Karpik 1990).

Community development looks past the symptoms of illness and deprivation to the structural causes of these problems. Community participation will be irrelevant if it does not lead to a consciousness of the need for social change, and community development will fail if it focuses on the local to the exclusion of the broader view of society (Boaden et al. 1982; Thorpe 1985). Ideally, health workers will encourage participation and involvement which both facilitate local change and subsequently develop into social action for more general structural change. However, before communities can progress beyond participation and organisational or

parochial change to a development approach of social action, they need to be empowered with the skills and strategies to achieve these changes.

COMMUNITY EMPOWERMENT

Recently the Australian Government Ministers of Health (1989) formally recognised what health workers have long known: the Australian health system is neither just nor equitable. Many services are unevenly distributed, there is little cohesion in service provision and access is influenced by factors such as geographical location, ethnic origins and socio-economic status rather than by assessed need. In contrast, a just society is one where measures to minimise exposure to health risks are combined with fair and equitable health services. Needless to say, current morbidity and mortality rates and inequitable access to health care demonstrate that Australia has not yet become a just society (Connell 1988). When priorities are based on the needs of wealth and power, 'community health' comes to mean residual health for those who cannot afford private health care. A more just society would strive for equity where the health of the least wealthy and powerful would be a major priority.

At a time when the gaps between the haves and the have-littles is increasing there is an acknowledged need for social justice and community empowerment to overcome inequity and oppression and so reduce the political disharmony these cause in society (Labonte 1989). Because health is a political issue, if health professionals are to be of any practical use to their community they must first recognise the causes of powerlessness and then be prepared for the difficult task of working together to challenge the authoritarian traditions which cause oppression (Kilian 1988; Fiske et al. 1989; McWaters et al. 1989; Ward 1993). Although some health professionals see political activity as being outside their realm of professional practice, if they are to successfully support their community they must be prepared to become involved in the social, economic and political arenas which influence the status of the local people in society.

- How then can health professionals generate the community enthusiasm necessary to undertake this type of social action? Practitioners do this by facilitating the self-esteem and confidence of community members, by increasing their opportunities for self-control and direction over their lives, and by enabling them with the strategies to take power over the decisions which affect their health and well-being (Kingsley & Johnson 1992). In her submission to the New Zealand Royal Commission into Social Policy, Peggy Koopman-Boyden (1988) noted three major strategies for empowerment. These are:

- Community education
- Full participation and representation of the community in decision making at all levels

- Elimination of political or legislative discrimination against the communities concerned.

Koopman-Boyden was speaking of empowering elderly people in the community; she was also speaking primarily of the New Zealand situation. Nevertheless, it is suggested that the principles behind these strategies apply equally to the wider population and to communities on both sides of the Tasman. Health practitioners have a major role in community empowerment and a responsibility to be involved in each of these three strategies.

PROBLEM-ORIENTED EDUCATION FOR SOCIAL CHANGE

Education is a powerful force for empowerment. However, unless it is used wisely, it has also the potential to reinforce disempowerment (Lane 1985). Paolo Freire, a noted sociologist and educationalist, suggests education can be used either as a weapon of positive social change or as a negative instrument of oppression. In this context, education is not only the formal system of school and tertiary learning or even formal community health education and promotion. It is also the non-formal learning and development that comes from experiencing, questioning and reflecting upon life.

To illustrate its negative power, Freire (1972), in a benchmark text on oppression, suggests education can be used as a form of banking where information is deposited and knowledge is bestowed as a gift from the powerful to the ignorant. Teachers pass on knowledge and students are expected to be the passive recipients of that knowledge. They learn about society as if the current system is the only or at least the superior system which cannot be questioned. Education becomes detached from reality as students memorise and unquestioningly act out what they are told without recognising the significance of the facts they learn. Although teachers are not deliberately oppressive, the system of education often influences how learners 'see' their world. It teaches them that their problems arise not from outside forces but from their own ignorance. Students, who are viewed as repositories of learning, are at risk of becoming alienated manageable beings who learn to blame themselves for their problems, who rarely question the existing structure and who accept that their world cannot be challenged or changed.

This style of education is often tied to paternalistic activities which reinforce oppression and teach people to adapt and learn to live with their situation rather than to question or change that situation. This attitude is seen in education programs which suggest oppressed groups, such as Aborigines, Maoris, women and migrants, would be liberated if only they were given more knowledge and technology. There is little recognition of

the maldistribution of power in society which prevents the liberation of these groups, regardless of their level of education or technology.

On the other hand, Freire's concept of education as 'liberation' involves reality-centred or learner-centred experiences which serve to liberate rather than oppress the learner. This liberation occurs when individuals who have confronted a problem or a situation which is not acceptable have gained understanding or resolution of the problem. This is more likely to occur when shared learner/teacher activities challenge the learner to critically experience and evaluate the existing structures of the real world. Teachers do not attempt to think or prescribe for learners nor impose their personal values. Rather, through shared experiences, education is used to raise the consciousness of learners so they are able to recognise, challenge and change situations that oppress them.

The current objective of 'Health for All' demands that all people have some level of literacy in order to read and understand what health can mean for them. The achievement of this learning generally involves some type of formal education system. However, much community education and health promotion occurs on a more informal basis. For example, when a youth health nurse was approached for help by some teenage mothers, she worked with them to form a self-help group. She offered supportive non-formal education to the small group which rapidly grew not only in numbers but also in skill and maturity as single parents. Over time, as new mothers entered the group, the older members assumed the education and support role. They taught by example, they shared experiences and acted as role models to empower the younger mothers with new abilities and skills. Together the group made a video so that they could tell others about their experiences and how they learned that, even though they might have problems as young single mothers, there were still many options open to them. This type of shared problem-oriented education has the potential to liberate and empower people with the confidence and skills to confront and solve their own problems.

Freire has had a profound influence on non-formal or community education, especially in development programs aimed at empowering disadvantaged groups. The use of problem-solving education can be effective in liberating people and mobilising them towards social action. Community education should be directed towards giving people the skills and confidence to confront the inequitable systems in society (Thorpe 1985). This does not mean the community worker's role in education is necessarily to build new systems, but to help the people become competent to bring about the change necessary to build their own systems (Anyanwu 1988).

Wendy Fatin (1988), a nurse and then Australian federal government minister, also believes that education is a major force for empowerment. She suggests it is one of the most powerful agents for positive change that

has existed this century. Information and knowledge give health workers and their clients the means to understand, analyse and participate in reconstructing their social, economic and political world. She goes further to suggest that together they can dispute the economic rationalist concept of health care, question unjust health policies, expose problems of inequity and through creative criticism challenge the .old and transform it into a new equitable system of health care.

LEGITIMATE DECISION MAKING FOR MEANINGFUL PARTICIPATION

Effective empowerment is a positive strategy to achieve more equitable distribution of resources and power within the community. To ensure that health resources are equitable, the community needs to be responsible for the decisions that control their distribution (Kilian 1988). This might be fine rhetoric but in real life, where people have come to accept that they are powerless to change the circumstances of their world, it is difficult to convince them that they have a right, and indeed an obligation, to be involved in making the decisions which affect their lives (Lane 1985).

Based on democratic principles, development aims for control by the community. However, people cannot control their own actions, let alone their own community, unless they make the decisions which concern them. On a national scale, both Australia and New Zealand have developed health advisory networks and community health committees to facilitate community participation in the health care systems. However, community workers lament the lack of real consumer participation in making decisions about the provision of community services, and the lack of notice that is taken of committee recommendations. Similarly, in New Zealand, it is suggested there is little, if any, evidence of community health committees having any impact on the decisions made by area health boards (Sagwa 1990a).

Unfortunately, the same difficulties exist on the local community level. Some people are permitted to participate on a superficial level, but they have limited opportunity for real involvement in the decisions that affect their health and well-being. From her experience, one community worker realised that unless the people have real decision making power, community participation is little more than a token gesture by the real decision makers. In her example, the community was asked to participate in child care centres that had been initiated by external funding bodies. The centres did not meet community needs and conflict and disharmony arose. Public meetings were subsequently held to placate the community and an advisory committee was appointed. However, it did not take the committee long to recognise that, although they were being 'consulted', they had no real power.

The failure of these centres could easily have been blamed on their being built in the wrong location or that they were not required in the first place. However, the real reasons for failure were that the community was not consulted and they were never allowed to participate in any of the planning or the real decisions that concerned the centres. Those on the advisory committee soon came to realise that they were being 'used' by the real decision makers and that the service would not alter, regardless of their participation or their decisions (Lane 1985). Richardson (1983), calls this 'unreal participation', which is only a facade because the real decisions are made before the community is ever asked to participate.

In another instance, and in stark contrast, a group of Aboriginal parents saw the lack of child care facilities for their children as a problem. With the support of an Aboriginal health worker and community health nurse they combined forces and wrote a successful submission for funding to develop and conduct their own centre. The group, and not outside forces, made the decisions to act on a felt need. Their centre is designed to meet their specific requirements; it is run by their own management committee; and there is a strong feeling of pride and ownership in the service they developed.

The first example illustrates how social problems can develop out of so-called participatory democracy when decisions are made by outside power forces, to the detriment of the local community (Thorpe 1985). These problems occur when people are not free to participate on their own terms but only within narrow parameters set by health professionals or outsiders. The second example demonstrates that successful empowerment can result when the community has true decision making control, from the beginning through to the completion of the project.

When planning community activities, many health workers will undertake a community assessment to identify community problems before they ever consult with the people to develop a program to address those problems. If the community assessment was based on joint decision making on how it could be conducted, the people would be involved in all stages of both assessment and planning (Anyanwu 1988). Anyanwu uses an analogy based on Freire's philosophy: community workers are revolutionaries who collaborate with the local community to oppose dominating power structures (including any discriminatory health systems) which work against the good of the people. If the people are meant to be the beneficiaries of community assessment or research, they must be involved from the beginning. Ideally they are included in decisions related to formulating the assessment plan, in providing the data, in interpreting the information and in planning how they can act to solve their own problems. If this procedure is followed the people will have more meaningful control over decisions and activities that affect them and their community.

ELIMINATING DISCRIMINATION TO OVERCOME OPPRESSION

It is obviously not possible to involve people in all the decisions that affect them. In many cases decisions are made by the elected representatives of the people, by the bureaucrats appointed to serve them or by the powerful socio-economic forces in society. In a complex social system, where communities are affected by a formidable number of structural forces, there will always be external policies and regulations which discriminate against some section of the community (Lane 1985).

In a democracy the people by definition relinquish some of their power to their elected representatives: community development suggests the people are asking for some of that power back (Boaden et al. 1982)..As they question the decisions of 'experts', many people are no longer prepared to passively accept health care decisions which discriminate against them. Some articulate, interested citizens have the time, energy and ability to participate by voicing their opinions in such a way that they will be heard and considered. Others, however, who are so overwhelmed by the outside forces that influence their lives will have little opportunity to be heard. These are the vulnerable, oppressed people who often comprise a major part of the community worker's responsibility.

Because of their position in the community, the health care team is well placed to recognise the oppression which results when one group is in a position to discriminate or legislate against another. In considering the etiology of health problems, practitioners assess how the social, economic and power structures influence community health. They then determine how the health care team can use those structures to redress inequality and oppression in order to meet assessed community needs. However, before they can begin, they must understand the nature of power in society. For example, those working in women's health need to understand the reasons why so many women have so little self-confidence, why they do not have control over their lives, why they feel trapped in marriages which starve them of love, money, self-esteem and independence. Health workers need to recognise and understand why women are in this position before they can ever begin to respond to the power structures which use discrimination to oppress and disempower women.

On the basis of the ideology of Paolo Freire, Alschuler (1986) describes three political problem solving responses to oppression and discrimination. The first is called 'magical conforming' where people do not recognise their position as oppressed. They passively accept their problems, or the problems of others, as inevitable or unchangeable. Their 'magical' explanations for discrimination go beyond any real or logical reasons when they say 'it's fate' or 'it's always been that way'. This fatalism rationalises their lack of action to fight against discrimination. Instead they comply because they do not feel

capable of challenging or changing the status quo, or they fear any negative consequences of such action. As a result, their inactivity serves to reinforce and maintain the existing power structures and oppression.

This is the situation of many depressed groups and communities in today's society. Health professionals can often see that public education and manipulative participation programs actually serve to reinforce rather than change the status quo (Lane 1985). Self-help groups and community development initiatives are all very well, but if the people are struggling against poverty, oppression and ill-health they have far too many problems and too little time or energy to become involved. As a consequence they are at risk of internalising their victimisation and becoming yet more isolated and powerless (Labonte 1989). In this context, Thorpe (1985) details the Marxist concept of hegemony where the people have not only come to accept, but actually support, the established order even though it may be against their interests to do so.

In his critique of the Declaration of Alma Ata, Navarro (1986) questions who in society is best served by social programs and structures such as primary health care and community participation. Just as health is a political issue, so the Declaration of Alma Ata was a political and economic document which reflected the beliefs and practices of the powerful nations involved in its development. Navarro implies that primary health care should not be blindly accepted. Rather, it should be carefully examined and used to ensure that power, wealth and access to resources are equitably distributed in society and not used to reinforce hegemony and maintain the political and economic position of those in power. It is a huge responsibility for health workers to help their community to look beyond 'magical conforming' and to question just who the structures and systems of society serve.

Alschuler's second problem-solving response to oppression, 'naive reforming', occurs when the oppressed come to accept that their problems are caused, not so much by the system, but because of their own inadequacies. People begin to blame themselves and others, such as politicians or the health system, for either causing or not doing anything to solve their problems. This situation can result in anger where an enormous amount of community energy and frustration is expended in attacking the symptoms rather than the causes of their problems. Some individuals or small groups naively expect that discrimination will cease and the system will function perfectly if only they educate or reform themselves. They may make some effort to oppose individual oppressors but are unlikely to challenge the underlying system that allows oppression.

Many health workers would recognise groups within their region who demonstrate this response to their life circumstances. Those who are striving for self-empowerment may educate themselves in an attempt to change their life circumstances, but then if things do not improve they blame themselves. Similarly if these victims of social inequity fail to solve

their own problems, there is a risk that those who are better off in the community, including health workers, can end up 'blaming the victim' rather than challenging the power arrangements which cause people to become victims.

It requires strong, well-organised community action over a long period of time to change the structures which have been developed by economic or political forces to meet their own needs, often at the expense of other less powerful groups (Lane 1985). Thorpe (1985) suggests the groups with economic and political power will use every means at their disposal to ensure their interests prevail. They will not easily relinquish their control over resources and it is often in their interests to retain the discriminative legislation or practices that maintain their power. Thorpe believes that lasting social change will occur only when empowered groups combine to tackle the difficult task of restructuring the economic, political and social systems which discriminate against particular groups in society.

Empowered communities act with what Alschuler calls 'critical transforming'. In this third approach to solving the problem of oppression, people recognise the historical, social, economic and political forces in the system which create inequity and powerlessness. They then use their combined social power to question, challenge and, where necessary, work towards changing any oppressive policies and discrimination within that system. Whereas discrimination usually arises out of ignorance and unequal power arrangements, community development attempts to transform communities by addressing ignorance and inequality in society.

Groups successfully overcome oppression only when they have been empowered with the knowledge and strategies to achieve social change. They will also succeed when they no longer allow themselves to be dictated to by outside forces, but when they begin to make the decisions which affect their lives. Common use of the word 'empowerment' might be a phenomenon of the late 1980s and 1990s but the sentiments and actions conveyed by the term existed long before that time. As with many ideals whose beliefs and activities challenge the status quo, their popularity is often minimised and therefore short-lived. However, regardless of the term used, the principles and strategies underlying the construct of empowerment are vital to community development. Because few groups or communities will instinctively have the skills and strategies to effect positive social change, empowerment, no matter what it is called, will always be an important role of the community health worker.

IMPLICATIONS FOR COMMUNITY HEALTH PROFESSIONALS

Community practitioners currently work in a climate of cutbacks and restructuring of the health system. In the recent Health Department of

Western Australia Strategic Plan the Executive spoke of the continuing community demand for services and of a corresponding public reluctance for them to be funded through increased taxation. In this economic climate there is more likely to be a decrease in funding or a reshuffling of resources from one area to another than any increase in community funding (HDWA 1990). Where development activities in the past were undertaken to increase community control over resources, today's community health worker will have a battle just to maintain those resources, let alone for the people to increase their level of control (Richardson 1983).

Community development is no longer the popular topic it was in the 1980s. Baum (1989) suggests community development is at risk of both becoming a 'red herring', a concept of rhetorical rather than practical use, and of being manipulated by bureaucracies and professionals to meet their own ends rather than those of the community.

Australia publicly supports Alma Ata, the Ottawa Charter for Health Promotion, and Health for All. This means that, officially at least, the Australian Government recognises that the fundamental prerequisites for health include education, participation, social justice and equity, which are all major components of community development (ANF 1990). Even so, although community development is recognised at an official level, some practitioners note that, in practice, it is marginalised because it presents too great a challenge to systems of commodified health care, medical empires and pharmaceutical industries (Fiske et al. 1989; Connell 1988). Workers in the field are told that cutbacks exist because there is only a limited health pie which must be equitably divided among many deserving programs. They must look beyond th's rhetoric to see just how that health pie is made in the first place. If there was some redistribution of wealth and power in society and if all sections of the community were forced to contribute more equitably to its well-being, there would be a substantially greater health pie to divide.

These might be difficult times for community development, but they are nevertheless times of great challenge for community health practitioners. When the powerful forces in society are identified, structural change can seem a very daunting task. Alone these workers cannot attack the roots of the structure; instead they consistently chip away at social injustice and inequity. They work to achieve a balanced practice of social justice and the efficient use of resources to gain maximum benefit for those who need them most (McClelland 1991). They also need some measure to evaluate how well they have been able to balance social justice with efficiency and to determine what benefit the community has received from their efforts.

Measurement and evaluation of the outcomes of development programs are obviously important activities. They take on even more importance if difficult choices must be made about which programs can be pursued and

which must be discarded. Process and outcome evaluation of community development programs should include questions about what changes have been made, what has been the impact on the people and on their standard of health, which were the important decisions made by the people and how much control over resources the community has gained.

Community development has been criticised because it is untidy, unwieldy and difficult to evaluate (Baum 1989). Until recently, there has been little documented evaluation of programs and few measures to help community workers assess the outcomes of development programs (Richardson 1983; McWaters et al. 1989). However, epidemiological assessment and qualitative research are very useful tools to measure and evaluate how the community has been strengthened through development activities. In times of economic rationalism community workers need to use measures such as service agreements and performance reviews to demonstrate their accountability and the success of their programs to their agency, their funding bodies, their peers and to consumers (Ward 1993). Similarly there is a need for rigorous evaluation, with data that show positive, efficient, cost-effective results for community development. Only then will there be a convincing argument for more funds, resources and decision making power to be given to the community.

Working with communities can be a frustrating and daunting task, especially when so many practitioners function alone or in small isolated teams. Based on the premise that 'only the empowered can empower', the health-related disciplines have a responsibility to adequately prepare future health professionals by teaching them the principles and practice of community development and to support practitioners in this very difficult area of professional service. Similarly education faculties must encourage critical thinking and problem-oriented learning; develop professional skills in collaboration, negotiation, leadership, change agent activities and political action; and endow graduates with personal strength, enthusiasm for community development and the ability to successfully translate theory into clinical practice (Carlson-Catalano 1992).

No one can work with a group that undergoes change and development without being affected themselves. Similarly, as any group or community changes, the impact is transposed to the people, their relationships, and indeed to the whole system within which they exist. Therefore, when development activities lead to positive community growth and empowerment, the health system will, by definition, be changed by the actions of the community. Health professionals will also be affected by their development activities. As the community with which they work experiences some success in achieving their goals and moves on to greater social action, all will experience reciprocal growth and empowerment. One could almost ask, who is empowering whom?

SUMMARY

This chapter has stressed that community development is about change. This does not mean that people have to change in order to survive in a system where health and wealth are inequitably distributed. Rather, it means that the people combine their energy and skills to question and confront the system and power structures which caused these inequalities. It has been suggested that community development is one means whereby these changes might be promoted. In this context, it has been advocated that two basic principles underlie the concept of community development: community participation and empowerment.

To be effective, participation by the community in their own affairs must be real and not in name only. Many people within the community will need practical education to empower them with the skills and strategies necessary to participate, and to recognise and question the causes of inequality in society. In addition, they must have the opportunity to exert legitimate decision-making power over the allocation and use of the resources which relate to their health and well-being. Similarly, there is a need for the community to become active in problem solving to reduce discrimination and inequity in society. Finally, the chapter discussed the implications that community development has for the professionals who work with and support communities in their efforts for social change.

Threaded through the chapter has been the theme of co-operation by all those involved in the development process. A highlight and common factor in many successful programs is the consensus on priorities, the mutual support, and the teamwork of community practitioners. Even though they operate from a position of strength and although health workers have, on occasion, been known to move small mountains, they are not omnipotent.

No one health discipline can achieve major change alone; this is best achieved by collaborative effort. Neither can health disciplines change the environment to promote good health overnight, for this is often a painfully long and slow process. Australia and New Zealand have little tradition of either community participation or empowerment, since both are relatively new concepts in the provision of health care. Health practitioners are now helping to build those traditions as they work with communities in the development process.

Community participation and empowerment programs are not the endpoints of development. Rather, they are the starting point of a process of social change which might take decades to achieve. Community development is often a long-term process which achieves small results over time. These advances might be small but they are nevertheless important to the community. In difficult times when directions about community programs tend to come from above down, community workers have to walk a fine

line between responding and initiating (Lane 1985). They must determine their priorities to solve problems of service delivery and maintain development activities to help the community resolve its own problems. Major reconstruction of society is often beyond the scope of single practitioners, but they can make significant dents in the existing structure (Thorpe 1985). Health professionals might not change society singlehandedly, but they certainly make a significant contribution.

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STUDY QUESTIONS

1 What elements must be included in a community assessment to effectively assess the deficits in community control over health resources?

2 Consider a local community health initiative and whether it includes the principles of community development. For example, what opportunities does the community have to participate in making the real decisions about the project? In what way will it empower the community to gain increased control over health resources? If necessary, how might this initiative be modified to encompass the concepts of community development?

3 Review your current community education/health promotion programs. If they are not based on the principles of empowerment, encouraging people to question reality and giving them the skills and strategies to challenge inequity and injustice, consider how they might be modified.

4 Plan a community education program which uses an empowerment/problem solving mode of learner/teacher interaction.

5 How could you plan a community assessment to evaluate the success of recent community development activities?

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Patterns of knowing in professional practice in dealing with the abuse of older people

The abuse of older people by someone they know and should be able to trust is a complex problem that faces nurses working in aged care. From the beginning days of dealing with this social problem, a great deal has been learned about elder abuse, about victims and perpetrators and about the difficulty of working in this area. A conceptual framework of knowing, such as that developed by Barbara Carper (1978), is a valuable framework to guide knowledge organisation and utilisation in confronting cases of abuse in clinical practice. This article briefly considers Carper's four ways of knowing to show how they can influence professional practice in general, and dealing with elder abuse in particular.

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INTRODUCTION

In Barbara Carper's seminal nursing paper 'Fundamental patterns of knowing in nursing' she argues that the body of knowledge which forms the basis of practice has 'patterns, forms and structure that serve as horizons of expectation and exemplify characteristic ways of thinking about phenomena' (1978:13). Carper suggests nursing should pay attention to the question of what it means to know and what kinds of knowledge will give the most

value in practice. From her analysis of the conceptual and syntactical structure of 'nursing knowledge' she identified four basic patterns of knowing, 'empirics', the science of nursing; 'aesthetics', the art of nursing; the component of 'personal knowledge'; and 'ethics', the moral component of knowledge.

This discussion is necessarily brief and is not a critique of Carper's (1978) framework, rather it illustrates how these four ways of knowing allow nurses to situate their knowledge development and clinical practice in responding to elder abuse within a conceptual framework. In dealing with a complex issue such as elder abuse it is important for nurses to understand their own ways of thinking and knowing and to recognise how they situate their practice within their chosen framework of knowing and doing. To gain successful resolution of cases of abuse, it is suggested that each of Carper's ways of knowing has a significant contribution to make.

THE ABUSE OF OLDER PEOPLE

It has long been acknowledged that all older people have the right to live free from threat, discrimination or abuse (McCallum, 1997). Unfortunately a significant number of older citizens, currently estimated at 4-6%, do experience physical, sexual, psychological or financial harm or neglect from someone they know and should be able to trust (Kingsley, 2001a; Sadler & Kurrle, 1993).

Abuse may be deliberate or unintentional, yet regardless of intent if the behaviour causes harm to the older person it is abusive. The very nature of elder abuse will not allow health professionals to stand by and observe but compels them to assist the older person to prevent or stop abuse. Responding to complex abuse cases will require nurses to apply a variety of patterns of knowing to identifying abuse and working with clients to implement creative and beneficial interventions to terminate the abuse.

PATTERNS OF KNOWING IN DEALING WITH ELDER ABUSE

Carper's patterns of knowing apply to many aspects of professional practice associated with understanding and developing the field of practice. The domain of inquiry into elder abuse must involve not only scholarly knowledge in the traditional empirical sense but also knowledge that stems from ethical and practical experience and wisdom. Carper argues that recognition of this 'determines the kinds of knowledge the field aims to develop as well as the manner in which that knowledge is to be organized, tested and applied' (1978: 13). This body of knowledge serves as both the rationale and expectation for practice, and elder abuse practitioners need to analyse and understand the different kinds of knowing that give their work its particular perspective and contribution in dealing with abuse.

Empirics: scientific knowing

Carper's first pattern of knowing, empirical

knowing, is important for professional practice because it provides a systematic understanding of the phenomena of interest and allows the organisation of knowledge 'into general laws and theories for the purpose of describing, and predicting phenomena of concern' (1978: 14). Because empiric data can be tested and verified (Streubert & Carpenter, 1999) nursing researchers collect, organise and analyse information into a credible body of knowledge, general patterns and theories that relate to the specific area of practice.

Many areas of practice, such as dealing with elder abuse demonstrate empirical ways of knowing. Carper distinguishes two empiric degrees of knowing as the 'natural history stage of inquiry' and the stage of 'deductively formulated theory' (1978: 15). Much Australian work on elder abuse currently falls within the natural history stage of inquiry. For abuse in general, research is still attempting to identify categories and estimate the incidence of elder abuse (Sadler & Kurrle, 1993). Similarly, most data on the abuse of nursing home residents is anecdotal and a serendipitous outcome of qualitative research on other topics that happen to include the observation and description staff behaviours that cause harm to residents (Fiveash, 1998; Nay, 1996).

There is an assumption here that empiric knowledge and understanding of phenomena such as elder abuse is dynamic and has changed over time and with new evidence (Payne et al., 1999). As a consequence changing paradigms and models give practitioners new perspectives and ways of looking at phenomena. These conceptual changes then allow new and innovative ways of dealing with the phenomena which in turn gives rise to new investigation, classification, explanation and theoretical models of practice. Some early explanations of abuse emphasised the frailty and vulnerability of the victim and the stresses and difficulties of being a carer as major causes of elder abuse, however there was little evidence to support these

explanations (Biggs et al., 1995). With further research, new explanations for elder abuse began to emerge which cited the characteristics and behaviours of the abuser, plus a number of issues relating to the context under which care was given and the social system that administered and regulated aged care as causative factors (Hudson et al., 1998; McCreadie, 1996).

As Carper's (1978) first empiric natural history stage of knowing moves into the stage of deductively formulated theory, knowing is aimed toward developing abstract and theoretical explanations of the phenomena of concern. This move in emphasis toward the theory stage of empirical knowing is one step towards the development of paradigms that will assist the explanation, prediction and control of the phenomena of elder abuse. Paradigms are useful in developing new research directions and can lead to new knowledge, the expansion of existing knowledge, and the transference of knowledge about one area of practice into new areas of practice (Polit & Hunger, 1995).

An example of transference is when the same causative factors contained in a seminal model of abuse causation in the residential nursing home setting (Pillemer, 1988) were also observed in cases of abuse in the community domestic setting. Transference of knowledge encourages new research into community abuse in an effort to determine whether similar factors influence the abuse of older people in the community as in residential care. However, elder abuse is still in its early days of developing theoretical frameworks that explain why one person will act in ways that harm another (McCreadie, 1996).

The aesthetic art of knowing

Aesthetics, the second way of knowing, is more abstract than empirical knowledge. It is the expressive or perceptive aspect of caregiving that involves a 'fluid and open approach to the understanding and application of the concept of art and esthetic meaning' (Carper, 1978: 16).

Aesthetics form part of the interpretive art of nursing and include the creative processes of perception and discovery in Carper's empirical patterns of knowing. In dealing with victims of elder abuse this aesthetic art includes care which involves the perceptive assessment and knowing of the unique particulars of a client's abuse situation and relationship, and involves some analysis, understanding and interpretation of their subjective experiences as a victim. This understanding in turn gives an appreciation of phenomena such as abuse, and of the client's experience with that phenomena (Streubert & Carpenter, 1999).

Carper suggests empathy is a vital component of the aesthetic pattern of knowing where the 'capacity for participating in or vicariously experiencing another's feelings' in order to gain knowledge of the other's particular felt experience is practiced (1978: 17). The empathetic nurse vicariously experiences client feelings of being abused as a means of relating to the client's felt experience of being a victim and the more skilled nurses become at empathising, the more they will understand the client's personal reality of being threatened or abused.

The art of knowing in practice is expressive and includes the feeling of experience which goes beyond identification, description and discursive language, to a wider perception of shaping 'scattered particulars into an experienced whole' (Carper, 1978: 17). Experience suggests that with increased awareness of a client's various ways of experiencing the reality of their abuse will come a corresponding and often intuitive recognition of the large potential repertoire of creative options and innovative interventions that can be used to deal with the abuse. As practitioners become more expert, intuition becomes an important part of clinical judgement in that it aids the development of creative client centred clinical interventions (Rose & Parker, 1994). The end aim is to gain a balance and rhythm between all the factors involved in the abusive relationship and situa-

tion, and to develop an integrated and creative unity of interventions that will achieve the best outcomes for both victim and abuser.

It is on this more abstract, qualitative and theoretical underpinning of aesthetic understanding as well as on an empirical level of knowledge that much elder abuse practice should be based. As the various levels and patterns of knowing develop and even change, so will professional practice change and evolve.

In the early days of responding to elder abuse, a limited range of responses to cases were evident. For example, many service providers would refer clients for a variety of community and health services in the belief that abuse arose from caregiver stress and that increased support and services would relieve caregiver burden and lead to the termination of abuse (Wolf, 1996). In retrospect, these interventions were appropriate for some abuse situations, but for many older clients they neither led to the cessation of abuse, nor did they meet either the victim's or the abuser's individual needs.

Aesthetic knowing and increased empathy with the lived experience and needs of the victim, plus new evidence which demonstrated that little abuse arises from carer stress alone, have led to new and more creative interventions to deal with abuser issues and the contextual and social factors related to abuse (McCreadie, 1996). An example involves mediation programs that confront the causes of abuse and strive to mediate the issues of the abusive relationship (Craig, 1994), that work to stop the abuse and satisfy the needs of both victim and abuser while supporting them to remain together and build a non abusive relationship.

The component of personal knowledge

Carper's third component of knowing, personal knowledge, comes from the domain of interpersonal interactions, transactions and relation-

ships where the practitioner utilises the therapeutic use of self in encounters with clients. The way a nurse views themself in relation to the client will have a significant influence on their perception and acceptance of that client, and on the authenticity and reciprocity of nurse client interactions. However, knowing is by no means all subjective and some level of empirical knowledge and prediction of potential behaviour are necessary when planning care and intervention. Nevertheless, even though each practitioner needs to recognise that 'models of human nature and their abstract and generalised categories refer to and describe behaviours and traits that groups have in common ... none of these categories can ever encompass or express the uniqueness of the individual encountered as a person, as a 'self'" (1978: 19).

Personal knowing and the therapeutic use of the self in nurse client relationships enables nurses to develop rapport and trust with clients, to approach them as equals and to accept them for who they are. However, before practitioners can begin to know or acknowledge the uniqueness or the experiences of clients they must first self examine and learn to know their 'personal self' and acknowledge their personal uniqueness (Streubert & Carpenter, 1999). In order to integrate this personal knowing into other forms of knowing and into actual clinical practice, each practitioner also needs to reflect on how and why they know what they know.

There must be reflection and an acceptance that clients are complex individuals who bring with them a unique set of experiences, values and belief systems, expectations and needs. The uniqueness of each client's personal traits or behaviours and the assertion of their 'self', which includes their right to make personal choices and decisions such as the decision to decline professional intervention in their case, cannot be denied (Bennett et al., 1997). The implications of this approach for practitioners in the field of elder abuse are profound. If they

are to work effectively with victims and abusers as functional beings, nurses must be open to learning to 'know the client' to the extent that they can empathise with the client's beliefs and needs, plus how the client perceives the reality of their abuse situation. Carper suggests that personal knowledge is 'knowing that promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment ...' (1978: 20). It is when nurses are able to perceive and engage with the older person's situation and the reality of their experience, that nursing interventions will begin to address client needs and the underlying causes of the abuse.

When confronted with a case of abuse, most nurses abhor the thought of anyone harming an older person. Some feel so strongly that they are not able to respond to the case with the open mind or the sense of unknowing that Munhall calls a 'position of openness' (1993: 128). Instead of acknowledging and placing personal opinions or preconceived views aside and being open to see things from the client's perspective, there is a distinct risk of apportioning blame to parties in the abusive relationship. For example, this could include blaming a nasty or difficult older person for almost deserving their abuse or making excuses when the abuser is a stressed carer, or feeling relieved at being able to say they are not a callous abusive person but a carer who has insufficient support or help to be able to give safe care (Fine, 1996). Many nurses are reluctant to acknowledge that a relationship is abusive or to apportion blame to a carer who appears to be a good or caring person (Phillips, 2000). However, with reflection and expanded personal knowing practitioners can come to a point of looking closely at themselves and their clients to gain a more accurate picture of the real situation, the parties involved, and their personal experience of living in an abusive relationship.

Awareness and reflection on personal knowing will change how nurses think about them-selves and their dealings with abuse, and will influence how they develop effective encounters with victims and abusers. These reflections will provide insight into personal knowing and give a broader perspective on elder abuse where nurses are able to consider not only victim or abuser issues but also the wider contextual and social causative factors when responding to abuse. Initial responses might be personal and limited but with developing personal knowing practitioners will be able to stand back and recognise a far wider domain of factors that influence elder abuse and which need to be considered when planning interventions to deal with a case of abuse.

Ethics: the moral component

Ethics, Carper's moral component of knowing, relates to the moral questions, obligations and choices of right and wrong that have to be made in times of 'ambiguity and uncertainty, where the consequences of one's actions are difficult to predict and traditional principles and ethical codes offer no help or seem to result in contra-diction' (1978: 20). The moral code of professions involved with older people will include obligations to give quality service, to respect client rights and to promote the safety and well being of the client group. It is suggested that the greater the potential to influence a vulnerable client's decisions or behaviours or to cause harm to an already damaged victim, the greater is the professional obligation to ensure actions do not cause further harm to the older person (Kingsley, 2001b).

The ethical pattern of knowing requires a clear understanding of the various ethical frameworks, codes and philosophical positions regarding what is good or right, plus a commitment to honour professional obligations for what ought to be done. It also means there must be a willingness to accept responsibility for actions when faced with complex or difficult moral choices and decisions. Like clients, workers are also unique individuals with a

unique set of values, principles and experiences and it can sometimes be difficult to honour client values, needs and goals and still make interventions that do not go against professional judgement or goals. Even in situations where there is a shared vision of common goals, the process of reaching those goals can still cause ethical conflict so that the 'vision and goals become lost in the shuffle' (Graham, 1997: 2). Streubert and Carpenter (1999) reinforce the value of this pattern of knowing and suggest that questions of right, wrong and obligation can become blurred when there are differences in the values, beliefs or the goals of the nurse and their client.

These differences in values and goals were demonstrated in past dealings with elder abuse. Given that the goal was to stop abuse, it was common to see the separation of the victim from the abuser where the victim was placed in institutional residential care (Sadler & Kurrle, 1993). Institutionalisation may have appeared to be the most logical intervention to stop the abuse and ensure safe quality care for the victim, and in some cases it was the only option. However, in other cases where the client did not wish to enter an institution, their goal and desired outcome of staying in their home was not met. With reflection on the ethical way of knowing practitioners may recognise that many of these early professional decisions in fact reflected their personal values and attitudes more than the client's needs and wishes, and they may begin to question why they chose this particular intervention against the client's wishes.

There were alternative interventions that might have been able to honour the victim's wish to remain at home whilst honouring professional requirements to ensure client safety. For example, one response strategy could have been to remove the perpetrator from the abusive situation and make referrals for the community services that would have been necessary to allow the victim to remain at home, with

support and abuse free. Meanwhile, the abuser could have been referred to an elder abuse perpetrator program that works specifically with abusers to help them address the reasons why they abuse, and supports them to terminate their abuse (Kingsley & Johnson, 1993).

These options may have been more complex and difficult to oversee, but when institutionalisation was chosen as the option of first choice, an already violated older person was at risk of being further traumatised when they were put in an institution, against their wishes (Mitchell, 1997) for no other reason than they were old, frail and had been abused. The aims of creative aesthetic, moral responses are to terminate the abuse, to address the underlying causes of the abuse and to allow the parties to remain together with increased levels of harmony and support but without any further harm to the older person.

UTILISING 'KNOWING' IN PRACTICE

In recognising the value of their acquired patterns of knowing and in utilising them in professional practice, each practitioner has an obligation to reflect on their personal values and attitudes about ageing and older people, about whose responsibility it is to give aged care, about elder abuse and what should be done to minimise abuse. This awareness will form an important part of the nurse's arsenal of knowing and have an impact on the assessment and intervention choices they make when dealing with clients. Upon reflection, even with the best motives and intentions, many nurses recognise they have not always made the most creative choices or the best decisions for their clients. In themselves, these decisions might not have been right or wrong, but what they have sometimes done is reflect the nurse's values and moral beliefs rather than the needs and desires of the client. Gaining a conscious recognition and appreciation of Carper's (1978) patterns of

knowing will assist nurses to utilise this knowing gained in their clinical practice.

Ideally, professional practice in dealing with elder abuse will be based on evidence of what is happening in the abusive relationship; personal knowledge and understanding of the older person, their experience of being abused and their needs and wishes; plus ethical and creative aesthetic ways of knowing and intervening to address the abuse. The application of this approach to knowing to the field of elder abuse illustrates that Carper's (1978) patterns of knowing are a legitimate source of knowledge in dealing with abuse. By working through and reflecting on how these patterns apply to elder abuse practice it is argued that scholars and practitioners will develop a deeper understanding of abuse and an enhanced ability to relate knowledge to practice

CONCLUSION

Barbara Carper may have developed her conceptual framework of patterns of knowing in nursing more than two decades ago but this framework still has relevance and application for clinical practice in dealing with the abuse of older people.

No one pattern of knowing will, on its own, be sufficient to deal with complex issues like elder abuse, and all patterns will be necessary for the successful resolution of abuse cases. Similarly, the various patterns of knowing are not mutually exclusive; rather they need to be interrelated and interdependent if knowledge and practice are to be situated in the experienced reality of the victim or abuser. The field of inquiry into elder abuse must involve not only scholarly knowledge in the traditional empirical sense but also knowledge that stems from ethical and practical understanding and wisdom that can be applied in clinical practice. If professional practice is to meet the needs of elder abuse victims and perpetrators alike, it will incorporate each way of knowing in dynamic patterns that are arranged and played

out according to individual client needs and the context within which the abusive relationship occurs.

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Themes of the Submitted Articles

The remaining articles in the body of work comprise four themes. Each theme illustrates the nature and diversity of the work involved in addressing elder abuse, and places the areas and phases of that work within a context. The themes also identify the contribution the body of work has made to this area of professional practice in Australia.

The first theme includes the articulation of the issues of elder abuse by and with professional aged care workers throughout Western Australia. The second theme includes two aspects of response to elder abuse, first in the development of principles and protocols to guide professional practice and professional education, and second in highlighting the ethical issues related to responding to abuse. Similarly, the third theme also incorporates two responses aimed at ameliorating elder abuse, these involve preventive measures in the community through community education, participation and empowerment to prevent abuse plus a community perpetrator program to work with abusers and help them terminate their abuse. The final theme relates to the issues of institutional care and the development of measures to facilitate the minimisation of resident abuse

The work was not deliberately divided into themes during its execution. It was in retrospect that the patterns and themes became evident from reflection on the directions the work had taken over the years. As there has been a development of themes there has also been a development in thinking and understanding of elder abuse that is evident in the style and manner of the written work.

Included in the body of work are four letters. Two are from Susan Johnson and Dr Sarah Mott, which outline my contribution to co-authored articles. The other two are from COTA and the Curtin University Centre for Research into Aged Care Services, to verify that both protocols were peer reviewed by senior aged care workers in Western Australia.

Theme 1. Articulating Elder Abuse in West Australia

The first formal work on elder abuse began in 1989-1990 when local SECDC community workers raised and acted on an issue they felt was significant enough to warrant their time and energy. Together we took the initiative, gained funding and held the first recorded West Australian professional education programs on elder abuse. These local efforts led me into a wider sphere of work and influence with the formation of the COTA Steering Committee on Elder Abuse in 1991.

An initial task for the Steering Committee was to conduct the first statewide conference on elder abuse. Aged care professionals were recognising abuse as an issue in their work, some workers confessed they did not respond to cases because they did not have the necessary resources or skills and they requested support in dealing with those situations. The conference was held following the 1992 State HACC Conference to allow as many workers as possible from rural and remote areas of the state who had attended the HACC Conference, as well as metropolitan workers, to attend.

As part of the COTA Steering Committee and a keynote speaker, I facilitated workshops and discussed with participants their experiences and understanding of abuse and identified what support they needed to deal with abuse. Their primary need was for education and guidelines on how to prevent, identify and intervene in abuse cases. To write the conference proceedings I analysed all workshop discussions, conclusions and what participants said they needed for this work.

From the papers, workshop findings, panel discussions and outcomes of the day's proceedings I made conclusions and formulated potential directions for the West Australian aged care industry in working with elder abuse. My editorial role in analysing and drawing conclusions from the proceedings and articulating recommendations for future directions was pivotal in identifying the key concepts of elder abuse for local conditions at that time and setting the likely directions that elder abuse work would take throughout Western Australia.

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PROCEEDINGS FROM

SMALL GROUP WORKSHOPS

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WORKSHOP ON IDENTIFICATION AND PROTOCOLS.

Following the three main papers and ...orning tea participants broke into groups to discuss issues relevant to the prevention, identification, and treatment of elder abuse. The following is a precis of the workshop proceedings and findings.

A. CASE IDENTIFICATION

PRIMARY PREVENTION :

The overwhelming response from the workshop was the need for primary intervention to prevent elder abuse before it occurs. Groups suggested that, to reduce the risk of abuse, there must be a significant increase in the community services for seniors, and expanded levels of support for both seniors and their carers. Preventive measures included the following.

* positive affirmation of the elderly in society
* empowerment of seniors in the community
* eliminate social abuse of senior by government and society generally
* community education / awareness raising of the issues of elder abuse
* increased referral agencies
* increased community services and support for carers / seniors
* increased financial benefit, tax rebate, domiciliary allowance for carers
* carer support groups, carer respite
* devolution of funding from the bureaucracy down to the grass roots
* increased information, access to services
* increased community health services for carers / seniors

SECONDARY PREVENTION :

Secondary prevention includes assessment and screening for early detection of elder abuse and the acute care of identified cases. The objective is to intervene and treat acute cases and hence reduce any long term or residual effects of abuse.

Warning Signs of Elder Abuse :

1. Carer Signs :
* carer under pressure, tired, stressed,
* carer also appears abused (social abuse by community)

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* insufficient community services, no flexible community supp.,
* lack of respite, relief from caring, no options for care
* carer under multiple social pressures e.g. employment, family
* senior discharged from hospital too early, with insufficient health support / aftercare
* carer not trained in the caring role, poor nurturing skills
* carer appears guilty, nervous, defensive
* carer displays fear, depression
* extreme care / hesitance in discussing senior
* reluctance to talk to community worker, withholds information
* carer refuses access to senior, unwilling to be separated from senior,
* refuses help / community services
* complaints about senior
* carelessness of senior, home in disarray

2. Client Signs :
* self reporting of abuse, complaints, accusations
* plays the victim role, emotionally blackmailing carer
* reluctance to talk to community worker, withholds information
* stories differ from carer
* refuses to acknowledge needs, unwilling to accept help
* unwilling to be separated from carer
* no consultation, no options, no voice in important personal decisions
* excessive hospital admissions

3. Physical Signs :
* injuries, broken bones, bruising, abrasions
* pressure sores, malnourishment, dehydration, weight loss, changed body functions
* over sedation, sleepiness, lethargy, clumsiness, anorexia
* conflicting stories regarding symptoms, unlikely explanations for injuries
* poor physical environment

4. Emotional Signs :
* depression, withdrawal, lethargy, altered mental state
* crying, agitation, aggression,
* defensiveness, threats, inducements, promises, emotional blackmail by either party
* lack of insight, low expectations, poor life skills

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* low self care, overcare, denying self determination
* poor family relationships, role reversal
* isolation, denied visitors or access to outsiders

5. Psychological Signs :

* unmet carer / caree expectations
* unmet cultural expectations
* intergenerational dynamics / power / conflict
* power differentials carer / senior
* poor communication, no communication, abusive language
* signs of substance abuse carer / senior
* denying information, help, social contact
* changed behaviour, unusual aggression, sudden withdrawal by carer / senior
* fear of being alone, of independence, of losing carer
* pressure to enter residential care

6. Financial Signs :

* financial dependence by either party - actual or perceived
* one has control over the other's finances
* unexplained changes in senior's finances
* senior's possessions go missing
* disorganised affairs, money / financial records are lost
* no access to personal finances

During the workshop, participants raised many of the ethical issues that community workers encounter in dealing with elder abuse. The underlying emphasis of many groups was that whatever we do our prime concern must be that "WE DO NO HARM". There was also an acceptance that we must recognise our own values and attitudes on this topic and not let them have any negative effect on our practice.

7. Ethical Issues in Case Identification :

* follow your gut feeling
* duty of care, responsibility to do no harm
* personal values versus professional (or agency) values
* organisational goals can conflict with client needs / rights

* be objective, make no value judgements
* the responsibility for care / safety of senior versus self determination and the dignity of risk / choice
* difficulty establishing the appropriate level of autonomy for seniors, e.g. in cases of dementia
* the risks of interference, paternalism
* issues of confidentiality, informed consent, choices, rights to make own decisions
* priority decisions between the needs of carers and seniors
* lack of community resources yet families made responsibility for care
* difficult / unfulfilled religious, cultural expectations
* clients right not to disclose abuse
* why are outcomes of disclosure often worse than the abuse?
* if abuse proven, decisions regarding support / counselling / contracting for cessation of abuse or separation or punitive criminal action
* if separation is necessary who leaves the home - carer or senior?
* question of mandatory reporting - who will it benefit, what will be the costs?
* adequate agency / bureaucratic protection of community workers

8. Legal Issues of Elder Abuse :

* affordable legal support for seniors
* modification / extension of existing law to cover abuse of seniors, e.g. family law, domestic violence, guardianship
* legal "backup" of response principles
* no legal guidelines for community workers
* duty of care, negligence
* mandatory reporting - positive / negative outcomes of reporting, penalties for non-reporting
* questions of accountability, liability for incorrect action or taking no action
* worker protection from defamation / libel because of inter-agency information sharing
* freedom of information
* workers being compelled to divulge confidential information in criminal cases
* right of entry (for police, community workers), trespassing
* assault / abuse of community worker
* legal protection for workers involved in abuse cases
* level of community worker's knowledge of legal policies and their implications

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9. Issues of Self Neglect and Neglect / Abuse :

* is self neglect a right or is it self abuse?
* when (if at all) should community workers intervene in cases of self neglect / abuse
* is unintentional neglect still elder abuse?
* when does poor care become abuse? this decision is a value judgement
* is it a matter of intent / lack of knowledge / inability to care?

TERTIARY PREVENTION :

Tertiary interventions aim for the long term safety of seniors and include measures to remove either the senior or their carer from the abusive relationship, to assist seniors to cope with abusive situations should they choose to remain within the relationship, to rehabilitate and support carers so that abuse ceases immediately, and to educate and support both parties so that no further abuse will take place.

* support of senior / carer when senior unwilling / unable to leave the abusive situation
* counselling options for senior / carer
* follow-up support, educative support to prevent re-occurrence of abuse
* contracts with abuser / positive interventions for immediate cessation of abuse
* separation by hostel, nursing home admission, removal of abuser
* punitive action against perpetrator where necessary / appropriate

B. PROTOCOLS FOR CASE MANAGEMENT

The response from workshop groups was that few, if any, agencies have formal protocols or procedures for identifying, reporting, or managing cases of abuse against seniors.

* agencies are not funded for the personnel, time, infrastructure necessary to deal with cases of abuse
* few community workers are specifically trained or experienced in this area
* few, if any, agencies have formal protocols for identification or treatment of abuse
* there are amazingly few indicators of high risk cases, identification tools
* most agencies follow ad hoc case management, multidisciplinary team approach
* there are insufficient referral agencies for difficult / unresolvable cases
* there is insufficient protection / management support for workers in this stressful area

Although no established formal protocols were noted, many participants described how they have attempted to deal with cases of abuse. Community workers acknowledge that even though agencies are under-resourced and there are no firm guidelines, they can not allow the abuse of seniors to be overlooked or go undetected and untreated. Most agencies have therefore developed their own procedures for intervention in suspected cases of abuse.

From these current activities three major principles emerged very strongly, the maintenance of the RIGHTS and SAFETY of seniors and the respect of their right for AUTONOMY and SELF DETERMINATION.

Another factor which emerged from the workshops was that no two cases of abuse will be identical. Consequently where there are differences in carer / caree relationships, power / family dynamics, levels of dependence, levels of mental competence, cultural expectations and behaviours, the social contexts of abuse, or the types of abuse involved, community workers will be presented with different symptoms and problems and will need different response protocols for each specific situation. This illustration of the complexity of the issues of elder abuse highlights not only the need for appropriate protocols but also the difficulties involved in developing such protocols.

From all the workshop groups a composite list is presented. Although this list is in no way complete, it is nevertheless extensive and may well form a basis for some future protocols and procedures.

1. CURRENT PROTOCOLS AND INTERVENTIONS :

* assess risk factors, what could be done to improve the situation / increase
      safety / prevent abuse
* take and document social and health history
* identify history re-occurrence, nature, extent and severity of abuse
* determine source of abuse and context
* determine any past abuse, past interventions and their success / failure
* accurate, objective case assessment and diagnosis
* ensure all parties that confidentiality will be guarded, even if it can not be guaranteed
* assess relationship and dependency levels of carer / senior

* interview senior and carer separately
* what fears does senior have, ask senior "what is the problem?"
* listen to senior, gain their trust and confidence, believe their story
* obtain senior's permission to speak to carer
* ensure you get both sides of the story
* determine carer difficulties / stresses, what problems do carers have?
* with senior's consent, interact with other agencies involved in care
* contact other carers if necessary and if senior agrees
* hold family conference or mediation where appropriate
* try to gain an understanding of the perpetrator and their problems
* offer more support, respite, community services
* to safeguard all parties, verify and document all data
* ask the senior what they would like to do, clarify their wishes,
* guarantee their right of choice, honour the dignity of risk
* with senior determine future action, living arrangements, safety measures
* with senior's agreement, refer case to relevant agencies
* develop treatment plans and contracts to ensure protection
* if carer admits abuse, initiate support / education / contracts for immediate
    cessation of abuse / separation / criminal or punitive action as necessary
* act as mediator or advocate as necessary
* implement action plan and document all interventions
* ongoing evaluation to determine effectiveness of interventions

Plus Some Important Issues - For The Community Worker :

* know your own limits
* build strong supportive peer networks
* insist on supervisor / agency support and protection
* protect your own health and well-being.
* acknowledge the value of your own work and the contribution it makes to the
    well-being of seniors

Although not a complete list of the issues related to the abuse of seniors, the workshops, in the brief time available, highlighted many of the major issues that affect workers directly involved in the day-to-day identification and management of cases. It is timely that those who are involved in formulating legislation and

polices related to elder abuse, should take account of these issues and ensure they are addressed in future legislation and policy.

2. WHERE TO NOW? :

The proceedings from the group workshops showed an overwhelming need for some national guidelines, which should be backed up by adequate community resources, standardised implementation strategies, effective policy co-ordination, strong legislative measures, and supportive mechanisms for the protection of community workers in the field. Suggestions for future directions and activities included the following.

* reduced gaps between needs of seniors and service delivery
* vastly increased supportive community services and resources
* appropriate legislation to deal with abuse of seniors
* co-ordinated, consistent national guidelines - which can be adapted to specific target
    populations / agency functions
* guidelines for specific groups - people with dementia / multi cultural groups / country
    seniors / age and gender groups
* guidelines for specific types of abuse - conventional crime / abuse, neglect / social abuse
* increased police powers to act on suspicion / report of criminal abuse
* co-ordinated service delivery within / between agencies
* effective case / team management procedures
* standardised documentation of statistics of cases
* increased agency accountability for actions, distribution of funds / services / evaluation
    of services, HACC to demand more evaluation and review of service effectiveness
* relief accommodation for seniors - refuges, affordable short term accommodation
* increased respite for carers
* adequate referral agencies / counselling services
* adequate financial re-imbursement for carers, to cover the high financial costs of caring

Participants noted that these measures were essential if effective prevention and intervention were to take place. They also noted that the community must be made aware of both the enormity of the crime of elder abuse and also the resources and supports available to people in an abusive situation. However, although this community awareness is essential it will be futile to alert people to resources which do not yet exist. A priority then is the urgent formulation of appropriate legislation, policies, protocols, and

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community supports. When these are in place, a next step will be a community awareness and education campaign which could include the following.

Community Awareness of Elder Abuse :

* affirm the positive role and position of seniors in the community
* alert the community to the issues, the existence and the enormity of elder abuse
* inform seniors of their rights, encourage them to assert those rights
* alert seniors to the issues, incidence, severity of abuse, that abuse is a criminal offence
* inform abusers that support / counselling is available, that abuse is a crime which may have punitive consequences for them as perpetrators
* advise legislators, policy makers, bureaucrats of the ongoing need for urgent preventive / protective legislation / policies / protocols / complaint mechanisms
* educate community workers., e.g. police, nurses, social workers, doctors, agency co-ordinators, with the skills and strategies for prevention, counselling, support and intervention

Throughout all of these suggestions ran a common concern, the need to safeguard the welfare of the community worker. All are aware of the stresses of dealing with elder abuse. Not only is the abused senior a client, the abuser is also invariably in great need of support and help. Workers can be torn between the needs of carer and caree; many are also torn between their wish to intervene and help and the policies or lack of support received from their supervisors or their agency. There is a great need for supportive protective mechanisms for community workers. As individuals, they also need to build strong peer networks from whom they will receive help and support.

3. WHO SHOULD BE RESPONSIBLE? :

From group discussions of what we need for prevention, identification and intervention in abuse against seniors, two streams of thought were evident. One suggested the need for a single agency or unit to hold ultimate responsibility for dealing with elder abuse. A number of suggestions were made.

* Senior's Social Justice Unit
* expanded role for the Office of the Public Guardian

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* an existing bureaucracy to be made responsible for abuse issues, e.g. Council on the Ageing, Offic⌐ f Senior's Interests, Older Person's Rights Service, Home and Community Care (for community abuse), Department of Geriatric Medicine or Commonwealth / State Health agencies (for institutional abuse)

It was interesting to note that specific reference was made, in a number of groups, to the un-suitability of some government departments to deal with the abuse of seniors. It was felt that the Department of Community Services would have difficulty making the "conceptual leap from child protection to protection of seniors". Similarly the Office of Women's Interests, the Office of the Family and the Domestic Violence Task Force were not considered suitable because of their lack of emphasis on the needs of seniors and their heavy emphasis on domestic violence and spouse / child abuse. So much abuse against seniors falls outside these areas that participants considered these agencies were not appropriate to deal with elder abuse.

The second stream of thought suggested that rather than one separate bureaucracy to deal with elder abuse, existing agencies should be expanded with units of people devoted to the special needs of seniors who can deal with specific issues of abuse.

* local community workers / agencies would deal with majority of cases
* intra / inter agency support would solve more complex situations
* where relevant referral to support groups or units within existing agencies, e.g.
    - HACC for community services / respite / support
    - Homeswest for housing issues
    - Department of Social Security for financial concerns
    - Geriatric Services for GAT assessment, Extended Care support
    - Community health services / counselling services
    - Police Department for criminal action
* more complex or unresolved cases to be referred to a Seniors Justice Unit - not a separate agency but a unit within an existing agency e.g. Council on the Ageing, Office of Senior's Interests, Office of the Public Guardian

Although there were similarities to these two suggestions, the conceptual differences in the administration of abuse issues were significant. In both schemes however, future actions were to be guided by the wishes of seniors with some mechanism for consultation with seniors to determine their needs and requirements. This consultation was to be both

individual, with seniors as a whole, and through extended advisory council consultation between government and seniors.
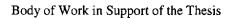
Most groups also mentioned the overall Government responsibility for the welfare and well-being of seniors. With the current emphasis on maintaining the elderly in the community, there must be increased support and services for the families who have been made responsible for the care of elderly relatives. If Governments do not accept this responsibility, they will be culpable for a large portion of any increased incidence of abuse which occurs subsequent to the introduction of their recent community care programs. Government expectation that families will care for relatives without adequate support was said to be a prime example of social abuse against both seniors and their carers.

IN SUMMARY :

The over-riding theme that ran through all of the workshops was that prevention of abuse is far more effective than having to deal with all the heartbreak and distress or the complex legal and ethical issues of abuse. The general consensus was that far more community funding, resources, services and support are necessary to eliminate the stress and burden of caring which is often the pre-cursor to abuse.

Tied to the theme of prevention was the issue of protection. Abuse against any person, including a senior, is criminal and it is unacceptable. Protection means making sure that community workers never do anything to harm their clients, they will ensure the safety and well-being of seniors is paramount, they will protect senior's rights to an appropriate level of autonomy, to self determination, to choices and options in the decisions which affect their lives. It also means that workers will guard, even if they can not guarantee, confidentiality at all times. Conversely community workers felt very strongly about protecting their own safety and well-being in dealing with cases of elder abuse.

With regard to future action, the obvious need is for guidelines to deal with abuse cases. These guidelines must be backed up with the appropriate legislation, policies, funding and administrative infrastructure to ensure effective implementation. This will assist in dealing with existing cases of abuse. With regard to prevention, participants were critical of the poor levels of community resources which they felt were not only insufficient, but contributed to rather than prevented abuse. They strongly recommended that these two issues - of prevention and guidelines for intervention must be addressed concurrently.

Kingsley, B. (1992b). Conclusions and recommendations. In B. Kingsley (Ed.), *Dealing with elder abuse* (pp. 85-90). Perth: Council on the Ageing.

CONCLUSIONS

AND

FUTURE DIRECTIONS

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CONCLUSIONS :

Abuse against seniors is a crime and a serious social issue. It is also an extremely complex issue, for which there is no simple antidote or cure. As conference participants, we were probably already aware of the seriousness and complexity of elder abuse, but for many this awareness was sharpened and extended as a result of the conference activities.

Although not unanimous, many participants suggested that abuse is basically about violence. This does not only include physical, psychological, emotional, sexual, social or financial violence, it includes any behaviour which violates the rights of a senior and which causes them harm. In these terms abuse would also include the societal abuse of a community which allows ageism, sexism, discrimination and violence against seniors. It would also include the public abuse by governments which allow inequitable distribution of resources to women, to the aged, to the frail, and to those of minority groups such as people from country areas or those of non-English speaking background.

As a social issue, most elder abuse is the result of broader social processes and attitudes. Many community workers have found that while they might have some success with counselling and conciliation, they will never succeed in substantially reducing abuse until community attitudes about seniors and social violence change. Similarly while much abuse seems to arise from the unequal power and financial relationships between senior and carer, from the issues of dependence of the senior on the carer, or from the psychopathology of the carer, even more abuse is attributable to the unmet needs of both senior and carer, and to the insufficiency of support and services for the caring relationship. The answer does not lie in addressing only one of these issues, rather they must all be addressed together if the problem of elder abuse is to be resolved.

From the three main papers, the group workshops, the questions to the panel, the discussion at the end of the day, and from the evaluation forms a number of common themes emerged. The essence of these themes relate to the issues which affect those involved with elder abuse: the seniors themselves, their carers, the general community, community workers and the bureaucracy including the legislators and policy makers.

SENIORS :

One of the major issues of seniors in society concerns the gap between their current and their ideal place in the community. Whilst this gap continues to exist seniors will be at risk of abuse. To help prevent abuse, it was agreed that there is a need to affirm the positive role and position of seniors in society and to empower them with the strategies to demand and enjoy their rights as first class citizens. The risk of abuse decreases as seniors have the opportunity to make a positive

contribution to their family or their community; they must be allowed the opportunity to both contribute and demand their rights. If seniors are to enjoy these rights then they, or at least those who are able, have a responsibility to become involved in their own welfare and to have a strong voice in the decisions which affect them both as individuals and as a group. This implies that groups with specific needs (e.g. dementia, cultural needs, gender needs) have special demands which must be met in order to maintain their rights and their well-being.

The message throughout the conference emphasised the need for support mechanisms which would protect seniors and prevent abuse rather than interventions to deal with cases of abuse. Although not stated in these words, the principles of the *United Nations Principles for Older Persons* were often mentioned, these include the need for independence, participation, care, self-fulfilment and dignity for all seniors.

To achieve these principles there is a need for education, support, protection and promotion of seniors. They must be given the skills and strategies to meet their own needs and be given the opportunity to be involved in their own future. For all seniors, but particularly for those who can not advocate on their own behalf, there is an added responsibility to see that discrimination and negative attitudes towards seniors are abolished so that their rights and their place in society is protected.

Community workers accept the responsibility that their interventions must be directed toward these principles, to ensure that their actions will cause no harm to seniors, and that the safety and well-being of clients, their choices and options, and their right to autonomy and self determination are of the highest priority and must be protected at all times.

CARERS :

In many instances the carer is also a victim of social abuse who will need support and protection. The types of support necessary to help carers cope are adequate community services, regular respite, sufficient financial assistance, and support in carrying out the caring role. If abuse does occur support, counselling and a contract / agreement for its immediate cessation may be enough to restore safety for the senior. However, counselling alone will not always be enough to stop abuse. Although the abuser may feel remorse and see that what they have done is wrong and completely unacceptable, with the best will in the world the senior is still at risk unless there is also significant change to the power relationships or the contextual factors which were the precursors of abuse in the first place.

If the abuse does not cease or if the risk of re-occurrence is too great, there might be a need to separate the parties either by removing the victim or the abuser from the relationship. For some types of abuse there may be no alternative but for the perpetrator to be referred for criminal action.

Again, in working with carers, participants recognised that their prime objective is to ensure that the caring relationship does not degenerate to the point where abuse occurs.

THE COMMUNITY :

As with child abuse a decade or so ago, there is little community awareness of the existence, the extent or the severity of elder abuse. Elder abuse is a form of social violence which is tolerated, even if not condoned, by the community. This situation must be reversed. With an increasing aged population the role and position of seniors in society is changing and it is unfortunate that ageism is alive and well. As one community worker remarked, sexism is rampant but few of us change our gender, racism is strong but we do not change our racial origins, but ageism abounds and yet we are all getting older and most of us will become seniors at some time. One of the ways to combat elder abuse is to change society's negative attitudes towards seniors until we reach the point where elder abuse receives the same public, bureaucratic and legislative attention and affirmative action as have child abuse and domestic violence.

Through education, media and awareness raising campaigns, through public discussion and debate, the community must be made aware of the complex issues involved in elder abuse. Ideally this community awareness would follow the introduction of appropriate preventive and management protocols. However, if they are not rapidly forthcoming, there might be a need to inform the public of the situation and engender a public groundswell of opinion which will force the legislators, the policy makers and the funding bodies to take strong affirmative action on behalf of seniors.

COMMUNITY WORKERS :

The difficulties under which community workers function and the stresses involved in dealing with elder abuse were recognised and acknowledged throughout the conference. Some participants felt that the problem was huge, that the known cases of abuse were just the tip of the iceberg and that, although they need to investigate the rest of the iceberg, tackling the whole question of elder abuse is indeed a daunting task. They appreciated the input from the conference and suggested the need for ongoing networking, information, support and education for community workers. Participants, in acknowledging their own need for support, also recognised that without adequate staffing, administrative infrastructure, funding, agency support and protective mechanisms, they can not function effectively in dealing with elder abuse.

Another issue of concern to community workers was how their own values and biases, their past experiences, their attitudes towards the elderly and their beliefs

about aged care have a profound influence on their decisions and their work. It was agreed by all that we must address our own value system and never permit any decision or action to cause harm to seniors.

Most agencies had developed some level of preventive and intervention measures and most carried out some type of case management. They worked successfully with multi-disciplinary teams, but regretfully agreed with the Australian Medical Association panel speaker that there was insufficient co-operative communication and liaison between medical practitioners and other practitioners in the community. Although participants are attempting to deal with elder abuse, they nevertheless recognised the urgent need for formal protocols and guidelines; for indicators to identify seniors at high risk, and for abuse identification tools. If however, we are to convince the legislators and policy makers that these mechanisms are warranted, we will need to be able to justify our demands with extensive and accurate data and statistics about the incidence and extent of abuse, the conditions under which it is most likely to occur, and the outcome of preventive and management interventions. No comprehensive data has yet been collected in Western Australia and agencies are urged to begin documenting cases and collecting data.

THE BUREAUCRACY :

The need for effective legislation and protocols was judged as urgent by most participants. Like the public it was felt that few politicians and bureaucrats were aware of the issues and the extent of elder abuse. Again, like the public they must be made aware of the current situation. This can be achieved by involving the legislators and policy makers in developing guidelines for prevention, identification and management of cases. They can also be alerted to the extent of elder abuse by the presentation of statistics concerning abuse; which implies that we need local research and the collation of statistics on this topic if we are to achieve bureaucratic support.

Everyone present recognised that if abuse is to be prevented, there is need for more community support, more respite, more counselling services, more referral agencies and more crisis intervention facilities. Participants correctly recognise that increased services alone will not eliminate the incidence of elder abuse. However, increased community support will go a long way towards alleviating the abuse of seniors. Obviously there are other causal antecedents to this type of abuse and these will need to be dealt with simultaneously with increased government support and services to family and community caregivers. Although they recognised that increased services are not the only preventive measure, participants were adamant that this should not be used as a bureaucratic excuse for governments to refuse any increased assistance to community aged care.

For existing abuse situations, workshop groups favoured the management of cases to be carried out by local agencies who would receive bureaucratic support and

assistance to deal with more complex cases. The majority of groups opted for small units of experts in relevant departments who would assist community workers, rather than the development of another bureaucracy to deal with elder abuse. Many participants felt there should also be one unit such as a "A Senior's Social Justice Unit" which, as part of an existing agency, would oversee and co-ordinate elder abuse activities and mediate or arbitrate on unresolvable cases.

There was no consensus on where the ultimate responsibility for elder abuse should lie. This decision will be influenced by both the directions taken in developing guidelines and protocols, and also by whether or not existing agencies are prepared to expand their current philosophy and activities to include elder abuse. With regard to the need for a social justice unit for seniors there are also a number of future options. Some participants felt that, for example, if those elements of elder abuse which occur in the private, familial or domestic rather than the social or public sphere are considered as elder abuse, then the domestic violence legislation and activities could be expanded to deal with unresolvable elder abuse. However on a more positive note, if adequate preventive community services, efficient detection guidelines, appropriate treatment protocols, and effective case management procedures were developed, the number of unresolvable cases of elder abuse could be so small as to not warrant any specific bureaucratic unit at all. The first step is to work together and develop the guidelines and protocols which will then drive much of our future activities and directions in this area.

WHERE DO WE GO FROM HERE?

Just as the Council On The Ageing (WA) Steering Committee on Elder Abuse and subsequently this conference developed out of a small South East Community Development Council workshop on elder abuse, it is hoped that the repercussions of today's activities will spread even further. We hope that what has begun as a ripple will develop into a groundswell of activity directed at raising community awareness and demanding solutions for the problem of elder abuse. This forum has opened up an issue that needed to be aired, although the task is daunting we must be positive and not let the momentum for action stop here. The Steering Committee plans to invite community, professional and government agencies to be involved in future activities, including the development of protocols and guidelines, which will then be presented to Government with recommendations for policy and legislation. It is also hoped that some time in the near future we will have progressed far enough to be able to hold public forums for seniors to discuss the issues and problems of elder abuse and to advise them of available resources and supports. Please accept this invitation to be involved!

Theme 2.   ***Response to Elder Abuse: Principles and Guidelines for Professional Practice***

Elder abuse protocols for responding to elder abuse

With the recommendations of the professional conference and the participant's collective request for assessment and intervention guidelines in hand, the COTA Steering Committee concentrated on developing an elder abuse protocol. The protocol, the first released in Australia, was launched by the Minister for Seniors and was distributed throughout the state and to a lesser extent around Australia.

My first protocol had concentrated on community abuse, however in more recent years I also began to publicly raise the unpopular topic of resident abuse. Following a series of conferences, meetings and nursing home staff development sessions on resident abuse, I was asked by representatives of the residential care industry to develop a protocol for use in West Australian nursing homes. With support from a small group of managers, development of the second protocol commenced in 1999. Many residential organisations also offered community care packages and I was asked to include guidelines for community abuse in the document. The first protocol, which was now six years old and out of print, had included more information on abuse for workers new to this area of practice than might normally be in a protocol; so it was timely to revisit community abuse and include it in the second document. It was encouraging that the aged care industry requested and remained involved in this work through trialling and critiquing the protocol, and feedback since its release suggests it is meeting a need in aged care.

The Curtin Centre for Research into Aged Care Services funded the first print of the second protocol. Together with this Centre and an OSI grant, an evaluation of the protocol and a prevalence study of abuse in West Australia is being undertaken. Due to the number of requests for the protocol from this state and around Australia, over 3,000 protocols were distributed and supplies were soon exhausted; the Health Department of Western Australia funded a second printing.

Kingsley, B. (Ed.). (1993). *Responding to elder abuse: a protocol for non-government agencies.* Perth: Council on the Ageing.

Kingsley, B. (2000a). *Elder abuse: Protocol and policy guidelines to prevent the abuse of older people in community and residential care.* Perth: Curtin University, Centre for Research into Aged Care Services.

Curtin

ELDER ABUSE

Protocol and policy guidelines to

prevent the abuse of older people

in community and residential care

Beth Kingsley

ELDER ABUSE

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Centre for Research into Aged Care Services

FOREWORD

The International Year of Older Persons was a significant year when we celebrated older people and the valuable contribution they make to society. However, the year was more than just a celebration. It was also a time to recognise some of the significant issues of ageing and to develop positive ongoing strategies that will both address those issues and promote the health and well being of older people.

Elder abuse is one such significant issue in aged care.

All citizens have a right to be valued, to live with dignity and independence, to receive quality care and to be safe from threat or abuse. Unfortunately some older people do experience abuse and neglect. Elder abuse is a term and a concept with unpleasant connotations. It is a symptom of unhealthy or broken human interactions and relationships. The contributing factors are varied and complex; they may be the result of an individual's problems or the expression of societal pressures and stresses. Elder abuse has probably existed since Adam was an old man but now, in this time when our population is rapidly ageing, it is an issue about which we must become increasingly aware.

Society should be judged by the way it treats its most vulnerable members and society must constantly review and reaffirm its values and behaviours.

Those of us who provide services to and care for older people have an absolute responsibility to ensure our behaviours and practices safeguard every aspect of the well being of those who entrust themselves to us. We must not only monitor our own attitudes and behaviour toward older clients, but we must also ensure others have the support, assistance and understanding to do the same. In dealing with elder abuse, the term 'zero tolerance' is a good one and provides the benchmark.

I am delighted to recommend this document to you. It is comprehensive, articulate, practical and very applicable. The issues are dealt with sensitively and with great clarity. I particularly encourage all agencies to develop a policy around elder abuse, one which is easily accessible and easily understood by all staff, and which can be integrated into everything they do and for which they are accountable.

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Executive Director
Brightwater Care Group (Inc)

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INTRODUCTION

The quality of care available to most older Australians is of a high standard. This protocol deals with that portion of care which is less than quality, the neglect and abuse of older people. Most families work tirelessly to care for a frail or dependent relative and most residential care staff take their duty of care seriously; yet elder abuse does occur. When all seniors have the right to live free from threat or harm, elder abuse is a tragedy that should never happen.

Elder abuse is a significant and complex social issue but because it often occurs in private, behind closed doors, it is a largely hidden phenomenon that is seldom recognised or acknowledged. This protocol aims to open the door and raise awareness about elder abuse, to prevent abuse by promoting the safety and well being of older people, and to assist agencies as they work to resolve cases of elder abuse.

The document talks about the abuse of older people, but no age limit is set as much of the content also applies to adults with chronic illness, disability or premature ageing. The protocol considers abuse by another person but it excludes self neglect or abuse by an unknown assailant. Likewise, in residential care it excludes the abuse of one resident by another. This does not mean these forms of abuse are not serious - they are. However, they are not included because the interventions required to deal with them lie outside the scope of this protocol.

There is no universal agreement on a definition for elder abuse or what behaviours constitute abuse and each person will judge the abusiveness of a behaviour according to their own values and experiences. Similarly, when assessing for abuse, few cases are black or white and rarely is there a cut-off point where a particular behaviour becomes abuse, or when poor care becomes neglect. This protocol does not give all the answers but it raises issues that each agency is encouraged to consider when developing and implementing their own protocols and policies for abuse prevention.

One thing on which there is agreement, however, is that abuse needs to be identified, dealt with and resolved in a way that best meets the needs of the older person, whist still honouring the rights of all parties involved in the case. To do this requires a balance between meeting the safety and self determination needs of the victim and giving therapeutic support for the abuser.

This protocol is written for managers and professionals who are responsible for identifying and responding to cases of abuse, rather than for staff or volunteers who see clues or indicators of abuse and report their suspicions to their supervisor. It is also intended for educators who teach about abuse prevention and intervention, and for agency managers who develop and apply policy that is aimed at promoting the well being and protection of older people. Managers are invited to take, modify and use this document to meet specific agency and client needs.

I acknowledge the support of colleagues and agencies who critiqued and trialled the protocol and policy guidelines. The financial support of the Nurses Board of W.A, Curtin University Centre for Research into Aged Care Services and Health Department of W.A. toward the development and publication of the document is also appreciated.

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PROTOCOL AND POLICY TO PREVENT ELDER ABUSE

1. ABUSE PREVENTION PRINCIPLES

This protocol acknowledges the worth of older people as citizens and their contribution to society. It promotes personal safety and upholds the right of older persons to 'live in dignity and security and be free of exploitation and physical or mental abuse' *(United Nations Principles for Older Persons, 1991)*. Some basic principles underpin the document.

- Older people have a right to live in safety without fear of threat or harm. Elder abuse is a violation of human rights which can never be accepted or condoned. Regardless of intent, mentally competent abusers are responsible for their behaviour.

- Older people have the right to make decisions that affect their care and well being. Should they be unable to make competent decisions, an advocate (of their choice where possible) upholds their rights in planning and decision making.

- Staff and management involved in aged care recognise the vulnerability of older people. They acknowledge their own attitudes and values concerning ageing and aged care, and ensure their actions do not cause harm to an older client.

- Quality work practice and the promotion of elder safety are the responsibility of both agency staff and management. To this end, aged care organisations, managers and workers alike are charged with a responsibility to provide quality care for clients and a safe supportive work environment for staff.

2. ELDER ABUSE AND PROTECTION

Elder abuse is a difficult concept to define. Nevertheless, for the purpose of this protocol the following notions are used to describe the complex issues of abuse and protection.

Elder Abuse   wilful or unintentional acts that harm an older person and which occur within a relationship that implies a level of trust.

Elder Protection   deliberate intervention to empower older people; to promote their safety and well being and reduce their vulnerability to abuse.

The protocol does not deal with self abuse or self neglect, nor with the abuse of one resident by another; these forms of abuse require interventions that lie outside the scope of this document. Elder abuse implies a relationship of trust with the abuser, such as that of relative, friend, practitioner, staff member or volunteer. It also implies that if actions cause harm to the older person, they are abusive regardless of the circumstances or intent.

Mistreatment or abuse by those from whom older people have every right to expect quality service, includes care that is inadequate, inappropriate, abnormal or which dishonours their culture, beliefs or rights. Elder abuse can be overt or covert and, because it often happens behind closed doors or behind the screens, it is hard to detect. Victims generally experience more than one form of abuse and it seldom occurs only once.

3. CATEGORIES OF ELDER ABUSE

Elder abuse is often hidden and so its exact nature and extent are difficult to identify. Nevertheless, it is recognised that those who are very old and frail, or living in a dependent relationship are at risk of experiencing some form of abuse.

The following list gives some examples of elder abuse, the list is not exhaustive.

Physical Abuse

e.g. physical coercion, pain or injury; substandard or poor quality living conditions, food or physical care; denial of choice of diet, hygiene care or physical activity; over-medication or refusal of medication; inappropriate use of physical or chemical restraint.

Sexual Abuse

e.g. sexually abusive or exploitive behaviour such as rape, indecent assault or sexual harassment; denial of the older person's right or opportunity to express their sexuality or personhood.

Psychological Abuse

e.g. threat, intimidation or coercion that leads to feelings of indignity, powerlessness or fear; labelling or treating seniors as children; disregard for dignity and personal needs; disrespect for elder's wisdom, culture or customs.

Social Abuse

e.g. isolation or exclusion from social contacts or activities; enforced involvement in activities.

Spiritual Abuse

e.g. disregard for spiritual belief, values or practice.

Financial Abuse

e.g. illegal, improper, uninvited use or inappropriate sharing of the older person's finances or possessions; denying access to, or control of personal affairs; forced changes to a will or other documents.

Neglect

e.g. active or passive failure to provide service or care to meet personal needs; lack of appropriate physical, mental, spiritual, social or cultural stimulation; making decisions for competent older people; delay or non compliance with medical or nursing orders.

4. RISK FACTORS FOR ELDER ABUSE

Elder abuse rarely has only one cause and a variety of issues seem to potentiate abuse. The risk of abuse is likely to increase where there is interaction between multiple risk factors.

Issues Relating to the Older Person
- vulnerability or dependence on carer / staff to provide care
- social isolation with few satisfying outside contacts or supports
- frailty, multi-pathology, polypharmacy that require skilled care
- constant and / or unreasonable demands for care and attention
- displays of difficult or volatile behaviour, or mood swings
- abuse of carer / staff with inappropriate or violent behaviour.

These issues make it hard for carers and staff but they never justify or excuse abuse. Other risk factors suggest abuse relates less to victim issues than to carer / staff issues, attitudes and behaviours, or to issues of service provision and agency management.

Ageism
- negative attitudes and values about older people and aged care.

Interpersonal Conflict
- history of family / relational dysfunction, conflict or violence
- conflict between the older person and carer / staff / management
- continual coping with difficult behaviours or abuse from senior.

Psychosocial Issues
- abuser hasn't learned to control anger, behaviour or emotion, or to respond non-abusively to stress; some have psychopathology
- dependent behaviour or substance abuse by carer, worker or senior.

Malevolent Intent
- deliberate intent to harm or exert control or power over another
- greed; intent to control senior's money or assets for personal use.

Carer Issues
- carer abuses unintentionally; pressure of caring responsibilities
- carer dependent on senior for practical, emotional, financial support
- insufficient support, respite or services; perceived reward from abuse.

Insufficient Resources in Residential Care
- poor quality or unsafe premises, inadequate supplies or equipment
- mixing competent residents and those with dementia / mental illness
- inappropriate staff mix or resident-staff ratio
- inadequate staff education, supervision and support.

Worker Issues
- caring responsible staff who harm unknowingly or without intent
- limited skill or experience in giving complex intimate care
- limited skills to deal with difficult behaviours and stressful work
- staff feel there is too much work and too little time
- staff working in a negative, punitive or unsupportive environment
- staff dislike the job but stay for the money, hours or location.

Policies and Practice
- social or agency policies that allow ageism and discrimination
- no elder or staff protection policies or protocols in place
- staff hiring practices do not select competent qualified staff.

5. RESPONDING TO ELDER ABUSE

5.1 Response Principles

Response principles guide case assessment and intervention. Ideally responses will uphold the rights and well being of all parties involved in a case of elder abuse.

- Mutual trust, respect and positive communication between all parties are essential for the effective identification and resolution of elder abuse.

- The safety, rights and well being of the client are always a priority. Nevertheless, the person suspected of perpetrating abuse also has rights that are respected.

- Disclosures by older persons, relatives and / or staff members, who give evidence about abuse, are accepted, as real, until investigations have been completed.

- The confidentiality of information or evidence is safeguarded in accordance with social and professional ethics, organisational policy and legal obligations.

- Self determination is encouraged. Even if they cannot make competent decisions, older people will have relevant information, their views are taken into account and their advocate (of choice where possible) is involved in planning and intervention.

- Where abuser self-resolution does not occur, the least restrictive intervention that stops the abuse and yields the best result for the senior is implemented. Interventions range from supportive education and counselling to punitive discipline or legal action.

- Some abuse is illegal and reported to the appropriate authority for action. Criminal proceedings may result should the abuse of an older person constitute a crime.

5.2 Assessing the Situation

When elder abuse is suspected, a first task for the assessor is to ensure the safety of the older person. Investigate to determine whether

- senior is in immediate danger and requires *emergency* services e.g. ambulance, police
- *urgent* help is required to prevent serious consequences of abuse e.g. refuge, respite
- it is a *non-urgent* request for help to prevent abuse e.g. community services, advocacy
- senior has the functional independence and competence to protect themself from harm
- the older person is able to understand what is happening to them and is competent to give evidence of abuse and consent for intervention.

A person may be identified as

Competent – the person is capable of making significant decisions and understands what has happened or is happening to them.

Not Competent – the person has an impaired understanding of what has happened or is happening to them; they are not capable of making significant decisions.

Client autonomy dictates that an older person who is capable of making significant decisions has the right to choose whether to accept assistance or decline consent for intervention. Seniors deemed not competent of making significant decisions may require assistance from an advocate. Similarly they may need referral to an Aged Care Assessment Team (ACAT) or to the Office of the Public Advocate (OPA) for substitute decision making via a Guardianship or Administration Order.

5.3 Response to Elder Abuse in the Community Setting

- In response to suspicion or report of abuse, ensure the safety and well being of the older person whilst honouring the rights of all who may be involved in the case.

- Assess the immediate situation as emergency, urgent or non urgent and respond accordingly.

- Each case of abuse is unique and interventions are dictated by the nature and context of the abusive relationship and whether consent for intervention is given.

ASSESSMENT FOR CASE IDENTIFICATION

- If time allows, build a relationship of mutual trust with the older person
- Gain consent for assessment / intervention from senior, advocate of choice or substitute decision maker as necessary
- Where possible interview the older person and suspected abuser separately
- Assess mental and physical competence and independence of the older person
  - to give evidence, to make competent decisions and to manage self care
- Accept disclosures and evidence of abuse unless proven otherwise
- As required advise all parties that police may be involved should abuse constitute a crime
- Document and verify evidence to establish reasonable grounds that abuse is occurring
- Determine nature, frequency, severity and, if possible, underlying causes of abuse.

INTERVENTION FOR CASE RESOLUTION

- Liaise with other service providers, identify key agency and primary case worker
- Assess current service needs; provide and / or refer carer and victim for necessary treatment, social or community support, medical, cultural, legal or advocacy services
- Consider options; ensure interventions give most benefit and least harm to the senior
- Choose least restrictive, supportive intervention before punitive, disciplinary action.

When consent for intervention is given
  * involve older person and / or advocate in planning and intervention
  * support abuser to accept responsibility for, and to stop abuse
  * use separate workers if both victim and abuser are agency clients
  * if unable to resolve abuse, refer to specialist agency for assistance with case
  * if victim / abuser need to be separated, ensure the best option for senior
  * monitor progress, follow up, evaluate effectiveness of interventions.

When consent for intervention is not given / able to be given
  * discuss issues of consent, offer information and counselling, offer community support and services, follow up as appropriate.

- *If older person is capable of making a decision*
  * without breaking client confidence, support carer to give safe quality care
  * if senior still declines intervention, continue support or document and withdraw.

- *If older person is not capable of making a decision*
  * refer to advocacy, medical or psychiatric services, police or community agency.

5.4 Response to Elder Abuse in Residential Care

- In response to suspected abuse by a staff member, safeguard resident safety and well being as a priority.

- Respect the rights of staff suspected of behaviour that harms a resident.

- Ensure interventions abide by agency policy and industrial guidelines.

ASSESSMENT FOR CASE IDENTIFICATION

- Provide mechanisms for confidential reporting of abuse and to protect those giving information or evidence
- Accept disclosures and evidence of abuse unless proven otherwise
- Review all circumstances; decide whether and / or when to
    * involve resident or advocate, relatives, staff member and advocate, unions or police in the case
    * seek resident or advocate consent to investigate suspicions
    * tell staff member that they are under investigation
    * suspend staff member, or allocate to other duties or clients during investigation
- Document and verify evidence to establish reasonable grounds that abuse is occurring
- Determine nature, frequency and severity of abuse and whether it is deliberate or unintentional
- Review the performance record of staff member suspected of abuse - seek evidence of competence and caring, or of neglect and abuse.

INTERVENTION FOR CASE RESOLUTION

- Consider options and choose interventions
    * that acknowledge and respond to the nature and severity of abuse and the context within which abuse occurred / is occurring
    * that are appropriate to resident needs
    * to maximise safety and well being and minimise harm or disruption to resident(s)
    * to address negative staff behaviours or ageist attitudes, and intentionality of staff abuse
    * to achieve abuser recognition and termination of abuse
- Where possible, implement least restrictive, supportive intervention before punitive disciplinary or legal action, e.g. staff education and counselling or work contracts to terminate abuse and institute safe care
- If unable to resolve abuse, refer to appropriate agency for assistance
- Ensure staff know elder protection skills and consequences of abuse
- Safeguard staff safety with education, counselling, supervision.

5.5 Documentation for Case Management

As with any record of care, all actions in dealing with elder abuse must be accurately recorded, signed and dated. Agency records of a case of elder abuse constitute a legal document that may be required as evidence should a case proceed to the courts.

5.6 Evaluation of Assessment and Intervention Strategies

At the completion of each case, evaluation occurs to determine how well the case objectives were met and whether interventions achieved the best possible outcomes. Case evaluation asks questions such as

- has the abuse stopped and, where possible, the causes of abuse been resolved?
- have the rights of victim, their abuser, informants and the agency been protected?
- was the client or advocate fully involved in planning and intervention?
- has the case been followed up to ensure no further abuse has occurred?
- did interventions constitute 'best practice'?
- what, if any, individual or organisational changes are necessary?

6. DUTY OF CARE

Workers involved with people who are frail and dependent because of age, premature ageing, chronic illness or disability are charged with a responsibility to protect the safety and well being of vulnerable clients.

The *Macquarie Concise Dictionary of Modern Law* (1991:88) defines 'duty of care' as a legal obligation to avoid causing harm to another person, which only arises where it is reasonably foreseeable that in a particular situation that other person would be harmed by one's action without the exercise of reasonable care.

The moral foundations of care demand interventions that honour the feelings and rights of clients whilst meeting ethical ideals and practice standards. Duty of care implies a moral and legal responsibility to ensure that personal actions do not harm a client. A worker who fails to act to protect a client could be deemed negligent.

Agency staff also have a responsibility in respect to the quality of their colleagues' behaviour. This includes reporting any observed behaviour that does not meet the requirement of duty of care; behaviour that is abusive or could harm the older person.

Duty of care also implies that aged care agencies will

- ensure their policies and procedures promote client safety

- provide clear guidelines on staff performance expectations, give staff appropriate education and supervision and provide a safe supportive working environment

- implement protocols to protect workers against wrongful action or dismissal during investigation and intervention in cases of abuse.

7. IMPLEMENTING THE PROTOCOL

The purpose of this protocol is to help management and staff promote the safety of clients and workers. To support staff give quality care the following are recommended.

Residential and Community Organisations

- develop or review agency policies and procedures to promote the rights and protection of older clients

- provide a supportive work environment plus education and supervision for staff to give safe quality care

- provide supervision and support for staff involved with elder abuse cases, especially those who work in isolation

- develop procedures to ensure the safety and protection of staff whilst they are carrying out agency business

- as appropriate, offer support and / or counselling for staff involved in a crisis incident or traumatic event

- regularly evaluate policies and protocols to measure their success in protecting client safety and well being

- collect and analyse data on abuse and intervention outcomes.

Monitoring Bodies, Unions and Staff Associations

- work closely with organisations and support their efforts to ensure the safety and well being of clients and staff

- offer support and education to assist organisations improve their standard of care.

Staff Members

- participate in developing elder protection policy and practice

- maintain competence in aged care and ensure all actions help but do not harm older clients

- reflect on and self evaluate the quality of input into cases

- take responsibility for personal safety, maintain professional support networks and look after personal health.

8. GUIDELINES FOR ELDER PROTECTION POLICIES

AND

ELDER ABUSE RESPONSE STRATEGIES

Agencies operating in metropolitan, rural or remote communities can deal with vastly different client groups and face a variety of elder protection and abuse situations. As each group of older people is unique, so each organisation may require an individual elder abuse prevention policy and response protocol.

The following pages give examples of policies that could apply to a community based agency or a residential care organisation. Obviously they do not cover all circumstances, nor do they give the answers for all situations. They are offered as a guideline to raise some of the issues you may wish to include in your agency policy and protocol.

It is timely that agency owners and managers consider the issues that relate to elder abuse, and implement policies and protocols to minimise the risks of elder abuse. Special guidelines are also necessary to ensure the personal and legal protection of staff who work in isolated or remote areas, or who work alone in dealing with cases of elder abuse.

You are invited to take, adapt and use these examples to meet the specific requirements of your client base and agency function.

Please acknowledge this publication in your document.

9. COMMUNITY SERVICE AGENCY
POLICY FOR THE PREVENTION OF ELDER ABUSE

9.1 Policy Statement

The management and staff of this agency are committed to promote client safety and well being, to support carers of frail vulnerable older people and to help prevent and stop the occurence of elder abuse. This commitment is demonstrated through strategies and practices related to

1. organisational management
2. human resource strategies
3. education, support and continuous quality improvement practices
4. programs to empower seniors and reduce their vulnerability to abuse
5. strategies to respond to suspected cases of abuse
6. research.

9.2 Policy Aims

This policy seeks to

- promote the protection and well being of older people
- minimise elder abuse
- support educative interventions to confront abusers and stop the abuse
- ensure safe high quality professional service to clients and carers alike.

9.3 Policy Guidelines

1. ORGANISATIONAL MANAGEMENT

1.1 Recognition of the vulnerability and needs of older people and their carers.

1.2 Strategic planning to acknowledge and address the difficulties of working with elder abuse
- commitment to the agency's mission, vision and policy on abuse prevention
- provision of a safe supportive working environment for staff
- precautions to ensure the safety of staff working in isolation, or working alone in dealing with cases of abuse
- development of professional networks for staff in remote or isolated areas
- guidelines to outline the responsibilities of both staff and managers
- commitment to provide staff with appropriate knowledge and work skills
- provision of documented procedures for response to cases of abuse
- provision of appropriate support and supervision for staff who identify and / or respond to cases of abuse.

2. HUMAN RESOURCE STRATEGIES

2.1 Promotion of management practices to protect the rights of clients and staff.

2.2 Staff selection according to evidence of
- positive attitude and commitment to aged care and abuse prevention
- skills in aged care, and for senior staff - the skill to deal with elder abuse.

2.3 Performance management with
- clear performance expectations of staff behaviour towards older clients
- regular formal and informal supervision and monitoring of work quality
- case management and evaluation to ensure best practice in dealing with abuse
- performance counselling and contracts to address unsatisfactory work
- documentation of individual and agency performance in abuse prevention.

3. EDUCATION, SUPPORT AND QUALITY IMPROVEMENT PROGRAMS

3.1 Orientation and ongoing education, relevant to position, function and learning needs e.g. normal / abnormal ageing; cultural issues; ageism; user rights; managing stress, managing difficult behaviours; counselling skills; risk factors and prevention of abuse, professional abuse of clients, dealing with abuse, working with perpetrators.

3.2 Supportive education, counselling and supervision for staff to recognise and change any behaviours that harm or have the potential to harm older clients.

3.3 Protection for staff who enter threatening situations in the course of their work.

3.4 Provision of staff counselling and support after crisis or abuse situation.

3.5 Implementation of continuous quality improvement practices
- include proactive abuse prevention practices
- ensure staff are aware of their responsibility in respect to the quality of their own and colleagues' behaviour, and to report any abusive behaviour.

4. COMMUNITY EMPOWERMENT PROGRAMS TO REDUCE VULNERABILITY TO ABUSE

4.1 Personal empowerment of older people to live safely and resist being abused
- support mature adults to plan ahead and prepare for safe ageing
- teach protective behaviours for safety at home and in the community
- support older people to remain active and recognise their value to society, to be assertive and expect quality care that meets their personal needs
- encourage victims to disclose abuse and seek support to stop it happening.

4.2 Carer support to
- confront the issues of caring for a frail older person
- give carers the skills to care and to deal with difficult behaviours
- teach carers stress management and self care techniques.

4.2 Education programs to raise community awareness of the issues related to elder abuse, its causes and what can be done to prevent it.

5. STRATEGIES TO RESPOND TO SUSPECTED CASES OF ABUSE

5.1 All responses to honour client well being and respect the rights of the abuser.

5.2 Identification of abuse
- identify if abuse is actually happening - emergency, urgent or non-urgent?
- establish a relationship of mutual trust with older person
- support senior to disclose abuse and give consent to intervention.

5.3 Assessment
- determine mental status / competency of the senior to give evidence / consent
- determine the nature and degree of abuse; its frequency, duration and severity
- focus on the effect on the victim rather than the intent of the abuser
- assess whether the older person can take care of or protect themselves
- determine whether it is necessary to separate the abuser from their victim
- involve the victim, family, advocate or police in case as appropriate
- try to identify underlying cause(s) and not just outward symptoms of abuse
- document all evidence and observation of abuse.

5.4 Intervention
- if competent senior refuses intervention, offer counselling and support
- identify key agency, key worker and action plan for case management
- to suit the circumstances and gives maximum benefit to the older person
- should be appropriate to client, the nature and context of abuse
- implement least restrictive interventions before punitive action
- use confrontation, support and counselling for abuser to stop their abuse
- address and, where possible, resolve underlying cause(s) of abuse
- if self resolution does not occur, consider referral to appropriate agencies for assistance with case or abuser referral to a perpetrator program
- make inter-agency agreements for any multi-agency involvement.

5.5 Evaluation of intervention
- has the abuse stopped and the causes of abuse been addressed?
- were the best possible outcomes achieved for the older person and carer?
- have the rights of the older person and their abuser been protected?
- did staff act professionally at all times?
- did organisational procedures constitute ethical and legal 'best practice'?
- were procedures sufficient and appropriate to effectively resolve the case?
- what, if any, organisational or practice changes are required?

6. RESEARCH

6.1 Research projects to study and identify
- preventive strategies to empower older people to resist being abused
- the incidence, etiology and risk factors of various categories of elder abuse
- effective response mechanisms to stop abuse
- organisation and professional factors that contribute to elder abuse
- optimal level of staff education, support and supervision for elder protection.

10. RESIDENTIAL CARE ORGANISATION
POLICY TO PROMOTE RESIDENT PROTECTION

10.1 Policy Statement

The management and staff of this organisation are committed to promote resident safety and well being and to minimise the incidence of abuse of residents by staff members. This commitment is demonstrated through strategies and practices relating to

1. organisational management
2. human resource strategies
3. education and support programs
4. continuous quality improvement practices
5. strategies to respond to suspected cases of abuse
6. research.

10.2 Policy Aims

This policy seeks to

- promote the protection and well being of residents
- minimise resident abuse
- safeguard the rights and well being of residential aged care staff
- ensure effective assessment and intervention strategies to deal with cases.

10.3 Policy Guidelines

1. ORGANISATIONAL MANAGEMENT

1.1 Recognition of the vulnerability of the people in residential aged care.

1.2 Strategic planning to acknowledge and address the factors that contribute to resident abuse
- human, resource, financial and environmental management policies and practices to enhance resident and staff safety and well being
- commitment to agency's mission, vision and policy on resident protection
- guidelines to outline the responsibilities of staff and managers
- provision of a safe, supportive working environment for staff
- precautions to ensure the safety of staff working in isolation, or working alone in dealing with cases of abuse
- development of professional networks for staff in remote or isolated areas
- commitment to provide staff with appropriate knowledge and work skills
- commitment to adequate staffing levels and appropriate staffing mix.

2. HUMAN RESOURCE STRATEGIES

2.1 Promotion of management practices to protect the rights of residents and staff.

2.2 Staff selection according to evidence of
- positive attitudes toward ageing and commitment to aged care
- understanding of and commitment to resident protection
- record of competence and quality performance in residential / aged care.

2.3 Orientation for new staff
- introduction to policy and guidelines for resident protection
- structured program supported by education, practice manuals and mentors
- ongoing support and performance monitoring during probationary period.

2.4 Performance management with
- clear documented performance expectations for all levels of staff
- regular staff supervision and formal / informal feedback on performance
- regular performance monitoring (at least annually)
- performance counselling where appropriate
- use of contracts to address unsatisfactory performance
- documentation of individual performance progress.

3. EDUCATION AND SUPPORT PROGRAMS

3.1 Orientation and ongoing education program for all staff; education to be relevant to staff member's position, function and learning needs e.g. normal / abnormal ageing; attitudes to ageing and aged care; aged care skills; culturally appropriate care; managing challenging behaviours; managing stress, conflict and change; resident rights and complaint mechanisms; resident protection, risk factors and prevention of abuse, individual and organisational response to incidents of abuse, likely outcomes of abusive behaviour by staff members.

3.2 Supportive education, counselling and supervision for staff to recognise and change any behaviours that harm or have the potential to harm a resident.

3.3 Provision of support and counselling after crisis or abuse situation.

3.4 Learning resources on resident protection / abuse available to all levels of staff.

3.5 Elder protection support, education and advocacy for consumers and relatives, plus information concerning agency and government complaint mechanisms.

4. QUALITY IMPROVEMENT PRACTICES

4.1 Implementation of continuous quality improvement systems
- include proactive elder protection / abuse prevention practices
- staff to be aware of their responsibility in respect to the quality of their own and colleague's behaviour, and to report any abusive behaviour heard or observed.

5. STRATEGIES TO RESPOND TO SUSPECTED CASES OF ABUSE

5.1 All responses to honour resident well being and respect the rights of staff.

5.2 Identification of abuse
- provide mechanisms for confidential reporting of suspected resident abuse
- provide a mechanism to protect informants
- ensure staff are aware of how suspected cases will be investigated and dealt with, and what disciplinary measures might apply
- develop written procedures to guide case identification
- safeguard confidence when collecting evidence.

5.3 Assessment
- identify nature and degree of abuse; its frequency, duration and severity
- involve resident, relatives, resident advocates, unions, staff associations or police in case assessment and intervention as appropriate
- in assessing if a behaviour is abusive, focus on the effect on the resident rather than the intent of the staff member
- document evidence and observation of abuse.

5.4 Intervention
- should be appropriate to nature, severity, circumstances and intent of abuse
- strive for abuser self resolution and cessation of abuse
- implement least restrictive (supportive educative) interventions before punitive, disciplinary or legal action where possible
- ensure interventions safeguard worker rights and protect them from wrongful accusation, discipline or dismissal.

5.5 Evaluation of intervention
- has the abuse stopped and the causes of abuse been addressed?
- were the best possible outcomes achieved for the resident and staff member?
- have the rights of resident, abuser, informants, the agency been protected?
- were workers offered sufficient support and their safety and rights upheld?
- did organisational procedures constitute ethical and legal 'best practice'?
- were procedures sufficient and appropriate to effectively resolve the case?
- what, if any, organisational or practice changes are required?

6. RESEARCH

6.1 Research projects to study and identify
- preventive measures for resident protection and abuse prevention
- the nature and incidence of resident abuse
- the etiology of abuse in residential aged care
- effective response mechanisms to stop abuse
- organisational factors that contribute to resident and staff safety
- optimal levels of education, staff support and supervision to ensure resident protection and well being.

ACKNOWLEDGMENTS

ELDER ABUSE - PROTOCOL AND POLICY GUIDELINES TO PREVENT THE ABUSE OF OLDER PEOPLE IN COMMUNITY AND RESIDENTIAL CARE

COUNCIL ON THE AGEING

2nd September 2001

Associate Professor Ric Lowe
Post Graduate Coordinator
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Curtin University of Technology
GPO Box U1987
PERTH   WA   6845

Dear Professor Lowe

I am pleased to provide a letter of support and confirmation of the scholarly work
undertaken by Ms Beth Kingsley on behalf of the Council on the Ageing (Western
Australia) (COTA (WA)) in relation to Elder Abuse.

In 1992 the Council's Ethnic Project Worker brought a concern to the Community
Services Committee in relation to cases of elder abuse which had been reported in the
southern suburbs. Further investigation revealed that this problem, either intentional
or unintentional was occurring throughout the whole community more frequently than
had previously been acknowledged.

This was of great concern to COTA (WA) and a sub-committee was formed to
undertake work on this subject. Members of the sub-committee included
representatives from Aged Care Assessment Teams, Multicultural Aged Care, Local
Government Community Services, State and Commonwealth Government, the
Director of the Public Guardian's Office, the Executive Director of the Office of
Seniors Interests, the Chief Inspector of Community Policing and the Police Victim
Support Service, Wesley Mission Perth and, Ms Kingsley representing Curtin
University School of Nursing.

From the outset Ms Kingsley was a driving force for the work of the Elder Abuse
Steering Committee and she undertook much of the initial research to establish what
work had already been done to identify and deal with this problem. Indeed, at her
own expense, she attended a Conference in Queensland which provided valuable early
material for adaptation and implementation in Western Australia.

A major issue was the lack of knowledge and therefore acknowledgement that this
problem was occurring in the community. We could find no material to guide
workers in how to deal with the problem once it had been identified.

The committee agreed it was important to raise awareness among service providers as
a starting point and the first Western Australian State forum "Dealing with Elder
Abuse" was planned   The objective was to assist them to identify this largely hidden
problem and to encourage them to take action to assist older people at risk. The work
Ms Kingsley did in preparation of a paper on issues in identifying cases of abuse

certainly came before the committee and was well reviewed prior to the forum. In the same way her collation and analysis of data and ideas for future directions, which arose from the forum group workshops, was thoroughly discussed and agreed to by members of the committee after the forum. Ms Kingsley was largely responsible for conceptualising and implementing the plans for future directions on dealing with elder abuse in Western Australia.

Having raised the issue it was then important to develop material to guide workers in steps to take to address the problems. As a result, "Responding to Elder Abuse, a Protocol for non-government agencies" was written. Ms Kingsley was responsible for the compilation and development of this protocol on which she worked and brought drafts to the committee for regular review. While the committee had a great deal of input into the final document, it was Ms Kingsley who researched and prepared the material, hence it was fitting that her name should be recorded as the editor.

To raise awareness among older people that they could and should seek help, a series of Seminars was arranged and hosted by a number of Local Government Councils. Ms Kingsley and Social Worker Ms Susan Johnson, were responsible for the development and arranging of a very innovative program for these Seminars. Through actors, various scenarios of abuse ranging from very mild to extremely serious were depicted. Seniors were encouraged to share their reactions to these scenes, empowered to acknowledge such behaviour as unacceptable and at each session at least four people utilised the services of counsellors who were present.

At all stages of the development of the Protocol and the Seminars peer review from members of the committee took place.

Ms Kingsley and Ms Johnson also undertook to make application on behalf of COTA (WA) to the Australian Heads of Government for a Violence Prevention Award. I am aware that Ms Kingsley worked very hard on this application and COTA (WA) received a Certificate of Merit and a cash prize as a result of her efforts.

On behalf of the Council on the Ageing (Western Australia) I wish Ms Kingsley well in her submission for the award of the degree of Doctor of Philosophy. The work she has done in her study of elder abuse certainly has contributed greatly to the level of understanding and knowledge of this insidious problem.

Yours faithfully

Bettine Heathcote
PRESIDENT

July 24, 2001

Associate Professor Ric Lowe
Post Graduate Coordinator
Faculty of Education

Dear Professor Lowe,

I am pleased to respond to your letter regarding Ms Kingsley's publication, "Elder Abuse: protocols and policy guidelines to prevent the abuse of older people in community and residential care".

Ms Kingsley is recognized throughout the aged care industry and within the nursing profession for her comprehensive understandings of the issues associated with elder abuse in community and residential care settings. She is frequently invited to speak at professional forums and conferences on the topic. I have presented at several forums with Ms Kingsley and recognize her for her expertise to this area. I had the privilege to launch this publication at the Geriaction National Conference in 2000. (Geriaction is a National Association of the aged care profession)

Ms Kingsley wrote this document in consultation with a special interest group of Geriaction WA in response to a need that had been identified by the profession. I was a member of that special interest group and can confirm that a panel of experience senior nursing professionals reviewed the content of the document during the writing phase. Financial support was obtained for its development from the Nurses Board of Western Australia and again, I was involved in the development of the submission for the funding. I can support that the submission was reviewed in this process and met the academic standards imposed by the funding body.

The Centre for Research into Aged Care Services agreed to fund the printing and dissemination of the publication in 2000. This Centre was very pleased to be involved in this project and viewed this publication as excellent example of the quality outcomes of this Centre. The Steering Committee reviewed and approved the publication before printing. Some 3000 copies have been circulated Nationally and the publication has received very positive feedback for both its content and its professional approach to this very sensitive topic.

We are in the process of developing an evaluation strategy and aim to complete a review of both the content and its application throughout the industry. This will be completed in consultation with the Office of Seniors' Interests, in Perth.

I trust that this supports Ms Kingsley's application in regard to this publication. Please contact me if you require further information.

Kind regards,

Barbara Horner, Senior Lecturer
Manager/Research Fellow

Members of the Steering Committee of the Centre for Research into Aged Care Services:
Professor Duncan Boldy, Freemasons Professor of Aged Care Services
Professor Michael Clinton, Professor assisting the Executive Dean Health Sciences
Associate Professor Ruth Marquis, Head School of Occupational Therapy
Ms Barbara Horner, Manager/Research Fellow

Theme 2.   *Response to Elder Abuse: Principles and Guidelines for Professional Practice*

Ethical issues in responding to elder abuse

Practitioners, who responded to cases of elder abuse, told of difficulties they experienced when confronted with identifying and intervening in complex cases. I had experienced similar problems in my own practice and over time had developed some personal guidelines that helped me in my professional dealings with the more complicated and uncertain cases of abuse. It was when there were difficulties in responding to complex or ambiguous cases that we faced ethical dilemmas, and practitioners' requests for support and guidelines to assist them make these hard decisions, led to the development of the submitted articles.

Nursing is often described as an art and a science where the 'art' of the discipline incorporates the moral foundations that underpin the scientific practice of nursing. Dealing with ethical problems requires we have a clear understanding of not only ethical ideals but also of our professional obligation to give quality service. In professional practice these moral ideals demand that our interventions are ethical and honour client rights and support their safety and wellbeing. The promotion of health and wellbeing is one of nursing's prime functions and we have a responsibility to promote safety and reduce the vulnerability of older people to being abused.

There are limited ethical guidelines that specifically relate to elder abuse. To assist professionals in making the decisions involved in responding to abuse cases, a number of articles have been developed and conference papers presented on this topic. One chapter from a nursing text and a journal article on some of the ethical hazards that can face practitioners are submitted.

Kingsley, B. (1997a). The older client. In G. Hawley (Ed.), *Ethics workbook for nurses* (pp. 181-192). Wentworth Falls, NSW : Social Science Press.

CHAPTER TWENTY

THE OLDER CLIENT

OBJECTIVES

On completion of this chapter you should be able to:

- identify the social issues related to abuse of older people; and

- honour the rights and needs of all parties when with a victim of abuse.

Introduction

Australia is an ageing society. As age increases the risk of experiencing chronic illness, disability and physical or mental frailty also increases. Yet most older people do not see themselves as sick and the majority still live independently in the community and manage at home with varying levels of community service or support. Over recent decades the move in aged care has been away from residential or institutional care toward a model of community care to maintain older people at home.

The Home and Community Care Program (HACC) is a major provider of health, welfare and domestic services to community based older people. The HACC program began in the mid 1980s to support vulnerable people to remain in their own home and to prevent premature or inappropriate admission to residential care. However, even in the early days HACC was not a 'panacea' for older people; it never met all of their recognised needs nor all the needs of family carers (Hicks, 1986). There has always been a heavy reliance on families to adopt the role of carer which the Department of Community Services and Health described as "the person who is providing substantial, constant, long term personal care for someone with an illness, disability or infirmity. The person is often a family member with whom they share the home, and whose care is essential to enable the person to continue living at home (DCS&H, 1991)".

Cliff Picton, then Chief Executive of the Australian Council on the Ageing (1989) said that in hard economic times spending on health and welfare is cut and old people are the first to suffer. In such times, when there is competition for scarce resources, the strong tend to oppress the weak who can end up losing what minimal resources they have. Many old people end up as part of the oppressed weak when their skills become outdated, their traditional roles have gone, they are no longer the respected custodians of culture, history and love; and they come to be seen as 'non persons'. Picton recalls hearing an exchange "why don't you hurry up and die you useless old bastard?" "I'm trying, I'm trying" was the reply. When older people are devalued in this way, there is a risk of ageism and the negative stereotyping of old age, where seniors experience bigotry, discrimination and abuse.

Obviously one brief chapter cannot consider all the ethical predicaments a nurse will face in working with older clients. To illustrate the scope and complexity of working with old people, one specific issue is discussed; the experience of aged abuse is a problem for many frail vulnerable seniors who are living in the community. This chapter discusses practical and ethical issues involved with assessment and intervention in cases of aged abuse. It also gives some guiding principles to nurses and considers the difficult decisions that confront those who deal with cases of abuse against older people.

Abuse of Older People

Back in 1982, the United Nations 'Principles for Older Persons' (Resolution 37/51) stated that older people have the right to live free of abuse, neglect and exploitation. Unfortunately a significant number of seniors experience physical, psychological, financial and sexual abuse or neglect at the hands of another. Elder abuse is referred to as the harm caused to a senior by another person with whom they have an ongoing relationship which implies trust (Kingsley, 1993). "It is claimed that two children a week die at the hands of their parents. Society does not

condone this but at least it appreciates the problem. It is not known how many parents die at the hands of their children. Society does not even accept that old age abuse takes place, let alone appreciate why it happens (Eastman, 1984)."

Extent of Aged Abuse

We need to ask then whether the abuse of older people is a significant health problem? Yes it is. It is estimated that more than half of all practising nurses and one third of doctors will deal with a case of identified aged abuse each year (Clark-Daniels, Daniels & Baumhover, 1989). Limited Australian research suggests about five percent of patients of Aged Care Assessment Teams (Kurrle, Sadler & Cameron, 1991) and up to seven percent of people with mental incompetence (OSI, 1996) experience abuse. Similarly anecdotal evidence suggests it is also a significant problem for people of Aboriginal (Morrison, 1994) and non-English speaking background (City of Canning, 1992). Of course these are only the cases that are reported and identified by health workers; extensive research is needed to show whether these figures indicate the real extent of aged abuse or whether they are just the tip of the iceberg. Nevertheless, with an ageing population and the emphasis on maintaining physically and mentally frail old people in the community, often with limited support, it is predicted the incidence of aged abuse will increase.

Nurses have only recently begun to confront the abuse of older people with any energy. Because this form of abuse has long been hidden, few health agencies have developed specific prevention and intervention strategies. Working with people in an abusive relationship is difficult, time consuming and stressful. There is rarely only one cause of abuse and rarely a simple solution to this complex issue.

How nurses perceive and deal with any health issue is influenced by the social culture in which they live and the professional culture in which they practice. All perceptions and behaviours are modified by personal knowledge and experience, by the values and behavioural norms of society and by the moral ideals held by the individual. For example, some cultures have a high baseline acceptance of violence within the family and some individuals learn to accept that the male has power over the female and so has the right to physically discipline or control her. Others believe that, no matter what the circumstances, no one person has the right to harm another. The attitudes we each hold about violence and the rights of individuals and our beliefs about the position of older people in society will influence how we work with older clients and how we 'see' and respond to aged abuse.

Issues Related to Aged Abuse

Nursing is often described as an art and a science where the 'art' of the discipline incorporates the moral foundations that underpin the scientific practice of nursing. As in all nursing practice, the moral foundations of aged care demand that our interventions are implemented within an ethical framework that honours the feelings, rights and dignity of clients and which promotes their health and well-being.

To be of any real use, ethical frameworks must not only be based on theoretical, ethical ideals, they must also address the practical issues of the situation (Jeffrey, 1993). Jeffrey proposes an ethical model of practice that combines respect for autonomy with a caring ethos of professional/

client partnership and a shared view of what are the ideal interventions and outcomes for everyone involved. In aged care it is often difficult to juggle the multiple, and sometimes conflicting, needs of clients, partners and families and it is almost impossible to achieve positive outcomes for all. It is in these cases of conflicting demands that nurses face complex ethical choices and have to work hard to get all those involved to see other viewpoints and to appreciate the needs and demands of others.

Ethics implies choices and an ethical problem implies difficult choices. The lack of ethical absolutes is generally well recognised and there are few prescriptive rules to make the resolution of difficult ethical problems simple. Legal, social and professional standards do guide decision making and action, but it is often their personal ethical ideals that determine how a nurse will act when faced with difficult choices.

Choices and Values

Dealing with abusive situations can involve choices between the needs of the victim and the abuser and resolution invariably requires the nurse to confront the abuse and take firm action to resolve the conflict.

For example, in dealing with the family where there is suspected or identified abuse of an older relative it is no easy matter to meet the needs of all parties. Where the abuse arises from malevolent intent, the needs and welfare of the victim are the immediate concern. However, cases where abuse is related to carer stress and lack of support in caring for a frail demanding older relative with dementia, the decision about whose needs are paramount is more difficult. Our job is to try and see and understand the different viewpoints of all the people involved in the case. If the family is seen as the client then the rights and autonomy of the older relative can be compromised. Similarly if the older relative is seen as the primary client then the needs of the carer for support, respite or community services can be overlooked. This means that decisions must be made about just who is the client - the family or the older person, and how the rights of all are to be honoured? (Kingsley & Johnson, 1993).

No nursing intervention is value free. We bring all our feelings, attitudes and values, like baggage, into our nursing practice and we need to unpack this personal baggage to make our actions as objective and value free as possible. In aged care, this means we need to confront our real feelings about old people, about who we feel should be responsible for their care, about what we think is acceptable behaviour, what we see as abuse, and what we believe should be done about elder abuse. If we are to be effective we must be prepared to be involved, to make the hard decisions, and to confront the difficult and often unpleasant tasks involved in identifying and dealing with the abuse of older people.

Some of these difficult decisions and tasks are discussed below as we consider the risk factors of aged abuse, the assessment of suspected abuse, interventions to deal with cases and evaluation of the outcomes of our nursing actions.

Risk Factors of Aged Abuse

There is probably no one single cause of elder abuse, nor is it limited by age, gender, education, socio-economic status, race or religion. Nevertheless there are a number of factors which combine

to place older people at risk of abuse. It is vital, that during assessment, we consider the circumstances and context of the abuse plus the factors related to both the victim and the abuser. Factors that relate to either or both victim and abuser include physical or social isolation, victim / abuser dependency or co-dependency, a history of psychopathology, emotional problems, chemical dependence or family dysfunction. The victim is often very old, frail and dependent and the carer may be experiencing unresolved stress and burden from the caregiving role. On the other hand, the abuser may maltreat the older person in order to punish or control, or they might abuse from uncontrolled anger, substance abuse, greed or revenge. So we must be aware of all these risk factors and indicators of abuse whenever we undertake the health assessment of an older client.

Assessment – Identifying Abuse

This form of abuse is often hidden, rarely disclosed by either victim or abuser and often under assessed by health workers. A number of difficult decisions face the nurse who is confronted with a suspected case of aged abuse. Careful assessment is necessary to determine whether abuse is actually taking place, to measure the older person's competence to disclose abuse, to determine its most likely etiology, and to assess the context within which it occurs. You will need to identify, not only the existence of abuse, but also the type and extent, its history, intensity, regularity, and all possible interventions that might help to resolve the abuse. Violent physical or sexual maltreatment, or gross financial abuse are easier to assess; it is the more subtle, the unintended, or the insidious abuse that is difficult to identify.

Try to imagine how you would feel if you lived under the threat of abuse. It can be a very frightening experience. Then think about how you would feel if you had to talk to a stranger about what happens to you when someone abuses you. As you can imagine some clients are embarrassed to disclose because they feel like a failure when they have not been able to prevent the abuse from happening, and others find it hard to describe the dreadful things that might have happened to them. This is a very delicate topic to raise and we need enormous sensitivity when working with a client to assess for abuse.

Assessment – The Nature of Abuse

In assessment, there are a number of difficult questions that must be asked. First there is the question of intentionality; is the abuse occurring from unintentional or malevolent motives? It is not always easy to determine whether or not the abuse is an isolated case or is likely to continue, whether there is one type or multiple forms of abuse involved. Is it new abuse, a continuation of domestic violence, or is it reverse or 'payback' abuse where a child or spouse abuses in retribution for harm that was perpetrated on them in the past? Similarly there is no magical line between non abuse and abuse. It can be difficult to answer the 'yes / no' questions of when do you call 'game playing' abuse, when does less than satisfactory care become neglect, and at what point is a negative relationship called abusive? The answers to these questions depend on the perceptions, ethical values and standards of the person who is making the judgement.

Assessment – Diagnosis and Acknowledgment of the Abuse

Nurses, and other health professionals, have been soundly criticised for being inept and ineffective in confronting all types of abuse; this is because we either deny it happens or refuse to 'see' and confront the abuse. Some say it is a private family affair, they blame it on pathology or underplay the fault of the abuser, or even suggest the victim deserved their abuse (Hatty, 1985). Similarly with aged abuse, while we see it as a private family affair and not a social crime, it will remain invisible and never be resolved. Those who see aged care as a family, rather than a social, responsibility will also see abuse as a family affair and not a social or criminal degradation of older citizens (Bookin & Dunkle, 1985).

It is important that we are prepared to confront the social issues surrounding aged care and abuse. We also need effective assessment skills to identify suspected abuse, to determine its underlying causes, and then to assess what can be done to prevent or deal with the abuse.

Intervention - 'best practice' to prevent and stop abuse

The conclusions that arise from assessment obviously influence any nursing intervention. But there are still more difficult questions to be considered before any action can take place. Discounting life threatening emergencies, nurses face a number of practical dilemmas in determining how best to intervene to resolve the case to the satisfaction of all concerned. We walk a fine line when we try to balance the rights of both the older person and their abuser, many of whom are themselves both aged and burdened with the stresses of caring. We also have to consider the ethical dimensions of client autonomy and choice, beneficence and justice when planning interventions.

Intervention – Confront the Abuse

Just as there are some who refuse to recognise the signs of aged abuse, there are others who recognise the symptoms but are unwilling or unable to confront the abuse (Bookin & Dunkle, 1985). These nurses may recognise the aged abuse, but for all sorts of reasons either do nothing about it or respond with actions that are inappropriate to the situation, the victim and the abuser (Fine, 1986).

Appropriate nursing action to safeguard the well-being of the victim is invariably a priority. However, we tend to concentrate on victim frailty and on the stress of caring for a dependent family member as the primary causes of abuse. Bookin and Dunkle, (1985) suggest it is easier and more comfortable to assign stress rather than culpable motives to the abuse. As a result workers implement caregiving interventions and flood the home with services instead of taking the hard option of confronting the abuser. Wolf suggests we do this because it is "easier to blame the victim than to challenge the family and societal customs that allowed mistreatment to occur" (1994, p. 61). This emphasis on the problems of the victim results in programs that deal with the issues of caring and victim vulnerability rather than with the abuser. To achieve the best outcome for all we must be prepared to focus on the abusiveness and not just limit our actions to caregiving. To do this our practice must involve prevention, education and support programs for abusers as well as victims.

Intervention – Difficult Decisions

The first step is to build a relationship of honesty and trust with the older person and gain their participation in and consent for nursing interventions. They are the person who knows their situation and they are the expert on what they need. However, not all victims will allow any intervention and we face difficult choices when an older person discloses abuse but makes us promise we will not do anything about it. Many victims decline to disclose abuse or accept help because they fear the outcome may be worse than the abuse; in other words the cure is often worse than the problem. Many victims fear that if they let us intervene they may be accused of dividing the family, they might lose all future contact with their family or be 'punished for telling' about the abuse.

Possibly one of the first difficult decisions confronting a nurse is when to abide by a client's decision to decline intervention in their case and when to intervene, regardless of the wishes of the victim. In such cases the nurse may be forced to choose between two sometimes contradictory professional obligations:

> to provide the intervention necessary to ensure client welfare;

> not to interfere with a client's freedom or autonomy (Kingsley & Johnson, 1993).

How can the nurse legitimise professional coercion, even when it is for their 'own good'. The general social ethic suggests coercion is justified only when:

> there is a grave threat to basic social values or to fundamental social institutions;

> there is a clear and present danger that very great or irreversible harm will occur unless prompt preventive action is taken by an agent of society (Rhodes, 1986).

We need to make sure that we are intervening rather than interfering in client affairs. This is especially so when the client has cognitive frailty. We talk of beneficence in terms of doing good for clients, respecting their rights of choice, self determination and the right to take risks. Yet we also seem very ready to assume the person cannot make or act on their own decisions and we step in and advocate on their behalf. This is commendable when it is necessary, but a potential ethical conflict suggests there are two risks here; a risk that we will become the 'gatekeepers' of care and a risk that our actions will be paternalistic rather than empowering. Probably the best guide is for us to consider all possible interventions and decide which would have the best possible outcome for the client. Then we should ask ourselves how we would feel if someone wanted to implement this action on us; would we like to experience what we are suggesting for this client - or would we politely decline the proposed intervention?

Intervention – Safeguarding the Client's Well Being

Mentally competent older people have substantial legal rights which include the right to decline or accept nursing interventions. These rights include the expectation that we will honour their decisions regardless of the circumstances or whether they make choices with which we do not agree. Nevertheless, should there be a danger of 'great or irreversible harm' we may have to intervene without their direct consent. The criteria for coercive intervention might seem straight forward, but it is not always easy to decide what constitutes 'present danger' or 'irreversible harm'. Should a team decision be made to intervene against a client's wishes, we must ensure

that client well-being is safeguarded, their rights are honoured wherever possible, that our actions are not paternalistic and our interventions constitute 'best practice'. For example, a common intervention of first choice is to rush into action with caregiving services or else the older person is removed from danger and placed in safe institutional care. We might be removing the person from the abuse, but we might also be contravening their rights and wishes. When most old people want to stay at home, why are already harmed victims further punished by separation from their family, removal from their home and admission to long term care - often rewarding the abuser with their freedom - and the house? Best practice demands we honour the needs and rights of all parties, but our prime obligation is to the well-being of the victim; institutionalisation is the intervention of last resort (Kingsley & Johnson, 1996).

Intervention – Duty of Care

Nurses have an obligation to duty of care, which in the case of aged abuse includes the provision of all necessary support, treatment and services for both victim and abuser. We are charged with the responsibility to serve all clients equitably, to enhance their rights and to maintain their autonomy, dignity, and well-being. Yet research suggests we are better at providing services for victims than for abusers (Sadler & Kurrle, 1993). If we acknowledge the extent of abuser problems in aged abuse, then we must deal with those problems. Even if stress is the primary cause of abuse, if we provide services but fail to teach stress management and the control of anger, depression or frustration, we limit the quality and effectiveness of our interventions. Possibly most important of all, we must also address the issues that underlie the abuse. If we only treat the symptoms and not the cause, then the abuse may stop for a time but it, or some other problem, will soon emerge.

Our role is to challenge, confront, support, educate and advocate so that older people can live in safety without fear or threat of abuse. To do this effectively, we must first be prepared to examine and confront our own values and attitudes about ageing, aged care, and elder abuse. We also need to confront our feelings about working with old people and dealing with aged abuse. Ageist attitudes and inaction in dealing with cases of abuse are in themselves abuses of older people, and as professionals we must be prepared to confront our own attitudes and feelings if we are ever to deal effectively with this form of abuse. All people have the right to live free of exploitation and abuse; nurses have a responsibility to uphold this basic human right and to work to prevent and stop abuse.

Evaluation - what is the outcome and did we do it right?

Nurses evaluate their interventions to determine the quality and outcome of nursing actions. Probably the first question to ask in evaluating the outcome of a case of aged abuse is 'has the abuse been stopped - permanently?' In other words has the best possible outcome been achieved? Were our interventions effective in preventing or stopping abuse, did we address the real cause of the abuse to allow permanent cessation, and have the abusive behaviours been substituted with non-abusive responses? For a successful outcome, the answer to these questions must be 'yes'.

To evaluate the quality of our interventions we also need to ask subjective questions about the process of implementing nursing actions. This means we not only ask whether our interventions worked but also did we do it right? Did the interventions constitute 'best practice, did we honour the autonomy and feelings of the client, did we make sure all actions benefited the client and caused no harm, and were interventions fair and equitable to safeguard the rights of all concerned?

We also need to reflect on our own behavioural ethics and practice. But, as we have responsibilities to clients we also have a personal responsibility to ourselves. Are our attitudes non-ageist and are our expectations of our own ability to resolve abuse realistic. Dealing with abuse is stressful work and we must act at all times to preserve our personal safety. If we visited a violent situation did we tell others where we were going and when we would return, did we take someone else with us and make sure the potentially violent person never got between us and a way of escape. Working with abuse can also be very stressful and we need strong support networks where we can take good care of ourselves and our colleagues.

Agencies also need to evaluate their contribution to the resolution of aged abuse. Are agency protocols effective in guiding assessment and intervention, is sufficient training available for staff and are appropriate supervision, debriefing and support mechanisms in place to assist staff in this difficult area of practice.

Promoting the Safety and Well-being of Older Clients

Obviously prevention is better than cure; and the prevention of aged abuse is preferable to the difficult complex task of responding to cases of abuse. The promotion of health and well-being is a prime nursing function and so nurses have a responsibility to promote safety and reduce the vulnerability of older people to abuse. The following notes include a number of strategies to promote the safety and well-being of older clients (Kingsley and Johnson, 1993)

1.   Strategies to Promote Autonomy

Autonomy - is no less important to older people than to any other citizens. Subsumed within the right to autonomy is the implication that older people are valued as individuals who have made and make a worthwhile contribution to the community in which they live. Competent adults have the right to take risks, to accept or decline care, and to make choices concerning their life. This means we treat older clients with dignity and respect and ensure they have optimal control of all decisions that affect their health and well-being. The promotion of autonomy includes:

> enhancement of the worth of older people as valued first class citizens;

> empowerment of older people to demand and enjoy rights, such as freedom of choice and informed consent, the right not to disclose abuse or to refuse nursing intervention;

> acceptance, by mentally competent older people, of their responsibility to be involved in their own welfare and to take control of the decisions that affect their life and safety;

> empowerment of carers to demand and expect adequate support and services to help them in the caring role;

> nurses believing a mentally competent older person when they disclose abuse;

provision of support, counselling and education to rebuild a victim's personal dignity and self worth.

2.   Strategies to Promote Well-being

Beneficence means that our interventions must be directed toward enhancing client safety and well-being. We must ensure our actions have a beneficial outcome for older clients and that they cause no harm, especially cause no further harm to the victim of aged abuse. The greater trust we have placed in us by clients, the greater responsibility we have to ensure that trust is never betrayed. Although the concept of 'doing good' is difficult to define, if we carefully consider the possible outcomes of all nursing actions we are less likely to do anything that will ever harm a client. Strategies to promote well-being include:

> nurse's recognition of personal attitudes or values that are ageist and abusive to older people;

> expansion of appropriate community services for older people and their carers;

> effective hospital discharge planning to ensure older clients are never discharged to a situation where they are at risk of abuse;

> use of less restrictive education, support, counselling programs to assist victims and abusers before proceeding to more restrictive intervention measures;

> development of agency policies, protocols and training for a team approach to dealing with the procedural, legal and ethical issues of aged abuse;

> recognition that inappropriate interventions can cause more harm than no intervention.

> recognition of the limits of the agency to resolve all cases and the need for referral;

3.   Strategies to Ensure Social Justice

Justice is an essential component of nursing. Equity demands our actions are fair to all regardless of age, gender, race, socio-economic status or the nature of their problem. In aged abuse justice demands fair dealings with all parties involved in an abusive relationship whether they be victim, family, or abuser. Strategies to ensure social justice include:

> community education to affirm the worth and value of older people, to eliminate ageist attitudes toward older people and to increase awareness of the issues surrounding aged abuse;

> adequate support and financial reimbursement to carers to compensate for the economic burden / penalties of caring;

> development of strategies where the admission of the victim to aged care is not the automatic option of first choice;

> where appropriate, implementation of the full force of the law to ensure the safety of the older person and fair judgement for the abuser;

> increased government protocols and police powers to intervene in cases of abuse;

> protective measures to ensure safety for nurses who intervene in abusive relationships.

Conclusion

The abuse of older people is a very serious and complex problem. Nurses have a vital role in promoting the safety of older people and in identifying and dealing with cases of abuse. Because of the complex issues surrounding aged abuse, there will always be many difficult choices to be made in both case identification and resolution. Nurses must first confront their own values about aged care and working with old people. They must ensure their attitudes are never ageist and that their actions never cause harm to an older client. To safeguard the interests of older people nurses respect their autonomy and freedom of choice, they make sure all interventions benefit the client and they ensure all actions are fair and equitable to all parties concerned.

Case Study 20.1   **Assessment**

The staff at the 'day centre' tell you that Mrs Brown rarely has any money to purchase her lunch when she attends the centre three times a week. You know that Mrs Brown, who receives the aged pension, lives with her daughter Mary and three grandchildren. The daughter is separated and receives no financial support from the children's father; she wants to keep mother at home and works part time.

1.   Decide how you would assess the possible abuse in this case.

2.   What issues would you consider and how would you assess the daughter's motives? Is Mary a loving person who is working hard to keep the family together and who needs every penny of mother's pension to manage?

      Does she believe that if she looks after mother then she is entitled to keep her mother's pension and if so, how will you determine the financial costs of caring and whether the daughter is entitled to a wage paid by the older relative? Or is she motivated by greed and knowing she will get any money her mother might have when she dies, wants access to some of it now?

3.   Clarify in you mind how you would fully assess this situation, what factors would you assess, who would you speak to and what information would you need to be able to make decisions concerning the existence or nature of any abuse.

Case Study 20.2   **Intervention**

Arthur and Nancy Johnson were happily married for 45 years before Nancy developed Alzheimer's Disease. Nancy has previously stated that she never wants to go into a nursing home and in moments of insight pleads with her husband to look after her at home. Arthur wants to honour

Nancy's wishes but finds it very difficult to care for her alone because she has dementia and wanders; she is also doubly incontinent with an unfortunate habit of daubing faeces on the walls. To be able to get a few hours sleep at night Arthur sometimes ties Nancy into the bed. He also needs to go out to do the shopping and banking and loves nothing more than the occasional game of bowls and to spend an hour with friends at the bowling club. Unfortunately Nancy's behaviour is not appropriate for the bowling club but if Arthur leaves her alone in the house she is incontinent and makes a terrible mess. Arthur's only solution to prevent the wandering and to save a mess from the incontinence is to tie Nancy to the toilet while he goes out.

1.   Professional carers have the responsibility of 'duty of care' but does that responsibility extend to unpaid, untrained family members who have, often unwillingly, been burdened with the responsibility of care. Does Arthur have a duty of care and if so what is it?

2.   Is this a case of abuse or neglect or is it a harassed caring husband trying to do the best he can to keep his wife at home with him?

3.   You are the nurse who is assigned this case. Consider the range of options for care you have, determine those most likely to achieve a positive outcome for both Nancy and Arthur. Decide what you would do, how you would involve Arthur in the care, and who else would you involve in the case?

Case Study 20.3   Evaluation

Mrs Roberts was admitted to casualty with a heart problem. During examination the nurse noticed bruising in the breast and genital area. She dealt with the heart condition and the patient was transferred to the ward. In the ward the nurse also noticed the bruising but she also limited her actions to the heart condition; she did nothing about her concerns regarding the bruises and her suspicions of sexual abuse. Mrs Roberts was eventually discharged into the care of her single middle aged son - without anything having been said or done about the suspected abuse. Some months later Mrs Roberts was again admitted to the same ward in the hospital and cared for by the same nurse: she died from her heart condition.

In reflecting on this case, the nurse considered her inaction about the suspected abuse during the original admission. She also considered her role in discharging this lady back to a potentially abusive situation and wondered how much the suspected abuse might have contributed to Mrs Robert's ill health and eventual death. What outcomes could the nurse have strived for, how might they have been achieved, what lessons can be learned from this case and what else might the nurse do if ever faced with a similar situation?

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Elder abuse

Ethical issues in professional intervention

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Abstract

Elder abuse is a tragedy of an ageing population that should never happen. Nevertheless some older people are abused and although there are no exact figures of the incidence of abuse, it is estimated that four to six percent of seniors experience harm at the hands of someone they know and should be able to trust to give them safe quality care (Sadler & Kurrle, 1993). Even though it is not known exactly how many elders suffer abuse at the hands of spouses, relatives, carers, friends or visitors to the home, what is known is that where older people are frail, dependent or under the control of others, they are vulnerable to abuse (Picton, 1989). The difficult question is how to deal with cases of elder abuse.

This paper describes the situation of Betty and Evan, and the abuse that occurs within their relationship. It also discusses some of the practical and ethical issues involved in assessment and intervention in their situation. It identifies some of the difficulties in confronting and dealing with cases of elder abuse and considers the ethical decisions that confront those who deal with abuse against older people.

Introduction: The reality of the relationship

Betty lived in the poor docklands of Glasgow until her family migrated to a small Australian timber town where her father often worked away from home and left her mother with five children. Overall they were happy but poor although father 'ruled the roost' and made the decisions. He was 'the boss', to be served and obeyed without question. He cared for his family and considered that he had the right to physically discipline and control them.

Evan lived in a Welsh coal mining town until they migrated to the same Australian timber town where they also had a difficult but fairly happy life. In a male dominated society, the men worked hard and though not rich they had a fierce sense of pride in their possessions, including their wife. They put their women on a pedestal, like 'apple pie and motherhood' held in high esteem, but still the women were expected to cook the apple pie and do all the mothering.

Evan and Betty married after Evan returned from WW2. They had a fairly hard life where they worked and played together, fought their own fights and asked no favours. Although Evan was very much the dominant partner, they were happy and made sacrifices to give their children a good education and life. They loved their children and adored their grandchildren whom they saw often. After their daughter went overseas they still saw their son's family whenever possible.

Evan began to experience trouble at work, he started to drink too much and lost his job. At fifty years of age and relatively untrained, he could only get casual work, and he would become angry and shout at Betty. She was constantly at his beck and call, and so to have some personal space she joined a book club. Betty loved the stimulation of reading books that challenged her thinking and so enrolled in a class on 'new opportunities for women' and became a volunteer at the local day centre.

Financially they experienced difficulties and although she didn't want to think of Evan as being deliberately mean, Betty was embarrassed to ask for money for class fees or to have coffee with friends. He humiliated her by belittling her activities as being less important than his, or else he joked about her friends. She became upset when he patted her on the head and said it was nice she had something to occupy her, but not to forget he was her first responsibility and to be home in time to make his lunch.

Betty is now frail and has Alzheimer's Disease. She always hated the thought of a nursing home and, in brief moments of insight, begs Evan not to send her away. He wants to keep Betty home but she wanders, especially at night, and she is doubly incontinent. To get any sleep Evan sometimes ties her to the bed, and at bath time, if Betty objects to being undressed or washed, he can become frustrated and angry and restrains her, leaving red marks on her wrists.

As a couple they had an active sex life. Evan still wants to make love, he knows what used to please Betty and believes sex is his right within the marriage. He is usually gentle, but Betty no longer takes an active role and sometimes calls out "dirty dirty".

Evan's main complaint is that he is tied to the house and is feeling tired, depressed and stressed. It is difficult to go shopping or do the banking, and he would love time to have a game of bowls and a drink at the club.

Betty's behaviour is no longer accepted at the club but if Evan leaves her alone he can come home to a mess or to find Betty has fallen and hurt herself. Evan's solution is to tie Betty to the toilet when he leaves the house.

Question: *Is Evan's behaviour elder abuse, and if so what do we do about it?*

The nature of elder abuse

Elder abuse is the harm caused to a senior by someone whom they know and trust, which means that it includes any behaviour, whether wilful or unintentional, that harms the older person (Kingsley, 2000). Most carers give quality care and take their caring responsibilities seriously (Foner, 1994), nevertheless some older people do experience physical, psychological, financial and sexual abuse or neglect at the hands of someone from whom they should be able to expect safe care. The emphasis here is on the outcome rather than the intent and, if the action causes harm, it is abuse regardless of the circumstances or motives.

Why does elder abuse happen?

Elder abuse is a complex social issue with many causes and possible explanations. Many of the contributing factors involve the characteristics, attitudes and behaviours of the abuser, which may include some level of psychopathology, or a mental or emotional inability to cope with the stress and difficult situations that arise in giving care (Wolf, 1996). Some abusers may unintentionally cause harm as a consequence of the stress and isolation of being a carer, but it is suggested that others abuse from intentional and malevolent motives, from greed or from a wish to assert power over the older person.

Within the family setting there may be a history of family dysfunction, disharmony, substance abuse or violence that contribute to abuse. However, there are additional contributing factors that arise from outside the home and family. The external social and economic forces that dictate the nature and quality of support in aged care services can also have an impact on the quality of care received by the older person (Bennett, Kingston & Penhale, 1997).

One of the difficulties in dealing with this social problem is unraveling the complex causes and contributing factors of elder abuse before any decisions can be made about how to work with the victim or abuser to resolve a case. The following discussion considers some of the ethical issues related to case assessment and intervention.

Ethical issues in professional practice

To be able to meet the needs of elder abuse victims, health professionals require an understanding of, and competence in dealing with ethical issues (Burke & Laramie, 2000). There are a number of principles that guide practice in making difficult ethical decisions. These include the ideals of '*self determination*' which are based on the concepts of client autonomy and informed consent; of '*beneficence*' which is based on the obli-

gation to do good and cause no harm to a client; and '*justice*' which is based on the concepts of dignity, worth and the right to fair and equal treatment (Rini, 2001). Dealing with elder abuse requires competence in implementing each of these ideals.

Ethical principles are conceptual in nature and do not translate easily into prescriptive guidelines that will make the resolution of ethical problems simple. Legal, social and professional standards offer some guidance but it is often the health professional's personal ethics that determine how they act when faced with difficult choices. No action is value free and each worker brings feelings and attitudes to their practice, yet their actions should be as objective as possible. In aged care, this means that every practitioner must confront their feelings about old people and who should be responsible for aged care, about what they think is acceptable behaviour and what is abuse, and what they believe they should do when confronted by a case of abuse.

Assessment — identifying cases of abuse

A number of difficult decisions face the health professional who is faced with a suspected case of elder abuse. Careful assessment is necessary to determine whether abuse is taking place, to identify the causes of the abuse, and to assess the context within which it occurs. At this point we could ask the question: Is Evan abusing his wife and if so why? Is he a loving husband who is struggling alone to survive and honour Betty's wish to stay at home or are his actions intentional, selfish and abusive? There are some difficult questions that must be asked and there is no magic line between non-abuse and abuse, making it difficult to answer the yes/no questions about when certain behaviours are assessed as causing harm to the older person.

Is Evan's present behaviour a variation on the theme of ownership? Over the years has he just been unthinking when he kept control of the finances and made Betty ask for every penny or was this a case of power and control, and was his shouting a case of frustration, a poor relationship or abuse? Was Evan's putting down of Betty's friends and belittling her activities psychological abuse? Were his demands on her time physically abusive, and was his expectation that she would come home and make his lunch a violation of her social rights? Does Evan restrain Betty at bath time because he is the more powerful partner, does he tie her down because he needs to stay in control of the situation, and are his sexual behaviours in fact sexual abuse?

There is a need to go back in time to consider the effect of early family experiences on adult attitudes and behaviour. Are these two people products of their childhood, and what is Evan's responsibility to ensure he does not repeat any abusive behaviours he learned in his youth? Can we expect Evan to change and break out of 'the mold' and behave differently toward Betty? And, even if she were mentally competent, could we expect Betty to suddenly become assertive and act to prevent abuse? These are difficult questions, nevertheless, the relationship between past experiences and present behaviour must be identified when assessing for abuse.

We also need to assess this case for social or professional abuse. Why have Betty and/or Evan not been referred to an Aged Care Assessment Team, to a Public Advocate, for community nursing and social work support, or for home help and respite services to give Evan a break from his heavy responsibilities? In these circumstances many would see both parties as victims of some form of social abuse, with Evan's behaviour being a cry for help from a tired, stressed and unsupported carer.

Intervention — dealing with cases of abuse

The conclusions that arise from assessment will influence subsequent interventions but there are still further issues to consider before any action takes place. Discounting life threatening emergencies, health professionals face a number of practical dilemmas in determining how best to intervene to resolve abuse. They walk a fine line as they attempt to balance the rights of both victims and abusers while implementing the ethical dimensions of client autonomy, beneficence and justice in case interventions.

It is in confronting these difficult issues that ethical dilemmas arise. Ethics are about choices and ethical problems are about difficult choices (Kingsley, 1997). Ethics ask questions about right and wrong, about duty and obligation and about moral responsibility to do good and prevent harm (Hawley, 1997). It is not always easy to implement these ethical ideals, yet the moral foundations of practice demand that interventions comply with an ethical framework that honours the feelings, dignity, rights and well being of clients (Jeffrey, 1993). Clinical practice also demands a caring professional-client partnership of shared respect and striving for the best possible results for all involved in the abusive relationship. Nevertheless, it can be difficult to juggle the multiple often conflicting needs of clients, partners, families and abusers, and it is a challenge to achieve positive outcomes for all.

In promoting the ideals of 'self determination', 'beneficence' and 'justice' there are also a number of potentially harmful ethical issues that must be considered and avoided. Practitioners need to be aware of ethical pitfalls such as 'ageism', 'idealism' and 'paternalism' that can be faced when dealing with elder abuse. The following discussion considers each of these issues and concludes with a brief examination of some possible professional responses to Betty and Evan's case.

Ageism

Ageism is the systematic stereotyping, prejudice, or discrimination about a particular age group of people (Long, 2001), and unfortunately many older people experience negative ageism that rejects their dignity, independence and safety, and leads to discrimination and dishonouring of their rights (Rowland, 1991). In difficult economic conditions and with ageist community attitudes, there is a risk that the rights of an ageing population will be denied and they will experience elder abuse (Kosberg, & Garcia, 1995).

Human Rights Commissioner, Brian Burdekin similarly accused aged care workers of ageist attitudes when he said

that they deny older people their rights and treat them as "disposable items not worth spending money on" (McMimmie, 1992, p. 22). If we refuse to become involved in responding to elder abuse and think the responsibility for aged care lies with the family, then we may see Betty's care as Evan's responsibility and her abuse as a private issue in which we do not interfere. If we do not see Evan's actions as abusive or if we think his stress forgives his behaviour then we are denying Betty her rights as a valued older person. All these attitudes are ageist and if we decline to become involved in this case we will condone and allow the abuse to continue and our action, or inaction, will itself constitute ageism and professional elder abuse.

Idealism

Some health workers who are unaware that much abuse begins at home may see the family as a haven of peace, love and harmony, and idealistically believe that if they can help families to be happy there will be no abuse. Ethical tensions can arise when these workers try to keep the balance between wanting to help and make things right, and recognising the complex set of rights, needs, motives and problems of victims and abusers (Simmons, & O'Brien, 1999). Ideally practitioners work with victims and abusers to agree on identified needs, and to set goals and plan interventions that address the causes of abuse and meet agreed needs. Idealism is commendable

when it honours duty of care and humanitarian action to achieve shared goals. Less worthy are idealistic goals that are fanciful rather than realistic and achievable.

An idealist response to abuse might be to flood the home with caregiving services in the belief that if carer stress is relieved the abuse will stop. Well in some cases it might. Community services can help stressed carers but they do not always stop abuse, especially that which comes from intent to harm or control. Service providers often concentrate on victim frailty and the stress of caring, and fail to confront abuse that arises from abuser psychopathology or culpable motives (Wolf, 1996). As health professionals we cannot hope to deal with elder abuse unless we accept that it can occur from motives of greed, power and control, and recognise that 'helping' will not always resolve cases of abuse.

Even if stress is the primary cause of Evan's abuse, if services are provided but he is not taught how to manage his stress or control his depression, frustration or anger, the effectiveness of interventions will be limited. Evan and Betty obviously both need health and welfare services to meet Betty's physical, emotional and social needs, to relieve some of Evan's caregiving burden, and to help him give safe quality care. Has anyone confronted the reality of Evan's abuse and offered him help, counselling, or referral to a perpetrator program to support him to terminate his abuse? If we only provide caregiving and fail to identify and address both the historical and present issues of Evan's behaviour then we are doing neither of them any favours and we will do little to stop the abuse.

Paternalism

When wanting to help and do good become the overriding forces in clinical practice there is a risk of paternalism. This occurs where workers make decisions for clients because they want to protect clients whom they believe are not capable of protecting themselves, or they believe that they, as professionals, know best and are acting for the client's good. A paternal relationship might be based on benevolent or solicitous motives but there is a risk of interfering rather than intervening when practitioners impose their own wishes and values rather than listening to and abiding by client wishes (Beare & Myers, 1990). Even if these actions arise from altruistic intent they can still be paternal and demeaning to the client.

As a general rule, competent older people have a right to control their own destiny, they know their situation and are the experts on what they need. Self-determination and freedom of choice require that professionals do not violate a client's rights even if they make informed choices and decisions with which the professional does not agree. However, when clients are not able to make informed decisions, a form of 'weak paternalism' may be justified where health workers and advocates make decisions on the client's behalf (Kerridge, Lowe & McPhee, 1998).

The simple option in this case could be to admit Betty to residential care where she should be safe from abuse. Institutionalisation could easily be justified as being for her own

good and to relieve Evan from the burden of care, but it would contravene Betty's rights and deny her dearest wish to remain at home. By admitting Betty, Evan would also be denied the opportunity for educative support to confront his abuse, to change his abusive behaviours, to give quality care to his wife, and to honour her wish to stay with him. We have to ask ourselves why, when most old people want to stay at home, are many abused victims further punished by separation from their family, removal from their home and admission to long term care. Are we taking what we think is the best option, or are we doing what is really professional best practice to meet the client's needs and wishes?

The professional response to elder abuse

Professional care will not be ageist, idealist or paternal in nature, rather professionalism implies that the practitioner and client (or their advocate) collaborate and work conjointly to prevent or stop abuse. Together they face facts, make difficult decisions and resist being carried away with what would be nice or what the practitioner thinks would be best.

The realistic professional approach to Evan and Betty's case is to include Evan in the planning and goal setting, to include Betty in any decisions she has the capacity to understand and to honour her wish to remain at home for as long as possible. There is also an obvious need for support and services and for referrals to be made to the appropriate agencies. Although institutionalisation is the intervention of last resort realistic decisions must be made about just how much care can be put into this couple, and plans will be necessary should the time arise when no amount of community support will allow Betty to remain at home.

Holistic care considers the needs of both victim and abuser and once Betty and Evan's immediate care requirements have been met there is a need to confront Evan about his abuse. This means he must accept that his actions harm Betty and are unacceptable; he has to confront and address his past experiences and his present behaviour and be prepared to stop his abuse. This would include supportive education for Evan to substitute his abusive behaviours with non-abusive responses to difficult situations and to address the underlying issues of why he abuses.

Conclusion

Working with elder abuse is time consuming and difficult. Our first responsibility is to the client and we must ensure our attitudes toward older people are positive, that our actions and expectations are realistic and our interventions honour client rights and choices. The moral codes of most helping professions involved in working with elder abuse include obligations to give quality service, to respect client rights and to promote the safety and well-being of the client group. The greater the potential to influence a vulnerable client's decisions or behaviours or to cause harm to an already damaged client, the greater is the obligation to ensure professional interventions do not cause further harm to the client.

The goals of community health care are to ensure older people receive coordinated high quality services that promote their independence and well being, which includes living safe and free from abuse. These goals are commendable and we must never lose sight of them.

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Carers Week — Raising Awareness and Promoting Carers

All around Australia, Carers' Week was celebrated during 21–27 October. The event not only increased an awareness of carers but also the contribution carers make to the community.

The theme, Listen to Carers, was interpreted in many ways through a variety of functions such as morning teas, information stalls, and 'pampering' activities for carers. Carers, their families and friends and service providers came together to celebrate the week and learn from each other. It was an ideal opportunity to build and strengthen community partnerships and future direction.

A part of the celebrations, the inaugural 'Listen to Carers Day' was held on Wednesday 24 October. The event aimed to collect information to assist Carers Associations to better represent carers and their concerns to government. Better information and representation leads to improved support and services.

Carer Resource Centres operate as part of the Carers Association in each State and Territory and provide carers with referral to services and practical written information to support them in their caring role. Carers can call their Carer Resource Centre on 1 800 242 636 (free call)

Theme 3. *Response to Elder Abuse: Community Participation and Empowerment*

Empowering community education: A response to prevent elder abuse

Following the first protocol, the COTA Steering Committee's goal was to raise public awareness about elder abuse. The committee recognised governments were unlikely to fund measures to deal with the increased disclosures of abuse that a public awareness campaign might produce. However, professional education had prepared many practitioners to recognise and deal with abuse, and so it was agreed that an empowering community awareness program was a priority.

The forum planning was based on a community development and participatory research approach. We wanted the forums to go further than raising awareness, by demonstrating new ways of behaving that could reduce participants' risk of being abused or their likelihood of abusing. Susan Johnson and I developed a program model to empower seniors to adopt an active role in their safety by confronting abusive relationships, acting to resist abuse and gaining the confidence to set their own agendas and take control of their behaviours.

The COTA Steering Committee adopted our program and in 1995 the Healthway (WA) funded forums were held under the COTA banner. In all 360 seniors and carers attended the forums that were held in conjunction with Local Government and community agencies around the metropolitan area. 'Staying Safe' became the focus as there were difficulties in advertising forums on elder abuse, and we used drama to give a sense of immediacy to the topic by showing abuse as it really happens and by demonstrating new ways of behaving to resist abuse. We based the drama on a psychodrama technique to help participants access deep seated personal issues within the safety of a dramatic presentation. Aragon and Associates, community drama specialists were then commissioned to present a series of psycho theatre type vignettes to illustrate a range of abuse scenarios. Two articles describe the development, conduct and outcomes of these forums.

Kingsley, B. (in press). Community empowerment: promoting the safety and minimising the abuse of older people. *Journal of Primary Health.*

Kingsley, B. (in press). Community education to reduce elder abuse and promote quality of life. *Journal of the Australasian Association of Rehabilitation Nurses*.

Kingsley, B., & Johnson, S. (1993). Resolution through confrontation: working with the perpetrators of elder abuse. *Australian Journal on Ageing, 12*(4), 20-23.

Kingsley, B., & Johnson, S. (1995). Resolving elder abuse: issues arising from a perpetrator program. *Australian Journal on Ageing, 13*(4), 168-171.

Theme 4.   Institutional Care and Resident Abuse

With decreased nursing home beds and increased resident frailty and dependency, there was a need for skilled staff to give complex care to older clients with multipathology and polypharmacy. However there was, and still is, is a shortage of licensed nurses and there are industry concerns that the complex intimate care of residents is being given by untrained, unlicensed workers. It was during this era of concern that I gained much of my nursing home experience and noticed industry's gradual recognition of resident abuse. Over recent years, even though governments placed increasing emphasis on the quality of resident care, there were still many reports of abuse. It is in this context that my work on resident abuse has taken place.

Since the 1993 community elder abuse protocol there has been considerable publicity on the quality of nursing home care and a growing awareness of resident abuse. As I raised the issues of resident abuse I was aware this was not a popular topic as it raised issues of poor quality care and actual abuse, and few owners or managers were happy to accept that their staff would cause harm to their residents. However, many Directors of Nursing and managers did recognise abuse as a problem and were open to supporting preventive measures.

It was encouraging that out of one industry conference came the request, and support to develop the second protocol to guide the prevention of and response to elder abuse. The Nurses Board of Western Australia Innovation and Motivation Award helped me develop the protocol. Funding for the first and second printings and distribution of this protocol by the Curtin Centre for Research into Aged Care Services and the Health Department of Western Australia, signal a recognised and growing urgency to guide and support the aged care industry to reduce and resolve elder abuse in both community and residential care.

Two articles are submitted, my contribution to the Mott Kingsley chapter in a nursing text (page 222-228), and a more recent journal article on resident abuse.

Mott, S., & Kingsley, B. (1999). Challenging behavious: the issues of quality care. In R. Nay & S. Garratt (eds.), *Nursing older people: issues and innovations* (pp. 212-232). Sydney: MacMillan & Petty.

Kingsley, B. (2001). Resident abuse: an unacceptable reality. *Geriaction, 19*(1), 21-25.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

In this chapter I discuss the rationale for the body of work, review the implementation of the work with major stakeholders, and summarise the outcomes of the work. The chapter concludes with recommendations for future directions in articulating and ameliorating elder abuse.

Conclusions Drawn from Scholarly and Professional Work in Elder Abuse

Rationale for the Body of Work

During the 1990s when much of the work represented in the thesis occurred, elder abuse was an emerging problem that required definite policy action, agency activity and professional response (Biggs et al., 1995). Aged care workers had been criticised for their ineffectiveness in confronting abuse; some denied it happened and refused to see the signs of abuse, while others recognised the symptoms but did not confront the abuse or the abuser (Bookin & Dunkle, 1985). This meant many were responding inappropriately to the victim, the abuser and the abusive relationship (Fine, 1986; Kingsley & Johnson, 1995b).

There was little local research on abuse before 1990 and, until beginning studies on the extent and circumstances surrounding abuse began to emerge, most Australian work was based on American findings (McCallum et al., 1990). In the UK, a 1997 pilot helpline project for 'British Action on Elder Abuse' found one quarter of abusers were paid helpers, 70% of abuse occurred in the victim's home and 27.5% occurred in residential care (Griffin & Aitken, 1999). No national rates were available for Australia, however if the figures for elder abuse here were similar to those in the UK, there was a need for a variety of studies and programs to address this issue in both the community and residential settings.

However, UK abuse authorities warned against accepting that research from one country would automatically apply in another country (Eastman, 1984). Eastman and others emphasised the need for work that considered the local characteristics of elder abuse (Ogg & Bennett, 1992). There was a need for work that related to our political and economic situation that reflected the delivery of community and institutional aged care and that suited the local experience of elder abuse.

There was a need to develop procedures to train and support workers identify abuse (Kurrle, 1995), and to give agencies practical and workable guidelines to help them respond to elder abuse (Meddaugh, 1993). Programs were required to give specialist practitioners the skills for their work with perpetrator programs (Gibb, 1998). There was also a need for informative empowering community education on abuse (Kurrle, 1995; Office of Ageing, 1994), one of the few interventions considered appropriate to address this problem (MacLean, 1995).

Throughout the conceptualisation, development and implementation of clinical practice described in the submitted work, there was also an ongoing need for scholarly contributions that would underpin and guide elder abuse prevention activities. From the above it was evident that this work needed to reflect aged care and elder abuse in Australia, to promote the safety and wellbeing of older people and to centre on three areas of response to elder abuse with

- *professionals,* to sensitise them to the issues of elder abuse and to educate and support them in their efforts to prevent and deal with abuse
- *perpetrators,* to terminate their abuse and rebuild non abusive relationships
- *older people,* and the wider community to raise awareness of elder abuse and to empower older people to resist being abused.

These three areas have been targeted as requiring attention. In my practice these areas were subsumed under one overarching rationale for all work on abuse, which has been, and will continue to be, the minimisation of elder abuse and the maximisation of the safety and wellbeing of older Australians.

The articles submitted in the thesis reflect significant continuing work that was conceptualised and designed to meet each of these identified needs. They also reflect some of the desired outcomes that have arisen from this work, outcomes that have made a meaningful contribution toward the advancement of safety for older people and their empowerment to resist abuse.

Summary and Outcomes of the Body of Work

The body of work undertaken to meet the needs articulated above was based on two generic philosophies. First the work was underpinned by the philosophy of community development where participation and empowerment of both practitioners and community members were directed toward promoting optimal wellbeing for older people by preventing abuse. Second, much of the work has involved naturalistic community action processes. A major impetus in this work has been to fully involve professionals and community members in the identification of their own professional and personal issues and problems relating to elder abuse. This process has involved cooperation and collaboration where stakeholders were empowered with skills and encouraged to take a participative and controlling role in resolving the abuse problems that can have such a devastating effect on professional, personal and community lives.

The three main areas of work reflect three of the four themes in the thesis and the outcomes involve the main stakeholder groups who are affected by elder abuse. Practitioners, the first group of people influenced by the elder abuse work are still being sensitised by the protocols, professional education and literature to recognise and appreciate the abuse and needs of older clients. These media give community and residential practitioners insight to conceptualise the causes and circumstances of abuse plus the knowledge to implement the best possible interventions to address specific cases.

Second, abusers have been supported and empowered, through the community forums with the skills to respond to stressful situations with non abusive

behaviours. They were also confronted and supported to terminate their abuse when they were prepared to participate in the Elder Abuse Perpetrator Program.

Third, older people have been empowered to resist abuse by following the preventive steps highlighted in the first protocol, and by the public empowerment forums and other community education to reduce their risk of being abused.

The remaining theme involved the early articulation of the issues of elder abuse. This work had a significant influence on the conceptualisation of elder abuse as a social problem in Western Australia and also on the direction that the immediate and later work took within this state. From these beginning activities there has been a consistent contribution to state and national thinking and knowing about abuse and on professional work to ameliorate elder abuse. This direction setting was ongoing with the development of the first protocol published in Australia, the development of the first perpetrator program, and it continues with recent activities that focussed attention on the issues of resident abuse in nursing homes and the inclusion of resident abuse in the second protocol.

In 1990 when my work in elder abuse was beginning, a preliminary study of elder abuse in Adelaide found 120 cases of abuse; the researchers concluded that elder abuse was clearly a significant problem that needed to be addressed (McCallum et al., 1990). The conceptual and practical work described in the submitted articles has contributed toward addressing this problem.

There have been direct outcomes of this work for the older people, perpetrators and individual practitioners who were directly involved in the programs, plus for the government agencies, peak bodies and policy makers who formed the fourth indirect group of stakeholders in elder abuse. There has also been a wider spread of outcomes for those victims and abusers who have been indirectly influenced by programs, publications and by contact with the professionals who have used the protocols or participated in the professional education programs.

Recommendations for Future Directions in Ameliorating Elder Abuse

Even though a significant contribution has been made to preventing elder abuse and to promoting the safety of older people, abuse still occurs and the work needs to continue and diversify. "Exciting new work is now appearing across many continents, with Australia becoming a source of some of the most innovative new work" (Bennett et al., 1997, p. 187). However, recommendations for future directions that arise from the submitted body of work, suggest there is still much to be done. From examination of the four themes and reflection on work to date, a number of areas of new and continued effort seem necessary if the social and personal issues of elder abuse are to be resolved in the foreseeable future.

Research to develop and test conceptual and theoretical frameworks regarding elder abuse is essential, and the application of Pillemer's (1988) model to guide research on community and resident abuse is recommended. However, in terms of Carper's (1978) ways of knowing about abuse, there is not only a need for empirical evidence and knowledge about abuse, it is also recommended that practitioners be educated and encouraged toward personal knowing of themselves, their client and the construct of elder abuse. This means practitioners would be enabled to explore creative and moral ways of working with victims and perpetrators, and of planning and implementing elder abuse interventions.

The above rationale for undertaking the elder abuse work demonstrated the need for programs in the three areas discussed. Based on my previous seminal research and the themes of the submitted studies, I would add further areas which expand on previous work and that suggest concerted effort in new areas of activity. In the remainder of this chapter I outline recommendations for future work on expanding research on abuse; the formation of policies and legislation to enable the safety of older people; lobbying for increased aged care funding for services and specific elder abuse programs; expanding professional education for elder abuse practitioners, plus community education to raise outrage about elder abuse.

Research

Carper (1978) talked of moving from a natural history stage of inquiry, the first empiric degree of knowing, to the second level of empirical knowledge, deductively formulated theory. In elder abuse the second level of theoretical writing is emerging and further research is recommended to advance the move from the use of models that describe what is happening in abuse (Sadler & Kurrle, 1993), toward the level of developing analytic theory that explains why abuse occurs and, which may in turn, lead to the prediction and control of abuse.

Elder abuse is an "exceptionally difficult area for research" (McCreadie, 1996, p.23) and after two decades, work is still needed to establish definitions of abuse (Quinn & Tomita, 1997). We need to develop testable definitions of abuse, plus empirical referents and research methodologies to ensure generalisable data.

Based on community development principles, it is recommended that this research be both qualitative, to give information that is holistic and contextual (Byrne, 2001), and quantitative, to provide empirical data for knowledge development. Qualitative research would include identification and assessment of the perceptions of older people about abuse, plus how they see and experience abuse whether as a potential victim or abuser or as an actual victim or perpetrator. This research would be oriented toward the perceived needs of older people and not just to the potential causes of abuse or the interventions most likely to resolve abuse: older people need to be consulted on how effective they feel interventions are in meeting their needs and terminating their abuse.

In terms of quantitative data, there is an urgent need for Australian national incidence and prevalence studies, because without hard data to show that elder abuse is a significant issue worthy of intervention, there is little chance of it being accepted as a problem that warrants political or community action. Governments are unlikely to formulate preventive policy or legislation, or to fund abuse intervention programs without sufficient evidence of the extent of elder abuse.

Legislation and Policy

Conceptual and practical effort is required to enshrine measures to promote elder safety, and prevent elder abuse, into legislation and policy. Much policy assumes older people are competent and responsible, however this is not always the case and legislation and policy are recommended to safeguard older people, with special provision being made for vulnerable or culturally diverse seniors or those with disability or cognitive impairment (Tatara, 1999). However, we need to distinguish between social policies that protect cognitively impaired seniors and those that empower competent seniors to self protect against abuse (McCreadie, 1996). Where possible, policy and legislation must invoke empowerment and advocacy (Phillipson, 1992), if they concentrate on protection, the empowerment potential of older people to resist abuse could be ignored (McCreadie, 1996).

Ideally, legislation and policy recognise and give financial expression to the worth of older people and set up the frameworks within which practitioners work to meet client needs in ways that promote empowerment and minimise abuse (McCreadie, 1996). In reality, there are few policies related to abuse (Leroux & Petrunik, 1990) and no protective legislation specific to elder abuse (James, 1994). There are criminal, civil, domestic violence and family laws to protect citizens but these are rarely invoked in cases of elder abuse (Bennett et al., 1997). Conversely, mandatory reporting and prosecution ignore the sensitive and subtle nature of that abuse which harms but is not criminal (Phillipson, 1992). Australia does not need mandatory reporting, but a balance between legislation to ensure law and order, and abuse prevention laws and policies based on the principles of maximum support and empowerment and minimal intervention or restriction.

Although legislation and policy alone will not stop elder abuse, they are a necessary adjunct to other preventive measures (McCreadie & Tinker, 1993). Measures to accord seniors universal services and safety are recommended to promote wellbeing and minimise abuse, and professional and community action is required to prompt political and policy intervention and funding for aged care.

Funding

Insufficient funding for services for older people and their carers, or to deal with elder abuse seems to be a problem around the world (Quinn & Tomita, 1997). In similar vein, Australian governments have been blamed for ignoring the existence of abuse; they disregard the fact that they underfund aged care services, and they deny the negative effects of nursing home waiting lists and the lack of funds to employ competent trained staff (National Aged Care Alliance, 2001). Protective aged care policies will ensure resources are earmarked to enact policy directions for aged care services and the prevention of elder abuse (McCreadie, 1996).

It is suggested that governments, especially Federal Governments, need to look away from privatisation (Griffin & Aitken, 1999) and user pay principles, toward increased funding for community services as a means of responding to an ageing population. Similarly, the economic rationalists need to acknowledge the input of carers of frail older people and recompense them for their caregiving, for without carers the total responsibility for aged care could revert back to governments (Hicks, 1986; Walker, 1989). To ensure adequate funding to employ trained staff to provide quality nursing home care, for aged care services, carer support and elder abuse programs, it is recommended that practitioners be encouraged to work with competent seniors and senior's organisations to lobby for increased funding.

Research data on the prevalence of elder abuse will give credibility to lobbying by practitioners and senior's peak organisations, about the plight and abuse of older people. Extensive lobbying is recommended to raise community outcry about the abuse of older people and to incite political and government action to address this issue. Providing the necessary services and programs to meet the needs of older people will cost money, even though providing these services will cost far less than advocated by the economic rationalists (Palmer & Short, 2000). Nevertheless, we need to strive for political consensus between all parties, to ensure adequate resource allocation that is not at the whim of political ideology, and that addresses the socio structural factors relating to elder abuse.

Aged Care Services

Aged care services are traditionally under resourced (Wolf, 1994) and the health care of older people is rationed (Bennett, et al., 1997), especially for those living in the community where Australia's aged care seems to remain firmly entrenched in Dickey's (1981) second minimal universal mode of welfare provision. There is still far more spending on residential care, with $3148 million allocated in 1996-1997 to the small percentage of older people in residential care (Palmer & Short, 2000), compared to only 5% of recurrent health spending that is directed toward maintaining over 90% of older people in the community (Minichiello, 1995).

Biggs et al. cite consultation by the UK 'Action on Elder Abuse' with seniors who "placed mistreatment within a context of reduced resourcing of services and ageism within health and welfare agencies" (1995, p. 96). It is recommended that HACC resourcing of aged care services be increased to offer realistic income support for carers, to provide sufficient community services to maintain frail older people at home, and to reduce waiting lists and unfair restrictions on eligibility for services. Aged care services, especially those in nursing homes, are said to be ageist and "less than sensitive" to the needs of specific groups such as those from other cultures (George & Davis, 1998, p. 286). As practitioners we must ensure our activities, and those of the bureaucracy, are not ageist, that they are appropriate and delivered in a way that is acceptable and affordable to clients.

One area of aged care services that some suggest is related to elder abuse is the lack of respite for carers. Carers are said to need respite, support, information on what is available and people to advocate on their behalf (Travers, 1996). Information and advocacy are fairly readily available however, UK research has showed "no significant increase in the demand for respite care, nor was it seen as more valuable by carers or patients who were in abusive relationships" (Bennett, et al., 1997, p. 191). It is recommended that local work be carried out to ascertain the amount of respite available for carers, to show how effective it is in reducing carer stress, and to determine the role of respite, or lack of respite, in elder abuse.

Elder Abuse Programs

In work to articulate and ameliorate complex social problems such as elder abuse, it is unlikely "that ideal 'once and for all' solutions" will be ever found and, because resources are finite, it is also unlikely that funds will be available to guarantee "top quality services" or the elimination of elder abuse (Bennett, et al., 1997, p.158). If adequate help to address the social causes of elder abuse cannot be expected from governments and bureaucracies, then it may be up to local communities, professional agencies and individual practitioners to implement abuse prevention programs that will at least address individual cases.

In considering intervention strategies, the principles of maximum support and minimal intervention and restriction should be the basis of all programs. Craig (1994) agrees and notes that Britain's interests lie less in mandatory reporting and more toward non iatrogenic forms of social intervention where abuse is prevented and stopped by voluntary non coercive means. The implementation of least restrictive interventions, in non emergency cases, should be tried before resorting to disciplinary or legal interventions (Bolton & Bolton, 1987). The US experience shows that arrest has "no crime reduction effect" (McCallum, 1993b, p.8) which suggests that, in non criminal cases, community support and empowerment services, educative supportive programs, or counselling and retraining programs to substitute non abusive behaviours for harmful behaviours, be attempted first.

Programs to prevent and stop elder abuser need to address the social, as well as interpersonal and individual factors of abuse. Because abuse is culturally defined, it reflects distinctions between acceptable and unacceptable behaviours, and denotes moral values and standards of conduct which can vary between cultures and groups (Hudson et al., 1998). Programs, therefore, need to be sensitive to the cultural and personal needs of older people and those involved in abuse.

In the community, resourcing is recommended for a variety of elder abuse programs such as telephone helplines for victims; perpetrators and others

concerned about elder abuse (Bennett, et al, 1997) or advocacy and mediation programs to allow older people to utilise the full extent of their ability for self determination (Craig, 1994). Victim rights are paramount and programs need to centre on least restrictive empowerment and support rather than on restriction, family policing (Craig) or the automatic removal of the victim, rather than the abuser, from an abusive relationship. We cannot further punish a victim by using nursing home placement as a first option of response, it is recommended that the removal of an older person from their home should be a last resort that is never undertaken without their consent or the consent of their advocate.

Overall however, we are better at caring for victims than abusers, who also need support, services and counselling to stop their abuse. Vinton (1992) found that although 25% of abusers were alcoholic, only 3% were referred for alcohol treatment, similarly Sadler and Kurrle (1993) found 46% of practitioners, who identified abuse, counselled the victim but only 25% counselled the abuser. Alarmingly, Sengstock, Hwalek and Petrone. (1989) found over 80% of abusers received no services at all. I agree with Gibb (1998), that if we acknowledge the extent of abuser problems, then programs that deal with those problems and stop perpetrator abuse are recommended, as is research to investigate which are the most effective abuser programs (Vladescu, Eveleigh, Ploeg & Patterson, 1999).

Agencies do exist for older people, families or staff to complain about abusive care and conditions. However in terms of nursing home care, Australia has looked to legislation, which concentrates on resident's rights (Department of Community Services and Health, 1989) and accreditation to ensure safe care for nursing home residents (Braithwaite, 1998). Nevertheless, abuse still occurs and it is recommended that either a specific aged care ombudsman be appointed or that current ombudsman services be expanded to deal with complaints against private as well as government agencies. Within the nursing home environment, programs are also necessary to ensure that management implement staff practices to employ, support and train adequate qualified licensed staff to give quality care.

Education

Because "the perceptions and attitudes of professionals are important" (Bennett et al., 1997, p.159), the education of elder abuse practitioners is an important task. Nurses, and other practitioners, must gain knowledge and skills in defining and identifying elder abuse, in confronting the abuse and the abuser, and in planning, implementing and evaluating interventions to address abuse (Pettee, 1997). Elder abuse practitioners in the community and nursing home settings will always need theoretical education and practical training in giving skilled care and in preventing and responding to elder abuse (Meddaugh, 1993; Payne & Cikovic, 1995). Professional education on these topics has been and is being undertaken, but it is recommended that this form of education continue on an ongoing basis, to meet the changing needs of practitioners and older people alike.

In terms of community education, while many still see the care, and abuse, of older people as a private family affair rather than a social problem that should be the concern of the wider society, elder abuse remains a hidden issue that deserves a higher profile (Leifer, 1996). I agree with Leifer, who recommends community education for older people, carers, health professionals, the community and governments, to raise awareness of abuse and to "give proper support and recognition to the problem" (1996, p. 9).

There is a need for community education and, though programs have been implemented, this need continues. Empowerment is as important as intervention against elder abuse (McCreadie, 1996), and ongoing community education is recommended to empower older people to resist abuse, and to support carers to give safe non abusive care (Hudson, 1989). However there is less preventive education that supports abusers and potential abusers, who may be experiencing appropriate feelings of burden or carer stress, but which are expressed through inappropriate or abusive behaviour (Sayles-Cross, 1993). Community education needs to not only raise community awareness and rejection of elder abuse, it also needs to empower older people and carers to resist being abused or abusing.

Conclusion

Rarely is there only one cause or one solution to a complex issue like elder abuse (Pillemer & Moore, 1990). In this chapter, I have given a number of rationales for undertaking the range of theoretical and practical works that form the submitted body of work. The positive outcomes of this work with practitioners, abusers and older people, suggest the work has made a significant contribution to addressing the social problem of elder abuse within the context of Australian aged care. These outcomes have also validated each of the rationales for the body of work

The issue of elder abuse is recognised as a social problem that requires attention, and my work forms an integral part of a body of work that is described as making Australia "one of the most influential new areas within the world working on elder abuse" (Bennett et al., 1997, p. 201). "In our earnest to establish the 'Let's Prove the Same Problem Exists Here' Syndrome" we may have adopted many of the American descriptions, definitions and data about elder abuse in the early years of elder abuse work (McCallum, 1993b, p. 10). However, rather than our early work "inhibiting the development of an original approach to the problem", as feared by McCallum (p. 10), I believe Australian initiatives reflect the dynamics of our current aged care services, local economical, social and political conditions, and the influence that these factors have on the abuse of older people.

The studies, comprising the body of work, were based on a conceptual framework that guided personal development and directed professional practice in dealing with the abuse of older people. Similarly, elder abuse activities were embedded in an empowering, participatory community development approach that allowed my work to arise from the stated problems and needs of older people, abusers and aged care practitioners. These frameworks have had practical and theoretical implications for my activities and they have guided the recommendations for future directions, in the six areas of research and work outlined in this chapter, to continue the work of articulating and ameliorating elder abuse in Australia.

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APPENDIX ONE

METHODOLOGY

The professional move from the secondary and tertiary fields of nursing practice into community aged care required me to adopt a more social framework of health in my work with older people. This move had a great personal influence on my ways of thinking and acting with clients, and on the development of scholarly work in elder abuse. However, not only did thinking have to change, so did practice. No longer could I only react to problems, I had to extend my practice and become more proactive in preventing the onset of problems. Similarly, no longer was I the practitioner who had the knowledge and the skill to direct what my patients should do to get better, now I became a tool or facilitator in a process to support competent clients as they worked to recognise and resolve their own problems. Of course there were always some clients who were not capable of taking part in this process, often their family member, an adviser or a government appointed substitute decision maker would act as their advocate in this process.

A Metaphor

A story I tell students about the process of community work, illustrates the evolution of my method of working with community stakeholders.

> Once upon a time I was standing at the base of a cliff by a swift flowing river. I hear the cry of a drowning woman, so I jump into the river put my arms around her, pull her to shore, apply artificial resuscitation and call an ambulance. Just as the ambulance arrives there is another cry for help; I jump into the river again reach the next person, pull them to shore, apply artificial resuscitation and then just as he begins to breathe there is another call for help. So back into the river again, reaching, pulling, applying, and then another yell. Again and again without end goes the sequence.

You know I am so busy jumping in at the bottom of the cliff, pulling them to shore, applying artificial resuscitation and putting them in an ambulance that I can make no time to go to the top of the cliff and see what is happening up there. I need to determine whether or not these people want to jump in and if not is someone pushing them, or maybe the safety fence on the cliff has broken and people are falling.

A social framework of health is not about calling ambulances to the bottom of the cliff, it is about going to the top of the cliff where the people live to find out why they are falling, why they are jumping or who is pushing them. This action involves working with those who are at risk of accident to identify what is actually the problem, to determine how they see their problem and to involve them in deciding how act to prevent further casualties. Depending on the cause of the problem and what goals the group set, actions could include working to build a strong safety fence to prevent people falling or changing things so people no longer want to jump off the cliff. Actions could also involve strengthening community resolve to not allow anyone to push them around, or off the cliff, plus working with those who are pushing them so they stop this activity.

Community-Based Action Research

Community-based action research (CBAR) (Stringer, 1996) is probably the best description of the general methodological process that has been used throughout my practice and the work that underpins the presented studies. The studies have been based on a naturalistic community process (Guba & Lincoln, 1985) and in accordance with this process every effort has been made to give stakeholders opportunities to have a voice and participate in addressing their own issues. Participatory approaches to inquiry are implied within this methodological framework where participants are encouraged to articulate their problems and to collaborate in the search for solutions (Gardner & Lewis, 1996). The process of

CBAR is appropriate to work in elder abuse. It compels community facilitators to commit to working with stakeholders in partnerships that advance new skills and knowledge whilst giving support for concerted action to resolve the issues related to abuse. Before giving any rationale for selecting CBAR and the reasons for its utilisation throughout the studies it is appropriate to give a brief description of CBAR and the basic principles that underpin the research process.

Identification of General Methodological Approach

"Community-based action research is a collaborative approach to inquiry or investigation that provides people with the means to take systematic action to resolve specific problems" (Stringer, 1996, p. 15). The purpose of CBAR is to enable the identification and resolution of social problems experienced by those who live and work in the community. Community research is more a process than a research method and CBAR means that it is a systematic methodical process of assessment and intervention to address or redress community problems.

Principles of Community-Based Action Research

There are a number of principles that guide community research. Stringer talks of how CBAR "seeks to develop and maintain non-exploitative social and personal interactions that enhance the social and emotional lives of all people who participate" (1996, p. 26). The purpose of this process is to build a sense of 'community' amongst the participants in a way that enhances their quality of life.

The principles of the process relate to the importance of four key elements in carrying out research. First, is the principle of 'building and working within collaborative, equitable and accepting relationships'. Stringer says "the type, nature, and quality of relationships in any social setting will have direct impacts on the quality of people's experience and, through that, the quality of outcomes of any human enterprise" (1996, p. 26). The researcher will have a primary interest in establishing and maintaining positive collaborative working

relationships where the nature and quality of the relationship between stakeholders, and how each is empowered to participate, will have implications for how interventions are developed and implemented.

Second, is the principle of 'effective communication' being a tool to bring together and involve all who participate in the process. Without building effective open and truthful communication patterns between the parties there is little hope of achieving the goals or the positive changes that the group has agreed upon. It is "when people feel acknowledged, accepted, and treated with respect, their feelings of worth are enhanced and the possibility that they will contribute actively to the work of the group is maximized" (Stringer, 1996, p. 32).

Stringer's third principle of CBAR, is the principle of 'personal individual participation' in the process of exploring and identifying the problems and situations that community members may want to change. The researcher's task is to "provide a climate that gives people the sense that they are in control of their own lives, and that supports them as they take systematic action to improve their circumstances" (1996, p. 32). When the group is supported to become personally and actively involved in finding and formulating the solutions to their problems, then they will feel some sense of ownership of the problem that will give them the motivation and the will to shape and change their lives.

Fourth, is the principle of 'inclusion' that involves encouraging individuals and groups to participate while including all stakeholders in the process regardless of their role and position, or their views about the problem to be resolved. If those who are affected by the problem are not included there is a risk that "the voices of the most powerless groups tend to go unheard, their agendas ignored and their needs unmet" (Stringer, 1996, p. 36). The more people who become involved, the wider is the potential scope of change activities. This principle of inclusion also implies that actions will look past the immediate to include the wider social, economic or political issues that might relate to a problem such as elder abuse.

The philosophy that underpins most participative community research emphasises the production of knowledge and empowerment (Rice & Ezzy, 1999), two vital factors in dealing with elder abuse. Rice and Ezzy talk of placing less emphasis on methodology and more on an alternative participatory method of knowledge production which is based on the people's role in setting the agendas, participating in obtaining data, in analysing data, and controlling the outcomes. They go on to suggest that research, which is an integrated part of a process toward empowerment and emancipation, should empower local community members and assist them to change their lived situation and solve their problems.

Process of Community-Based Action Research

This process begins with an interest in a problem that affects a community or group, and the purpose is to "assist people in extending their understanding of their situation and thus resolve problems that confront them" (Stringer, 1996, p. 9). To be fully participative and empowering, this process needs to be

- *democratic*, enabling the participation of all people
- *equitable*, acknowledging people's equality of worth
- *liberating*, providing freedom from oppressive, debilitating conditions
- *life enhancing*, enabling the expression of people's human potential (p. 10).

As a sociable research process, through ongoing interaction with clients we enter their world, their cultural setting, their interactions, emotions and history and we have the potential to touch and make a positive contribution to their lives (Stringer, 1996). Stringer suggests some of the dialogue of this process will be at odds with the general conventions of research or community work. He says "we need to understand the complex interactions among people, events, and activities, and to comprehend the various ways in which they interpret their situations so that any activity we initiate sits easily in the minds of the people with whom we work" (p. 57). This is something I have tried to achieve in my work.

Participatory action research is a process of problem solving more than a research method; I had been using this type of process in my practice for years before I became formally acquainted with CBAR and it seemed to be the process most similar to my practice. In agreement with community research processes, my practice is aimed at being participative and empowering and this is grounded in my field activities. There has been a great deal of reflection and analysis, alone and with other participants, that have led to new theoretical outcomes for me and new cycles of reviewed and modified actions. Participatory community processes have guided most of my work and studies in both community and residential care and they underpin the activities and work that make up the submitted studies.

Rationale for the Methodology

In the remainder of this chapter I describe my rationale for utilising a CBAR approach in the studies, and outline the three main phases of the research process. My choice of a participative form of research was based on features of the participative process of knowledge development, empowerment and action; these processes will be evident in the community work undertaken during the studies contained in the thesis. To illustrate how each rationale applies to my elder abuse work and studies, one practice example will be used to demonstrate the application of the rationales. During 1995 a series of empowering community education forums was conducted around the metropolitan area of Perth to raise awareness of the issue of elder abuse and to empower older people with the skills, the strategies and the will to resist abuse. Aspects of this program are drawn upon to illustrate the value of each rationale to my community research and work.

Linking Knowing and Action

This is a key rationale that underpins the majority of my practical and scholarly work. Rice and Ezzy (1999) suggest participatory forms of action research are based on a link between the processes of knowing and action. This philosophical and practical linking implies the same premise on which much of Paolo Freire's

(1972) education message was based. Freire worked to link knowing and learning through an ongoing cycle of action and reflection. From this ongoing process comes a critical awareness about the world inhabited by the people of interest who, in this group of studies, are older people and those who abuse them, plus the workers who intervene in cases of abuse. My participatory community empowerment work utilises a similar cyclic process that is central to all CBAR work. In this cyclical process, new learning is followed by reflection on that learning, which leads to new action, that in turn gives rise to new knowledge, further reflection and where appropriate modified action (Stringer, 1996).

The same principles that guide CBAR also underpinned the elder abuse prevention community education forums on 'staying safe'. The forums did not use traditional chalk and talk education formats where the professional stands at the front of a room - often in a white coat - and talks about health and what people must do to be healthy. Learning implies a change of behaviour and the forums aimed to empower competent seniors to adopt an active role in becoming or staying safe, to confront abusive relationships and to act to resist abuse. In participatory research processes people are assisted to gain the confidence to set their own agendas and take control of the outcomes of their behaviours (de Koning & Martin, 1996). This process utilises participation to help people acquire new skills, often using group interaction and dialogue to empower them to act by changing oppressive realities or relationships (Rice & Ezzy, 1999).

From our use of drama and interactive dialogue to raise abuse issues, many forum participants linked knowing and action when they took the opportunity to tell their stories about the reality of their abuse while they learned how to act to prevent or stop that abuse. These sessions were interactive and, though they gave information and knowledge about abuse and available supports or resources, they also pointed a way forward by linking new knowledge with future action by enabling older people to resist being abused, and their carers to resist abusing.

Origins in Community Development

The framework for this group of studies is based on a belief in the two vital principles of participation and empowerment that have underpinned my previous work in community development (Kingsley, 1994). Participatory forms of action research had their origins in community development work with marginalised or oppressed peoples and community action research comes out of a variety of areas such as the education and management work of Kurt Lewin (Rice & Ezzy, 1999). Friere's philosophy is more comprehensive than action research processes, yet much participatory community action research is based on similar community development principles, and it is an ideal methodology for health related programs which focus on participation and empowerment (Hall, 1981).

In terms of 'bottom up' community development and primary health care (World Health Organisation (WHO), 1978), it is essential that the impetus for development comes from the community. This means that the local people who experience or are involved in the problem to be resolved will actively participate in the problem solving process. Rice and Ezzy (1999) emphasise the importance of the local community as a central point of concern where their participation and action to resolve their problems is informed and enthusiastic.

Planning for the forums commenced after focus groups discussions with older people had identified their fears, and what they needed to be able to do to maintain their safety. The forums were an outcome of grassroots requests for help in how to remain, or become, safe. In accordance with primary health care and community development principles (WHO, 1978) the forums were 'accessible' in that they were taken to where people lived and worked, they were funded and hence were 'affordable', and they were 'appropriate' to meet the stated needs of older people. At first it was a concern of how to make the content of the forums 'acceptable' because abuse is a very private and rather taboo topic. However, after much consideration the theme of 'staying safe' and a drama format were chosen to introduce a difficult topic in an acceptable and non threatening manner.

Community development entails a strong commitment to social justice and a vision of a better world for those involved; participatory action research processes are based on the same commitment (Kingsley, 1994; Rice & Ezzy, 1999). Rice and Ezzy suggest that participatory processes focus on emancipation, collaboration and empowerment, and they note that action research in Australia has mainly been undertaken with disempowered people, such as older people. The aim here is to provide a context and environment that helps older people and their carers to work collaboratively toward empowerment and problem resolution.

Empowering Qualities

Participatory and action research generally form an integral part of a process for the empowerment of oppressed or disempowered peoples (Rice & Ezzy, 1999). Being disempowered suggests that an individual is limited in the degree to which they can impose their will on others (Haralambos, 1980). In many cases people are disempowered when their behaviours and life activities are largely, or even wholly, dictated by another person or group. It often means they receive little affirmation in life and lack sufficient autonomy or power to control their own decisions or to demand the support or resources they require. Overall, events or situations seem to prevent or inhibit them from developing their full human abilities or from participating in solving their problems or having control over their own life and situation (Freire, 1972).

Power, empowerment and disempowerment all occur within social relationships and so does elder abuse (Johnson, 1989), where a disempowered person may be at great risk of being abused. Participative research processes apply well to changing relationships where people participate in a process whereby they can become empowered to resist abuse and take control of their relationships, their lives and their wellbeing. My clinical and scholarly work with individuals and agencies is underpinned by the concept of empowerment, to facilitate competent participants to take control of their skills and resources in order to address and resolve the issues that influence their lives and work.

The community forums were based on the premise that community education is an effective method to promote personal learning and empowerment (Rice & Ezzy, 1999). The aim was to empower participants both internally and externally to minimise the risk of abuse. Internal empowerment includes intrinsic learned characteristics plus the ingenious responses that arise from within people to allow them to confront, cope with and, where possible, change difficult situations. Education and information can reinforce and reactivate internal factors such as being more hardy in difficult times or gaining the determination to be assertive enough to resist being abused. External factors include the outside people, the supports and institutions that help and support people to gain greater control over their lives and safety. Empowering external factors include the knowledge, skills and support to resist abuse, that is given by individuals and social networks or by health, community service, mediation or advocacy agencies.

The forums were conducted in the belief that empowerment can alter the nature of a senior's relationship with an abusive carer. Empowerment programs for older people support them to use all their internal and external resources to resist the imposition of power by an abuser and so reduce their risk of being abused.

Natural Extension of Everyday Activities

Stringer describes how community workers are expected to solve social problems with interventions at an individual or program level, yet many fail. He says we need to see workers, not as technicians working with limited resources but more as a "creative investigator and problem solver" (1996, p. 3). Stringer sees CBAR as a natural extension of everyday activities and a methodical process of inquiry "that enables people to understand the nature of problematic events or phenomena and incorporates action to resolve the problem" (p. 5): it involves

- *a problem*, to be investigated
- *a process*, of inquiry
- *explanations*, that enable individuals to understand the nature of the problem
- *action*, by all stakeholders to resolve the problem.

Many life problems are played out in everyday activities and one positive aspect of this research process is that many solutions can also be located in everyday life. This was one empowering quality of the process that made it acceptable to a range of professional and para professional workers as well as to the older people and carers who attended the forums. We used drama scenarios of everyday activities and relationships to illustrate abuse and we used participants existing everyday life skills to show how they could react differently in stressful situations and so resist being abused or abusing. Being actively involved in their own learning process helps people realise how much they actually know and that their knowledge is valuable, this in turn can empower them to more effectively take control of their own situation and relationships (Rice & Ezzy, 1999).

Democratizing Process

Being a natural extension of everyday activities is also a democratizing process where participants are involved and included in the research process. CBAR is a collaborative and democratic activity where those who might otherwise be treated as research 'subjects', participate directly in a process of disciplined inquiry which aims to empower them and improve their quality of life (Stringer, 1996).

The more voices that are heard and the more interactive the process, the more information becomes available on what the group sees as their problem. Similarly, when stakeholders are encouraged to participate in setting goals and determining interventions, then individual agendas or contentious views seem to become less important than concerted action to resolve the problem at hand. One of the equalising factors of this process is that it allows professional groups to develop respect and empathy for both the insights and knowledge clients have, and the problems they face (de Koning & Martin, 1996). Older people are the experts on their safety, their abuse and what they need to be able to stop abuse. As we learn to understand their experiences we will become more sensitive to their fears and needs and will then be able to work together, as equals, and help them take action to resolve their abuse.

Part of the democratizing process for the forums was the inclusion of as many stakeholders as possible. Early focus groups involved the voices of older people and more formal meetings with the professionals who would be involved in each forum carried on this process. Older people and carers were active participants not passive subjects having something 'done' to them (Rice & Ezzy, 1999). There were also meetings with local government authorities, community service and support agencies, and community police agencies plus volunteers, such as counsellors, who would assist at each forum. CBAR suggests it is necessary to recruit and enthuse workers to be involved, to be self governing and to input considerable time and energy into the research (Stringer, 1996). This occurred with the forums. Once news of the forums spread, we had many requests from agencies to hold additional programs in their local government area, and these workers were willing to contribute to the planning and conduct of the program.

In accordance with CBAR, an evaluation process was undertaken at the end of each forum. Based on participant evaluation and observer feedback, and as a self governing process, we met at the end of each day to review and reflect on the day and to make any modifications that were felt necessary to meet the specific needs of the particular client group who would participate in the next forum.

Problem Solving Heuristic

One aim of CBAR is to assist marginalised or disempowered people to gain the self confidence and pride to take an active role as part of the group who is working to solve its problem (de Koning & Martin, 1996). Stringer (1996) describes how many professional programs fail to resolve social problems and de Koning and Martin suggest this is because few programs take into account the situations and conditions which influence program outcomes. The problems need to be clearly identified and causative and influencing factors analysed before program plans or outcomes are identified. The problem of elder abuse is heuristic, it offers CBAR opportunities and suggests problem solving interventions for victims and abusers, as well as for workers who deal with abusive relationships.

Basically CBAR is "a practical tool for solving problems experienced by people in their professional, community or private lives" (Stringer, 1996, p. 11). For the victims of abuse there are obvious problems of physical, emotional or financial harm which results from the abuse. Many abusers have psychological, emotional or stress related problems that may contribute to their abuse. The professional workers who respond to abuse have problems of knowing how best to deal with their various clients and how to resolve cases whilst achieving the best possible outcome for all. These are people whose personal, community and professional lives are affected by elder abuse and it is only logical that they should take an active role in resolving their issues. Any practical tool that can empower each of these groups to face their own difficulties and participate in meeting their own needs is of great value to those of us who facilitate this process.

This rationale for CBAR is especially valuable in my work as my approach is a problem solving heuristic. As a community practitioner, elder abuse is a problem that cannot be observed and ignored. There is an imperative to become involved and work with clients to learn why abuse is occurring and to actually do something to help them prevent or stop the abuse. It was not good enough to just raise issues and concerns about elder abuse at the community forums and then walk away, there also had to be some avenue to offer practical support and intervention in cases. To do this trained counsellors were present as were community police, service and advocacy agencies, so that those who disclosed being at risk of abuse, being abused, or being an abuser could have immediate and ongoing access to support to resolve their problems.

Potential for Transformative Power

Health education programs that employ a didactic approach to telling people what they must do to be healthy can fail because they do not assist people to critically examine why they are not healthy (Rice & Ezzy, 1999). The same applies to elder abuse if we tell people to stay safe without giving them skills, to examine why they are being abused, and support to transform or change abusive relationships.

Participatory learner based education is a powerful means for empowering people with the skills to make transformative changes (Freire, 1972). This transformative power for change has both internal subjective and external behavioural aspects. Through CBAR the skilled empathetic worker can recognise the subjective world of the client and can work with the client to modify or change their internal or subjective reality (Rice & Ezzy, 1999). Following one of the community forums a carer disclosed that she now realised she was abusing her parent. Her mother was difficult to care for and she had been blaming mother for her unsociable and often difficult behaviours. With ongoing support this daughter was able to modify her perceived reality of her mother's behaviour. She began to realise that her mother's actions were not deliberate and intended to annoy, she came to the more realistic recognition of her mother's increasing dementia and decreasing ability to make sound cognitive judgements or behaviour decisions. As this carer was empowered to transform her own subjective perceptions of her mother's behaviours so her own outward behaviours also changed and her abuse ceased.

During the CBAR process the professional can work with clients to transform external social realities and improve their lives. The programs that fail are unlikely to identify the means by which social, political and personal action can transform this situation and reduce the risk of social, institutional or personal abuse against older people. One advantage of participative forms of research is their potential for change in that they aim to examine the political structures that empower or disempower marginalised, deprived and oppressed groups of people and to find ways to make the appropriate changes to these structures (Rice & Ezzy, 1999). Rice and Ezzy advocate that participative forms of action research aim to "create new forms of knowledge through a creative synthesis of the different understandings and experiences of those who take part" with an end result of transforming 'social realities' (p. 173). If we as professionals and communities could change and solve the major causative factors of elder abuse, then we would be transforming the social reality of abused older people.

Implementing Community-Based Action Research

Each of the rationales for CBAR was important in planning and implementation most of the interventions throughout my dealings with elder abuse. A positive aspect of this process is that it is practical and has the facility for ongoing development and improvement of both clinical and conceptual outcomes. The process involves three basic steps or phases to 'look' by gathering data and building a picture of the situation or problem, to 'think' by interpreting data and explaining what is going on and to 'act' to resolve the issues or problems. Stringer's (1996) text is acknowledged as a major beginning of CBAR and his model has helped me formalise the general process that I had been following in my work with elder abuse. Participative CBAR processes are based on the three steps which may sound simple but which involve complex information gathering, analysis, intervention, reflection and evaluation. Stringer describes the three phases that are generally based on a continually recycling set of activities.

Phases of Community-Based Action Research Development

Before the CBAR process begins Stringer (1996) suggests it is important to take preliminary action to set the scene for all involved and to gain an understanding of the situation to be resolved. If people are to become involved in a collaborative process to solve their problem they first need to become aware of the complexity that surrounds them and set the stage for beginning the research process. The various stakeholders will negotiate and come to some consensus on how the problem is perceived and experienced so that all involved can begin to make sense of what is happening and can work to address their common problem. Once the stage has been set, early negotiations have taken place and some agreement has been reached with stakeholders, that they will become involved in the problem solving process, then the three general phases can commence.

Phase One: Look

The first phase of the process involves seeking and gathering information about the problem at hand. This systematic inquiry is necessary if we are to build any picture of what constitutes the problem and to be able to define and describe the issues that concern the people who experience the problem. Stringer (1996) suggests the objective of this first phase is to help stakeholders describe their situation and to gain some definition and description of the problem as they see it.

Problems such as abuse do not exist in isolation and as new information emerges about the circumstances relating to abuse, each stakeholder may come to perceive their personal or professional situation in a new or transformed way. However, with many voices in this process gaining any consensus on the meanings of the problem may be difficult. As the worldwide work on elder abuse progresses, this first phase of CBAR would align with Carper's (1978) 'natural stage of inquiry' of her empirical way of knowing. Elder abuse work is still largely at the beginning stage of data gathering, description and definition where a picture of what constitutes abuse is being developed. Some of Carper's 'deductively formulated theories' about the causes and relationships of elder abuse are slowly and tentatively beginning to emerge and these more theoretical activities are taking 'elder abuse work' into the thinking phase of the CBAR process.

Phase Two: Think

Stringer's second phase of thinking and hypothesising allows stakeholders to interpret and construct explanations for the problem. It is during this phase that the problem definitions and descriptions are explored and analysed through conceptual frameworks, in order to interpret and build explanation, and clarify the meaning of why things are as they are. It is at this point that theorising on issues like abuse begins in an attempt to infer relationships, for example between risk factors and the occurrence of abuse. Much reflection is usually involved in this phase as people analyse why problems exist, explain what causes them and determine what each stakeholder wants done to resolve their part of the problem.

Critical thinking and reflection are integral aspects of the 'thinking' phase' of any goal oriented process. It is at this stage that disciplined conceptualisation, analysis, evaluation and synthesis of the gathered data is undertaken as a precursive step toward informed decision making about appropriate and creative future actions (Adams, 1999). In relation to Carper's (1978) ways of knowing, 'thinking' relates most closely to personal knowing. This is where the researcher learns to know both themselves, and how they experience the reality of the problem, as well as coming to know and empathise with the client's reality and experience of the problem. It also involves hypothesising about the causative factors of elder abuse and the relationships between factors associated with abuse. Thinking gives rise to a range of potential creative and aesthetic interventions.

Phase Three: Act

Phase three of Stringer's (1996) CBAR includes processes whereby all those involved in the process take the time to consider their situation and reflect on how they can act to resolve their problem. Stakeholders then consider and weigh up all the potential interventions, decide which course of action is best to achieve their goals, work collaboratively to implement the agreed interventions and then evaluate the success of the program in solving the problem.

Great care must be taken when implementing actions that will have personal or professional impact on participants; to ensure the best possible outcomes are achieved for all concerned in a case of elder abuse. It is here that Carper's (1978) aesthetic and ethical ways of knowing are important to us who, as professionals in this research process, work with clients to develop innovative interventions that will have a positive impact on their safety and wellbeing. This phase includes deliberating on the most creative and positive interventions and planning for outcomes that will achieve the best possible results for all involved. This phase also includes an evaluation step where both the quality of the process and the achievement of goals are evaluated and, if necessary, the cycle recommences.

The Three Phases in Action

The development of the elder abuse protocols is used to illustrate the phases in action in my elder abuse work. Included in these phases of protocol development, I had a major part in writing two protocols and took part in the development of a protocol for government agencies. Throughout the process there were extensive periods of 'looking'. In my early practice in elder abuse I observed cases and talked to older people and other health professionals involved in similar work about their experiences with and knowledge of abuse. This phase of activity involved research on the topic to clarify what elder abuse was, who was at risk of being abused and why it happened? As discussed in the literature review there is little consensus on any of these questions. Nevertheless a picture is emerging about elder abuse, and even if the edges are blurred there is enough information to tell us that abuse is a significant problem and to give some guidelines on how to address the issue. This investigative phase allowed me, alone and in concert with others, to gain some picture of elder abuse, to understand how complex an issue it is and to develop beginning ideas on how to deal with the problem.

There were also periods of 'thinking, analysis and reflection' on all I had read, seen and heard. I analysed the images of abuse seen by victims and abusers as well as the theoretical images of abuse, how to deal with it and how to define and describe the situation to workers who respond to abuse. Upon reflection and case analysis I came to hypothesise three causes of elder abuse. These included the attitudes, characteristics and behaviours of the abuser, the environment and context in which the abuse occurred and the socio structural factors that contributed to the abuse. One further factor that appeared to be related to, but not a cause of, elder abuse included the characteristics and behaviours of the older person who was the victim of abuse. Extensive personal reflection, alone and with clients, on how these clients saw their abuse and felt about our interventions in their case also guided my hypothesising on causes, and on the best ways of 'acting' or intervening in abuse cases and in preventing abuse.

The 'action' outcomes of the 'thinking' phases of my early learning about elder abuse are evident in the original protocol (Kingsley, 1993). This phase of thinking, analysis and reflection has also had an evolving influence on other clinical and education activities, on work with perpetrators and the general community, and on my scholarly work on elder abuse over the years. The outcomes of this clinical and conceptual growth are evident in the direction and content of the recent protocol (Kingsley, 2000a).

This cyclical process was completed many times during the development of each protocol, but especially for the second document as I recognised the need to take extra steps to involve as many stakeholders as possible. Workers, community agencies, government, non government and peak bodies critiqued and trialled the document and their feedback was included. In writing the first protocol I was less conscious of CBAR processes and, even though many people participated, I was more conscious of linking Freire's 'knowing and doing' than of working through a specific process. I did this by including information in the protocol on the concept of elder abuse, on the categories of abuse and the potential causes relating to victims, to abusers and to the context within which care is given. I also included material that gave guidelines for preventing and dealing with abuse.

The ongoing cycle of CBAR will continue with current research with the Curtin University Centre for Research into Aged Care Services on the prevalence of elder abuse in Western Australia and the evaluation of the second protocol. When the evaluation is complete there will be room for more redefining of the situation, more thought and reflection on why things are as they are, and more ideas on what ought to be done to address the problem of elder abuse. If a third protocol or future programs are ever developed, different actions that can be taken to implement new information and ideas will be included in these activities.

Participant Stakeholders in the Community-Based Action Research Process

At first thought it might seem logical to include victims and abusers as the two main categories of stakeholders who participate in the process of dealing with elder abuse. However, to be inclusive a third group, the workers who identify and deal with abuse cases, also need to be included as participants in the CBAR process. Rice and Ezzy (1999) agree that involving field workers in the process helps to sensitise them to the needs and problems of the community, a factor that is essential if professionals are to work successfully with community clients to resolve their abuse. Essentially these three groups comprise those who experience abuse, those who abuse and those who work to prevent and resolve abuse.

One further group comprises the organisations that make policy, the bodies that fund and administer aged care, plus the agencies that advocate on behalf of older people. Government and policy agencies that deal with aged care and peak bodies that represent older people may not constitute a separate group of stakeholders but nevertheless, as interested parties, they need to have some participative voice in the process. Ideally, as a more distant or indirect stakeholder group, they will take an active role in supporting the work to resolve the problem of elder abuse and will advocate for adequate funding, resources and legislative support to allow the three main stakeholder groups to act to minimise abuse.

Use of this grouping of participants in the CBAR process foreshadows the three general areas of practice and scholarly work that comprise this thesis. These areas include the innovative community activities with older people who are actual or potential victims of abuse, the development of a program to work with the perpetrators of abusers, and the initiation, conduct and evaluation of professional education programs for those who respond to and deal with abuse. Much of the more clinical work that forms the background for the thesis studies was conducted with the support, and under the umbrella, of the fourth and more bureaucratic group of participants in this process.

Conclusion

Stringer (1996) was unlikely to be thinking of elder abuse when he developed his process of CBAR. However, experience suggests CBAR demonstrates a positive fit with practical and outcome based community research into the issues of dealing with elder abuse. The theoretical perspectives of CBAR have had a major influence on the process and direction of my practical work and in turn they have had a significant albeit indirect influence on the conceptual development of my scholarly work. As Stringer has said, CBAR is a collaborative approach of assessment and intervention to address community problems, this process gives a participative framework whereby these problems can be resolved by those who experience them in their personal, community and professional lives.

This appendix outlined the principles of CBAR and applied the theoretical rationales of the process to the practice setting. This application justifies the use of CBAR as a legitimate method for dealing with elder abuse whether it should occur in the domestic or residential care. The participatory process has been appropriate for most of my work as it is a process of qualitative study that is both academically rigorous and socially responsive (Stringer, 1996). Throughout my work I have applied this theoretical base both practically, for example in the use of interactive drama in the community education forums, and theoretically in the linking of this research process to my ways of knowing about elder abuse.