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From Suspicion to Intervention:

Improving responsiveness to abuse of the elderly in acute and sub-acute healthcare

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Student Number: 122400

A thesis submitted in fulfillment of the degree of

Doctor of Philosophy

Melbourne School of Health Sciences

The University of Melbourne

November 2017

Completed under the supervision of:

Professor Lynette Joubert

Associate Professor Marie Gerdtz

DECLARATION

This is to certify that:

(i) the thesis comprises only my original work towards the PhD

(ii) due acknowledgement has been made in the text to all other material used,

(iii) the thesis is less than 80,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Meghan O'Brien

ABSTRACT

Background: Elder abuse is a recognised form of family violence. It is an act of harm towards an older person by someone known to them - usually within their family network or trusted social environment. Because of the private nature of elder abuse, it remains a hidden problem. Hospitalisation has been identified as offering a "window of opportunity" (Joubert & Posenelli, 2009) to support older people at risk of abuse however very few health professionals have received any training alerting them to issues of elder abuse (Dow et al., 2013). For this reason, health professionals need to be equipped with the required knowledge to be both confident and competent in supporting older people at risk of abuse.

Thesis Aims: This thesis is nested with an Australian Council Linkage Grant study - number LP0989536. The aims of the research are:

- To identify the barriers to health professionals' identifying and responding to suspected elder abuse
- To examine current knowledge on elder abuse and to describe models, approaches and frameworks for identifying and/or responding to elder abuse, including the education and training of health professionals
- To develop an evidence informed elder abuse training intervention for health professionals working with older people in an acute, sub-acute and Emergency Department setting
- To implement the training intervention and evaluate its impact on the awareness, knowledge and confidence of health professionals working at the study site, in facilitating their responsiveness to suspected elder abuse

Methodology: This research has applied a sequential, mixed methods design (Creswell, 2003); across four interrelated phases. The explanatory sequential design (Plano Clark, 2011) was fixed in that it was predetermined and planned at the commencement of the research to collect analyse, and interpret both quantitative and qualitative data in a single study to investigate the same underlying phenomenon (in this case elder abuse) and training targeted health professionals to identify and respond.

Phase 1: involved an extensive examination of both peer reviewed and grey literature to scope key themes - elder abuse and the health context; theoretical perspectives, the models and frameworks in place in hospital contexts for responding to elder abuse as well as effective training strategies and approaches for health professionals. The phase involved further inquiry to identify the barriers to responding to elder abuse and how these might be

addressed as part of this study. A descriptive design was used and included feedback from health professionals with different roles and years of experience at the study site to obtain their perspectives via a confidential online staff survey, focus groups and in-depth interviews (n =300).

Phase 2: considered the key components needed for the training intervention – the content, the targeting or selection of trainees and effective strategies or methods for delivering the training. This phase entailed conceptualisation and decision-making in relation to the knowledge, ideas and insights generated by the findings of Phase 1 to inform the development of the training intervention.

Phase 3: focused on application of the knowledge synthesis and decisions made in Phase 2 to inform development of the tools and products for the training package at the study site. In this phase, consideration was given to relevant features of the policy context. This phase describes the outcomes achieved at the study site which includes a governance framework relating to the protection of vulnerable older people which was developed and implemented to support the roll out of the training intervention as part of this study.

Phase 4: applied a pre - post test to determine the effectiveness of the training intervention. The training intervention was evaluated by measuring changes in knowledge and confidence to act on suspected elder abuse in a hospital setting for a targeted group of experienced health professionals. This phase used a quasi – experimental design to test the effectiveness of the training intervention.

Results: The outcomes of this study have resulted in identifying and analysing the perceptions, barriers and knowledge of health professionals regarding the problem of elder abuse. This has included targeted training through a competence based framework and the development of a governance framework, hospital wide policy and a model of care. The findings from the evaluation of the training intervention demonstrate that the training package which included an evidenced informed training DVD was successful in increasing the participants' level of suspicion and the level of confidence to deal with suspected elder abuse cases. There have been several other unintended outcomes of this research. While the training package was developed to meet the aims of this study there have been significant changes in clinical practice at the study site. Training health professions in relation to indenting and responding to elder abuse has been embedded into practice and has resulted in significant systems change including ongoing data collection at the study site relating to cases of suspected elder abuse.

DEDICATION

This thesis is dedicated to my friend and mentor Ms Sonia Posenelli. Without her unconditional support, vision and leadership I would not have had the courage or commitment to take this journey. No words will ever be able to express my gratitude to her for all she has done in supporting my social work career and keeping me focused when everything seemed impossible. I would also like to thank her for reading every single word of my thesis and for her invaluable contribution in strengthening our work at St Vincent's Hospital in supporting older people at risk of elder abuse.

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To my mum for everything she has done and continues to do for me. I love her with all my heart and she has shaped me into the person I am today. I made a promise to my dad just before he died that I would finish my PhD and I am sure that he has helped me get to the finish line. Finally, thank you to my sisters Carmel and Lucy for being so proud of me and for your sense of humor and jokes along the way.

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GLOSSARY OF TERMS

The following glossary arranged in alphabetical order, lists the definitions of terms commonly used in this thesis:

Australian Bureau of Statistics (ABS)	Australia's national statistical agency providing official statistics on a wide range of economic, social, population and environmental matters.
Aged Care Assessment Service (ACCS)	The Aged Care Assessment Service assists frail, older people and their carers identify what kind of care will best meet their needs.
Aboriginal Hospital Liaison Officer (AHLO)	The Aboriginal Hospital Liaison Officer delivers culturally appropriate care across an organiastion.
Assessment Liaison Early Referral Team (ALERT)	ALERT provides coordinated care for clients who present to the Emergency Department (ED) with complex psychosocial and medical needs, aiming to prevent or reduce the need for clients to present to the ED.
Australian Institute of Family Studies (AIFS)	The AIFS is the Australian Government's key research body in the area of family wellbeing.
Australian Research Council (ARC)	A Commonwealth entity that advises the Australian Government on research matters, administers the National Competitive Grants Program, a significant component of Australia's investment in research and development, and has responsibility for Excellence in Research for Australia.
Department of Health and Human Services (DHHS)	A Victorian Government department that deliver policies, programs and services that support and enhance the health and wellbeing of all Victorians.
Elder abuse	"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"(World Health Organization, 2002).
Education	Education is the process of facilitating learning, or the acquisition of knowledge, skills, values, beliefs, and habits. Educational methods include storytelling, discussion, teaching, training, and directed research.
Emergency Department (ED)	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care.
Family Violence (FV)	Family and domestic violence is any violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships. This includes not only physical injury but direct or indirect threats, sexual assault, emotional and psychological torment, economic control, damage to property, social isolation and any person which causes a person to live in fear (Family Protection Act 2008).
Geriatric Evaluation and Management (GEM)	GEM units utilise the expertise of health professionals to achieve the best outcomes for older patients.
Governance	Governance ensures the governing body, managers, clinicians and their staff are responsible and accountable for the safety and quality of care they provide.
Health Justice Partnership (HJP)	A HJP integrate legal assistance as an element of a health care team. A HJP address social and health issues that may manifest in the form of a legal problem.

Health Professionals	Qualified professionals who work within the health care system to provide health care services to individuals, families and communities
Hospital Admission Risk Program (HARP)	HARP is a coordinated multidisciplinary team consisting of allied health staff who manage patients with complex care needs and chronic disease.
Mandatory Reporting	The obligatory reporting of a particular condition such as elder abuse to local, state or national health authorities.
Person of Concern (POC)	Person(s) suspected of perpetrating abuse towards an older person
Power of Attorney (POA)	Legal documents that enable someone appoint another person who can make decisions for them or support them to make and give effect to their own decisions.
Safeguarding	Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.
Senior Rights Victoria (SRV)	Provides information, support, advice and education to help prevent elder abuse and safeguard the rights, dignity and independence of older people.
St Vincent's Health Australia (SVHA)	The nation's largest Catholic not-for-profit health and aged care provider. A clinical, research and education leader working in private hospitals, public hospitals and aged care services in Australia.
St Vincent's Hospital Melbourne (SVHM)	A tertiary public healthcare service providing a range of services, including acute medical and surgical services, emergency and critical care, aged care, diagnostics, rehabilitation, allied health, mental health, palliative care and residential care.
Training	Training is teaching, or developing in oneself or others, any skills and knowledge that relate to specific useful competencies. Training has specific goals of improving one's capability, capacity, productivity and performance.
United Nations (UN)	The United Nations (UN) is an intergovernmental organization to promote international co-operation. Its objectives include maintaining international peace and security, promoting human rights, fostering social and economic development, protecting the environment, and providing humanitarian aid in cases of famine, natural disaster, and armed conflict.
Vulnerable Older Person (VOP)	An older person aged 65 and over at risk or experiencing Elder abuse.
Royal Commission into Family Violence (RCFV)	The Royal Commission into Family Violence inquired into and reported on how Victoria's response to family violence could be improved by providing practical recommendations to stop family violence. The Royal Commission provided its report and 227 recommendations to the Victorian Government on Tuesday, 29 March 2016.
World Health Organization (WHO)	A specialized agency of the United Nations that is concerned with international public health.

PREFACE

Preceding Pilot Survey

It is important to understand that this current research was informed by a pilot study conducted at the study site in 2005. The findings from the pilot study informed the submission which resulted in this Australian Research Council (ARC) linkage project being undertaken. This pilot study identified a significant gap in health professionals' confidence to act on suspected elder abuse.

The aim of the pilot study in 2005 was to examine health professionals' recognition and management of elder abuse at the study site. The research design had two phases. In phase 1 - 166 staff were surveyed which included allied health, medical and nursing staff who worked in the Emergency Department and in acute and sub-acute wards across the organisation. Using a self-report questionnaire, health professionals from the different clinical backgrounds were asked to identify and discuss any incidents of situations of suspected elder abuse. This data was analysed in four different timeframes: previous one month, three month, six month and twelve month time periods (Joubert & Posenelli, 2009)

Phase two of the research design involved individual staff interviews using a semi-structured questionnaire format. The types of responses explored related to the detection, management, referral and follow-up of the elder abuse cases that they had identified in the survey. The data was qualitatively analysed for thematic content relating to the incidence of elder abuse as well as management protocols. A focus group was held with all staff consenting to the interview (Joubert & Posenelli, 2009)

Analysis of the survey data (n = 166) confirmed that the respondents came from the following backgrounds: nursing, medical, and allied health professionals. Of these staff, 77% stated that they were familiar with the concept of elder abuse. However, only 14% of clinical staff had received any education or training on how to respond if they suspected elder abuse. Of the sample group 32% of respondents indicated that they had a good understanding of elder abuse while 54% reported they had a fair to poor understanding of elder abuse. Of interest, 47% of the respondents reported that they had never suspected any incidents of elder abuse in the previous twelve months (Joubert & Posenelli, 2009).

In reference to how elder abuse was suspected: respondents reported elder abuse suspicion was based on direct clinical observation of the patient and their family or carer in 22% of cases, during routine assessment in 46% and lastly in 32% of cases the older person was

referred to them by another member of the staff (32%).The highest percentage of suspected elder abuse was undertaken by an adult child (39%). Similar percentages were reported for the spouse, carer, and staff in a residential care facility (10%) (Joubert & Posenelli, 2009).

The results of the pilot study (2005) suggested that elder abuse could be managed through timely and appropriate response and intervention strategies (Joubert & Posenelli, 2009). The results from the survey reported that a collaborative response across the health service could be effective in responding to the complexity of elder abuse in a hospital context. The pilot project undertaken in 2005 was a joint collaboration between the Social Work Manager at St Vincent's Hospital, (Ms S Posenelli) who engaged with the University of Melbourne (Professor L Joubert) in developing and evaluating the need for a pathway for vulnerable older patients. The outcome of this Pilot Study supported a submission to the Australian Council Research Linkage Project to further expand the preliminary work undertaken as part of the 2005 pilot study.

Elder abuse has become an all-encompassing professional interest for me spanning my professional social work career over the last twenty years. I first became aware of elder abuse when I worked in a community Aged Care Assessment Team. From my first clinical experience when I was exposed to the needs of vulnerable older people I decided to pursue a career committed to working with older people. My ongoing studies have followed this pathway. These studies and my clinical experience in a number of hospitals across Victoria have led me to undertake this important research in my current workplace as a Senior Social Worker.

CHAPTER 1 - INTRODUCTION

This thesis aims to evaluate the feasibility of developing and introducing a training intervention to support health professionals at the study site to respond to suspected elder abuse. This chapter will provide background to the topic and describe the study setting. It will outline the research aims, questions, scope, design and methodology, as well as describing the four phases of the research.

At the time of writing this thesis, there is no evidence to support a best practice model for hospital staff regarding the management of elder abuse. The thesis aims to support health professionals' move: from suspicion to intervention - improving responsiveness to abuse of the elderly in acute and sub-acute healthcare.

This chapter will introduce The Knowledge to Action Framework as a practice framework and its utilisation as a 'road map' to assist by drawing on available knowledge regarding the detection of and response to elder abuse and using this knowledge to inform subsequent phases of this study.

1.1 Background

Elder abuse is a recognised form of family violence (Royal Commission Family Violence (RCFV), 2016). It is an act of harm towards an older person by someone known to them - usually within their family network or trusted social environment. Elder abuse has been identified as both a medical and social problem which can have devastating consequences for an older person.

Elder abuse is a complex issue, encompassing a wide range of negative outcomes which have the potential to greatly affect the lives of older people (McCreadie, 2002). The impact of elder abuse on older people can include both physical and mental health problems, feelings of social isolation due to reduced social networks, financial loss and in some situations increased risk of death (Dong et al., 2009). The characteristics associated with elder abuse include: cognitive Impairment (Wiglesworth et al., 2010); social isolation (Lachs et al., 1994); lower household income, need for assistance with activities of daily living (Acierno, 2009), and previous traumatic event (Acierno, 2009).

Further issues for the older person include depression, anxiety, fear, feelings of unworthiness and other psychological stressors (Dong et al., 2013). Elder abuse has also been associated with substance abuse in older people and suicide (Kaye, Kay, & Crittenden,

2007). These effects will be described in more detail in chapter 2 as part of the literature review.

According to the World Health Organization (WHO) (2014) elder abuse remains one of the most complex and challenging situations any health professional will face and it is a serious issue that undermines the independence, dignity, health and sense of security of an older person. Preventing and responding to elder abuse requires greater profiling of the problem within our community, resources to effectively respond and appropriate strategies to assist in dealing with elder abuse. The WHO states that healthcare professionals who routinely interact and assess older people are well placed to identify those at risk of abuse and also to provide support to those experiencing abuse (WHO, 2011).

The literature suggests that health professionals in hospitals are well positioned to identify and respond to elder abuse (Dong, 2012; RCFV, 2016) because of the association between older people and the utilisation of the hospital system. It has been suggested that hospitalisation offers a 'window of opportunity' (Joubert & Posenelli, 2009) to support older people at risk of abuse. Education has been identified as a critical strategy to assist in the prevention of older people at risk (Walsh et al., 2007; RCFV, 2016). However very few health professionals have received any training relating to issues associated with elder abuse (Dow et al., 2013). The research seeks to address these challenges and opportunities.

1.2 The Research Setting

The study site for this research was St Vincent's Hospital Melbourne (SVHM), a health service which is part of Australia's largest not-for-profit health and aged care service provider. SVHM is governed by a national body, St Vincent's Health Australia (SVHA) (formerly known as the Sisters of Charity Health Service). As a tertiary public healthcare service, SVHM provides acute medical and surgical services, emergency and critical care, aged care, diagnostics, rehabilitation, allied health, mental health, palliative care and residential care. The organisation works with a number of stakeholder partners to deliver high quality treatment, teaching, education and research. SVHM has more than 6,100 staff and 880 beds across multiple services in Melbourne. These services include St Vincent's Hospital Melbourne in Fitzroy, St George's Health Service in Kew, Prague House and Caritas Christi Hospice, also in Kew.

In June 2015 St Vincent's Health Australia launched '*enVision 2025'*, a 10-year strategic plan for the group and its three divisions: Public Hospitals, Private Hospitals, and Aged Care. The SVHA group is Australia's 12th largest privately held company, with 27 public and private hospitals and aged care facilities along the eastern seaboard. The strategy *enVision 2025*

invites all SVHA staff to '*serve* something greater, *see* something greater and *strive* for something greater' (SVHM Annual Report 2015). This plan reflects not only a striving for excellence; it also reflects that the work of the organisation is underpinned by its mission and core values. The organisation – at both a local and national level – has a historical and enduring commitment to vulnerable populations. The study setting is therefore one in which seeking to improve responsiveness to older people at risk abuse, has a degree of 'fit' with the organisation's commitment to social responsibility.

1.3 Research Aims

The aims of the research are:

- To identify the barriers to health professionals' identifying and responding to suspected elder abuse
- To examine current knowledge on elder abuse and to describe models, approaches and frameworks for identifying and/or responding to elder abuse, including the education and training of health professionals
- To develop an evidence informed elder abuse training intervention for health professionals working with older people in an acute, sub-acute and Emergency Department setting
- To implement the training intervention and evaluate its impact on the awareness, knowledge and confidence of health professionals working at the study site, in facilitating their responsiveness to suspected elder abuse

1.4 Research Question

To address the research aims, the following question is posed:

- Can a training intervention improve the responsiveness of health professionals in responding to suspected elder abuse?

1.5 Scope of the Research

The study focuses on health professionals working in a hospital setting in the Emergency Department and acute and sub-acute wards. It seeks to improve health professionals' responsiveness to suspected elder abuse, enabling them to move from suspicion to intervention. It does not try to explain the causes of elder abuse or measure prevalence

within a health context. Instead the study seeks to address elder abuse training needs and to evaluate the impacts of an elder abuse training intervention.

1.6 Research Design, Methodology and Scope

Health care systems in Australia are becoming more complex, impacted by population ageing, the rise in chronic and complex diseases and resource constraints. Social, political, environmental, cultural and economic forces contribute to the complexity of health care management (Lavelle et al., 2013). As the system increases in complexity, so do the challenges in practice based research within a health context that embrace the multidimensional nature of health issues (Creswell & Plano Clark, 2011).

This challenge has resulted in interest around mixed methods research in recent years in the fields of social science, education and health (Glogowska, 2011). Mixed methods research offers a methodology to address complex issues in a way that is more comprehensive than purely quantitative or qualitative research (Creswell & Plano Clark, 2011).

This thesis has applied a sequential, mixed methods design (Creswell, 2003) across four interrelated phases. The explanatory sequential design (Creswell & Plano Clark, 2011) was fixed in that it was predetermined and planned at the commencement of the research to collect, analyse, and interpret both quantitative and qualitative data in a single study to investigate the same underlying phenomenon, in this case elder abuse and training health professionals to respond.

Four sequential, inter-related phases were underpinned by different research methodologies and data analysis approaches. The Knowledge to Action Framework (Graham et al., 2006) was used as a 'road map' to guide the key phases of the study. These included knowledge inquiry, to synthesis of the knowledge.

1.7 Conceptual Framework

A framework represents the synthesis of literature on how to explain a phenomenon (McGaghie et al., 2001). It maps out the actions required in the course of the study based on other researchers' points of view and observations on the particular subject (McGaghie et al., 2001). As McGaghie et al. (2001) suggested, a framework "sets the stage" for the presentation of the particular research question that drives the investigation being reported, based on the problem statement. The problem statement of a thesis presents the context and the issues that caused the researcher to conduct the study. A framework serves as a conceptual hook upon which hang study procedures, analysis, and re-presentation. Findings

are presented in straightforward language that clearly describes the phenomena of interest (Colorafi & Evans, 2016).

1.7.1 Knowledge to action framework.

The Knowledge to Action Framework has underpinned the phases of the research resulting in the implementation of the St Vincent's Hospital organiastion wide response to elder abuse.

The Knowledge to Action Framework (Graham et al., 2006) is a practice framework which originated in Canada and is intended to help those concerned with knowledge translation to deliver sustainable, evidence informed interventions. Graham et al., (2006) reviewed thirty-one planned-action theories resulting in the development of the Knowledge to Action Framework. This framework supports the synthesis, dissemination, exchange and sound application of knowledge to improve more effective health services and strengthen the health care system' (Graham et al., 2006).

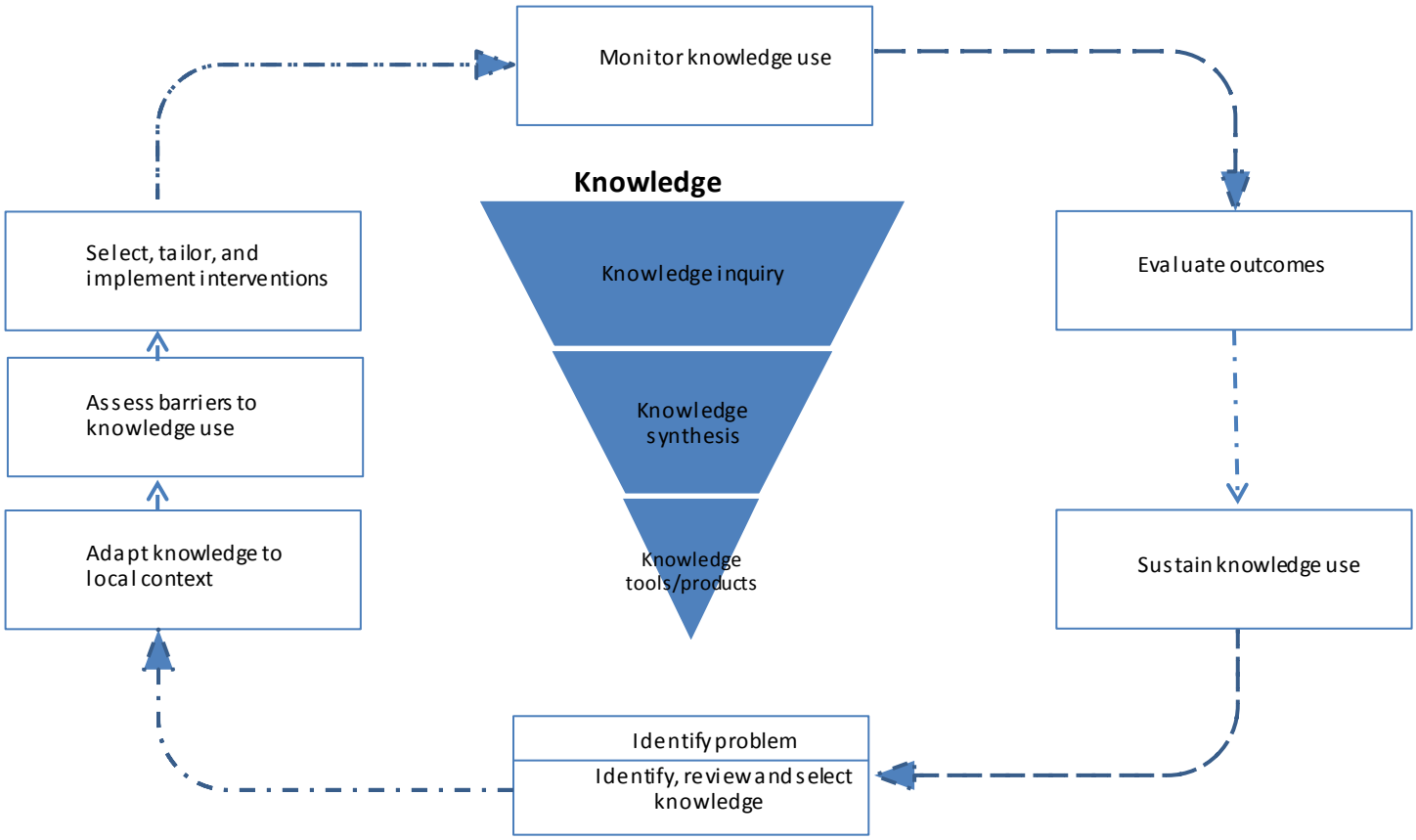
The Knowledge to Action Framework is commonly employed for the transfer of research knowledge into practice. It can be broken down into two concepts: knowledge creation and the action cycle. This study has focused on knowledge creation which includes the important steps of inquiry (e.g. primary research), synthesis, creation of tools or products and the evaluation of the tools. (e.g. guidelines, decision-making tools) (Graham & Tetroe, 2007).

The Action Cycle is the implementation of the knowledge. The application of the knowledge from this research to the study site and beyond will be outlined in chapter 7 – the post script.

In the context of health care, the implementation of knowledge in real life can be met with barriers. Therefore, available research data and literature needs to be synthesised and the resulting knowledge contextualised prior to implementation. Moreover, interventions to introduce evidence informed knowledge in practice may need to be tailored to individual study sites (Graham et al., 2006).

Knowledge generation and the implementation of existing and new solutions is an intricate cyclical process has been summarised by Graham et al., (2006) as the 'Knowledge to Action Framework' below:

Figure 1: Knowledge to Action Framework (Graham et al, 2006)



The application of the Knowledge to Action Framework supports the aims of the thesis by drawing on available knowledge regarding the detection of and response to elder abuse and using this knowledge to inform subsequent phases of this study. Importantly knowledge inquiry and its synthesis informed the development and evaluation of the subsequent phases of the research process from the online staff survey to the evaluation of the training intervention. In the next section, to facilitate flow and to assist the reader the Ecological and Competency Framework will be introduced.

The inclusion of the Ecological Framework and the Competency Framework has complimented the research design and application to practice. The Ecological Framework will be described in detail in chapter 2 and the Competency Framework will be discussed in chapter 5.

1.7.2 The Ecological framework.

The Ecological Framework states that elder abuse is a complex issue, embedded in individual, relationship, community and societal factors. It focuses on the relationship of the processes that link the individual to their family, community or hospital system. The literature supports the use of this framework and suggests that it can be applied to the health context

in understanding the phenomena of elder abuse and the role that health professionals can play in prevention and response (Norris et al., 2008).

The thesis draws on the framework because it helps to identify, categorise and evaluate interventions that take into account the multiple, yet interlinking, levels and approaches in responding to elder abuse (O'Donnell et al., 2012). Ecological theory draws parallels with the practice of health professionals in responding to elder abuse because it takes a holistic approach towards understanding the older person as a total person in the context of their own environment and the interface with the hospital system.

Ecological theory was applied to this study to examine interventions from the perspective of the older person as well as the environmental, social and cultural systems in which the individual is situated. This framework underscored the need to consistently be mindful of both the hospital context and policy context in developing the training intervention.

At the outset the study sought to take a holistic approach which places the older person at the centre of the work and takes into account micro, meso and macro systems to understand the issues and frame a response. This meant that it was essential to understand elder abuse from the perspective of the older person within the family and community (the micro system), to situate the problem and possible responses in the hospital or environmental context (meso system) and, in developing the proposed response or intervention, to be mindful of the policy environment – state, national and global (macro system).

In developing the training intervention it was seen as important that this would be congruent with current frameworks and approaches to delivering training in hospital settings and consistent with policy directions in education in health care in Victoria.

1.7.3 Competency framework.

The role of competency development is a strong theme in the literature relating to workforce development in health care. The development and use of competency standards has been identified as an emerging factor in supporting health professionals' education and training. It has been suggested that training programs should also focus on the competencies required for protecting older people from abuse (DeHart et al., 2009).

However, a thorough review of health professional education literature reveals that little attention has been given to the training requirements needed for health professionals in relation to elder abuse. This appears to be a significant gap needing further attention and effort. Consideration of what competencies are needed for health professionals who have

different roles and levels of experience in recognising and responding to elder abuse, needs further examination.

This study examined the available literature to guide the development and design of a training intervention for health professionals using the principles of the Allied Health Competency Framework (Victorian Department of Health and Human Services, 2014). At the core of this framework is the concept of knowledge translation for health professionals (Department of Human Services, 2009). This framework seeks to understand and develop strategies to narrow the research and practice gap to facilitate the use of available evidence as part of everyday practice.

Using the 'road map', the following diagram provides an illustration of the connection between the research aims, the research design, conceptual frameworks used, methodological approaches and the intended outcomes. The following table (Table 1) provides an overview of the research phases, designs, frameworks and intended outcomes of this study.

Table 1: Overview of the research phases, designs, frameworks and intended outcomes

Design	Elements /Actions	Methodology	Framework (as relevant)	Intended Outcomes
Sequential mixed methods Creswell (2003); Plano & Clark (2007)	**Phase 1: Inquiry & Descriptive Analysis** Aims: To identify key themes including the barriers to health professionals responding to suspected elder abuse			
	Literature Review	Interpretation and Synthesis of the published and available material (secondary sources) (Polit et al., 2001)	Ecological Framework (Brofenbrenner, 1979)	Scoping review of peer reviewed and grey literature. Key themes will be identified and findings described which are pertinent to the research aims. Key elements of the Ecological framework will be applied to understand the complex issue of elder abuse and how it might be addressed in a health context. This includes micro factors (patient, family and community); meso factors (the hospital context) and macro considerations (the policy context).
	Online staff survey	Quantitative (Polit and Hungler, 2013)	Descriptive exploratory research (Burns and Grove 2009)	The findings will inform the design of the qualitative data collection instrument for use via focus groups and interviews regarding the barriers for health professionals
	Focus Groups & individual interviews	Qualitative (Cresswell & Plano Clark, 2007)	Ritchie and Spencer Framework (1994). The four categories outlined in the framework will be used to answer a range of questions – contextual, diagnostic, evaluative, strategic.	Findings will provide a picture of the participants. Qualitative data will be ordered around key themes to help to understand the knowledge and attitudes of health professionals at the study site and their perspectives regarding barriers and enablers in responding to elder abuse. From these findings descriptive and explanatory conclusions will be drawn.

Design	Elements /Actions	Methodology	Framework (as relevant)	Intended Outcomes
Sequential mixed methods Creswell (2003); Plano & Clark (2007)	**Phase 2 : Knowledge Synthesis** **Aim:** To use the findings of Phase 1 to conceptualise what is required & make decisions regarding the training intervention based o n the findings of Phase 1.			
	Conceptualisation of the training intervention	Knowledge enquiry, synthesis and the creation of tools and products	Knowledge to Action Framework (Graham et al., 2006)	The approach to the training intervention will be decided including the content, selection of staff to be trained and the strategies and methods to be adopted.
	Conceptualisation of the intervention	Review of evidence informed Government policy	Competency Framework (Department of Health and Human Services, 2014)	Development of the training intervention will be informed by evidence and strategic directions in relation to workforce training and development in the Victorian health care context, to ensure policy 'fit.
	Phase 3 **Aim:** Development of Tools and Products for the training intervention.			
	Development of the elder abuse training intervention	Development of evidence informed knowledge in response to the problem	Knowledge to Action Framework (Graham et al., 2006)	Knowledge and decisions from Phase 2 will be applied. This will result in the development of tools and products for the training and into practice/trialled at the study site. It is expected that some organisational process or systems changes at the study sight may be required. Any outcomes achieved in this regard will be highlighted.
	Phase 4 **Aim:** To undertake a pre – post-test to determine the effectiveness of the training intervention for health professionals to respond to suspected elder abuse			
	Testing the effectiveness of the training intervention	A quasi-experimental method was used with a pre-test and post-test design (Creswell, 2013)	Descriptive exploratory design Burns and Grove (2009)	This phase will determine whether the training intervention has impacted the responsiveness to elder abuse by health professionals in the intervention group at the study site and whether or not the findings are statistically significant and can inform future research in this area.

1.8 The Research Phases

Knowledge inquiry and its synthesis informed the development and implementation of the training intervention. The four phases will now be described:

1.8.1 Phase 1 – Inquiry and descriptive analysis.

Aims:

To extensively examine both peer reviewed and grey literature to scope key themes - elder abuse and the health context; the models and frameworks in place in hospital settings for responding to elder abuse as well as effective training strategies and approaches for health professionals.

To identify barriers for health professionals in responding to elder abuse and how these might be addressed as part of this study. A descriptive design was used and included feedback from health professionals at the study site to obtain their perspectives via a staff survey, focus groups and in-depth interviews.

1.8.2 Phase 2 – Knowledge synthesis.

Aim:

To consider the key components of the elder abuse training intervention – the content, the targeting or selection of trainees and effective strategies or methods for delivering the training.

This phase entailed conceptualisation and decision-making in relation to the knowledge, ideas and insights generated by the findings of Phase 1 to inform the development of the training intervention.

1.8.3 Phase 3 - Development of the training Intervention.

Aim:

This phase was informed by Phase 2, to develop and trial the tools and products for the training package at the study site. This phase was characterised by knowledge enquiry and synthesis to support the creation of tools and products.

This phase describes the outcomes achieved at the study site which included a governance framework relating to the protection of vulnerable older people which needed. This phase presents a synthesis of research findings regarding effective intervention and service delivery for the management of elder abuse by health professionals working in a hospital context.

1.8.4 Phase 4 – The Evaluation Phase

Aim was to undertake a pre - post test evaluation to determine the effectiveness of the training intervention. The training intervention was evaluated by measuring changes in suspicion and confidence to act on suspected elder abuse in a hospital setting for a targeted group of health professionals. This phase used a quasi – experimental design to test the effectiveness of the training intervention.

The next section will briefly outline the key conceptual frameworks which emerged from the examination of the literature which were of relevance for the study.

1.9 Summary and Evaluation of the Current Situation

This thesis will outline current knowledge on the problem of elder abuse; describe models and approaches to responding to elder abuse within international and Australian contexts; identify barriers and gaps for health professionals in a hospital context in responding to elder abuse; and consider questions relating to training and education. These themes will be covered in depth in Chapter 2. It is important at this point to make some general comments on the current 'state of play' in relation to elder abuse, the fact that it is under-reported and the role of the health system.

Progress towards understanding elder abuse and developing effective response and prevention measures, is thought to be less well developed than in other areas of family violence (WHO, 2014). Responses to the prevention and management of elder abuse sit within a range of policy and practice structures across different levels of government, justice frameworks and across non-government organisations. All jurisdictions in Australia have adopted a human rights approach to elder abuse, as opposed to a protective and mandatory reporting approach (AIFS, 2015).

It is important to highlight that elder abuse is now recognised as a form of family violence which continues to remain hidden (RCFV, 2016). Complex family dynamics are relevant to consideration of the current situation relating to our response and prevention of elder abuse

(RCFV, 2016). There is often discomfort with discussing elder abuse as well as a culture of secrecy and shame that is associated with elder abuse (WHO, 2008; Office of the Public Advocate, 2006).

According to the World Health Organization (2008), 80 per cent of elder abuse is unreported. Dow et al., (2013) suggest that under-reporting appears to be directly related to issues of family bonds and fear of any repercussions which may occur as a result of reporting any type of elder abuse to anyone outside of the family system. It is now widely accepted that elder abuse cases are not reported by older people because of shame, embarrassment and fear (Dow et al., 2013).

Health professionals have been recognised playing a critical role in identifying and responding to elder abuse because of the interface that older people have with the hospital system (Joubert & Posenelli, 2009). However, health professionals lack specific education and training in both the recognition of symptoms of elder abuse and the strategies for intervention (Dow et al., 2013). The findings of published literature suggest understanding the training needs of health professionals is a critical first step, adapting training content to make it relevant to health professionals' practice and tailoring and targeting of training programs. However, there is limited evidence to demonstrate the impact of educating health professionals to improve their response to suspected elder abuse.

These important considerations informed the development and evaluation of a multifaceted training package to improve responsiveness to elder abuse by health professionals working in a hospital setting. In the next section the significance of the proposed research will be discussed.

1.10 Significance of the Proposed Research

Elder abuse is a significant medical and social problem that crosses all boundaries of society and has both physical and emotional impacts on an older person's health and wellbeing (WHO, 2008). This thesis is timely in light of the ageing of the population in Australia (ABS, 2013) and estimates that by 2030 one quarter of Victoria's population will be over the age of 65 years (Victorian Department of Human Services, 2009).

Expected growth in the numbers of older Victorians who may be subject to elder abuse is driven by three factors; increasing numbers of older people living than previously recorded, increasing longevity due to medical advances and technology and increasing numbers of

older people with dementia or cognitive issues (Victorian Department of Human Services, 2009).

Elder abuse is a complex issue, encompassing a wide range of negative outcomes which have the potential to greatly affect the lives of older people (McCreadie, 2002). The costs of elder abuse on the older person can be devastating. Elder abuse can result in higher dependence in activities of daily living (Cohen, 2008), depression (Baker et al., 2009) and premature death (Baker et al., 2009). In addition to the human impacts, at an economic level the estimated cost for Australian hospital admissions due to elder abuse for 2007/2008 was between 9.9 and 30.7 million AUS dollars (Choo et al., 2013). Responding effectively to suspected elder abuse has the potential to benefit older people at risk and also to have broader societal impacts.

At the present time there is increased attention to family violence and the utilisation of the health system (RCFV, 2016). The abuse or harm inflicted towards older people from a partner is recognised as a form of family violence that has 'grown older' (Budd 2010; AIFS 2015). The attention to family violence and the role that health professionals can play is a critical consideration in this research (WHO, 2014).

Hospitalisation has been identified a 'window of opportunity' (Joubert & Posenelli, 2009) to support older people at risk of abuse. However, in spite of the growing awareness of elder abuse, it is currently beyond the scope and capacity of most health services to identify and respond to the challenges in a clinical setting.

There is no uniform or consistent approach to elder abuse across Australia. Chesterman (2015) suggests that attempts to improve strategies have relied on existing services to drive change and implement service improvements for at risk older people. This research aims to support health professionals to move from identifying older people at risk to responding to suspected elder abuse through an evidenced informed training intervention. Importantly this intervention aims to drive improvements in the response of health professionals to elder abuse, through effective training and in a 'real world' setting at the study site. Furthermore the research seeks to develop an approach that is deliverable within existing service provision arrangements and within existing resources.

1.11 Overview of the Thesis

Seven chapters are presented in this thesis.

Chapter 1 (Introduction) will provide background to the topic and describe the research setting. It will outline the research aims, questions, scope, design and methodology, as well as describing the four phases (or the 'road map') for the research.

Chapter 2 (Literature Review) presents an in-depth examination of the literature pertaining to elder abuse. The phenomenon of elder abuse is discussed and the related definitions and terminology used in the thesis are clarified. International and Australian literature is examined on the basis of four emergent themes: the paradigm of elder abuse; review of models and approaches to responding to elder abuse within an international and Australian context; role of health professionals in responding to elder abuse in a hospital context and training and education. The complexity of elder abuse is examined and described in this chapter and linked to the research question. The chapter introduces the Ecological framework which underpins this thesis and helps to identify, categorise and evaluate interventions that take into account the multiple, yet interlinking, levels and approaches in responding to elder abuse.

Chapter 3 (Inquiry Phase and Descriptive Analysis) describes the inquiry phase of this study. This chapter focuses on the barriers to responding to elder abuse and how these might be addressed as part of this study. There is preliminary discussion of the research design including ethical considerations. The chapter also focuses on the descriptive analysis of a confidential online staff survey, focus groups and individual staff interviews findings and provides an overview of the framework used to analyse the qualitative findings. This chapter proposes how the inquiry into the perspectives of staff/health professionals can contribute to the study design and testing the effectiveness of the training intervention.

Chapter 4 (Development of the Training Intervention) focuses on the design of the training intervention providing an overview of the development of the products and tools for the training. This includes a justification for the chosen approach – content, targeting, strategies and methods - and outline of the key findings from the literature and staff feedback which informed the intervention. The chapter describes a Competency Framework which was used to inform the development of competency based training for health professionals which was used for the study.

Chapter 5 (Evaluation of the Training Intervention) describes the methodology and findings from the evaluation of the pre and post training which was developed as part of this thesis. The scope of this phase is also described in this chapter.

Chapter 6 (Discussion and Recommendations). In this chapter the findings will be discussed in relation to the thesis aims. These findings focus on current practices of training health professionals in a hospital context to enable them to act on suspected elder abuse. This chapter will address the thesis conclusion; outline the strengths and limitations of the study, implications for practice and recommendations for future research.

Chapter 7 (Post Script). This chapter will outline the outcomes from this research and how the knowledge gained is being translated into current practice at the study site and beyond, in policy development and in collaboration with key stakeholders such as Government, peak bodies, legal services and other hospitals in Victoria Australia.

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

My literature search seeks to identify, inquire, summarise, and synthesise studies that report on the association between elder abuse and health professionals. This chapter provides a critical review of international published peer reviewed literature regarding the phenomenon of elder abuse. Models and approaches to addressing the problem in practice are described. Barriers to providing an effective response to older people at risk of elder abuse are then considered.

The chapter is organised around four key themes prominent in the literature addressing the problem of elder abuse. These themes include:

- the problem of elder abuse
- review of models and approaches for responding to elder abuse
- responding to elder abuse – the role of the health services
- education and training for health professionals in detecting and responding to elder abuse

This chapter reports the methods and outcomes for the first phase of the study. An extensive examination of both peer reviewed and grey literature was undertaken to describe, scope and critically examine definitions for elder abuse in the health context; the models and frameworks currently in place in hospital contexts for responding to elder abuse as well as effective approaches and strategies for health professionals. The chapter concludes by discussing the implications for the literature review and how they apply to the thesis.

2.2 The Search Strategy

A comprehensive literature search of peer reviewed published works was undertaken to identify elder abuse interventions targeting older people within a health context. These interventions included a review of organisational approaches to support health professionals identify and respond to elder abuse, governance arrangements and training strategies. Elder abuse is recognised by health professionals as both a medical and social problem. For this reason relevant citations appear in both medical and social-science publications. Sources included peer reviewed journals, texts and grey literature. The term grey literature commonly

refers to a range of sources produced and published by government agencies, academic institutions, and other groups including hospitals which are not distributed by commercial publishers. A total of 15 databases were searched including AgeLine Database; Cochrane Database of Systematic Reviews; Nursing and Allied Health Literature (CINAHL) PubMed, which included MEDLINE and Social Work Abstracts.

The keywords searched were “elder abuse”, “elder mistreatment”, “elder neglect”, “domestic violence in the elderly”, “elder abuse management in hospitals”, “health professionals and education” and “elder abuse education”.

2.3 Inclusion and Exclusion Criteria

The main criterion for the inclusion of studies in this review was published material in peer-reviewed English language publications. Only studies which were relevant to health professionals’ within a health context were closely examined and those which could contribute to achieve the intended purpose of the review. A review of the literature highlighted gaps in knowledge and awareness around elder abuse and revealed some disparity relating to how elder abuse is approached in a health context.

2.4 Search Results

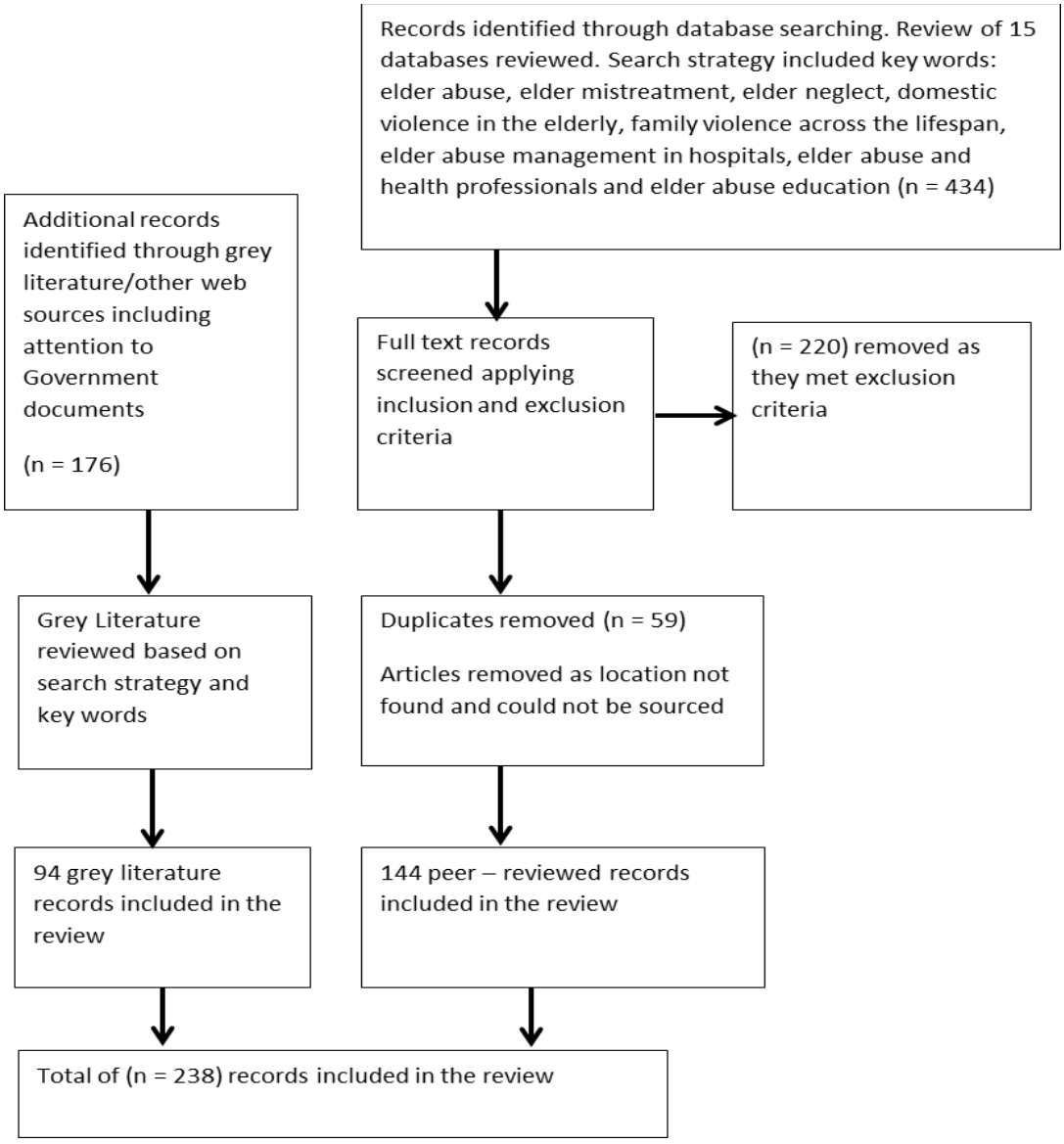
A scoping review was appropriate for this study where the topic had not previously been extensively reviewed. Scoping reviews can be used to map areas of study where little is known about the nature of the work (Arksey & O’Malley, 2005). Over 2000 citations were identified from the initial index and database search and close to 1500 of these were excluded from the review as they were not relevant to elder abuse within a health context. Titles and abstracts of papers were screened to determine if they related to elder abuse within a health context. Full text of studies that appeared to meet the inclusion criteria was read to determine eligibility for review. This yielded 434 full-text peer-reviewed articles and research publications, which were examined to determine if they met the inclusion criteria for full review. A further 220 articles were excluded at this point, yielding a search result of 144 full text articles and research publications for full review. The results provided different types of studies examined which included systematic reviews, primary investigations, descriptive and only two randomised controlled trials.

An additional 176 records identified through grey literature/other web sources including attention to Government documents were examined, with 94 grey literature records included in the review. There was widespread search of government and non-government websites in

United States of America, United Kingdom, Canada, New Zealand and Australia. This search was beneficial in reviewing the approaches and varied responses to elder abuse policy and training interventions within a health context.

Figure 2 shows search strategy which informed this thesis.

Figure 2: Thesis Search Strategy - Literature Review



2.5 Structure of Literature Review Chapter

Theme 1 - The problem of elder abuse. This section considers the problem of elder abuse: the phenomenon of elder abuse which includes the definition and types of elder abuse, understanding it within a family violence context, the origin of elder abuse, the prevalence and under-reporting. The associated between risk factors and vulnerabilities will be described and in particular those which are important for consideration within a health context. This section will explore the key theoretical perspectives used to inform our understanding of elder abuse. This section will examine the impacts of elder abuse on the older person and broader social and economic considerations.

Theme 2 - Reviews models and approaches to elder abuse within an International and Australian context. This theme will examine the models and approaches to elder abuse within International and Australian contexts.

Theme 3 - Responding to elder abuse – the role of the health services. The third theme addresses the barriers and gaps for health professionals in a hospital context in responding to suspected elder abuse.

Theme 4 - Training and education – what, who and how. The final theme that emerges from the literature relates to the training and/or education of health professionals to support them to respond to suspected elder abuse.

2.6 Theme 1 - The problem of elder abuse

The far reaching physical, psychological, social and financial effects of elder abuse are broadly organised within the literature around three core dimensions. These include:

(1) the phenomenon of elder abuse (Blundell 2015), which includes the definition and types of elder abuse, understanding it within a family violence context, theoretical perspectives, the emergence of elder abuse, the prevalence and under reporting of elder abuse.

(2) literature regarding the correlation between vulnerability and risk factors associated with elder abuse and in particular those which are important for consideration within a health context.

(3) the impacts of elder abuse on the older person and in a broader social and economic context.

2.6.1 Defining elder abuse and use of terminology.

Definitions of elder abuse vary in the literature, however all definitions include at their core, a breach of trust for the older person. It has also been proposed that the essential elements in an elder abuse definition include the intentionality of the action, harm and vulnerability of the older person (Chesterman, 2015). The variation in definitions reflects differences in understanding the causes and risk factors of abuse of elder abuse (Lachs & Pillmer, 2004).

The definition of elder abuse adopted in this thesis suggests that it is, "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" (World Health Organization, 2002).

The need to specify age parameters of what constitutes 'elder' remains subject to ongoing debate. Some individuals identify themselves as older persons based on their individual circumstances – which may include their actual age, working status, level of health and level of independence. For the purposes of this thesis, the age that will be that adopted for older people is 65 which is consistent with the definition used by the Australian Commonwealth Government for eligibility for the old age pension (Australian Government Productivity Commission, 2013). For Aboriginal and Torres Strait Islander people, who have a substantially lower life expectancy than non-Indigenous peoples, a lower age for those who are 'older' is considered appropriate (Cotterell et al., 2015).

2.6.2 Types of elder abuse.

A recurring theme in elder abuse literature is the lack of agreement and variation in the definition and types of elder abuse (Anetzberger, 2012). The international literature refers to seven types of possible elder abuse. There is now general agreement internationally regarding the scope and definitions of five main types of elder abuse affecting our elderly population (WHO, 2008).

The five recognised types of elder abuse include: physical, psychological, sexual, financial and neglect (Naughton et al., 2010; WHO, 2008, Victorian Department of Human Services, 2009). Debate remains regarding the notion of self-neglect whether it is a recognised form of elder abuse. Because there is no person inflicting harm on the older person, it can be argued that self-neglect differs from other forms of elder abuse. As such, evidence suggests that

self-neglect is not defined and managed in the same way as physical, psychological, sexual, financial, or neglect which can be caused directly by another individual (WHO, 2008).

These types of elder abuse are widely accepted within government policy documents (Victorian Department of Human Services, 2009). The rationale as to why these types of elder abuse have been selected for use in this thesis relate to the study site, a large hospital being located within Victoria, Australia and consistent with the policy context in that state.

The Victorian Government in their policy document, With Respect to Age – 2009: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse, recognises five types of elder abuse:

- Physical abuse: Infliction of pain, injury, physical coercion or physical or drug induced restraint
- Psychological or emotional abuse: The infliction of mental anguish
- Financial: The illegal or improper exploitation or use of funds or resources of the older person
- Sexual abuse: Non-consensual sexual contact of any kind
- Neglect: The refusal or failure to fulfil a care giving obligation. This may or may not involve a conscious and intentional attempt to inflict physical or psychological harm on the older person.

2.6.3 Terminology used in the thesis.

The language associated with elder abuse is important an important issue to address at the outset. This thesis does not refer to the older person as a 'victim' or 'survivor', which are common terms used in the literature for individuals experiencing elder abuse or other forms of family violence. They will be referred to as the 'older person' or 'vulnerable older person'. The term 'perpetrator' has also been replaced with the term 'person of concern'. The choice of terminology for describing individuals associated with elder abuse is the language which has been adopted at the study site.

2.6.4 The link between elder abuse and family violence.

In examining the problem of elder abuse, it is important to consider the links to family violence. The definition of family violence in the Victorian Family Violence Protection Act (2008) is not limited to acts of physical or sexual violence, which constitute criminal offences. It also includes: economic, emotional and psychological abuse; as well as behaviour

that is threatening or coercive, or controls or dominates a family member and causes them to fear for their wellbeing or safety, or the wellbeing of or safety of others. It includes conduct which exposes a child to abusive behaviour, even where the behaviour is not directed at that child. Actions like damaging property and limiting a person's liberty may also fall under this definition.

Family violence may involve any members within a family system including: partners, siblings, parents and children. The definition includes violence committed by a same sex partner, violence by young people against parents or siblings, elder abuse, and violence by carers in a residential care setting (Victorian Law Reform Commission, 2011). The literature highlights that family violence is considered a social, economic and political issue that has the potential to create overwhelming negative consequences for individuals, families and the community as a whole (Victorian Law Reform Commission, 2011).

Elder abuse is often seen as a separate issue to family violence; however, the two have many similarities and the occurrence of family violence at a young age can continue on to become elder abuse in later life (Dow et al., 2015). Recent research carried out by the National Ageing Research Institute (2014) indicates that approximately 67 per cent of elder abuse is undertaken by a son or daughter of the older person, and 92 per cent of the people causing harm are related to the older person (including those in an intimate partner relationship) – this research supporting the view that elder abuse is in fact a family violence issue. The abuse or harm inflicted towards older people from a partner is recognised as a form of family violence that has "grown older" (Phillips, 2000; Budd, 2010).

Age and vulnerability can influence the power imbalances that are at the core of family violence. Many of the same factors that contribute to family violence contribute to elder abuse, including gender inequality, the use and abuse of power within relationships, a history of family conflict, and negative community attitudes (Budd, 2010). There is agreement that family violence occurs when one person in a relationship uses violence (physical or verbal) to inflict power and control over another person (Phillips, 2000). People who experience such forms of violence often feel fearful and unsafe. However, the dependency of some older adults on their caregivers increases their vulnerability and for this reason different strategies and intervention approaches are needed to address the problem of violence towards an older person (Culo, 2011).

Budd (2010) suggests that family dynamics can be a major risk factor for family violence which extends into later years. Evidence further suggests that women who have a history of

family violence are at the highest risk of elder abuse because it is associated with long-standing patterns of physical or emotional abuse within a relationship (WHO, 2014). The association between experiences of elder abuse and previous traumatic events, including interpersonal and domestic violence, is highlighted in a range of sources (Acierno et al., 2010).

Elder abuse is a recognised form of family violence because it occurs within the context of a family relationship or system (RCFV, 2016). Given that abuse of older people occurs predominantly by family members, there are ongoing challenges to how we respond to elder abuse to ensure that we are not causing more harm to the older person through the response pathways that are implemented.

2.6.5 Emergence of elder abuse in Australia.

An important starting point for examining the literature regarding elder abuse is its emergence as a construct in health policy in Australia. Elder abuse has been identified by health professionals in Australia as a serious issue for many decades (Kurrle, 2004). However the issue of elder abuse has been largely a hidden problem in Australia as the prevalence remains unknown. To date, no single source of elder abuse data provides an accurate account into the nature and true extent of elder abuse in Australia. Current estimates suggest it is 5% of our older population experience or are at risk of abuse (Seniors Rights Victoria, 2015).

The first documented citing which related to elder abuse in Australia was in 1975 by the Social Welfare Commission which stated that older people were at risk of exploitation from their family members, friends and the general community. However, elder abuse was not recognised in Australia as an issue until it became apparent that hospital nurses, geriatricians and social workers were dealing with increasing numbers of suspected elder abuse cases as part of their core clinical work (Kurrle & Naughtin, 2008).

Elder abuse research was first initiated in the late 1980s in a number of states in Australia including Victoria, New South Wales and South Australia (Kurrle & Naughtin, 2008). Awareness of elder abuse increased due to the publication of an elder abuse case series in the Medical Journal of Australia in 1991 (Kurrle, Sadler & Cameron, 1991). As early as 1992 these researchers attempted to establish a prevalence rate for elder abuse in Australia, estimating that approximately 4.6% of older people had experienced or were at risk of elder abuse. The validity of this early research has been debated as it only focused on certain

aspects of known incidents of elder abuse and it did not incorporate any views or barriers for older people around disclosure of elder abuse.

It would appear that it took until the 1990s before all level of government in Australia introduced guidelines and policies to address the growing concern of elder abuse (Dunn & Sadler, 1993). All states and territories in Australia, have applied various approaches to the development and implementation of government and non-government policies and protocols to support and assist older people at risk of elder abuse. Despite the emergence of these approaches elder abuse research, policy initiatives and advanced clinical practice appears to be decades behind other forms of family violence relating to children and women.

There is no uniform or consistent approach to elder abuse across Australia and the management of elder abuse differs from state to state. This is in relation to inter-agency formal protocols in some states and less informal responses in others. Chesterman (2015) argues that fragmentation of responses across states in Australia provide an opportunity to examine important principles to improve the knowledge of service providers, older people at risk of and the general public about elder abuse.

Chesterman (2015) suggests that attempts to improve strategies have relied on existing services to drive change and implement service improvements for at risk older people. The examination of elder abuse within the broader system beyond healthcare is important as a means of understanding the phenomena of elder abuse as a construct within a larger political and family violence context.

2.6.6 International prevalence studies.

Available data describing prevalence of elder abuse has been found to have several limitations. International data on the estimated prevalence rates of elder abuse cites significant variations in the figures from 1% to 20% (WHO, 2010). Some of the reasons include the differences between the studies in the definition relating to elder abuse, the use of different tools to measure elder abuse and the different sources used for collecting data. For these reasons it could be concluded that relatively few studies use consistent or reliable elder abuse measures, or have clearly defined target populations or use standardised data collection methods. Therefore because elder abuse lacks clarity in definition and is not well defined and measured it is difficult to determine the actual prevalence of elder abuse (Wilber & Acierno, 2008; WHO, 2008).

The information on elder abuse prevalence has relied on a few studies conducted to date. Estimates from Norway, Spain, the United States and Canada use prevalence rates between 1% - 5%, increasing to as high as 20% in France (Lowenstein et al., 2009). There have been nine large-scale surveys of elder abuse. National prevalence studies of elder abuse have occurred in the following countries: United Kingdom, Spain, Portugal, Israel, Germany, Canada and the United States of America. Two other prevalence studies have occurred in Boston and Amsterdam using selected samples of older people (Kaspiew et al., 2015)

Overseas studies suggest that between 4 - 10% of older people have experienced elder abuse (McCreadie, 1991). Ogg and Bennett (1992) found in a United Kingdom study of 2,000 older people that 5% of this sample had experienced at least one type of abuse. This study draws parallels with research in Finland which concluded that 5% of older people had experienced some form of elder abuse. Similar statistics of elder abuse have emerged in Hong Kong and Africa (Kaspiew et al., 2015). An Irish Prevalence Study completed in 2010 confirmed that the rate is estimated at just over 2% (National Centre for the Protection of Older People, 2011). A recent prevalence study from Portugal, based on a sample of 1,123 people aged over 60 living in private households, found that 12% had experienced elder abuse in the preceding twelve months (Gil et al., 2015).

An American study based on 5,777 respondents (aged 60 and over), conducted in 2008 with a random sample found that one in ten respondents had experienced elder abuse in the previous 12 months (Acierno, Hernandez, & Kilpatrick, 2010). The most common types of abuse were: financial abuse by a family member (5%), neglect (5%), emotional abuse (5%), physical abuse (2%) and sexual abuse (1%).

A study by Kahan and Paris (2003) discussed the elder abuse strategies being undertaken in Mount Sinai Hospital in America. Over a 2-year period there were 182 cases of elder abuse reported. More than 50% of these cases related to older people with dementia. In most cases of elder abuse reported in this hospital involved a family member as the person of concern. Referrals included different types of elder abuse including verbal, neglect and financial exploitation. 5% of the elder abuse cases involved a long history of family violence. Patients were found to be fearful of disclosing elder abuse to hospital staff

In a Canadian study in 2002 conducted at the Montreal General Hospital, the Geriatric Psychiatry Service sought to determine prevalence of elder abuse and neglect and identified four types of abuse in patients being treated by the service. The authors studied the 1990 calendar year retrospectively (n = 126), conducting cross-sectional, retrospective chart

reviews of new inpatients and outpatients. Abuse or neglect was suspected or confirmed in 20 (16%); financial abuse 16 (13%); neglect 7 (6%); emotional abuse 5 (4%); physical abuse 3 (2%); multiple abuse in 7 (6%). The mean age of those abused was 76.4 years.

In Israel, at the Rambam and Hadassah Medical Centers - two major university hospitals - the authors (Cohen, Levin, Gagin, Friedman, 2007) described a collaborative study involving 730 patients hospitalised in the departments of general medicine and orthopaedic surgery. Patients 70 years and older who needed help prior to hospitalisation and their principal caregivers were interviewed separately by social workers, to elicit disclosure of elder abuse. Excluded were cognitively impaired patients and those unable to communicate because of their physical condition. Strict criteria were set for types of abuse and the interviewer had to describe this in detail. The authors distinguished between disclosed and suspected signs of abuse. Although 5.9% of respondents confirmed elder abuse, 21.4% were identified with suspected signs of elder abuse, and 32.6% were classified as being at high risk for abuse.

The older patients interviewed in the study described feeling threatened by a family caregiver and about psychological abuse. 32 (74.4%) of those disclosing abusive behaviours agreed to disclose the person causing the abuse. 14 (32.6%) identified a partner; five (11.6%) identified one of their children; five (11.6%) identified a son-in law or daughter-in-law; one (2.3%) identified a son and his spouse; one (2.3%) identified a partner and two of the respondent's children. For 156 patients, evident signs of one or more types of abuse were identified. One type of abuse was identified for 95 (83.3%); two types for 35 (22.4%); three types for 22 (14.1%); four types for 2 (0.2%); five types for 2 (0.2%). Physical and sexual abuse was rare. Neglect, psychological abuse and financial exploitation ranged from 8.9% to 14.4% of the sample (Cohen, Levin, Gagin, Friedman, 2007).

A very different approach was taken in assessing prevalence and incidence in the United Kingdom Study of Abuse and Neglect of Older People (O'Keeffe et al., 2007). This study was based on face-to-face interviews with 2,111 people aged over 66 living in private settings across the UK in 2006. The study measured whether the participants had experienced any type of abuse in the preceding 12 months by a family member, friend or care worker. Overall, 4% of the sample reported abuse including: neglect (1%) and financial abuse (0.7%) were the most common forms of abuse, followed by psychological and physical abuse (each 0.4%). Sexual abuse was reportedly uncommon (0.2% of women). The dominant relationship dynamic associated with abuse in this study was from a partner (51%).

The other group identified as causing harm to the older person was another family member (49%).

This UK study (O'Keeffe et al., 2007) proposed that adult children were responsible for financial abuse while spouse/ partners were more frequently involved in physical and psychological abuse. The person of concern was estimated to be aged between 30 years and 64 years in the study however, younger adults and even some teenagers were reported as causing harm to the older person. Particular risk factors in this study included the older person living with the person of concern (37%), the person of concern being unemployed (51%) and the person of concern having a dependency on alcohol (19%).

Age Concern in New Zealand (2006) undertook a qualitative study of 137 cases from their database between 2002 – 2006. Essentially 47% of the elder abuse cases identified financial abuse and in 91% of these cases a family member was identified as the person inflicting the abuse on the older person.

There is agreement in the literature that universal elder abuse prevalence data is lacking because of differences in definitions and methodologies used in trying to gain an accurate picture of the problem. Limitations of the studies include differences in research settings, patient groups and definitions of elder abuse according to the evidence. This view is supported by McDonald & Collins (2000) who suggest that different definitions of elder abuse and variation in research methodologies make it difficult to measure prevalence. Added to this barrier is the debate around the underreporting of elder abuse – under reporting by older people themselves and by staff in key organisations who may come into contact with older people at risk. The hidden nature of elder abuse contributes to it being unrecognised, unreported and hard to detect (Jackson & Hafmeister, 2015). Further exploration relating to the under reporting of elder abuse will follow in this chapter.

More recently the WHO (2015) reported that estimated prevalence rates of elder abuse in high - or middle-income countries ranged from 2% to 14%, with the following prevalence rates for the most common types of elder abuse: physical abuse (0-5%); sexual abuse (0-1%); psychological abuse (1-6%); financial abuse (1-9%) and neglect (0-6%). This updated information confirms that elder abuse is a problem of international significance requiring further attention. It is important to compare the findings of these studies conducted in Australia.

2.6.7 Australian prevalence.

Like many other developed countries, Australia too has an ageing population. Data from the Australian Bureau of Statistics (ABS) suggests that Australia is currently home to approximately 24 million people (ABS, 2015) and as of the 2011 census, 3.1 million Australians (14%) were aged 65 years and over (ABS, 2013). Australia has a culturally diverse population with 20.1% born in a non-English speaking country (Federation of Ethnic Communities Councils of Australia, 2015). Australia currently has with 0.7% people aged 65 years and over identified as Aboriginal and Torres Strait Islander people (ABS, 2013). The ABS (2013) suggests that the number of older Australians is expected to increase to between 18.3 and 19.4% of the population by 2031 and the number of people from culturally and linguistically diverse backgrounds is expected to increase to 30% by 2030.

Findings from earlier Australian studies are consistent with current research. Over a 12 month period, 4.6% of older people presenting to a hospital in New South Wales had experienced some form of elder abuse according to a review (Kurrle et al., 1992). In another study elder abuse was documented in 1.2% of all referrals to four different Aged Care Assessment Teams (ACAS) located throughout Australia. In this study the risk factors that were identified which contributed to the abuse included: mental health and substance abuse issues relating to the person of concern (30%), dependency of the person experiencing abuse (25%), history of family violence (19%), carer stress (18%) and financial hardship (8%) (Kurrle et al., 1997).

Australian studies indicate that more older women than men are subject to elder abuse; with the gap widening in the older age groups indicating that approximately two-thirds of people aged 85 years and over are women (Australian Institute of Health and Welfare Studies, 2013). The ABS (2013) suggests that most older Australians live with a spouse or partner (56%), or alone (25%). Older Australians are considered to have a lower income than the general population, but most people 65 years and over own their own home outright (74%) or with a mortgage (10%) (Centre of Excellence in Population Ageing Research, 2014).

Findings from the Australian studies support the view that in a high percentage of cases, the people causing the abuse (persons of concern) are immediate family members, either the older persons' partner/spouse, adult child or other family member and they usually live with the older person they are harming. In the case of children causing the elder abuse, it can be proposed that it is more likely to occur if they are financially reliant on the person they are abusing (Lacey 2014; Joosten, Dow, & Blakey, 2015). Researchers suggest that spouses

tend to be more associated with causing physical abuse which is consistent with patterns of family violence (Budd, 2010). Not surprisingly children are mainly identified in the research as committing financial abuse towards their parents or other trusted relatives (Joosten, Dow, & Blakey, 2015). Australian studies estimate that approximately 50% of persons committing elder abuse will have significant risk factors of their own which could include both physical and mental health problem (Kurrle, Sadler, Lockwood et al., 1997; Joosten et al.,2015).

There have been no detailed studies on the prevalence of elder abuse undertaken in Australia however it is estimated between 1% to 5% of older people are at risk or have experienced elder abuse in Australia (Chesterman, 2015). These estimates have been based on data obtained from organisations who have undertaken a review of elder abuse activity within their individual study site. For the past 10 years, elder abuse advocates and academics have been calling for investment in research to better understand the prevalence and factors associated with elder abuse in Australia (Ozanne, 2009).

Although there are no Australian prevalence studies, there are two population-based studies that offer important information about abuse of older women. An analysis of data from the 2012 Australian Bureau of Statistics (ABS) Personal Safety Survey found that approximately 12,800 (0.4%) women aged 55 years and older reported experiencing physical abuse from a partner and approximately 7,000 women (0.2%) reported sexual assault in the previous 12 months. This compared with a national average across all age groups of 2.1% for partner violence, and 1% for sexual assault (Cox, 2015).

The Australian Longitudinal Study of Women's Health is a population-based study which began in 1996 with a sample of over 58,000 women in three cohorts who were aged 18–23, 45–50 and 70–75. Vulnerability to elder abuse is measured in this study using a 12-item measure that includes four factors relating to risk of abuse, vulnerability, coercion, and dependence and dejection. Data showed 8% of the oldest cohort (aged 85–90 years) experienced vulnerability to abuse in the 2011 survey (Women's Health of Australia, 2016).

A recent Australian study estimated that up to 5 per cent of older people have experienced or are at risk of elder abuse (Joosten, Dow, & Blakey, 2015). The data on the incidence of the types of elder abuse experienced by older people is unlikely to accurately reflect the true extent of the problem. This is because of the lack of recording or variations in which organisations record data on elder abuse, the multiple services that older people can have contact with and the difficulty in defining and agreement on what constitutes elder abuse. There is however emerging evidence from key organisations and researchers that incidence

of elder abuse is increasing for many older people in Australia who experience, or are at risk of experiencing a form of elder abuse in their lifetime (Office of the Public Advocate, 2006; Dow et al., 2013; AIFS, 2016).

Studies based on data from calls to helplines for elder abuse provide some insight into the occurrence of elder abuse in Australia. There are three recently published sources from Queensland (Spike, 2015), Victoria (Joosten, Dow, & Blakey, 2015) and NSW (NSW Elder Abuse Helpline and Resource Unit, 2015). The data describes situations in which elder abuse is known or suspected and the older person has contacted an advice line. These studies reflect the findings of international prevalence studies in terms of the frequency of abuse types, characteristics of the person of concern and risk factors, with financial abuse being most common, male adult children the most likely person causing the abuse, and being female (Joosten, Dow, & Blakey, 2015).

In Queensland calls to the elder abuse helpline have increased substantially over the period that it has been operating, from just over 200 in 2000-01 to nearly 1,300 in 2014-15 (Spike, 2015). The analysis of call data suggests: mainly female older people (68%). The most common age group of older people was 80-84 years (23%), followed by 75-79 years (16%) and 85-89 years (15%). The person of concern were male in 50% of calls and were predominantly children of the older person (31% sons, 29% daughters).

In 2014-15, the most commonly reported type of abuse to the Queensland helpline was financial abuse (40%) and psychological abuse (35%), which had been the most common type up to 2012-13. The next most common types were neglect and social isolation, at about 10% each. Physical abuse was reported in fewer than 5% of calls from the older person. Where the person of concern was a partner or spouse, the most common type of abuse was psychological (41%). Where the person of concern were adult children, financial abuse (39%) and psychological abuse (38%) were the most common types of abuse.

In Victoria a recent study by the National Ageing Research Institute (Joosten et al., 2015), commissioned by SRV, was based on an analysis of data from records of calls to a helpline operated by SRV between July 2012 and June 2014. Of the 755 calls, 455 involved elder abuse issues. The most common concerns raised in relation to elder abuse were about financial abuse (61%) and psychological abuse (59%). Physical abuse was raised much less frequently (16%), as were social abuse (9%), neglect (1%) and sexual abuse (0.4%). Elder abuse issues were more likely to be experienced by older women (73%) and the most

commonly reported person of concern were male (60%) and children of the older person (67%), predominantly sons of the older person (40%).

In New South Wales two years of call data (n = 3,388) to the NSW Elder Abuse hotline (NSW Elder Abuse Helpline and Resource Unit, 2015) suggest similar patterns to the Queensland and Victorian data. Women were most commonly reported to be experiencing the abuse (71%) and the most common age group of concern were 75-84 year olds (33%). In 71% of calls, the persons of concern were family members, predominantly adult children (26% sons and 21% daughters) and partners or spouse were reported in (12%) of calls. The most common abuse type reported in the calls was psychological abuse (57%), followed by financial abuse (46%), neglect (25%), physical abuse (17%) and sexual abuse (1%).

In summary the hidden phenomenon of elder abuse creates complexities in gaining accurate statistics on prevalence of elder abuse however there are some consistencies in the data we have regarding the likely person of concerns and the highest type of abuse experienced by an older person.

2.6.8 Under reporting of elder abuse.

Health professionals have difficulty identifying and responding to suspected cases of elder abuse, and the percentage of reported cases is very low even (Yaffe, Wolfson, & Lithwick, 2009). Elder abuse is difficult to quantify due to the issue of under- reporting. The World Health Organization confirms that elder abuse is under reported (2011) and even after decades of attention by researchers, it remains a hidden phenomenon (WHO, 2008). It has been estimated as many as 1 in 14 elder abuse cases remains hidden or not identified (WHO 2011). A more recent study has suggested that for every case of elder abuse reported, 23 remain undetected (American Psychological Association, 2012).

There are many reasons for the under-reporting of elder abuse. Underreporting appears to be related to the fact that the people committing the abuse are usually family members and of equal importance is health professionals' lack of education in recognition of aged abuse (Joubert & Posenelli, 2009). It is a challenging subject to discuss with people and it is an issue occurring within private family and trusted relationships (Lacey, 2014). There is often discomfort with discussing elder abuse as well as a culture of secrecy and shame that is associated with elder abuse (WHO, 2008; Office of the Public Advocate, 2006). The view held by many includes the notion that family relationships should provide a safe and trusted haven for older people (Joosten, Dow, & Blakey, 2015).

It has been proposed that most elder abuse would appear to occur in the privacy of an older person's home and is undertaken by a person that the older person knows and trusts – usually an immediate family member (O'Keeffe et al., 2007; Joosten, Dow, & Blakey, 2015). However, the issue of elder abuse remains complex due to the private nature of the family being identified as creating a barrier to acknowledgement of elder abuse as family dynamics and possible abuse are seen as shameful and taboo. This factor creates complexities in gaining accurate statistics on elder abuse.

There is evidence to suggest that elder abuse is often unrecognised and under-reported by older people themselves, families and health professionals (O'Keeffe et al., 2007). South Australian research undertaken by Bagshaw, Wendt & Zannettino (2007) identified many important barriers which are associated with under reporting. These include factors affecting both the older person and the person of concern such as reduced cognitive capacity, physical disability, mental health issues, restricted mobility leading to dependency, lack of understanding of what constitutes elder abuse, lack of knowledge about rights and legal options, social isolation, stigma or shame, language or cultural barriers; fear of retribution from the person of concern or just a lack of service options available to older people at risk of elder abuse.

Dow et al. (2013) suggests that under-reporting appears to be directly related to issues of family bonds and fear of any repercussions which may occur as a result of reporting any type of elder abuse to anyone outside of the family system. Evidence supports the view that elder abuse along with other forms of family violence is a problem but abuse of older people is thought to be seriously under-reported because estimates suggest that close to 90% of elder abuse cases involve a direct family member as the person of concern causing harm to their own family member (Joosten, Dow, & Blakey, 2015). It is now widely accepted that elder abuse cases are not reported by older people because of shame, embarrassment and fear (Dow et al 2013). Whilst there is still a need for more reliable empirical research into how shame and fear is associated with elder abuse, the available broader elder abuse literature will provide some valuable insight into understanding elder abuse through the lens of various theoretical perspectives.

2.6.9 Elder Abuse – an Introduction to Theoretical Perspectives

Theories help make sense of a social phenomenon, like elder abuse. Theories can be used to understand why something like elder abuse exists and they can assist in the integration of theoretical approaches into practical interventions.

An important consideration of any form of elder abuse is the reason or trigger behind the act itself. In examining the literature, it appears there has been little advancement in the views associated with the main theories which have been applied to elder abuse to try and understand the emerging approaches and frameworks. Jackson & Hafemeister (2013) suggest that elder abuse lags behind other areas of family violence in theory development. However, it is important to examine a number of the theories which have emerged and which seek to explain why elder abuse may exist our society.

The complexity of elder abuse is underscored by the difference in theories used to explain and understand it. The theories used to inform our understanding of elder abuse have mainly been adapted from other fields of family violence. Researchers have cited a number of theoretical explanations as to the reasons why elder abuse may occur. From a review of the literature it can be argued that no individual theory can explain all dimensions of elder abuse (Bonnie & Wallace, 2003). Jackson & Hafemeister (2013) support the view that because elder abuse tends to be multidimensional, with a significant number of factors contributing to its occurrence and considerable variation existing across the different types of elder abuse, no single theory can explain the phenomenon.

The literature is consistent in the view that there is no single factor which causes abuse towards older people. However, there is ongoing discourse around which approach is best suited to address the multiple dimensions that may impact on a vulnerable older person (Bonnie & Wallace, 2003). The literature places emphasis on interpersonal relationships existing in the field of elder abuse. This involves carefully assessing the older person's family dynamics and relationships, social networks in the community, physical and mental health status, financial position and their cultural background using a framework or theoretical approach (Penhale, 2003).

Much of the literature on elder abuse does not distinguish between theoretical views and the individual factors related to elder abuse. McDonald (2011) argues that factors such as caregiver stress or dependency on carers can be the main reason why elder abuse may be occurring (Wolf, 2000). However, it could be suggested that such issues are only risk factors and they do not necessarily explain how these risk factors translate into actual abuse towards an older person.

Several approaches have been used to try and explain the phenomenon of elder abuse. They include: the situational approach; social exchange theory; the caregiver

psychopathology approach; social learning theory; the political approach; the social interaction model, the feminist model and the ecological model. It is useful to consider these and clarify the rationale for selection of the ecological model to inform the research.

The situational approach or caregiver stress theory states that elder abuse can result from a situation in which a carer cannot cope with the pressure or demands placed on them which creates an environment for the increased likelihood of elder abuse (Nerenberg, 2002). This theory is based on the belief that elder abuse can be attributed to the stress associated with providing care and assistance to frail and highly dependent elderly people (Jackson & Hafemeister, 2013). The situational approach suggests a dependent relationship between an older adult and the person of concern are related to long standing interactions and conflict in family life that may have been occurring for many decades (Moghaddon, 1998).

Social exchange theory conceptualises social behaviour as involving negotiated exchanges of material and nonmaterial goods and services (Jackson & Hafemeister, 2013). The caregiver psychopathology approach proposes that a caregiver with mental health issues is unable to balance both their needs and the older person and subsequently places an older person at increased risk for abuse (Anetzberger 2000).

The social learning approach (Bandura, 1978) states that elder abuse is a learned behaviour which has arisen from actions within one's own environment. The political approach suggests that elder abuse can be associated with challenges faced by older people once there is a change in their roles and they start depending on others for their own physical and mental well-being (Lachs & Fulmer, 1993). The symbolic interaction model suggests that elder abuse occurs in the interaction between carer and older person, based on the differences in the views regarding the concept of ageing between the care and older person (Bonnie & Wallace, 2003). The feminist model argues that elder abuse occurs in situations similar to domestic violence in which there are issues of power and control over another person (Bagshaw, Wendt, Zannettino, & Adams, 2013)

This thesis draws on the ecological framework for consideration in understanding the impact of elder abuse precisely because of the recognition of the complexity of the issue and the challenges for health professionals in responding effectively. Importantly health professionals should think systematically and be informed by a framework which focuses on the individual, family, organisational, professional and policy/political levels (Sandmoe & Kirkevold, 2013) The ecological framework is based on notion that no single reason or

rationale can explain why some older people are at higher risk of elder abuse compared to other seniors who may be in the same situation.

2.6.9.1The Ecological Framework

At the outset the study sought to take a holistic approach which places the older person at the centre of the work and takes into account micro, meso and macro systems to understand the issues and frame a response. This meant that it was essential to understand elder abuse from the perspective of the older person within the family and community (the micro system), to situate the problem and possible responses in the hospital or environmental context (meso system) and, in developing the proposed response or intervention, to be mindful of the policy environment – state, national and global (macro system).

The Ecological model states that elder abuse is a complex issue, embedded in individual, relationship, community and societal factors. It focuses on the relationship of the processes that link the individual to their family, community or hospital system. The literature supports the use of this framework and suggests that it can be applied to the health context in understanding the phenomena of elder abuse and the role that health professionals can play in prevention and response (Norris et al.; Phelan, 2014; Wango et al., 2014).

The thesis draws on the framework because it helps to identify, categorise and evaluate interventions that take into account the multiple, yet interlinking, levels and approaches in responding to elder abuse (O'Donnell et al., 2015). Ecological theory draws parallels with the practice of health professionals in responding to elder abuse because it takes a holistic approach towards understanding the older person as a total person in the context of their own environment and the interface with the hospital system.

It has already been stated that Ecological theory was applied to this study to examine interventions from the perspective of the older person as well as the environmental, social and cultural systems in which the individual is situated. This framework underscored the need to consistently be mindful of the hospital and policy contexts in developing the training intervention

Ecological Theory was developed to try to capture a number of potential causes and organise them into groups (Bronfenbrenner, 1979). To understand the complexity of elder and the many issues associated with it, a number of authors have relied on the ecological model, which was first applied to the research of children at risk. Importantly, the ecological

model is able to provide a rationale behind the connections that take place across a number of different systems. Schiamberg & Gans (2000) support an ecological framework for the study of elder abuse. Rather than conceptualising elder abuse as a phenomenon that exclusively relates to older people and the person causing the abuse, this model highlights the importance of studying the ways in which multiple systems are associated and interconnected.

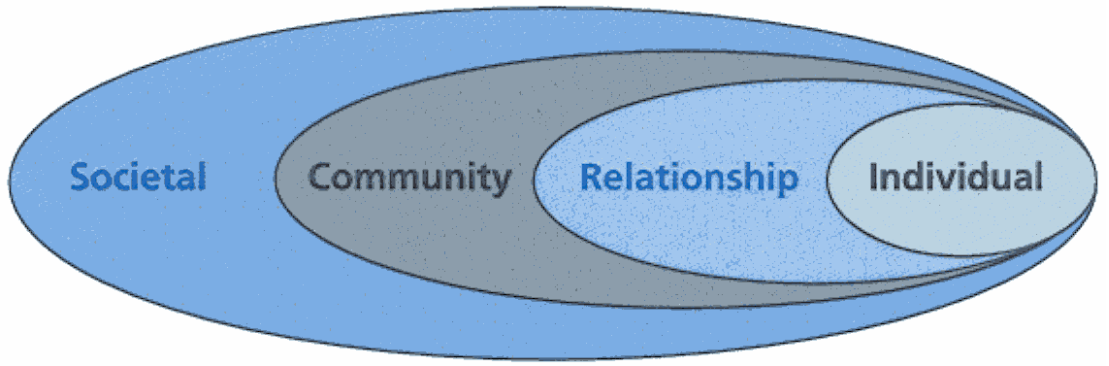
The ecological theory draws parallels with the practice of health professionals because it takes a holistic approach towards understanding the older person as a total person in the context of their own environment and their own perception or understanding of their life. This theory focuses on the interactive processes that link the individual to the community or wider environment. Germain & Bloom (1999, p.9) state: "...it facilitates our taking a holistic view of people and it's environments as a unit in which neither can be fully understood except in the context of its relationship to the other. That relationship is characterized by continuous reciprocal exchanges, or transactions, in which people and environments influence, shape, and sometimes change each other."

In 2002, the World Health Organization published a ground breaking report 'World Report on Violence and Health'. This report used an ecological model to understand the multidimensional nature of family violence. According to WHO (2002) the ecological model can "help understand all violence, including interpersonal violence, as a contextualised phenomenon: the aim of this approach is never to condone any violence, but to understand better the different personal, social, economic and cultural contexts of the difficult reality" (WHO, 2002).

The ecological framework consists of a hierarchy which suggests four levels within our environment: individual, relationship, community and society. This theory focuses on the relationship of the processes that link the individual to the community or their larger environment. Rather than making an assessment simply based on cause and effect, the ecological model examines individual personal circumstances, including their environment.

In Ecological theory, cultural and societal beliefs are grouped in the outer ring of concentric circles as depicted below in diagram 3.

Figure 3: Ecological Framework (WHO, Violence as a Public Health Issue, 2002)



The four elements are described below.

Individual: the first level identifies biological and personal history factors that increase the likelihood of experiencing or causing abuse. Some of these factors include age, education, income, substance use, or history of abuse. Prevention strategies at this level can include education or training (WHO, 2002).

Relationship: the second level examines close relationships that may increase the risk of experiencing abuse. A person's trusted network influences their behavior and contributes to their range of experience. Prevention strategies at this level include promotion of healthy relationships (WHO, 2002)

Community: the third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with abuse. Prevention strategies at this level are typically designed to impact the social and physical environment – for example, by reducing social isolation for an older person (WHO, 2002)

Societal: the fourth level looks at the broad societal factors that help create a climate in which elder abuse exists. These factors include social and cultural norms that support abuse such as ageism. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society (WHO, 2002).

According to an ecological framework older people are part of microsystems: the microsystem (individual), the mesosystem (relationship), the exosystem (the community), and the macrosystem (wider society) (Connard & Novick, 1996; Schiamberg & Gans, 1999).

For the purposes of this thesis, micro-system interventions can be understood as directly targeting the older person experiencing or at risk of experiencing abuse (Lachs & Pillemer, 2006). Interventions classified under the micro-system level target the relationship between the older people and their environment such as their family home, their family, social or community networks (Grossman & Lundy, 2003).

Meso-system interventions can be understood as targeting the connections or relations between microsystem settings such as family, friends or community groups. Interventions classified under this ecological level include those targeting caregivers including health professionals (Schiamberg & Gans, 1999).

Exosystem interventions are understood as targeting the links between the individuals and their immediate context. Interventions included in this address the social structures and systems that do not support the older person.

Macrosystem interventions pertain to the overarching culture in which an older person lives. Interventions classified under this level target the overarching beliefs and values of societies such as discriminatory social values and beliefs

There is a consistent view that hospitals could be a place of primary prevention and should focus on reducing the possibility of elder abuse becoming a reality for vulnerable older people. The interconnectedness of elder abuse among individuals, within relationships and families, and across communities and society underscores the need to adopt an ecosystemic perspective.

Much of the literature on elder abuse does not sufficiently distinguish between theoretical explanations and the individual factors related to elder abuse. In summary, the Ecological Framework is intended to provide a way of understanding the complexities of elder abuse by considering the importance of contextual factors such as risk factors and the reasons why elder abuse continues to remain so complex and why it is under-reported by both older people and health professionals.

The response to elder abuse requires an understanding of the unique risks and vulnerabilities associated with older people. Health professions have a unique opportunity to empower older people to consider their interconnectedness to family, community and society. Importantly this framework guides health professionals to establish relationships

with older people within their own microsystem to assess the risk factors and to implement intervention strategies (Penhale, 2010).

2.6.10 Risk factors and vulnerability associated with elder abuse.

While it is important to recognise and understand the risk factors of elder abuse, further research is needed better to understand why some people with these risk factors may be more vulnerable to elder abuse and why some people are more likely to inflict abuse. The ecological approach is a framework which suggests that a combination of individual, relational, community, and societal factors contribute to the risk of elder abuse occurring. There is a further correlation between risk and vulnerability when examining the construct of elder abuse. Consistent themes relating to risk factors is established in the research literature as having a strong association with being vulnerable to elder abuse (Acierno et al., 2010; Gil et al., 2015; WHO, 2015). The term vulnerability is a broad concept and has different meanings dependent on the application in different settings.

A review of the literature suggests that vulnerability for an older person concentrates on a combination of three factors: health status, cognitive function (capacity), and social support (Culo, 2011). In the case of elder abuse, vulnerability refers to the personal qualities or attributes of the person and their environment which can predispose the person to an elder abuse risk factor (Culo, 2011). This is consistent with the ecological approach. Vulnerability can be assessed by looking at both the risk and the degree of likelihood to the risk and, second, the extents to which individuals are likely to experience that risk. The goals of intervention in cases of older people at risk of abuse due to vulnerability are to promote autonomy, ensure safety, reduce morbidity and mortality, maximize function, and improve quality of life (Pavlou & Lachs, 2008)

The Australian Bureau of Statistics (2009) supports the view that the impact of the aging population both in Australia and internationally has increased the number of older people at risk of elder abuse (WHO, 2008). While many older people live independent and active lives, issues such as frailty, vulnerability or dependence that influence the day to day functioning add to a person's vulnerability (AIFS, 2015). Those older people who do experience the associated challenges of ageing are most likely to require support and assistance. In most cases, this care is given routinely by family without any problem. However, in some situations, the relationship between the vulnerable older person and the person of concern

can be impacted by physical harm, emotional manipulation, unacceptable forms of neglect, or financial exploitation (Joosten, Dow, & Blakey, 2015)

Studies suggest that elder abuse is a combination of a number of factors including psychological, social, and economic factors, along with the mental and physical conditions of the older person and the person of concern which can all contribute to the likelihood of elder abuse (Budd, 2008). Elder abuse can be considered a multisystem problem that can affect older people from different cultural origins, family composition and involves a wide variety of risk and contributing factors. Once a hidden and taboo issue, elder abuse has gained more recognition as the baby boom generation continues to age and as more people begin to live for longer than ever before (Australian Government Productivity Commission, 2013).

Elder abuse is most often intertwined with medical, psychological and social issues, often within a family system (Budd, 2010). Numerous factors have been associated with elder abuse. Some relate to the older person's characteristics, such as the presence of dementia, social isolation, lower household income, and need for assistance in activities of daily living. Other factors relate to the person of concern, such as the presence of mental illness (including depression), substance abuse, and social dependency on the older person for finances, housing, or food (Joosten, Dow, & Blakey, 2015).

Research has shown that identifying risk factors of family violence, such as financial pressures, gambling, alcohol and drug abuse, and mental illness, are important to assist in identification and the ongoing management as these factors can be minimised through targeted interventions (Budd 2010). An examination of risk factors for elder abuse also includes caregiver stress, poor physical health, frailty and functional dependency of the older person (Johannesen & LoGiudice, 2013).

Insight into the factors associated with older Australians experiencing abuse, or the factors that may protect them against this risk would appear to be limited compared to other forms of family violence. In the literature, factors associated with elder abuse are referred to both as risk factors and risk indicators. The literature further suggests that there are different risk factors for different types of elder abuse (Johannesen & Lo Giudice, 2013).

Risk factors are key indicators in elder abuse detection that can be identified with the aim of reducing the probability of an abusive situation occurring (Darzins et al., 2009). The complex dynamics in which elder abuse occurs within a family or community further compounds the difficulty in trying determine or identify the likely factors associated with an increased risk.

(Johannesen & Lo Giudice, 2013). Some of the considerations by health professionals in identifying risk factors are focused on preserving the autonomy of an older person and the impact of family relationships for the older person is consistent with the ecological framework (Phelan, 2008).

Responses to understanding elder abuse risk factors and prevention are generally seen to be underdeveloped in Australia (AIFS, 2016). Literature suggests that a number of risk factors can be associated with elder abuse, and that the occurrence of more than one of these factors can put an older person at higher risk of abuse (Budd, 2010). However, the complex dynamics in which elder abuse occurs make it difficult to predict or confirm all the factors associated with an increased risk of abuse for our vulnerable population of older people (Budd, 2008). Risk factors for elder abuse do provide some understanding to why older people can experience abuse from within their trusted family relationships. The issue of substance abuse including both drug and/or alcohol issues are considered significant risk factors contributing to higher rates of elder abuse (WHO, 2014).

Elder abuse is rarely defined by one single risk factor and is likely to be influenced by a number of social factors. It remains an international problem and it is estimated that the number of cases of elder abuse is likely to multiply due to the rapidly ageing population (Department of Health and Human Services, 2009). For this reason it is important to understand key risk factors.

2.6.10.1 Ageism.

Ageism is a consistent theme in the literature. It refers to is stereotyping and discriminating against individuals on the basis of their age. The literature cites community attitudes and poor understanding of issues affecting our ageing population as risk factors contributing to elder abuse (Phelan, 2008). The notion of ageism by health professionals, carers, and the general public can contribute to low self-esteem and increased vulnerability for the older person (Phelan, 2008). Dunn (1995) suggests that negative attitudes towards the ageing population, lack of community awareness about elder abuse, lack of support, education and training for family members who take on a caring role are all likely contributors. In Australia, research has shown that older people are strongly affected by ageist attitudes (Minichiello, Browne, & Kendig, 2000). Phelan (2008) states that the consideration of elder abuse through the construct of ageism, human rights and citizenship offers an opportunity for a health professional to reflect on their moral and social responsibilities associated with supporting older people.

Lane (2009) suggests that whilst ageism has not been found to overtly contribute to acts of elder abuse it is believed that negative attitudes towards older people are a contributing factor which can underpin such acts. Ageism directed towards older people reinforces stereotypical ideas of older people being seen as dependent, vulnerable, declining physically and mentally and generally as burdens to families and the community (Phelan, 2008). A review of the literature suggests that ageism permeates all aspects of society and occurs in language, media, politics, employment and technology. Walsh et al. (2007) argues that raising awareness of ageist attitudes in our society is the first step in reducing elder abuse and suggests that education of health professionals is a positive platform which will help combat ageist beliefs in our community.

Negative attitudes or behaviours towards older people can influence how care can be delivered and the quality of care to an older person. Evidence suggests that older people themselves can contribute to the problem. According to Phelan (2008) older people do very little to change the negative view of old age and subjectively perceive themselves as being dependent and reinforce stereotypical views compared to younger people. According to Brozowski and Hall (2010) elder abuse exists because of deeply entrenched ageism within our community.

2.6.10.2 Carer stress.

Carer stress refers to the physical and emotional demands of caring and has been highlighted as a factor needing greater understanding by health professionals and those who interface with older people (WHO, 2004). Carer stress can become evident in situations in which older people become dependent on family to provide care due to cognitive or physical dependency can result. According to Budd (2010) a major risk factor of elder abuse is in situation in which family members who take on a caring role are unable to cope with the burden and responsibility.

Stress in the relationship between the carer and the older person can be extremely stressful for family members who may have assumed the role through duty or pressure from other relatives. Sometimes, carers experience daily pressures, resentment, frustration or anger (Pillemer, et al., 2008). Anetzberger (2000) suggests that caregiver stress can contribute to elder abuse due to conflicting roles for family members. Penhale & Kingston (1997) found that the risk of elder abuse is higher in situations in which there are other contributing factors, such as a history of conflicted relationships, carer stress or mental health issues.

Carers of older people living with dementia demonstrate a great degree of anxiety and may employ strategies which may be seen as causing harm to an older person (Cooper et al., 2008). The presence of an older person with dementia appears to be risk factor for carers who may be becoming increasingly stressed which can contribute to situations in which carers may make decisions which may not be in the best interests of the older person they are caring for. This may be considered a form of unintentional abuse. This is in addition to the multiple other factors such as substance abuse issues like alcohol and drugs, mental health issues and cognitive impairment (Kurrle ,2004).

2.6.10.3 Dependency.

Dependency refers to when an older person becomes reliant upon others for day to day tasks that many people take for granted. Evidence suggests that elder abuse can be attributed to changes in living situations brought about by the older person's increasing health needs and dependence on others for their basic needs (Stanley & Manthorpe, 2004). Dependence of a frail older person on a family carer is not a direct cause of abuse however heightened risk factors exist when the older person depends on the person of concern for day to day tasks (Pillemer et al., 2008).

Research undertaken by Conner et al. (2011) found that the more care that was needed by an older person, the greater the likelihood that they may experience elder abuse. Conner et al. (2011) state, "excessive demands made on caretakers result in decreased tolerance, loss of self-control, and reduced time and energy…they are more likely to feel tired, frustrated, and angry and exercise poor judgment" (p. 22). Unfortunately these situations increase the likelihood that a person will be harmed by a carer or family member. Joubert & Posenelli (2009) agree that dependency of an older person on a family member increases the likelihood of elder abuse.

2.6.10.4 Social Isolation.

Social isolation is defined as the absence of social interactions, contacts and relationships with family and friends (Acierno et al., 2010), can greatly influence the wellbeing of the older person when they are less likely to access their community. The literature suggests those older people at risk are those who are isolated from family or support networks in their local community (Grenade & Boldy, 2008). Social isolation has a well-established association with being vulnerable to elder abuse (Acierno et al., 2010; O'Keeffe et al., 2007; WHO, 2015). By the time people reach their 80s, the majority live on their own, mostly because of death of a

spouse. This is particularly the case for older women who are more likely to be widowed than older men (Grenade & Boldy, 2008)

The literature suggests that older people are at increased risk of being socially isolated or lonely. According to a report from The National Centre for the Protection of Older People (2012) in Ireland, preventing social isolation and helping older people to develop the own emotional resources will help prevent abuse and support older people who have experienced abuse.

2.6.10.5 Family Violence.

Family violence is a risk factor associated with elder abuse. Family and domestic violence is any violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships. This includes not only physical injury but direct or indirect threats, sexual assault, emotional and psychological torment, economic control, damage to property, social isolation and any person which causes a person to live in fear (RCFV 2016).

Elder abuse often takes the form of a process rather than a specific event according to Faye and Sellick (2003) and James and Graycar (2000) believe that when a family relationship exists, any form of elder abuse is usually part of an established pattern of behaviours rather than a single occurrence. This view is consistent with the notion that elder abuse is a form of family violence growing old. Some instances of elder abuse may represent abuse which has continued for many years (Budd, 2010).

2.6.10.6 Cultural Diversity.

Cultural diversity is attributed to older people from culturally and linguistically diverse (CALD) backgrounds, can impact on those older people who are reliant for day to day tasks on family members (Advocare, 2009). In CALD communities, the literature suggests that older people can be more vulnerable to abuse because of language difficulties for those whose primary language is not English, social dependence on family members for support, and the potential conflict caused by cross-generational expectations in relation to care (Bagshaw, Wendt, & Zannettino, 2009).

2.6.10.7 Dementia or cognitive impairment

Dementia is considered a high risk factor for older people at risk of elder abuse (Dong, 2014). Dementia is defined as a loss of cognitive function due to changes in brain function as a result of disease or trauma (Victorian Department of Health 2014). Over the next three decades, the number of people with dementia both in Australia and around the world will almost triple (Victorian Department of Health, 2014). One of the most difficult dilemmas for health professionals is acting on suspected cases of elder abuse where the older person may have cognitive issues such as dementia (Cooper et al., 2008). Cognitive impairment and other forms of disability are established in the literature as having a strong association with being vulnerable to elder abuse (Acierno et al., 2010; WHO, 2015). Older female people with dementia are reported to be more likely to have a higher risk of experiencing elder abuse than other similar groups of older people (Natan, Lowenstein, & Eisikovits, 2010).

Dementia is recognised as the second highest disability experienced by women and the fourth highest for men in Australia. Dementia is now the second leading cause of death in Australia. In 2013, 10,993 Australians died because of dementia. It is estimated by 2061, that dementia will be the biggest disease burden for women (Victorian Department of Health, 2014). The emergence of dementia is an important risk factor for health professionals because older people with dementia are at higher risk of elder abuse (Cooper et al., 2008). Research confirms that older people living with dementia may be at increased risk of financial abuse because they have a reduced ability to be aware of their financial status and may experience confusion, or memory loss in relation to their financial affairs and payment of such things as bills (Penhale & Kingston, 1997).

Elder abuse as a topic requires further research, community awareness and wider community consultation to explore and identify local solutions to address the identified risk factors. The task of addressing the issue of why elder abuse occurs and its meaning for some older people remains complex and hence, is beyond the scope of the current thesis. The implementation of effective elder abuse interventions in Australia should be built on the understanding of risk factors for both older people and persons causing harm.

2.6.11 Impact of elder abuse.

Elder abuse is not specific to any country, age, gender, socio-economic, religious or cultural background (WHO, 2008). Elder abuse can result in a range of adverse health outcomes for older people. There is evidence of premature death (Baker et al., 2009) and higher

dependence in activities of daily living (Cohen, 2008). One of the most disturbing suggestions from the literature proposes that older people who experience elder abuse, particularly neglect are three times more likely to die at an earlier age compared to other seniors (Lachs et al., 2004).

Elder abuse is a complex issue, encompassing a wide range of negative outcomes which have the potential to greatly affect the lives of older people (McCreadie, 2002). Whilst the research does acknowledge that the population is growing older and living longer, this does not mean that all older people are exposed to elder abuse risk factors.

In recent years, research studies confirm the association between elder abuse and emotional distress for older people (Luo & Waite, 2011). According to some studies older people with depression have a higher risk of being exposed to elder abuse (Cooper et al., 2009). It has been concluded that elder abuse is a contributing factor for psychosocial distress for an older person who may feel unsafe (Pico-Alfonso et al., 2006) and older people experiencing elder abuse are likely to report feelings of depression and anxiety (Yan & Tang, 2001). Some older people have described their elder abuse experience as 'devastating' with a number of older people stating that they would never fully recover (Mears, 2003). From the studies it would appear that the level of distress can differ depending on the impacts of the abuse experienced (Baker et al., 2009). Emotional abuse is more significantly associated with psychological distress than physical abuse (Pico-Alfonso et al., 2006).

Despite gaps existing in our current knowledge on the management and prevalence of elder abuse, the evidence suggests that abuse can be attributed to significant adverse health outcomes for older people. In relation to the issue of elder abuse and older people, few studies have considered the views of older people who have experienced the impacts of elder abuse (Hightower et al., 2006). Annetzberger et al. (1996) cited in their research that abuse towards older people was one of the "worst things that a family member can do to another older family member". One study found that neglect was associated with an increased risk of mortality (Lachs et al., 1994). In addition, neglect towards an older person can be associated with 15 times increased risk for cancer-related mortality and 10 times increase in nutritional- and endocrine-related mortality (Dong & Simon 2011).

Some observations also suggest an increased risk for nursing home placement for older people experiencing elder abuse. The research undertaken by Dong and Simon (2011) used data from the Chicago Health and Aging Project (CHAP) which included a large number of

community-dwelling elderly persons (n = 6674). The authors highlight significant relationships between elder abuse reported to social services agencies (106 participants) and increased rates of hospitalisation. Overall, the findings by Dong and Simon (2011) are consistent with earlier findings that described an association between elder abuse, higher vulnerability, poor health outcomes and hospital utilisation.

Older adults who are subject to elder abuse, neglect and exploitation face a greater risk of being hospitalised than other seniors, according to the results of a study published in the April 8 issue of JAMA Internal Medicine. According to Dong (2013) older people experiencing elder abuse may be put in situations that may threaten their health and safety, which further increase their likelihood to have more frequent hospitalisation. This study was the first study to examine the association between of elder abuse with respect to rate of hospitalisation.

Older people are admitted to hospitals in Australia with greater frequency (Oliver, 2007) and have longer admissions than younger people (AIHW Bulletin 53, 2007). Hospital admissions are associated with substantial risk of iatrogenic harm (functional decline and other adverse outcomes) among older people who are physically or cognitively frail (Podrazik & Whelan, 2008).

2.6.12 Theme 1 – The problem of elder abuse summary.

Overall, the literature suggests that elder abuse is difficult to detect, unlikely to be reported by older people due to shame, is usually undertaken by a trusted family member and incudes higher rates of financial and psychological abuse. For these reasons it is imperative that health professionals working with older people understand the complexity of elder abuse as well as their own values and attitudes to minimise contributing factors such as ageism.

For the most part the literature appears consistent in understanding the definition, types and risk factors of elder abuse. However, studies are limited in quantity and scope relating to the impact of elder abuse on older people and their family, particularly in relation to how they interface with the hospital system.

2. 7 Theme 2 - Review of Models and Approaches to Responding to Elder Abuse

This section focuses on examining, through the literature, the approaches that have been adopted in thinking about the most effective way in responding to elder abuse within a health context. This is relevant for this study to be able to determine the most relevant approach for

informing the development of the training intervention specific to the study site. The focus is on 'real world' models and frameworks for responding to elder abuse in comparable international jurisdictions.

This chapter will now address a review of models and approaches to responding to elder abuse within both an international and Australian context in a health care context. However, to commence this discussion it is important to understand the view of elder abuse held by the World Health Organization (WHO) as the specialised agency of the United Nations concerned with public health. The WHO is responsible for the World Health Report a leading international publication on health. The view held by the WHO on elder abuse is supported by this thesis.

2.7.1 Elder abuse – a human rights issue.

The World Health Organization (WHO) identifies elder abuse is a serious phenomenon that undermines the independence, dignity, health and sense of security of an older person (WHO, 2002). It is a violation of the basic human rights of older people and the consequences of elder abuse for older people and their families can cause devastating effects. Despite the growth in knowledge about elder abuse, it is one of the most complex and challenging situations any health professional will face (WHO, 2008).

In 2000, the Ageing and Life Course Program of the World Health Organization in Geneva, Switzerland, identified elder abuse as a priority theme requiring attention. The notion to support older people to uphold their rights is guided by the United Nations (UN) Principles for Older Persons (1991). In 1991, the Assembly established the "United Nations Principles for Older Persons", to ensure that all governments abide by these principles when developing any legislation or policy frameworks for action.

These principles are the foundation for health professionals working with older people. In late 2012, the Victorian Human Rights and Equal Opportunity Commission launched a report that identifies the key human rights issues facing older people living in Victoria. This report highlighted that older Victorians reported concerns about their rights to equality, autonomy, respect, dignity, freedom from discrimination and freedom of speech.

2.7.2 International approaches to elder abuse.

The study has been predominantly guided by inquiry into models which include the United Kingdom's 'safeguarding' approach and learning's from United States of America, Canada

and New Zealand. For this reason, it is important to summarise key international legislation and models for responding to determine what is relevant and applicable to the study site.

The area of elder abuse is not a new phenomenon with countries such as the United States of America and United Kingdom. Subsequently, much of the current research and literature which is available has international origins. The WHO (2002) suggests that many countries around the world have different national and local responses to responding to elder abuse. Some countries have comprehensive and interagency policies, protective legislation, and support services to address the problem, while others are still learning about the impact of elder abuse on their local communities.

While many countries including Australia have concentrated on priorities such as policy development, research and education programs, countries like USA and Canada have established mandatory reporting laws for elder abuse in some states or districts. These international approaches will now be briefly described.

2.7.2.1 The United Kingdom.

The United Kingdom (UK) manages elder abuse within general welfare or support services, rather than having specific services for older people. Therefore, the approach is not specific to age, but more to the vulnerability of an adult person. The focus of the UK adult protection model is on 'safeguarding' and achieving a balance between autonomy and protection for all adults (Phelan, 2008).

Elder abuse is addressed through safeguarding policy documents and codes of practice to support health professionals in effectively following guidelines in cases of abuse for any adults at any age. Similar to Australia, reporting of suspected elder abuse is not mandatory in the UK, but legislation and policies are in place to protect both staff and older people in cases of suspected elder abuse (O'Keeffe et al., 2007). The UK response is based on the premise to provide necessary services to minimise any type of abuse and restore family relationships, rather than punishing the people inflicting the harm to the older person or vulnerable adult (Filinson, 2006).

In the UK, a number of adverse events including death's and pressure from older people's lobby groups resulted in a landmark national strategic response entitled 'No Secrets' (Department of Health, 2000). The 'No Secrets' document published by the Department of Health in UK in 2000 (Department of Health, 2000) highlighted the importance of elder abuse training for all healthcare professionals. . 'No Secrets' (2000) states that '…the key to

protecting vulnerable adults from abuse is engaging 'all responsible agencies' to work together … [to ensure a] 'consistent and effective response to any circumstances giving grounds for concern' (p.6). As a result, from as early as 2000, all staff working in a National Health Service (NHS) were required to attend mandatory training on elder abuse. Prior to 2000 the emphasis on elder abuse education in the UK had focused on general practitioners.

Each NHS hospital in the UK has a defined senior member of staff called a 'safeguarding lead' who has the prime responsibility in each health service. 'No Secrets' (UK Department of Health, 2000) gave the local authorities responsibility for establishing and coordinating local systems, education and policies to protect vulnerable adults including older people at risk of elder abuse.

In October 2008, the Department of Health in the UK undertook a large national consultation on elder abuse to understand the impact of the current policy and to evaluate how it could be further improved. Over 12,000 respondents took part in this consultation including 3,000 residents living in the UK. There were around 500 responses – of these 67 responses were from NHS organisations. Significantly, the report identified the critical role that healthcare professionals can play in safeguarding vulnerable adults at risk of elder abuse.

The United Kingdom Department of Health (UK DOH) has recently included investigations of elder abuse to the range of statutory responsibilities of local authorities, which currently investigate referrals of suspected child abuse and neglect as a result of The Care Act 2014, which came into effect in April 2015. This model does not prescribe any particular form of investigation, allowing a flexible approach that accommodates the older person's circumstances (UK DOH, 2014). The Care Act provides professionals with principles that suggest the assessment and management of any form of abuse or harm should be 'person-led and outcome-focused' ensuring the affected adult is involved in the decision about how best to respond to the safeguarding situation.

For NHS Trusts, adult safeguarding teams generally provide advice and expertise to fellow professionals and have a key function in promoting good professional practice through effective governance arrangements e.g. facilitating training and supervision, contributing to decisions made at strategy meetings and auditing safeguarding processes. The UK governance approach includes routine data collection on elder abuse including demographic data, types of abuse, sources of harm and whether safeguarding 'alerts' were substantiated. Auditing is usually standardised and trends are analysed from year to year.

Following the changes to the management of elder abuse in the UK in 2008, the Department of Health undertook a large national consultation relating to safeguarding across the country. Over 12,000 people took part in it, including 3,000 adults. There were close to 500 responses – of these 67 responses were from NHS organisations including a number of major hospitals. The report identified the key role for healthcare professionals in safeguarding adults was education to assist in the identification of abuse and developing appropriate responses to it. New legislation was introduced in the UK in 2010 which strengthened local governance (UK Department of Health, 2009).

The United States (US) is well recognised as a leader in elder abuse research and practice (World Health Organization 2002). The elder abuse literature suggests that the United States is generally regarded as having the most longstanding and fully developed system for reporting and treating cases of elder abuse (WHO, 2014). The majority of states in the US have adult protection workers focused on working with adults of any age who are considered vulnerable or at risk of harm or abuse (Stiegel & Klem, 2007). Mandatory reporting is a key feature in the US relating to protection of any adult at risk (Bonnie & Brownell, 2010). Specialist multi-disciplinary elder abuse teams have been established to address issues within some hospitals and staff from these teams provide education, and assessment and assistance in dealing with complex elder abuse cases (Dyer et al., 2005; Nerenberg, 2006).

The US has seen vast development of their laws surrounding elder abuse over the past 40 years. Prior to 1977, no US state had any specific form of elder abuse legislation to assist with protection. In almost all states in the US (48 of the 50), failure to notify authorities of Elder abuse continues to be recognised as an offence. Adult Protective Services have been set up and have a legal obligation to provide support to older people who have experienced abuse. The use of elder abuse screening tools in US hospital emergency departments is becoming more common (Dyer et al., 2005).

A landmark reform in the US relating to elder abuse occurred when President Obama passed the Elder Justice Act (EJA) as part of the healthcare reform bill known as the Patient Protection and Affordable Care Act in March 2010. The Act signifies three significant approaches to elder abuse: (1) the creation of a Coordinating Council and Advisory Board (2) a boost in funding to support staffing, quality of care, and technology in residential care facilities and adult protective services departments. The third and perhaps the most significant approach is a provision of the act itself which requires any facility receiving federal

funding to adhere to a strict reporting requirements relating to adults of any age at risk of harm or abuse.

Under the auspices of the U.S. Administration on Aging, the National Centre on Elder Abuse (NCEA) is a national resource established to assist in the prevention of abuse towards older people. It works to ensure that older people living in the US live with dignity and integrity and importantly live free from abuse, neglect, and exploitation.

2.7.2.2 Canada.

The Canadian response to elder abuse is managed principally at the local level, with a wide variety of approaches occurring in every day practice (Canadian Department of Justice, 2012). A review of the evidence suggests that Canada has developed four major kinds of programs to address issues of elder abuse:

- adult protection program legislation has been rolled out in four provinces with an emphasis on drawing on community resources to provide a coordinated response.
- family violence programs respond to incidences of suspected elder abuse
- advocacy programs are based on a philosophy that the least restrictive and intrusive interventions should be used.
- integrated models bring together a number of key stakeholders to form a multidisciplinary team.

The approach in Canada draws on collaboration across sectors and increased attention to the impact of family violence on older people.

2.7.2.3 New Zealand.

A more recent international approach to adult protection comes from New Zealand (NZ) where the issue of elder abuse is considered within a broader family violence framework. In NZ, service responses to elder abuse are provided through the Elder Abuse and Neglect Prevention (EANP) program. EANP service providers provide client coordination and referral for individuals reported as experiencing or at risk of elder abuse through effective care coordination. EANP services are also required to develop and provide training and education to older people and their families (including carers) as well rolling out public awareness programs (Ministry of Health, New Zealand 2007).

Within NZ, there are six different provider groups who operate the 22 contracted EANP service sites. A comprehensive approach to service delivery is provided by 19 of these sites. The other three services focus on a greater emphasis on different cultural perspectives unique to NZ.

Age Concern in NZ has developed the service delivery program model for EANP services which is based on the use of a multidisciplinary coordinated team approach (Ministry of Health New Zealand, 2007). There are four key components which make up this model: local EANP service delivery, intervention professionals and specialists, an advisory group and importantly national coordination.

In summary international responses to elder abuse do vary but at the core of all approaches is having a national framework to respond to older people at risk. To date in Australia we are yet to have such an approach. The other shared elements between the jurisdictions refers to the role that key groups like health professionals can contribute in supporting older people at risk. The applicability of varied approaches to responding to elder abuse within a hospital setting needs to be considered further to determine what service delivery approach is effective in identification and responding to elder abuse. However, this is beyond the scope of this thesis as this study examines the role of training for health professionals.

2.7.3 Current practice in Australia.

The service approach to elder abuse in Australia varies across jurisdictional boundaries. Elder abuse strategies and practice initiatives have generally relied on existing organisations to drive change and develop service improvements within existing resources.

Despite the lack of a national policy framework in Australia, there has been consistency among the states and territories regarding the approach needed to address elder abuse (Chesterman, 2015). All jurisdictions have adopted a human rights approach to elder abuse, as opposed to a protective and mandatory reporting approach. The approach to elder abuse is informed by human rights conceptualisation that emphasis self-determination, autonomy and respect (Victorian Department of Health, Victoria, 2012). This approach empowers and encourages older people experiencing elder abuse to take action through information, education and advocacy, but does not expect the older person to take legal or responsive action (Kurrle, 2013). An empowerment model assumes all adults are competent to make informed decisions, unless proven otherwise, and that they have a right to self-determination and informed choice (Chesterman, 2015; AIFS 2015).

2.7.4 Australian state and territory approach to elder abuse.

This next section will cover an overview of individual states within Australia regarding their approach to elder abuse. The service approach to elder abuse in Australia varies considerably from state to state. In Australia there are no specific laws (at a state or national level) or a national government policy framework related to elder abuse. The one exception is the introduction of mandatory reporting of certain types of abuse for older people living in Commonwealth funded residential care facilities.

The issue of mandatory reports remains hotly debated in the area of elder abuse. The term "Mandatory Reporting" in relation to elder abuse refers to the introduction of legislation to establish or require specific staff to report elder abuse situations to a statutory body. The Commonwealth Government adopted a new legislation toward the protection of older Australians by introducing a framework of law reform including amendments to the Aged Care Act (1997) to include sexual and serious physical abuse for residents in a commonwealth residential care facility. Mandatory reporting of alleged and suspect sexual and serious physical assault came into effect on 1 July 2007 for all Public Sector Residential Aged Care Services (PSRACS) in Australia. However even with public attention focused in Victoria the introduction of mandatory reporting as a new management approach is not supported by the Victorian Government or a number of peak bodies (Department of Human, Services 2009).

Australian law works on the assumption that all adults aged over 18 can make their own decisions about whether or not they choose to do anything about what they may be experiencing. Under law, the legal rights and responsibilities of the individual does not change simply because the individual has reached the age of 65 years.

An inquiry by the Australian Law Reform Commission (ALRC) into laws and frameworks to safeguard older Australians from elder abuse is currently underway. The ALRC issues paper called for submissions to describe elder abuse as it relates to a wide variety of areas including social security, aged care, the National Disability Insurance Scheme, superannuation, financial institutions, family agreements, appointed decision-makers, public advocates, health services, forums for redress and criminal law. The Commission Inquiry has also been asked to examine the interaction and relationship between Commonwealth and state and territory laws as they relate to elder abuse (ALRC, 2016).

The response to elder abuse is reliant on state and territory government policies and strategies and general state and territory criminal and civil laws (including guardianship and powers of attorney). Most Australian states and territories have some guiding policy or strategy to prevent and respond to elder abuse with the exception of the Northern Territory and Queensland. However, Queensland does have an elder abuse website and a state-funded Elder Abuse Prevention Unit run by community service provider Uniting Care.

Policy documents and strategies vary significantly between states and territories in focus, length and content. Policy documents generally outline the various types of abuse, how to identify and address elder abuse and they make reference to the referral sources. The need for community awareness, information and education for older people and professionals, and the need for coordinated multidisciplinary support services, pathways and protocols are also highlighted. Chesterman (2015) concludes by suggesting that the level of state-wide actions and initiatives vary greatly in Australia.

Some states have very detailed elder abuse prevention and response strategies, such as New South Wales, Tasmania and Victoria. Other states have far less detail in their policy documents and strategic frameworks. The Australian Capital Territory's 2012 Elder Abuse Prevention Program Policy is a 33-page document that was informed by a strategic review of the implementation of the territory's 2008 Elder Abuse Prevention Program. The 16-page Western Australian 2013 Elder Abuse Protocol Guidelines for Action provides basic information to community service providers. Neither document includes direct key strategic actions or initiatives.

The need for a multidisciplinary approach to the prevention and response to elder abuse is acknowledged in all policy and strategic documents. Tasmania calls for a "whole of government" approach and South Australia promotes a multidisciplinary and interagency approach built on the Charter of the Rights and Freedoms of Older People. New South Wales highlights the roles and responsibilities of a range of stakeholders including police, government and non-government agencies and Victoria refers to the need for coordination of services (multi-agency) and an integrated state-wide response. The Australian Capital Territory recommends a coordinated and multidisciplinary approach.

These policies have been critiqued for having an undue focus on vulnerability; lack of service specialisation and skills acquisition, and no clear strategy or processes to identify lead agencies or key agency roles. A lack of emphasis on service improvement, the development

of expertise, and facilitating collaborative practices has also been identified (Chesterman, 2015).

In the past there has largely been a piecemeal approach to addressing elder abuse in Australia, largely due to it being seen as a state, rather than federal issue. This has led to gaps in knowledge and services – particularly regarding the prevalence of elder abuse in Australia – as well as the fragmentation of support systems. However, there are some recent developments that provide encouragement for a coordinated national approach to this issue.

2.7.4.1 Victorian approach to elder abuse.

Given that the site of this study is located in the state of Victoria, it is important to review in more detail the policy link under which directs the role of health professionals within a hospital context in responding to suspected elder abuse. With the ageing population and numbers of people living beyond previous trends it is estimated that by 2030, one-quarter of Victoria's population will be over the age of 65. The number of older people living alone with limited support from service providers or their community is also likely to grow. Expected growth in the numbers of older Victorians who may be subject to elder abuse is driven by three factors; increasing numbers of older people living than previously recorded, increasing longevity due to medical advances and technology and increasing numbers of older people with dementia or cognitive issues.

A review of the grey literature from individual Australian state and territories would suggest that Victoria has a more collaborative approach to responding to elder abuse compared to other states in Australia (Chesterman, 2015). The outcome of a report, 'Strengthening Victoria's Response to Elder Abuse (Office for Senior Victorians, 2005)', provided $5.9 million of funding to implement a number of key recommendations from the report. These recommendations focused on developing a whole of government response to elder abuse. A large proportion of the allocated funding was used to establish SRV in April 2008. SRV provides a telephone helpline, advocacy and support, legal services and community education. SRV is an entity consisting of four parties; Council on the Ageing (COTA) Victoria as the lead agency, the Public Interest Law Clearing House (PILCH), Loddon Campaspe Community Legal Centre (LCCLC) and Eastern Community Legal Centre (ECLC) (Seniors Rights Victoria 2012)

The Victorian Department of Health updated its 1995 Elder abuse publication by updating and re launching: 'With Respect to Age – 2009', Victorian Government practice guidelines

for health services and community agencies for the prevention of Elder abuse. The Victorian elder abuse guidelines support the view that:

- older people have a right to live safely, free from any form of violence
- older people should be respected to make their own decisions on matters affecting their lives as far as they are able.
- the older person who has experienced or at risk of elder abuse is supported and protected
- other individuals and the public are protected
- the risk of further abuse is minimised through appropriate intervention strategies
- the older person's life is disrupted as little as possible.

The policy document, 'With Respect to Age' (2009) is aimed to target a wide ranging audience including key clinical staff working in health services. The guide is presented in a way to mirror the Victorian Government Elder abuse prevention strategy and provides key evidence and templates to support collaboration and interagency guidelines.

The guide has seven principles underpinning the approach to working with older people at risk of elder abuse. They include competence, self-determination, appropriate protection, best interests, importance of relationships, collaborative responses and community responsibility. The principles endorsed in Victoria view the important concept that we need to work towards a skilled and engaged workforce use existing or shared resources and strive towards continuous improvement and innovation. These guidelines detail important priorities and principles relating specifically to the management of elder abuse in Victoria.

As a follow up to 'With Respect to Age' (2009) the Victorian government released a document in 2012 titled: 'Elder Abuse Prevention and Response Guidelines for Action 2012 – 2014'. These guidelines support the 'Victorian Health Priorities Framework 2012 – 2022'. These guidelines reflect the Victorian government's commitment to ensuring that key agencies are working towards to protect older people at risk of elder abuse. The framework provides an opportunity to consider the health system as a whole and allows us to work together to effectively achieve shared goals (Victorian Department of Health, 2012).

The release of the 'Victorian Health Priorities Framework 2012-2022' has established performance measures for hospitals to implement referral policies and protocols with respect to identifying and responding to elder abuse. One of the key measures of success according to the framework is data collection on patients where elder abuse is suspected or detected.

Addressing this requirement for a large number of hospitals in Victoria remains a work in progress and it is contingent upon organisations first being able to identify and respond to elder abuse.

The recent attention on family violence in Victoria has created an opportunity for elder abuse to gain greater recognition and the role of health professionals is a key strategic direction moving forward. Synthesis of this inquiry phase will assist to inform the development of the training intervention to support health professionals' respond to suspected elder abuse.

2.8 Theme 3 - Responding to Elder Abuse – the Role of the Health Services

The third theme which will be examined this chapter relates to the role that health professionals play in responding to suspected elder abuse. This section will consider opportunities and barriers identified in the evidence which will be analysed to inform the training intervention.

According to the World Health Organization (2014) progress towards understanding elder abuse and developing effective responses is considerably less well developed than in other areas of interpersonal violence, including family violence and child abuse (WHO, 2014). The emerging evidence identifies the healthcare sector as playing a critical role in elder abuse awareness, detection, intervention and prevention. For this reason, the role that health professionals' play becomes even more relevant and critical in overall management strategies for elder abuse (Joubert & Posenelli, 2009).

2.8.1 Addressing opportunities and barriers.

The literature suggests that health professionals are well positioned to identify and respond to elder abuse (Dong, 2012; RCFV, 2016) particularly because of the association between older people and the utilisation of the hospital system. However, literature suggests that health professionals report that lack of confidence and knowledge regarding defining, diagnosing, and reporting abuse can be barriers to managing abuse effectively (Cooper, Selwood, & Livingston, 2009).

An examination of the literature suggested the following barriers for health professionals are important to highlight in this thesis: lack of confidence in defining, identifying, and reporting abuse; reluctance to report abuse unless there is certainty that abuse had occurred; concern for the therapeutic relationship; potential consequences for the older person ; empathy with the abuser; not having clear definitions of abuse; shortages of available interventions for the

older person; a lack of training; a lack of time; the older persons health; absence of clear legislation; not knowing where or how to report; a lack of protocols; ethical dilemmas; the belief that abuse is a private family matter; and insecurity about whether the informant will be protected (Joubert & Posenelli, 2009; Cooper et al., 2009).

A study by Dong (2013) confirmed that older adults who are at risk of elder abuse are likely to face a greater risk of needing a hospital admission (Dong, 2013). Hospitals provide an opportunity not otherwise available, for health professionals to respond if they suspect an older person may be subject to abuse (Joubert & Posenelli, 2009). For many older people the hospital emergency department is the main way in which they access health support (Fulmer, 2004) Evidence further confirms that hospitals may offer a 'window of opportunity' for help and support to older people at risk of elder abuse (Kahan & Paris, 2003). Healthcare professionals who routinely interact and assess older people are best placed to identify those at risk of abuse and also to provide support to those experiencing abuse (WHO, 2011).

In contrast to the role that health services can play in supporting older people, a large number of studies identify barriers which exist for health professionals in responding to elder abuse. Nerenberg (2008) asserts that the professional response to elder abuse is often inadequate, services are lacking or nonexistent, fragmented, and offer different levels of expertise. In addition, elder abuse is not well understood by the general public.

There is growing evidence that lack of knowledge of the mechanisms, protocols and legal framework around reporting of elder abuse hampers effective management for health professionals (McLaughlin & Lavery, 1999; Cooper et al., 2009; Thompson-McCormick et al., 2009; Sugita & Garrett, 2012).

Nerenberg (2008) further argues that legal responses, support agencies, courts, and healthcare providers do not work together on addressing elder abuse at a systems level. Given the interconnection between an older person's health, social and legal issues arising in the context of elder abuse, (Adamson & Noble, 2011), there is an emerging body of knowledge illustrating the benefits of combining legal and healthcare services to address elder abuse, which has led to the establishment of Health Justice Partnerships (HJP).

In Victoria, Justice Connect Seniors Law, a pro bono legal service, has established two Health Justice Partnerships (HJP) to help older people experiencing elder abuse and other associated legal issues. One is a partnership with a community health service and the other

is a new partnership at the study site of this research. Evaluation findings confirm that HJPs are one of the most effective ways to reach older people experiencing elder abuse and they can assist in resolving the underlying legal problems which can improve clients' health and wellbeing (Adamson & Noble, 2011). The legal response to elder abuse should advance the human rights of older people, balancing their right to be safe and their right to exercise self-determination. HJP's achieve this through collaboration with organisations such as hospitals recognised as having a greater reach with older people.

McCallum (1993) suggests that the law and protective services alone cannot protect older people. Education is identified as a critical strategy to contribute in the prevention of older people at risk. It is essential for understanding and having an awareness of elder abuse (Walsh et al., 2007). Dye & Rowe (2011) propose that hospital emergency departments are often the first point of contact for an older person, but very few have procedures for handling suspected elder abuse. Raising the awareness of health professionals in this area is argued by some as a critical strategy in responding to the problem (Walsh et al., 2007).

Health professionals experience a number of system barriers in relation to the management of elder abuse (Thompson-McCormick et al., 2009). Healthcare organisations need to develop policy and practice guidelines for responding elder abuse which assist staff in understanding their clinical responsibilities and legal processes and feel confident to act in the event they encounter an older person at risk (Chesterman, 2015). It can therefore be proposed that a lack of governance regarding appropriate interventions by healthcare professionals is one of the contributing factors to why elder abuse remains such a problem in our community.

Responding to elder abuse can be problematic, with clinical symptoms sometimes confounding health professionals who are not familiar with the indicators or associated sign of elder abuse. In addition, the lack of clarity around what constitutes elder abuse and the ethical issues that are frequently encountered add to the challenge of identifying and responding to elder abuse (McGarry & Simpson, 2007; Cooper et al., 2009; Alt et al., 2011; Sugita & Garrett, 2012).

Another contributing factor for health professionals' lack of responding is fear that the relationship established with the older person might be negatively impacted by addressing suspected abuse or reporting it, especially in cases where the older person cannot or does not confirm the abuse is occurring (Cooper et al., 2012). Hesitancy in reporting may also due to consideration of how to report to senior management and one's relationship with

colleagues or family members (Grainger, 2009). The literature suggests there is a suggestion that feelings of empathy towards a suspected person of concern can also prevent the reporting of abuse (Richardson et al., 2004; Thompson-McCormick et al., 2009). It can also be concluded that health professionals fear that as a result of their actions and reporting, there may be legal consequences for the person of concern (Richardson et al., 2004).

The literature suggested that years of professional experience and knowledge regarding the assessment of abuse indicators were predictors of appropriate measures being taken to address cases of suspected abuse, since experience could influence the decision-making process (Meeks-Sjostrom, 2013).

Grainger (2009) suggests that the emotions that professionals can encounter when they suspect abuse, such as, fear, lack of confidence and uncertainty, can lead to avoidance strategies and result in under reporting of elder abuse. Notwithstanding the contribution that health professionals can make in supporting older people is well recognised (RCFV, 2016).

2.8.2 Training of health professionals in elder abuse.

The evidence concerning the effectiveness of education and training in changing healthcare professionals' behaviours in relation to elder abuse reporting is equivocal. As already cited, many of the barriers to the identification, reporting and management of elder abuse in literature relate to a lack of awareness, knowledge and skills among health professionals (Alt et al., 2011). Several studies have examined healthcare professionals' ability to recognise elder abuse but report a lack of competence in identifying intervention strategies (Thompson-McCormick et al., 2009).

There is emerging literature supporting the view that recognising and knowing how to respond to elder abuse is critical for health professionals (RCFV, 2016; AIFS, 2015). Education and training of professionals in elder abuse is regarded as an important means of ensuring the early identification, prevention and effective management of elder abuse (McGarry & Simpson, 2007; DeHart et al., 2009; Day et al., 2010).

The broad aims of education and training programs for health professionals are to increase awareness and knowledge of elder abuse among those working with older people and to improve their confidence and knowledge to more effectively assess, identify, report and manage suspected cases of abuse (Cooper et al., 2009; Thomson et al., 2010; WHO, 2011; Sugita & Garrett, 2012). However, the literature suggests that there is a lack of quality in

elder abuse training programs. Several gaps in professional elder abuse education and training programs have been identified (Kingston & Penhale, 1997; Seamon et al., 2007; Thompson-McCormick et al., 2009). These gaps relate to consistency of approaches in identifying and responding to suspected elder abuse. Hence, the challenge appears to not only reside in the need to provide education and training on elder abuse to health professionals, but also to ensure that the training provided meets key learning objectives and results in better outcomes for older people.

Education and public awareness are cited as important features in any systems approach to managing elder abuse. Moreover, education and training of professionals is regarded as an important means of ensuring the early identification, prevention and effective management of elder abuse (Day et al., 2010). Of importance in responding to elder abuse in our community is the general community lack of understanding of elder abuse and health professionals' lack of education in recognition of the signs and risk factors (Levine, 2003). However, it is now accepted that recognition, assessment and intervention of elder abuse by health professionals can contribute to improved wellbeing for older people.

The role of competency appears to be a strong theme in the literature relating to training of health professionals'. The development and use of competency standards has been identified as an emerging factor in supporting health professionals' education and training, particularly around health workforce development. A thorough review of health professional education literature reveals that little attention has been given to the competencies for health professionals' in relation to elder abuse. This appears to be a significant gap needing further consideration in addressing the research aims in this thesis. The consideration of what competencies are critical for different levels of staffing roles and experience needs further examination.

2.8.3 Under reporting of elder abuse by health professionals.

It is estimated that 70% or more of elder abuse case identification comes from healthcare professionals (Kurrle, 2013). The issue of under-reporting and detection of elder abuse nevertheless remains a difficult and complicated issue for many health professionals (Joubert & Posenelli, 2009). Under-reporting is an area of further reflection as rarely is the health professional present or a direct witness when the abuse is occurring to the older person (Alt et al., 2011). Several reasons for the under-recognition and underreporting of elder abuse by health professionals have been cited in the literature (Cooper et al., 2012; Sugita & Garrett, 2012).

Lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse have been identified as significant impediments to tackling elder abuse (Cooper et al., 2009). A significant body of evidence points to deficits in awareness, knowledge and confidence among health professionals in relation to elder abuse and documents the importance of education and training in the area (McLaughlin & Lavery, 2000; Sugita & Garrett, 2012).

Elder abuse may be undetected because of the failure of professionals to identify the problem or simply because they are unaware that abuse may have occurred. It has been suggested by Boldy (2004) that elder abuse is complex, multidimensional and placed in the 'too hard basket' by health professionals who are not confident in responding to suspicion. Furthermore, limited action by health professionals in responding to elder abuse may be as a result of health professionals lacking knowledge about where and who to report suspected elder abuse to in organisations which may not have policies or protocols in place for staff (Halphen et al., 2009).

There is increasing evidence that lack of knowledge of the mechanisms, protocols and legal framework around reporting of elder abuse hampers effective management (Cooper et al., 2009; Thompson-McCormick et al., 2009; Sugita & Garrett 2012). Education; policies and specific elder abuse training resources for doctors, nurses and other health professionals are considered an important contribution to raising awareness about elder abuse and how to respond.

It should be noted that hospitals in the UK and US are well advanced in this area with regards to actively involving health professionals in elder abuse education. The Mount Sinai Hospital in New York (2004) confirms that elder abuse is an escalating problem which can be addressed when patients present to hospitals through the provision of education and awareness generation for all hospital staff. This is further supported by the model in the UK which requires all staff working in a National Health Service hospital or community agency to receive mandatory training in the area of elder abuse.

A US study tilted: 'Elder Abuse and Neglect: The Experience, Knowledge and attitudes of Primary care Physicians' (2004) concluded that 23% of respondents believed that elder abuse was a significant problem in their own patient populations and the overwhelming majority of respondents felt elder abuse was a significant health concern. However the results indicated that when respondents suspected elder abuse, they did not always act appropriately. The majority of physicians in this research did not ask their older patients

about instances of possible elder abuse. When confronted by a case of suspected elder abuse, 94% of respondents reported that they could not prove the suspicion. Of note, 96% stated that the identification and long-term management of elder abuse should be included in medical training.

The American Journal of Geriatric Psychiatry reported a study by Cooper, Selwood, Livingstone and Gill (Cooper et al., 2009) who reviewed 32 articles which investigated health professionals' knowledge, detection, and reporting of elder abuse. This research included 21 surveys (5,325 professionals), nine analyses of elder abuse reports to regulatory bodies, and two intervention studies. In summary, this report highlighted that health professionals underestimated the prevalence of elder abuse on a number of occasions. Despite the fact that many of the states in the US have mandatory reporting, only a quarter of U.S. physicians were aware of American Medical Association elder abuse guidelines (Cooper et al., 2013). The authors concluded in their research that 33.7% of healthcare professionals had detected a case of elder abuse in the previous year however less than half of these detected elder abuse were reported to the appropriate authority. Importantly, the review demonstrated that more than 6% of the general older population in the study site at risk of elder abuse.

A study (2009) on the recognition and perception of elder abuse by pre-hospital and hospital-based care providers in the UK aimed to evaluate the differences in knowledge and attitudes of pre-hospital care providers (PCPs) and hospital care providers (HCPs) to elder abuse. A 20-question survey was designed to determine the providers' perception, knowledge and ability to identify older people that were at risk of elder abuse. A total of 645 surveys were distributed and 400 surveys were returned. 51.3% of those surveyed did not suspect any older people at risk of elder abuse, although it needs to be noted that 60.5% of the respondents admitted little or no contact with older people (Richardson et al., 2012).

McLaughlin and Lavery (2000), who examined elder abuse awareness and knowledge among community health and social care staff in Northern Ireland, found a low level of knowledge and poor perceived competency in relation to identifying and managing elder abuse. They also reported that the knowledge and understanding of some health and social care professionals appeared to be guided more by practice and experience and less by evidence. The emotions that professionals can encounter when they suspect abuse, such as, fear, lack of confidence and uncertainty, can lead to avoidance strategies and result in low levels of reporting (Grainger, 2009). McLaughlin and Lavery's study (2000) found that

only a quarter of health professionals working with older people believed they could identify suspected elder abuse with any confidence.

Emergency physicians are frequently in contact with older people seeking care for acute illness or injury. However, a study of four hospitals in Turkey (Kissal, 2010) reported that doctors working in the emergency department could not identify risk factors for elder abuse. In this study, most participants stated that did not know what to do if they suspected elder abuse. They reported that they would contact the social work department.

Studies conducted in Ireland have examined health professionals' knowledge of elder abuse. McLaughlin and Lavery (2000), who examined elder abuse awareness and knowledge among health professionals in Northern Ireland, found a low level of knowledge and poor competency in relation to identifying and managing elder abuse. They also reported that the knowledge and understanding of some health and professionals appeared to be influenced by practice and experience and less by evidence. Further research in Ireland by Kennelly et al. (2007) examined elder abuse awareness and knowledge among hospital doctors and medical social workers working at a large urban hospital in Dublin and reported a lack of knowledge and familiarity with guidelines for managing abuse, especially among doctors.

It is widely reported in the literature that doctors in their work have regular contact with older people and are well positioned to detect signs and risk factors of elder abuse. A report published in 1997, 'Detecting and Managing Elder Abuse: Challenges in Primary Care', described the results of a survey of 122 family doctors practicing in Canada. This research concluded that barriers did exist in the detection and management of elder abuse – most significant was the lack of education for health professionals including doctors.

Health professionals who have not typically been involved in elder abuse issues require education to alert them to their roles and responsibilities in relation to responding to elder abuse (Kingston & Penhale, 1997).

2.8.4 Value of a multidisciplinary approach in responding to elder abuse.

An emerging theme in the literature concerns the multi-faceted nature of elder abuse and the associated need for multidisciplinary and multi-agency responses (Penhale, 2008). Prevention requires a multifaceted, multidisciplinary approach targeting a range of stakeholders (Chesterman, 2015). Increasingly, it is being recognised that the responsibility for detecting and responding to suspected cases of elder abuse should be shared across a

range of diverse professional disciplines and across a range of sectors in society (Weiner, 1991).

The use of multi-disciplinary teams which consist of health professionals' across medical, nursing and allied health disciplines when intervening in cases of elder abuse appears to be a strategy which is gaining traction (Day et al., 2010). Review of the literature confirms that countries like UK, United States of America and Canada support a multi-disciplinary approach to elder abuse interventions (WHO 2014). Multidisciplinary teams promote elder abuse detection and intervention (Teaster & Nerenberg, 2004). The responsibility for detecting suspected cases of elder abuse should be shared across a range of diverse professional disciplines and sectors in the society (Weiner, 1991). Thus, professional groups who have not typically been involved in elder abuse issues require training to alert them to their roles and responsibilities in relation to the prevention and management.

Teaster and Nerenberg (2004) suggest that multidisciplinary teams can assist in the detection of elder abuse by offering a more holistic perspective. This approach assures that no single discipline has single responsibility for handling complex and challenging situations, further confirming that the clinical management of elder abuse requires both discipline-specific and multidisciplinary perspectives. A shared learning approach to elder abuse training has the potential to improve interdisciplinary working by enhancing different professional groups' understanding of each other's respective roles and responsibilities, as well as attitudes, beliefs and approaches to elder abuse (Kingston & Penhale, 1997; Day et al., 2010).

Best practices in the field of elder abuse prevention and intervention should promote interdisciplinary collaboration (Day et al., 2010). The importance of multidisciplinary collaboration and multi-agency coordination in the effective prevention and management of Elder abuse is widely recognised according to a number of authors (Anetzberger et al., 2000; McGarry & Simpson, 2007; Nusbaum et al., 2007; Day et al., 2010). For this reason, an interdisciplinary and multi-agency approach to training in elder abuse is recommended in order to promote collaborative working in the area of elder abuse prevention and management (Kingston & Penhale, 1997; Day et al., 2010).

A study conducted at Beth Israel Hospital in Boston (1981) USA has a 12 member team (5 nurses, 3 social workers, 3 physicians and 1 health policy expert) to respond to and manage elder abuse. The team was established in 1981 in a response to Massachusetts State Law (1980) which mandated the reporting of elder abuse. The team had two functions: to provide

consultation and support to hospital staff who suspect elder abuse and to provide education to staff on the identification of signs and the development of appropriate interventions. If a staff member suspects abuse – there is a clear plan for action. The medical file is reviewed, the patient and family are interviewed and there is significant consultation with all staff involved. The presence of the team has increased the hospital staff's awareness of elder abuse and their willingness to refer for specialist consultation if they suspect abuse (Matlaw & Spence, 2008).

Multidisciplinary input and multi-agency collaboration in the design of elder abuse educational initiatives, has described benefits which include identifying all relevant issues and areas in which training is required, fostering an awareness of elder abuse from multiple perspectives and increasing the potential for future coordination and collaboration in the management of elder abuse (Anetzberger et al., 2000). The role of the multidisciplinary team in a hospital setting needs to be examined in further research to determine if this model is effective in identifying and responding to elder abuse.

Increasingly, it is recognised that the responsibility for detecting and responding to suspected cases of elder abuse should be shared across a range of diverse professional disciplines and across a range of sectors in society (Weiner, 1991). The assumption here is that professional groups who have not typically been involved in elder abuse issues, should attend training for education on their roles and responsibilities in relation to the prevention and management of elder abuse (Kingston & Penhale, 1997). This may include groups such as allied health staff and nursing staff. The World Health Organization supports inter-professional education as a way to achieve and improve effective collaboration and quality of care for older people (WHO, 2014). Trevitt & Gallagher (1996) suggest that training for health professionals could promote awareness and improve responsiveness for older people at risk of elder abuse based on a study of health professionals' knowledge about the types of abuse, skill recognition and intervening in cases of elder abuse.

In summary, the clinical management of elder abuse requires both discipline-specific and multidisciplinary approaches. The WHO (2011) suggests that managing this problem in our growing elderly population, interdisciplinary collaboration between health professionals is critical.

2.8.5 Screening for elder abuse by health professionals.

There is a premise that health professionals have a duty to act on suspected elder abuse in relation to older vulnerable people presenting to hospital. However, as demands on emergency departments and hospitals increase and models of patient care change, the current health workforce needs to be both skilled and flexible to respond to emerging complexity in our ageing society. There is an ongoing debate regarding the use of screening tools for improving how we respond to elder abuse in hospital settings.

Screening has been identified as one intervention strategy to assist in the detection and prevention of elder abuse (Naughtin, 2008). The basic premise for screening supports health professionals being able to recognise the signs, symptoms, behaviours and attitudes of those who may be at risk of elder abuse. As such, screening tools offer a method of assisting health professionals to detect only the risk of elder abuse not how to respond if it is present (Fulmer et al., 2005). Many different screening and assessment instruments have been developed to support healthcare professionals in identifying elder abuse and are widely used internationally (Naughtin, 2008). However, there is no elder abuse current screening tool that has been developed for use in Victorian hospitals.

Several tools are available to screen for elder abuse. The tools may be short screening questions or in-depth assessments, depending on the individual being assessed and the practice setting. The literature suggests that the use of elder abuse screening tools greatly differ and for this reason it is likely that many elder abuse cases actually end up being not detected (Cohen, 2011). There is also a view that elder abuse cases may need to be assessed or monitored over a period of time and a single act of screening may not pick up any indicators (Johannesen & Lo Giudice, 2013). Literature also suggests that health professionals may not feel confident to ask an older person questions relating to their feelings about family members and safety in the event that the actual older person might confirm a problem (Walsh, 2007). For this reason, the application of screening tools in hospitals may not strengthen practice in identifying older people at risk.

2.8.6 Responding to the issue of capacity by health professionals.

For healthcare professionals, the challenge of elder abuse and dementia is best understood in terms of decision-making capacity (Dong & Gorbien, 2005). It is important to note that the presence or absence of capacity is often a determining factor in how healthcare professionals act in relation to elder abuse. However, what we know about capacity is that

for some older people it may not be completely present or completely absent. This may apply to older people with a fluctuating mental state due to ill health or delirium.

Capacity is not necessarily an indicator of dementia. Capacity is considered a changing relationship between the issues needing clarification and the older adult's ability to make these decisions. For more complex health issues, capacity determination is required for higher levels of decision making capacity. At the same time, for less complex matters, an older person may have decisional capacity on a given day. However, health professionals are often forced to make a decisive decision to assist in next steps such as consideration of applications to the Victorian Civil and Administrative Tribunal (VCAT). A person's capacity can be temporarily affected by stress, anxiety, medication, illness, infection or injury, and then regained after a temporary illness or stressful situation passes.

Decision making capacity can vary depending on the issue being decided. For example, it may be difficult for a person to understand complex banking arrangements, but they may be quite capable of deciding things such as medical treatment or where they want to live. Capacity is a legal definition; however, it is assessed by the medical sector and doctors are often asked to make a judgment on whether an older person either has or has no capacity.

An adult may have capacity for some things but not for others. For example, a person may have the capacity to manage a pension but not to make complex investment decisions; a person may have the capacity to decide what to wear but not to decide where they should live. Health professionals are often asked to establish capacity so that an older person can make a will or to change an Enduring Power of Attorney. These considerations are important when considering such issues as financial abuse from family members who may have a vested interest in such matters including an older person's legal affairs. In situations of suspected elder abuse in where the older person lacks capacity relevant policies and legislation have been established to protect the older person. Understanding the capacity of an older person at risk of elder abuse is critical as this will assist in guiding the intervention strategy to support the older person. The challenge in working with older people at risk of elder abuse for health professionals is to balance a duty to protect the safety of older persons with their right to choice or self-determination. (Donovan & Regehr, 2010). The issue of both dementia and capacity will continue to remain at the forefront in how we understand and respond to elder abuse.

In summary the literature suggests that health professionals are well positioned in hospitals to identify and respond to elder abuse (Dong 2012; RCFV 2016) particularly because of the

association between older people and the utilisation of the hospital system. The current debate on elder abuse appears to have shifted from trying to define the different forms of abuse to trying to identify the most appropriate and effective response to protect older people at risk. However, many of the barriers to the identification, reporting and management of elder abuse cited in the literature relate to an underreporting of elder abuse (Halphen et al., 2009), a lack of awareness, knowledge and skills among health professionals to screen cases of suspected elder abuse and identify opportunities to respond (Alt et al., 2011). Several studies have examined healthcare professionals' ability to recognise elder abuse however they report a lack of competence in identifying response practices (Pelotti et al., 2013). Of significance is the evidence to confirm that that the lack of knowledge relating to the specific elder abuse mechanisms, protocols and the legal framework around responding to elder abuse hampers effective management (McLaughlin & Lavery, 2000; Cooper et al., 2009; Thompson-McCormick et al., 2009; Sugita & Garrett 2012).

There is growing evidence that lack of knowledge of the mechanisms, protocols and legal framework around reporting of elder abuse hampers effective management for health professionals (Cooper et al., 2009; Thompson-McCormick et al., 2009; Sugita & Garrett 2012).

2.9 Theme 4 - Education and Training for Health Professionals in Detecting and Responding to Elder Abuse

The aim of this study is to test a training intervention to determine if it is effective in improving health professionals' response to suspected elder abuse. Therefore, it is critical to examine the effectiveness of elder abuse training approaches within a health context. Elder abuse training may improve health professionals' skills in managing elder abuse and may help to overcome some of the barriers experienced in relation to responding to suspected elder abuse (Grainger, 2009).

Education and training focused on older people at risk of elder abuse have been shown to be significant in the prevention of abuse (Sturdy and Heath, 2007). The identification of elder abuse is well recognised in the literature as a barrier for health professionals (Phelan, 2009). Evidence further suggests a lack of confidence in reporting and responding to elder abuse can be due to an absence of policies or guidelines (Buchwald et al., 2000, Wong & Marr, 2002).

The literature recommends that a key strategy for preventing elder abuse is education or training, usually directed at those caring for older people or those in contact with vulnerable older people on a regular basis such as hospital staff. A description of the education strategies that have been developed and gaps for health professionals will be described. The importance of providing specific elder abuse training to health professionals is becoming well recognised and is supported by the literature.

Educational interventions for professionals tend to focus mainly on the nature and prevalence of elder abuse, training in awareness and recognition of elder abuse as well as training in professional roles and responsibilities in relation to reporting abuse (Schmeidel et al., 2012). Very few training interventions incorporate assessment and screening skills, problem-solving skills, strategies for managing conflict, stress and challenging behaviour, strategies for effectively managing cases of elder abuse and discussions of ethical issues around reporting (Schmeidel et al., 2012). DeHart et al. (2009) argue that in addition to providing training in recognising and reporting elder abuse, training programs should also focus on the competencies required for protecting older people from abuse.

An unexpected discovery in the literature related to the role of competency based training. This appears to be a significant gap needing further consideration in addressing the research aims in this thesis. The consideration of what competencies are critical for different levels of staffing roles and experience needs further conceptualisation to inform the development of the training intervention for this thesis.

2.9.1 Education and training – international perspective.

It should be noted that hospitals in the UK and US are well advanced in this area with regards to actively involving health professionals in elder abuse education. A US study compared pre-test and post-test scores for health professionals who participated in a continuing education initiative which involved viewing a video on interpersonal violence (IPV) (McCauley et al., 2003). The video included information about IPV and a demonstration of skills for identifying, preventing and intervening in IPV. Unfortunately, only a small number of the evaluation questions related specifically to elder abuse and the authors reported no significant improvement in physicians' knowledge of reporting requirements for elder abuse, a finding which the authors attributed to the participants' higher baseline knowledge (McCauley et al., 2003).

A UK Women's Health study (Tilden et al., 1994) undertaken in 2003, suggested that further research on factors related to health professional's unwillingness to identify and intervene in elder abuse was needed. This research explored factors, such as gender and reviewed differences in the disciplines of dentistry, dental hygiene, medicine, nursing, psychology, and social work. Results indicated that there are similarities within and wide differences among three groups of subjects: (1) dentists and dental hygienists (2) nurses and physicians and (3) psychologists and social workers. Although, the findings overall showed low rates of suspecting abuse, it did conclude that clinicians who have received education are more likely to respond if they detected risk factors (Tilden et al 1994).

In Ireland, Kennelly et al. (2007) explored the term 'elder abuse' with doctors and social workers in a hospital setting and found that staff would prefer not to use the term 'elder abuse'. In this study it was deemed that social workers in hospitals had more knowledge and confidence in the area of elder abuse than doctors because of the education they had received.

A pilot study in Tower Hamlets London (2000) indicated that General Practitioners (GP) were not recognising elder abuse because of a lack of training (McCreadie et al., 2000). This research concluded that the strongest indicator predicting diagnosis of elder abuse was knowledge of risk factors that could be obtained from education and GPs who were well informed on elder abuse were four times more likely to recognise elder abuse than those who had not done training.

These findings highlight a need to promote awareness of elder abuse risk factors and signs for all health professionals working with older persons. Evidence suggests that targeted education and training for staff on elder abuse help to address barriers and improve staff's knowledge in identifying the signs and risk factors (Kennelly et al., 2007, Wang et al., 2009). However, there is a suggestion that educational programs should be tailored to participant's baseline knowledge (Richardson et al., 2002) and also to the environment in which they work (Phelan, 2009). It could be concluded from this literature that staff working in hospitals are likely to require different education to health professionals working in the community as both environments will have unique training requirements for health professionals.

Kingston & Penhale (1995) suggest that health professionals need to better respond to older people at risk of abuse and suggest that sensitive skills are required in order to ask older people very difficult and confronting questions about their personal circumstances.

Hospital staff can act after they suspect something is wrong, which can be based on little evidence and often without proof. Increasing evidence also supports that health professionals are unlikely to act upon a situation if they suspect something is wrong (Joubert & Posenelli, 2009).

2.9.2 Design and pedagogy of training interventions.

The literature underlines the importance of assessing the training needs of healthcare professionals, adapting training content to make it relevant to health and social care professionals' practice and tailoring training programs to the target audience's baseline knowledge (Phelan, 2009).

The interventions described in the literature varied in terms of content, structure, mode of delivery and methods of evaluation, making it difficult to draw conclusions from cross-study comparisons. However, many themes emerged from the literature in relation to best-practice approaches and strategies for designing and implementing elder abuse training programs. Multiple studies utilised the value of interactive methods of training, such as role plays, group discussions, and the use of case studies, as a way of engaging participants, ensuring long-term retention of learning and enhancing application of knowledge to practice (Cooper et al., 2012).

Researchers confirm the importance of assessing the training needs of healthcare professionals, adapting training content to make it relevant to health and social care professionals' practice and tailoring training programs to the target audience's baseline knowledge. The literature also emphasises the need for training to equip healthcare professionals with the knowledge and skills to work effectively as part of a multi-disciplinary team in managing elder abuse.

The WHO's European Report on Preventing Elder Maltreatment identified two studies evaluating professional awareness and education on elder abuse (Jogerst & Ely, 1997; Richardson et al., 2002). The report examined changes in health professionals' awareness and knowledge around elder abuse following education (Anetzberger et al., 2000; McCauley et al., 2003; Cooper et al., 2012; Sugita & Garrett, 2012). The report highlights the numerous biological, social, cultural, economic and environmental factors that interact to influence the risk and protective factors of experiencing or causing elder maltreatment.

Cooper et al. (2012) found that an educational intervention, comprising presentations on elder abuse and an elder abuse awareness DVD, improved knowledge and confidence about recognising and managing elder abuse among 40 trainee psychiatrists at three months following the intervention.

2.9.3 Learning strategies for health professionals.

Training that incorporates active learning strategies is deemed to be more effective in terms of long-term retention and application of knowledge to practice when compared to training approaches that adopt passive learning techniques, such as didactic lecture presentations (Nusbaum et al., 2007; Gironda et al., 2010). Active learning engages participants in critical thinking and problem-solving which, in turn, facilitates the reinforcement and real-life application of new skills learned (Nolan et al., 2008; Gironda et al., 2010).

Active learning strategies, like role playing and small group exercises, generate discussion, provide stimulation for participants and have the potential to empower participants by allowing them to draw on their own experiences and knowledge in a discursive and reflective process (Smith et al., 2010). By acknowledging and drawing on participants' experiences, such approaches may also enhance their motivation to learn (Huba et al., 2010).

The value of case studies is that they present the complexities of elder abuse cases and enable participants to actively engage in and explore approaches and solutions in the context of best practice, policy and legislation (Day et al., 2010). Case studies also give participants opportunity for discussion, reflection and feedback (Smith et al., 2010). Small group discussions and exercises allow participants to explore how their own values impacts on how they perceive, feel and act in relation to elder abuse (Vinton, 1993). Interactive learning is considered to be the most effective means of learning and it is also the method preferred by adult learners (Smith et al., 2010).

Literature cites numerous elder abuse training programs which have incorporated the use of audio-visual media (Seamon et al., 1997; McCauley et al., 2003; Smith et al., 2010; Teresi et al., 2013). The advantages of using audio-visual media is that it is easy to disseminate, gives consistent information, provides a flexible and convenient form of training for healthcare professionals, and can depict realistic role play scenarios, which demonstrate appropriate approaches to the management of elder abuse (Seamon et al., 1997; McCauley et al., 2003). Smith et al. (2010) reported the benefits of an online elder abuse training program for students enrolled in a nursing assistant course which consisted of 12 minutes of text and

video materials and reflective online interaction. Post-training trainee comments and online discussions indicated that students were engaged with the course content, demonstrated a growing awareness of elder abuse and demonstrated thinking about prevention and management techniques.

The provision of training by an internal member of the organisation or service who is knowledgeable about elder abuse is seen as an important factor in the success of elder abuse education and training for staff (Nusbaum et al., 2007; Nolan et al., 2008). Some authors suggest that the delivery of training by an internal trainer facilitates the development of rapport with participants and provides them with the reassurance that that they can discuss or report any barriers that they may have (Pillemer & Hudson, 1993; Radensky & Parikh, 2008). The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda et al., 2010).

There is evidence concerning the effectiveness of education and training in changing healthcare professionals' response to elder abuse. Several studies demonstrated no improvement in these outcomes (Nusbaum et al., 2007; Jogerst et al., 2004; Cooper et al., 2012), while, others showed improved participant outcomes in responding to elder abuse (Anetzberger et al., 2000; Radensky & Parikh, 2008; Teresi et al., 2013).

Evidence of the effectiveness of face-to-face training on elder abuse compared to printed educational material alone reinforces the need for training on elder abuse. Although many educational interventions demonstrated improved awareness and knowledge of elder abuse, it can be proposed that improved knowledge does not necessarily translate into improved clinical practice. From a review of the evidence it would appear that significant barriers to managing elder abuse continue to exist in spite of different educational interventions being implemented.

2.9.4 Evaluation studies.

Some studies examined whether education had an effect on health professionals' practice behaviours with regard to screening for abuse and reporting of abuse (Nusbaum et al., 2007; Sugita & Garrett, 2012; Cooper et al., 2012). Most of the published evaluation studies have reported the effects of elder abuse training using a pretest-posttest thesis (Nusbaum et al., 2007; Sugita & Garrett, 2012).

Two studies reported the use of experimental design involving an intervention group and a control group (Richardson et al., 2002; Teresi et al., 2013). Other evaluation studies included a post-program evaluation of an education program immediately following implementation of the training and again, six months after the training (Mills et al., 2012) and a controlled survey design which assessed the effectiveness of an elder abuse education session (Uva & Guttman, 1996).

Most studies identified in the literature examined changes in health professionals' awareness and knowledge around elder abuse following training (Anetzberger et al., 2000; McCauley et al., 2003; Cooper et al., 2012; Sugita & Garrett, 2012).

Many studies reported the use of self-report measures of changes in knowledge and behaviour (Seamon et al., 1997; Anetzberger et al., 2000; Nusbaum et al., 2007; Sugita & Garrett, 2012). A small number of studies have used objective data to assess the effectiveness of training (Jogerst et al., 2004; Radensky & Parikh, 2008; Teresi et al., 2013). For example, the Knowledge and Management of Abuse (KAMA) questionnaire, an objective, validated instrument, has been used to assess how professionals would manage possible elder abuse scenarios presented to them in vignettes (Richardson et al., 2002; Richardson et al., 2004; Cooper et al., 2012). This study also found that having more baseline elder abuse knowledge at the outset resulted in less knowledge gained after the implementation of the intervention, leading them to suggest that for educational interventions to be effective, they should be tailored according to participants' baseline knowledge (Richardson et al., 2002; Richardson et al., 2004; Cooper et al., 2012).

Using a pretest-posttest design, Seamon et al. (1997) evaluated the effectiveness of a training intervention that comprised a 45-minute video on pre-hospital emergency services personnel's knowledge and willingness to report elder abuse. The post-test results indicated significant improvements in participants' knowledge of elder abuse; however, there remained a substantial proportion of professionals who reported a lack of confidence in their ability to recognise abuse and a lack of clarity regarding some aspects of how the law interacted with elder abuse.

Nusbaum et al. (2007) reported on an evaluation of an educational intervention targeted at emergency services personnel and showed that the intervention did not produce lasting attitudinal or behavioral changes with regard to detecting possible abuse and screening for elder abuse and neglect. The authors argued that a change in organizational culture, norms and attitudes are needed for change to take effect and for the intervention to be effective.

Sugita and Garrett (2012) investigated whether a symposium on elder abuse involving a panel of experienced multidisciplinary experts would increase oral health care providers' knowledge of and likelihood to report elder abuse. The post-test results indicated that the participants perceived themselves to be more confident in recognizing the indicators of Elder abuse more knowledgeable about elder abuse and reporting requirements and procedures, more likely to ask patients about suspected abuse and more likely to report suspicions.

Using a pretest - posttest design, Vinton (1993) evaluated an elder abuse and neglect prevention program for healthcare professionals. Program participants were provided with written material on elder abuse, case scenarios, video examples, written materials and a presentation. The education program incorporated a broad range of elder abuse topics, including barriers to identifying and intervening in cases of elder abuse and a discussion of ethical dilemmas. The results of the program evaluation demonstrated a significant improvement in knowledge scores overall for all groups participating, except law enforcement personnel.

In an examination of the grey literature, it is important to highlight that only a small number of guidelines and training packages have been developed throughout Australia which have been implemented to educate health professionals in relation to responding and managing elder abuse within a health context. However, on examination of the literature there has been little research conducted on these guidelines to determine their effectiveness in increasing awareness, detection and prevention of elder abuse amongst healthcare professionals.

In summary it does appear that education and training is somewhat effective in increasing awareness and knowledge of elder abuse among health professionals (Seamon et al., 1997; Anetzberger et al., 2000; Sugita & Garrett, 2012; Cooper et al., 2012). In studies involving participants who had a good baseline knowledge of elder abuse, interventions did not appear to be effective, thereby highlighting the importance of tailoring training programs to the target participants' baseline knowledge (Richardson et al., 2002; McCauley et al., 2003). Evidence strongly supports that face-to-face delivery of training is more effective as a mode of intervention when compared with dissemination of information through printed educational materials. Literature further proposes the benefits of using case studies in the delivery of elder abuse training. Case studies also give participants opportunity for discussion, reflection and feedback (Smith et al., 2010).

The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda et al., 2010). These findings have informed the education framework for the study site as part of this research.

Several studies have shown that healthcare professionals who received elder abuse training and had more experience were not more knowledgeable about what constituted abuse when compared to those who had not received training and were more inexperienced (Cooper et al., 2012). Knowledge deficits that persist even after the provision of training raise a question over the effectiveness of elder abuse training. Continuing professional development and refresher training may be required in order to ensure that knowledge is retained in the long-term and that clinical practice does not result in the staff adopting inappropriate management strategies.

2.10 Implications of the Literature Review for this Thesis

This chapter has revealed the complexities of understanding and addressing elder abuse within a health context. This chapter has examined the literature using four key themes which have emerged in the inquiry phase. A summary follows regarding each of these themes and the implications for this thesis.

2.10.1 The problem of elder abuse.

There is a growing social awareness of the prevalence of abuse or neglect of older people as a form of familial violence and of the impact of this on older people. Fear of punishment, isolation, shame and guilt often means that the older person may remain silent.

For many older people at risk of elder abuse, the hospital is the first contact point with the health system and may offer a “window of opportunity” for help and support (Joubert & Posenelli, 2009). Hence, healthcare professionals who routinely interact and assess older people are in the best position to identify those at risk of abuse and also to provide support to those experiencing abuse.

Overall, the literature suggests that elder abuse is difficult to detect, unlikely to be reported by older people due to shame, is usually undertaken by a trusted family member and incudes higher rates of financial and psychological abuse. For these reasons it is imperative that health professionals working with older people understand the complexity of elder abuse as well as their own values and attitudes to minimise contributing factors such as ageism.

The literature on prevalence of elder abuse is wide-scale but there are limitations including the application of varying definitions and research parameters. There have been no prevalence studies on elder abuse in Australia to date. Existing research has largely focused on risk factors—the presence of vulnerabilities or problems that increase the chances of elder abuse – not the most effective response.

2.10.2 Review of models and approaches for responding to elder abuse.

A summary of the literature confirms that Australia has adopted a more cautionary approach to the management of elder abuse (Chesterman, 2015). This is evidenced in the approach taken by the Victorian Government which supports older people having a right to self-determination and being empowered to make their own individual choices.

In Australia there appears to be an absence of consistent approaches and legislation to protect vulnerable older people. As an alternative, Australia has preferred to develop individual state protocols and guidelines that emphasise a multi-disciplinary approach and effective cooperation between key stakeholders such as hospitals (Department of Health and Human Services, 2009).

An examination of the safeguarding approach in the UK has raised the important issue of governance at the study site. The UK approach has required systematic consideration to how training of health professionals was going to be undertaken within a large health care environment.

2.10.3 Responding to elder abuse – the role of the health services.

It can be proposed that elder abuse may also be under reported because of the barriers relating to health professionals having the confidence to identify the problem (Krueger and Patterson, 1997). Reporting may be complicated by a lack of knowledge about where to report suspicion of elder abuse due to a lack of policy or appropriate education strategies in place for staff. According to the literature reviewed, barriers to responding to elder abuse include lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse.

2.10.4 Training and education – what, who, how.

The literature underlines the importance of assessing the training needs of healthcare professionals, adapting training content to make it relevant to health professionals' practice and tailoring training programs through competency based modules to target the audience's

baseline knowledge. The literature also emphasises the need for training to equip healthcare professionals with the knowledge and skills to work effectively as part of a multi-disciplinary team in managing elder abuse.

Training in how to respond to elder abuse which presents in a hospital context is important. Training should also provide professionals with the information, knowledge and tools to respond appropriately if they encounter an older people at risk of elder abuse or who may disclose to them directly.

Multidisciplinary input and multi - agency collaboration in the design of elder abuse educational initiatives, has described benefits which include identifying all relevant issues and areas in which training is required, fostering an awareness of elder abuse from multiple perspectives and increasing the potential for future coordination and collaboration in the management of elder abuse (Anetzberger et al., 2000; Gironda et al., 2010).

The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda et al., 2010).

Professional training has the potential of increasing the knowledge amongst health professionals; however, without a cultural change that allows for education, supervision and support, elder abuse may continue to be under reported.

CHAPTER 3 – INQUIRY PHASE AND DESRIPTIVE ANALYSIS

3.1 Introduction

Phase 1 of the thesis sought to identify the factors required to facilitate health professionals' response to suspected elder abuse and to identify barriers and enablers to practice. This phase involved, as a first step, an extensive examination of both peer reviewed and grey literature to scope key themes - elder abuse and the health context; the models and frameworks in place in hospital contexts for responding to elder abuse as well as effective training strategies and approaches for health professionals. This was reported in Chapter 2.

Chapter 3 will describe the next step which was to identify the barriers to responding to elder abuse and how these might be addressed as part of this study. A sequential mixed methods design was used to ascertain the perspectives of health professionals via a confidential online staff survey, focus groups and in-depth interviews. This phase aimed to find out the preliminary knowledge of health professionals at the study site which would provide further inquiry as to the problem of elder abuse. This phase would inform the conceptualisation of the research question and aims of the thesis.

The chapter will begin by providing a rationale for the study design and methodology and then go on to report the findings of the online staff survey, focus groups and individual interviews with clinicians. Ethical considerations will also be discussed.

A total of 300 health professionals took part in this phase. 275 participated in the online survey, 21 participated in the focus groups and 4 in the face-to-face individual interviews. Although the number of staff who participated in the focus groups was small, it was balanced in that the groups represented different age ranges, disciplines and years of clinical experience. Data saturation was achieved in this phase due to the overall number of health professionals' who provided their experience and knowledge.

3.2 Rationale for the Research Design and Methodology

The research utilised an explanatory sequential design (Plano Clark, 2011). In terms of methodology the three elements of this phase consisted of differing methods to capture and analyse the data. This consisted firstly of collecting quantitative data (the online survey) and secondly qualitative data (focus groups and interviews) to elaborate on the findings of the data from a large sample of health professionals at the study site. Researchers select mixed

methods in order to search out the opportunity for a greater assortment of divergent views (Creswell, 2003).

The rationale for this approach suggests that quantitative data can provide a general picture of the problem of elder abuse within a health context but further analysis through qualitative data collection is needed to understand and inform the preliminary findings (Plano Clark, 2011).

An examination of the literature suggests that in a health context the explanatory sequential design is widely used among researchers (Creswell, 2003). In adopting this design, a researcher first collects and analyses the quantitative (numeric) data and in the second step, qualitative data is analysed to further explore a problem in more depth (Plano Clark, 2011). In this phase a confidential online survey was undertake and the quantitative data was analysed. This was then expanded on in a series of focus groups and individual interviews to further identify barriers and enablers for health professionals' in responding to suspected elder abuse. The data from the focus groups and individual interviews was analysed qualitatively.

The richness of the qualitative data obtained from the focus groups required consideration of a framework to assist in understanding and capturing the core themes and implications which would inform the training intervention. The Richie and Spencer (1994) Framework Analysis approach was applied to assist in presenting this data for the thesis. This framework identifies commonalities and differences in qualitative data, which aims to focus on parallels or similarities between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes (Srivastava & Thomson, 2009).

This phase of the thesis has adopted a descriptive research design (Burns & Grove, 2003), to begin to understand and describe phenomena such as elder abuse and how health professionals respond within a health context. Descriptive designs are typically used as either pilot or preliminary studies and have basic statistical procedures (Polit & Hungler, 1999).

3.3 The Selection of a Descriptive Exploratory Design

A descriptive exploratory design was used to address the aims of Phase 1 which focused on understanding the barriers and enablers for health professionals. Descriptive exploratory

designs can be used to provide context for understanding these barriers and enablers and assist in analysing large numbers of staff responses. Descriptive research does not fit neatly into the definition of either quantitative or qualitative research methodologies, but instead it can utilise elements of both, often within the same study (Burns & Grove, 2003).

The term descriptive research refers to the type of research question, design, and data analysis that will be applied to a given topic. The descriptive exploratory approach seeks to provide a picture of a situation as a whole (Burns & Grove, 2003). For this reason, descriptive research is usually undertaken in one of three ways: observational (recording the participants), a case study or via a survey. The approach involves the collection of data that will provide a description of individuals, groups or situations. Instruments used to obtain data in descriptive studies include questionnaires and interviews (Polit & Hungler, 1999).

A descriptive approach can provide a knowledge base which can act as a springboard for other types of research methods (Polit & Hungler, 1999). This is of relevance for this phase as the knowledge gained from the perspectives of health professionals at the study site would inform and address the research questions in this thesis. The sequence of the data collection was a confidential online survey followed by focus groups, then interviews. The individual interviews were conducted with targeted key staff who could not attend the focus groups at the study site and were therefore followed up with an individual interview.

The rationale for the quantitative online staff survey related to the goal of achieving greater reach in relation to participants across the study site. The popularity of the internet has made it possible for research to be undertaken in a less intrusive and timely manner including speed of delivery, no cost, greater control over the audience and convenience of sending and receiving the responses.

The qualitative data collection method using focus groups was selected for several reasons: (a) group interviews are considered to facilitate discussion of uncomfortable subjects such as elder abuse (Polit & Beck, 2004) (b) focus groups provide opportunities to examine how participants view different topics such as elder abuse (Kreuger & Casey, 2000); and (c) the type of exploratory communication techniques used in focus groups helps the researcher understand participants' knowledge and attitudes (Kitzinger, 1995). Importantly focus groups can help reveal group meaning, agreement or disagreement about a particular topic (Kitzinger, 1994).

Wilkinson (2004) further supports the benefits of focus groups as they provide the researcher with an understanding of participants' experience with a sensitive topic. It has been suggested (Hollander, 2004) that focus groups create a sense of belonging amongst colleagues and are more natural in conversation flow than one-to-one interviews. Importantly, Krueger and Casey (2009) value using focus groups as they help to identify needs and they support the development of policy and effective clinical practices. This is of relevance for the study which aims to improve health professionals' response to suspected elder abuse.

Results from previous studies suggest that focus groups act as a collective activity, where several views can be obtained, and where the data is produced by group interaction on a shared topic (Gibbs, 1997). According to Gibbs (1997), a focus group is made up of individuals with specific experience in the topic of interest. Focus group interview technique is also thought to facilitate identification of areas of controversy and agreement, and understanding of how perspectives arise or are modified (Hollander, 2004).

The research student was very mindful of the sensitivity of the topic of elder abuse and was aware that elder abuse was not a clinical issue that all health professionals had confidence in managing in their day to day practice. The method of focus groups was established as they are considered an opportunity to collect meaningful and contextual data from participants' experiences and views that may not have occurred without group interaction (Liamputtong & Ezzy, 2005). Ideally to facilitate an effective group interaction a focus group should comprise 6-8 people to discuss a topic in which they have a shared experience (Creswell, 2003).

3.4 Ethical and Practice Considerations

The ethical aspects of this thesis were approved by the Low Risk Thesis sub-Committee of Human Thesis Ethics Committee – A (HREC-A) of St Vincent's Hospital, Melbourne. The study protocol was assessed using the National Statement on Ethical Conduct in Human Research (2007) published by the National Health and Medical Research Council of Australia (See Appendix 1) for confirmation of the Ethics Approval received for this research– LR 067/11

Participants from the focus groups and individual interviews were provided with an Information Sheet and were also asked to sign a Consent Form to ensure they met the SVHM Human Research Ethics Committee Guidelines. Participants were informed that participation was voluntary and they could withdraw from the research at any time without

implications. The research was designed to comply with ethical standards published by the National Health and Medical Research Council of Australia's National Statement for the Ethical Conduct in Research involving Humans (National Health and Medical Research Council, 2007). The design carefully considered research merit, integrity, justice, beneficence and respect (National Health and Medical Research Council, 2007).

3.5 Research Rigor

There are five standards (objectivity, dependability, credibility, transferability, and application) typically used in descriptive studies to assess quality and legitimacy (trustworthiness and authenticity) according to Colorafi & Evans (2016). This phase of the thesis examined data from the online survey, focus groups and individual interviews. Objectivity was met by reason of reasonable freedom from research bias. Dependability was fostered by having consistency in procedures and tools across participants over through various methods.

Credibility was addressed by providing context-rich description and interpretation of the data (Sandelowski, 2004). Transferability was considered as to how this study could have implications for other hospital settings or studies. The final standard of application was considered in how the findings from this study could stimulate further research or promote policy discussion

3.6 Online Staff Survey

The survey questions, designed for the research, inquired about health professionals' experience and knowledge of elder abuse using a confidential Survey Monkey online tool.

3.6.1 Purpose.

The online confidential survey targeted health professionals at the study site across different campuses and targeted a range of healthcare professionals working. The focus of the staff survey was to identify any enablers, gaps or barriers from health professionals at the study site regarding their identification and response to suspected elder abuse. These enablers, gaps or barriers could include either clinical or organisational elements.

3.6.2 Participants.

The online survey was sent via email to Heads of Departments across the organisation targeting three key areas – health professionals working in the Emergency Department,

Acute and Sub-acute wards. Participants comprised staff across the study site that completed the survey within the nominated time period. These staff had varied roles and experience at the study site.

There was no expectation that all health professionals at the study site were required to respond to the survey. The response rate of the participants was not a factor for consideration or explanation as the data was being used to inform a larger research study. In this case, the data from this phase contributed to understanding the factors that were needed to facilitate the response of health professionals working in a hospital setting, to suspected elder abuse.

3.6.3 Instruments.

The staff survey was designed in 4 parts: Part 1 identified the staff demographics; Part 2 identified if the respondents had any experience of elder abuse; Part 3 of the questionnaire was a self-rating scale, and Part 4 inquired about their own identified training needs (See Appendix 2). The survey used a 10-point Likert scale in some questions to assist with the analysis of quantitative data.

The survey was developed by the student researcher with the assistance of the principal investigators. Once the survey design was completed, it was pilot tested with five social work staff. These staff volunteered to complete the survey and offered feedback on ease of use, availability of data requested and comprehension of questions and terms used. Prior to distribution, the final questionnaire was reviewed by the principal investigators group.

This questionnaire asked for information about 'suspected' cases, which was consistent with the aim of the research and to ensure a more 'realistic' estimate of the barriers which health professionals were identifying in the management of elder abuse within the study site.

3.6.4. Procedure.

Purposive sampling was used in this baseline phase of the study. Parahoo, (1997:232) describes purposive sampling as "a method of sampling where the researcher deliberately targets who to include in the study based on their ability to provide necessary data". The rationale for choosing this approach was to ensure that the study included views from health professionals across different disciplines with different experience to inform the descriptive analysis for this phase.

The survey questions, designed for the research, inquired about staff's experience and knowledge of elder abuse using the Survey Monkey online tool. The survey was sent via email to Heads of Departments across the organisation targeting three key areas – staff in the Emergency Department, Acute and Sub-acute wards. Staff were given a three week period to complete it. A reminder email was sent after two weeks and staff were given a further week to compete it. The survey took approximately 10 minutes to complete.

Following the completion of the questionnaire, staff did not receive any direct education on the subject of elder abuse. The questionnaire was accompanied by a detailed summary and instructions. It advised participants of where the results and further information would be made available following their participation.

Online survey participants were asked at the conclusion of the online survey if they were interested in participating in a follow up focus group. This was a non-coercive process which involved them separately expressing their interest and providing contact details.

3.6.5 Analysis.

The method of analysis for the online survey was quantitative which can measure specific characteristics through structured data collection procedures.

The themes or trends were summarised, based upon whether the majority (more than 50% of the participants) agreed or disagreed with the questions. The trend of the distributions (e.g. whether the highest frequencies were located at the agreement or disagreement end of the scales) was recorded where applicable.

The current role of the survey participant at the study site was collapsed into the categories of allied health, nursing and medical. This variable was then cross-tabulated with a range of responses to see any noteworthy trends.

Cross-tabulations were undertaken to establish if there were any differences in staff experience of elder abuse and their educational needs based on their professional background. These trends are discussed below.

To establish if there is an association between having attended training or a workshop on elder abuse and experience with elder abuse, knowledge and confidence in the area of elder abuse, management of suspected cases, and educational needs, cross-tabulations with chi-square tests of independence were performed.

3.6.6 Online survey results demographic profile.

The total number of staff respondents was 275. A large majority of staff were females (n =225, 82.1%). The largest age group was respondents between 25 and 34 years of age (n= 117, 42.5%), followed by almost equal proportions of people aged 35 to 44 years (n=52, 18.9%), 18 to 24 years (n=46, 16.75), and 45 to 54 years (n=43, 15.6%). A large majority of the respondents were working full-time at SVHM (n= 183, 66.5%).

With respect to the profession of the participants, almost half were nursing staff (n= 136, 49.5%), followed by allied health staff (n = 97, 35.3%) and the smallest group was senior management/executive staff (n= 9, 3.3%). Most respondents worked in the acute units (n= 119, 43.4%), followed by the sub-acute units (n= 85, 31%), and the emergency department (n= 33, 12%). The largest group of participants had between 1 to 5 years of experience at the hospital (n= 122, 45%).

Table 2 below provides a breakdown of the demographic data of the staff who responded to the online survey.

Table 2: Sample characteristics (n= 275)

Characteristic	Category	N	%
Gender	Male	49	17.8
	Female	225	81.8
	Missing	1	0.4
	Total	275	100
Age	18-24	46	16.7
	25-34	117	42.5
	35-44	52	18.9
	45-54	43	15.6
	55-64	16	5.8
	65+	1	0.4
	Total	275	100

Employment Status	Full-time	183	66.5
	Part-time	85	30.9
	Casual	7	2.5
	Total	275	100
Current Role	Executive/Management (non-clinical role)	9	3.3
	Medical (clinical)	32	11.6
	Nursing (clinical)	136	49.5
	Allied Health (clinical)	97	35.3
	Support Staff	1	0.4
	Total	275	100
Area of Work	Acute	119	43.3
	Emergency	33	12
	Sub-Acute	85	30.9
	Palliative Care	3	1.1
	More than one area	28	10.2
	Other	6	2.2
	Missing	1	0.4
	Total	275	100
Years Employed	Less than 1	54	19.6
	1-5 years	122	44.4
	6-9 years	44	16
	Over 10 years	51	18.5
	Missing	4	1.5
	Total	275	100

3.6.7 Professional experience of elder abuse.

The staff participants were questioned about their professional experience in relation to elder abuse. A large majority (n= 215, 78.2%) of the participants indicated they had never attended a training or workshop session on elder abuse. Of these staff 39.3% (n= 108) indicated that they had suspected incidents of elder abuse in the last 12 months. Out of these staff, the majority (n= 94, 87%) suspected elder abuse in 1 to 2 cases of elder abuse in the last 12 months. The two most significant types of elder abuse suspected were financial abuse (n= 45, 41.7%) and neglect (n= 27, 25%).

Participants were asked the basis of their suspicions. The two most common reasons identified were clinical judgment (n= 35, 32.4%), and information disclosed by another person (n= 21, 19.4%). The three highest actions undertaken by the staff when they suspected abuse were to refer the older person to another program/team within SVHM (n= 52, 28.3%), consultation with seniors/managers (n= 38, 20.7%), and referring the case to an external agency (n= 21, 11.4%). When asked if they would have managed the suspected elder abuse case differently if they had received education and training on elder abuse, more than two-thirds (n= 41, 38.7%) of staff indicated that they believe that they would have managed it differently. Approximately one-fifth of staff indicated that they would not have managed the case differently (n= 21, 19.4%) or done anything differently (n=23, 21.3%).

3.6.8 Knowledge and experience in the area of elder abuse.

A number of respondents did not answer all of the questions in the area of elder abuse. With regards to the specific questions about elder abuse, the responses to the following questions resulted in a mean response of less than 50%.

- How confident do you feel you would know the legal responsibilities for your patient/client if they were being abused?
- How confident do you feel you would know the legal responsibilities for you as a worker if you suspect abuse?
- Are you familiar with The Victorian Civil and Administrative Tribunal (VCAT) and how to make an application?
- How confident do you feel you would know the different types of resources available to you in relation to cases of suspected elder abuse? For example in the community, in the hospital, financial resources

- How confident do you feel that you would know the different types of resources available to your patient/client in relation to cases of suspected elder abuse? For example in the community, in the hospital, financial resources
- Please rate what you believe would be your level of skill in being able to effectively assess an older person at risk of abuse. For example would you know what questions to ask the older person?
- Please rate your level of skill around the principles of appropriate documentation - what do you need to record if you suspect abuse?

When asked about the action they take when they identified or suspected elder abuse, the largest proportion of valid responses (n= 55, 30.9%) indicated that they refer the case to the relevant department, 11% said they "offer direct service" (n= 19, 10.7%), and just under one-third stated they would follow both of these actions.

When asked what kinds of interventions they thought could assist in the overall understanding and management of elder abuse in a hospital setting, one-quarter of respondents stated education of health professionals (n = 174, 24.8%), with around 15% suggesting education of older people to protect their rights (n= 100, 14.2%) and education of the general public (n= 93, 13.2%).

3.6.9 Differences between professional groups.

A higher proportion of allied health staff reported they had received training or education related to elder abuse compared to participants in other roles (40% compared with 9% to 27% for other roles) and of significance allied health staff reported having had exposure to more cases of suspected elder abuse compared to staff in other roles. Approximately one-fifth of allied health staff said they suspected 3 or more cases. There is no significant theme with regards to the exposure to the nature of suspected abuse and the role of the participants at the study site. Similarly, there were no trends with regards to the main reason for suspected abuse and the action taken when abuse was suspected by role of the participant.

More nursing staff (n=21, 47%) and allied health staff (n=16, 39%) indicated that they would have managed the most recent case in which they suspected abuse differently if they had received any/further education and training on elder abuse, compared to medical/clinical staff (n=3, 20%).

Reflecting their professional roles and responsibilities, allied health staff (29%) reported they had offered direct service in response to suspected elder abuse compared to staff in other roles (medical clinical staff - 18%, nursing staff - 18%). Allied health staff were more likely to endorse education (100%) to older people to protect their rights, education to health professionals, and education to the general public as interventions that would improve understanding and management of elder abuse compared to people in other roles (medical staff - 13% and nursing staff - 53%).There was no significant theme in suggested improvements in knowledge and confidence in identifying and acting upon suspected elder abuse for patients by the current role of the participants in the hospital.

3.6.10 Differences according to past training about elder abuse.

A significantly larger proportion of staff who had never attended a training or workshop on elder abuse indicated that further education/training would have helped them to manage the suspected case of elder abuse differently (n=31, 44%) compared to the proportion of staff who had attended a training or workshop on elder abuse before (n=10, 29%).

3.7 Focus Groups

This phase included focus groups to further address the research aims and question.

3.7.1 Purpose.

The aim of the focus groups in this phase of the study was two-fold: firstly, to broaden the knowledge basis on elder abuse across sites and professions at the study site; secondly to use the findings to assist in the development of the training specifically designed to meet the clinical needs of hospital staff at the study site.

3.7.2 Participants.

The focus group technique was applied in this phase of the research as a recommended method for exploring the attitudes regarding elder abuse in a hospital setting. Participants in the focus groups were chosen carefully in order to generate as many perspectives as possible. Each focus group comprised staff from different disciplines. The research team obtained permission from the General Manager/Director of the Aged Care and Continuing Care Program for staff to participate during work hours. Evidence supported the decision that the focus groups should be multidisciplinary. These focus groups were formulated based on staff experience and comprised between 6-8 people to discuss a topic in which

they had a shared experience. The table below illustrates a breakdown of the health professionals who participated in the focus groups.

Table 3: Focus Group participants

Participant	Role	Years of experience	Years at SVHM
Focus Group 1			
1	Grade 1 Social Worker	3	3
2	Nurse from Transition Care	4	4
3	Grade 1 Physiotherapist	2	1
4	Grade 1 Dietician	8	2
5	Grade 2 Occupational Therapist	9	5
6	Nurse from the Rehabilitation Ward	4	3
7	Nurse from GEM	3	3
8	Resident (junior doctor) from GEM	2	1
Focus Group 2			
1	Nurse Unit Manager Transition Care	20	4
2	Nurse Unit Manager GEM	22	12
3	Nurse Unit Manager Rehabilitation	24	15
4	Manager Aged Care Assessment Service (ACAS)	15	4
5	Grade 4 Social Worker	20	10
6	Manager from HARP Program	15	11
Focus Group 3			
1	Senior Nurse from ACAS	20	20
2	Grade 2 Social Worker	8	6
3	Grade 2 Social Worker	5	5
4	Grade 3 Social Worker/Team Leader	11	7
5	Grade 3 Occupational Therapist	7	3
6	Nurse from Emergency Department	19	16
7	Nurse from St. Vincent's @ Home	20	15

3.7.3 Instruments.

A tool was developed which aimed to explore the participants' perspectives on the topic of elder abuse in a hospital setting which supported the aim of this inquiry phase. A semi-structured interview guide comprising open-ended questions was used during the focus groups. Questions focused on participants' understanding of elder abuse, the forms of abuse, reasons why older people may experience abuse, ways of preventing abuse and support for those who have experienced abuse (Appendix 3)

3.7.4 Procedure.

Participants in this research who participated in the focus groups were provided with an Information Sheet and also asked to sign a Consent Form in line with SVHM Human Research Ethics Committee Guidelines. Participants were informed that participation was voluntary and they could withdraw from the research at any time without implications (Appendix 4).

Health professionals were approached for inclusion in the focus groups once permission from Departments Heads was given. The research student had no dependent working relationship with any of the staff selected to participate in the focus groups.

The focus group sessions lasted one hour each with the permission of the participants, the sessions were tape-recorded and transcribed. The three focus groups were conducted with participation from nurses, doctors, social workers and other allied health staff at the study site who provided direct care to older people.

All staff participating in the focus groups was asked to provide consent and some personal details including demographic data, qualifications and levels of experience. During the focus groups, the participants were asked to respond to a series of two hypothetical scenarios which described different types of elder abuse (Appendix 9). These scenarios were presented as vignettes and described interactions between older people and health professionals where abuse is suspected. Responses were sought in respect to:

- participants' exposure to similar situations
- responses to the two hypothetical situations
- barriers and facilitators to action for each scenario and for elder abuse across the organisation

The focus groups in this phase were based on guidelines suggested by Krueger and Casey (2009). These guidelines outline two distinct roles: the moderator or facilitator directs the discussion and ensures that the conversation is flowing between the participants. The focus group assistant moderator observes, takes notes and further probes topics of interest that the facilitator may have missed or not heard.

The focus groups were conducted by the research student as the facilitator and a moderator. The facilitator had experience in appropriate working group techniques and endeavoured to provide equal opportunity for participation by all focus group participants. The facilitator generated discussion and stimulated conversation by specifically raising the following questions:

- How many of you have attended education or training on elder abuse?
- Definition of elder abuse – what is it?
- What are the different types?
- What are the signs?
- What are the risk factors?
- Is it different to other kinds of abuse?
- Who abuses older people?
- Where does abuse happen?
- How often does it happen?
- Acting on suspicion – what does this mean? What would trigger suspicion? What signs would you act upon?
- Do you believe you have ever worked with a patient where you have suspected elder abuse?
- Does your department/ward currently have a policy that you are aware of in relation to elder abuse?
- If SVHM was to have an overall policy – what do you think should be included?
- What suggestions do you have about the ways in which SVHM might respond effectively to elder abuse?
- What are the most effective ways that SVHM can educate staff about elder abuse?
- Do you think everyone should be trained about elder abuse?

3.7.5 Analysis.

Qualitative data analysis was undertaken from the focus groups to identify themes and draw conclusions (Miles & Huberman, 1994). Comparing themes within and across participants, noting patterns and discrepancies, and drawing conceptual maps to examine relationships was completed (Polit & Beck, 2004).

The most challenging part of undertaking a focus group is the transcription and analysis of the data Morgan 1988). The Framework Method (Ritchie & Spencer, 1994) was applied to the analysis of the focus groups in this phase. The Framework Method was developed by researchers Jane Ritchie and Liz Spencer in the late 1980's from the Qualitative Research Unit at the National Centre for Social Research in the UK. The Framework Method is also referred to as thematic analysis or qualitative content analysis. This approach identifies commonalities and differences in qualitative data, and aim to focus on parallels or similarities between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes (Srivastava & Thomson, 2009).

Framework analysis is not considered a mechanical process, but relies on the creative and conceptual ability of the researcher to determine the meaning and relationships between data sources (Ritchie & Spencer, 1994). Koch (1999) notes, the interpretation of the data is dependent on reading the transcribed texts of interviews, observing and listening to the respondents during the interviews and reflecting on their experiences. The data analysis needs to be flexible, as new ideas and concepts emerge. It also needs to be clearly visible, so that it may be verified by one's peers and it is apparent to the reader how the findings of the study have been obtained. Framework analysis was developed in order to achieve these aims.

This framework includes four categories – contextual, diagnostic, evaluative, and strategic to answer a variety of questions. These categories are:

- Contextual: Identifying the form and nature of what exists
- Diagnostic: Examining the reasons for what exists
- Evaluative: Appraising the effectiveness of what exists
- Strategic: Identifying new theories, policies, plans or actions

The focus group sessions were tape-recorded and transcribed verbatim. Data collection and analysis used thematic qualitative analysis. Tape recordings of the sessions confirm that participants were able to express their feelings and their personal opinions and without being governed by a pre-arranged questionnaire.

Framework Analysis involves a systematic process of sorting through the data to capture key issues and themes for the direct purpose of undertaking an analytical process which can be carefully articulated and documented. The themes from this research were identified and compared across the data and the use of quotes from the participants were then chosen to expand on the particular issues/themes described (Srivastava & Thomson, 2009).

According to Srivastava and Thomson (2009), framework analysis involves the sifting, charting, and sorting of data in accordance with the key issues and themes. They have proposed a 5-step process for the same:

Familiarisation: a process during which the researcher become familiar with the data and gains an overview of it (Ritchie and Spencer, 1994). In this case, the data collected was the focus group audio and the transcripts. During this stage, effort was made to gain an overview of the focus group transcripts and audio by going through these repeatedly in order to identify key ideas and themes.

Identifying a thematic framework: during this stage emerging themes in the data should be identified. According to Ritchie and Spencer (1994), the key issues, concepts and themes that have been expressed by the participants now form the basis of a thematic framework that can be used to filter and classify the data (Srivastava & Thomson, 2009). During this stage, themes such as the definition and types of elder abuse, signs and symptoms of elder abuse, risk factors, departmental policy, key challenges, effective ways for staff education and training needs, emerged from the analysis of the focus group transcripts.

Indexing: according to Srivastava & Thomson (2009), it is the process during which the researcher identifies sections of the data that correspond to a particular theme. During this stage, the researcher used the transcripts of the 3 focus groups and marked out specific portions and sections corresponding to the themes that had been shortlisted earlier.

Charting: during this stage, specific sections of the data which had been indexed earlier, are now placed in charts which have headings and subheadings depending upon the themes that had emerged earlier in the process. The researcher used MS Excel spread sheets to make the charts used during this stage. The portions and sections marked out in the

previous stage were actually placed according to the headings and sub-headings related to the themes.

Mapping and interpretation: at this point, the key characteristics as laid out by the charts are analysed. According to Srivastava and Thomson (2009), this analysis provides a guide to illustrate the phenomenon, thus guiding the researcher in their interpretation of the data set.

While the overall sample size for the focus groups was small (total n =21) it was appropriate in order to meet our study purpose which was to identify the range and complexity of issues and barriers perceived by different healthcare disciplines in relation to elder abuse.

Data saturation is not about the numbers used in the focus groups, but about the depth of the data (Burmeister & Aitken, 2012). For example, one should choose the sample size that has the best opportunity for the researcher to reach data saturation. The small sample size in this phase allowed for in-depth exploratory qualitative discussion relating to elder abuse.

The three focus groups were conducted with participation from nurses, doctors, social workers and other allied health staff at SVHM who provide direct care to older people at the three study sites. Each focus group comprised staff from different disciplines (n = 21).

The focus groups were formulated based on three levels of staff experience. Three focus group sessions were carried out: Level 1 with junior level allied health and nursing staff; Level 2 with managers and Heads of Departments; and Level 3 with senior clinicians (frontline staff).

All focus groups had semi-structured questions and two case scenarios.

3.7.6 Results – Focus group level 1.

Level 1 focus group consisted of less experienced or more junior staff from nursing, medical and allied health. An overall lack of formal education or training regarding elder abuse identification or appropriate care planning emerged. These were staff that had a minimum of 3 years of experience since graduating in their field.

While the staff acknowledged the barriers relating to their knowledge, they did emphasise that they were able to recognise elder abuse in some situations with older people however the definition and understanding of elder abuse varied amongst participant responses:

Participant 1: *in relation to elder abuse I automatically thought it was physical and financial, but it's a bit more than that…*

Participant 2: *I think generally people tend to associate the word 'abuse' with the physical side of it, rather than anything else rather than thinking that there's the emotional side*

Participant 5: *the tricky part is the bit where what you consider to be okay, someone else may not perceive to be okay*

Participant 8: *for me elder abuse has more of a connotation of taking advantage of, in some way whereas domestic violence can, at times, just be a violent act towards somebody else, but not necessarily taking advantage of. So it has an air of manipulation around it.*

The participants identified a recurring theme of exploitation of older people for financial or material gain. Many participants expressed ambiguity regarding assessment and confirmation of elder abuse.

Participant 1: *What usually raises the red flag to me sometimes is you hear about families coming in and trying to get the patient to sign a power of attorney and you know that there's already some cognition issues going on there. And again, is it that they are deliberately trying to exploit that person, or is it just that they don't really understand that in order to sign a power of attorney, the person has to be in a position where they can make a reasonable decision for themselves*

Participant 4: *I think there was even an article again in the paper today in terms of, you know, the amount of financial abuse that's actually going on in our community. It's frightening.*

Participant 8: *think another red flag with me is either seeing it or other staff overhearing it and passing that information on. I had a case where a neighbour had come in and staff overheard him pressing my patient to sell his residence which was a very big house in a beautiful area, going for a lot of money, but he was really prying my patient for details and so that triggered off an alarm for me.*

Three main types elder abuse were identified by the participants - financial, emotional and physical. Participants recalled from personal experiences how older people are more at risk of elder abuse when they made allowances for their family members, or when they were dependent on the family or carers for support.

Participant 1: *I guess in case of discharge planning, you don't want to be sending someone home to a poor environment if it is neglect – it could be intentional - it might just be about*

education, and then they'll go home and they'll be okay and is it an appropriate discharge plan.

Participant 7: *I've met one patient who came in with a very large pressure area from a nursing home....and I just said to myself…"How could you not notice that?"*

Dependent on their experience with various elder abuse situations, participants were able to explain the person of concern's behaviour in cases where there was a lack of motive, e.g. cultural reasons, burden of care, financial hardship. Many of the participants' discussion throughout the focus group encouraged them to share or reflect on a patient situation which resonated with them about an older person at risk.

Participant 2*: One of the patients that we've got at the moment was talking to me yesterday evening. I think she has two daughters that she's always been very close to. And when her family home was sold two years ago, one of the daughters had a caveat put on it. And she said it made me realise that for years, my daughter been using me for financial gain and their relationship has now completely broken down. And I thought, having read this document that you sent me, that that really is a form of abuse.*

Participant 5: *We had a case on the general ward and it was a patient who had no inside bathroom – it was completely out of action. And the family had made a makeshift commode themselves. I felt kind of alarmed, it was this kind of like that grey area. I was wondering– "are they consciously doing that or are they not understanding that they can go and buy a commode from a service? Is it just their lack of understanding and knowledge of services? It was a very uncomfortable feeling.*

Participant 6: *I was looking after a patient who lived in in a granny flat with a son who had fallen and broken a hip and was lying on the floor of the granny flat for 12 hours because the son had gone to work. There was nothing put in place, so she, she may as well have been living independently. And you'd assume that that son had taken a certain responsibility for caring for his mother but nothing had been put in place as far as what to do if something like that had happened. Nobody had keys, and the son was un-contactable. So that worried me that nothing had been put in place.*

Participant 7: *I've had a patient that came in with lice and clothes that were disgusting. He was unkempt, his hydration was really down, his intake was down. So it was just pure bad health and fingernails, really long and dirty, toenails really dirty, really uncared for. But his*

daughter was claiming the carer's allowance and carer's pension...so, I'm thinking something is not right.

All participants in level 1 recognised the need for such training and agreed that it would be important to incorporate elder abuse education into training as currently all staff received mandatory training on other important areas such as aggression training. They advocated a need for an interactive, team-based training which educated them on the different types of elder abuse and how to identifying and respond. It was also expressed that senior staff and management should also be trained to offer less experienced staff support in situations in which staff needed direction or clinical advice.

Participant 1: *I think it's important to have some sort of interactive component to the education where staff can share their own experiences, to identify from case scenarios. I also believe our managers needs to be aware of elder abuse so if we consult with them they are able to support us to make sure we are doing the right thing.*

Participant 2: *I guess, what is important is if I was able to go to a senior staff member and they were really able to just point me in the right direction and make me feel like it was okay to be quite assertive in some situations.*

Participant 3: *I think it is much more practical to have team based education so we don't deal with it just in isolation; we're dealing with it all together; you sort of piece together bits of the puzzle irrespectively when you are talking with patients. We each talk and we each train each other. So, to me it makes perfect sense.*

Participant 5: *The more people that keep their eyes/ears open for signs – the more older people can be helped. It shouldn't always be left for one person to deal with – should work as a team.*

Participant 7: *We have training for aggression prevention, but I've had more patients who've had elder abuse than have been aggressive, you know what I mean, so, judging by their statistics of patients you have talked about that it affects, I agree that all staff should have training.*

Participants were also asked to reflect on case based scenarios on suspected elder abuse. The participants were able to acknowledge their ambiguity regarding acting on possible scenarios in a clinical context.

Participant 2*: I got such a strong reaction to that, to that idea of somebody being tied to a chair. The son could be putting on a show, he might not be, but how can we have a true sense of what happens at home.*

Participant 3: Her capacity would come into play in terms of her ability to make that decision to return living with her son. We would need to wonder whether she has the capacity to actually assess her situation and then make her own decision.

Participant 5: *And that's the challenge, because let's say the son is very loving and she also wants to return living with the son. So, that's where the conflict is – the perception of that situation by others, rather than the people within that situation.*

Participant 7: The thing that got me is if this poor woman's tied in her chair for at least 4 hours before the neighbour comes, did she have a pad on? Was she able to go to the toilet, was she voiding? Did she have any pressure area care as she sat in the same place, so she's at risk of skin breakages and sores.

Participant 8: *I've had pressure to just discharge when there've been quite obvious signs of potential elder abuse.*

The following quotes summarise the ongoing challenge for health professionals when working with older people in the context of their family.

Participant 1: *It is amazing how loyal elderly can be to less than perfect children. Love is blind.*

Participant 8: *Money does some incredible things to family dynamics and relations*.

3.7.7 Results - Focus group level 2.

Level 2 focus group comprised managers and heads of department and many participants suggested an overall need for implementation of an organisation-wide policy and set of guidelines in cases of suspected elder abuse. Overall, the senior staff in this focus group reported a level of ambiguity when it came to defining elder abuse and the associated signs. In fact some managers admitted to relying on colleagues to support them in situations of suspected elder abuse due to a lack of knowledge in process and legal responsibilities.

Participant 1: *We would be referring within the multi-day team, usually to a social worker, case manager type role, who would then I presume discuss it with their manager who would have more experience than us.*

Participant 2: *To me elder abuse is about someone using power in order to put someone else at risk and whether that be financial, sexual, physical, emotional or whatever the fifth one is. I would be hoping that those sorts of signs would come up if, someone's got no clothes or they're malnourished or if the family are acting in a way. I would hope that my consultant would also be saying "hmmm, something's not adding up here!", where a junior clinician might say "oh well, they don't want any services so what are we going to do? They've got wounds; now they are saying they don't want the district nurse. Is that because they don't have any money or their family are not wanting to pay the bill?*

Participant 4: *I'm probably a little bit different because the ACAS staff are working with varying patients, we get often asked for an opinion or a secondary view. So, I suppose I have to be more confident that I need to understand, elder abuse signs, because the staff will come to me to discuss it. I need to make sure that I understand the definitions and the signs.*

Overall, the participants of this focus group could name most of the types of elder abuse – financial, physical, sexual, and emotional - but not all. Again, the theme of recognising financial abuse was the most common. It also emerged that these managers and heads of department identified an area for further improvement is supporting staff with lack of experience or lacking elder abuse education. The participants felt that some of the key challenges that they faced included ambiguous intervention strategies due to various clinical and legal factors, management of risk, communication strategies and lack of standardised SVHM documentation. Most agreed that they advised their less experienced staff to refer to the Social Work Department or consult with the senior team in cases of suspected elder abuse.

Participant 2: *Because of his own mental health issues, or his understanding of what was happening, he actually took his mum away from the hospital. And there had to be police intervention to bring her back and there had to be a guardian - he nearly ran over nurses that were trying to stop him in the driveway with his car. There were obviously things that were not going right. And he didn't understand what was really happening. But whether there was purposeful abuse, I cannot conclude that 100%. This case was so difficult and challenging for us as a ward.*

Participant 3: *The only other thing I would add is the importance of our grassroots staff being educated in the hospital policy about not signing legal paperwork because probably one of*

the most common things we have is the lawyer who trots into the ward to change a will or do a power of attorney for a patient whose cognition is poor, who's probably not competent.

Participant 4: *When it's really obvious, it's much easier to deal with them; when it's around those shades of grey in the middle. We got into problems with someone that we saw at ACAS where we suspected there was some level of stress involved in the family and the issue was that the carer had started to have emerging signs of dementia but the person who was being cared for was competent and she was saying "No, there's nothing wrong with my husband. But the issue was the lady was our patient and so we couldn't get the man's cognition assessed and so, as professionals, our hands were tied.*

Participant 5: *In the absence of a current hospital policy I would imagine it would come to the senior team within Social Work.*

Participant 6: *If in doubt I would refer it to a social worker.*

Dependent on their experience with various elder abuse situations, participants were able to see a correlation in the behaviour of the person causing harm to the older person in situations where there was a lack of intent, e.g. carer stress, poor judgment, lack of knowledge and financial stress. Many of the participants were able to reflect on cases they had been involved with – directly or indirectly.

Participant 1: *The one that immediately comes to mind is the sister-in-law of somebody who worked for the hospital, who attends my day program and we noted that her husband was getting increasingly impatient, who was actually striking her during activities and yelling, striking…she seemed fearful of him; she also seemed, concerned about going home. She's got a case manager so we reported to both ACAS and the case manager. There was a relieving case manager; she didn't even bother to inform the normal case manager. So, it was, sort of, washed over. We're just monitoring things at the moment. But I think we have got a situation of extreme carer stress.*

Participant 2: *I haven't been involved in a circumstance where there's been any confirmation of abuse but often what we'll see is carer stress or carer burden or a carer with their own health problems, whether that be, cognitive decline or physical health issues and the patient, or our client, looks like there are probably risks and things deteriorating if there are not strategies put in place. I've got a particular person at the moment, who's on my ward, who does have cognitive decline, and is really struggling with learning new information. We're in the process of referring to home-based case management, so that they can be monitored in*

the community. I've got a view to make sure that we are looking after their best interests at heart, there's no immediate risk but his cognitive decline might lead to some kind of, not purposeful, but reflective risk.

Participants in level 2 discussed the need for an overall SVHM policy and clinical practice guidelines. It also emerged that annual education and refreshers, especially in a tiered format would be beneficial. Some staff also suggested including training on elder abuse in the hospital orientation process. Staff from this group also discussed the need for standardised documentation to ensure consistency across the organisation and to build evidence for cases of suspected elder abuse. There was also some discussion around the introduction of an elder abuse screening tool that prompts staff to ask questions for vulnerable older people presenting to hospital.

Participant 3: *We are currently dealing with a situation where a family trotted mum down to the lawyer, the lawyers changed mum's will and left out one son. And fortunately, staff discovered what had happened and we escalated that through to senior management.*

Participant 4: *I think having a policy to reference to is really valuable because whilst policy identifies the overarching ways in which we should deal with a particular situation, it also has that narrative that explains usually and has a definition and it has the starting points, I think that's something that's good to have along with an education campaign.*

Participant 6: *What becomes important with the people that we're suspecting but there's no evidence – time and time again, people will visit us and you can build that evidence up over time if there's good, solid documentation. Do we need to consider screening our patients for elder abuse. Is this common in other hospitals?*

In conclusion feedback from the level 2 focus group confirmed the challenges for elder abuse when there is insufficient evidence to act and there was acknowledgment that different staff require different education interventions based on their individual discipline.

Participant 1: *The clinical staff need something, managers need something different, social workers need something different again. It really needs to be very tiered.*

Participant 5: *I can think of one that we had when I was in ACAS where the gut feeling was there. We did everything we could and had layer upon layer upon layer of intervention but just wouldn't get the evidence and in fact, that person did end up in, quite a shocking way, in*

hospital later on. And there was abuse, we all knew there was, but we just couldn't collect the information to substantiate it….

3.7.8 Results – Focus group level 3.

The level 3 focus group consisted of experienced clinical staff. These staff included health professionals at the study site who had a number of years clinical experience and who were in role that required them to provide a front line response to older people at risk of elder abuse. The need for formalised education and training for all SVHM staff emerged prominently.

The participants agreed that some form of annual refresher course as well as education would prove to be beneficial when an actual policy is implemented, emphasising the need for an organisation-wide policy. This focus group also discussed the benefits for having either a specialised team to deal specifically with elder abuse at SVHM or having 'clinical champions' of elder abuse in each unit, department and ward.

Participant 1: *Child protection does have policies and procedures and education and we learn about that quite a lot whereas elder abuse has nothing - we really need to start getting more education around that.*

Participant 2: *In terms of social work, I think there are certain areas that we'll probably pick up but physical maybe lesser initially because we are not specifically trained in that area. A team approach would certainly assist with providing a complete picture of a patient's situation.*

Participant 3: *I do feel confident but usually I like to have like a guideline even where I think you've got a level of confidence with something, to be able to have something as a guideline just confirms that "I am on the right track" or "I'm moving in the right direction". Guidelines or policies can be helpful.*

Participant 5: *I think having clinical champions in each team that are more knowledgeable around a particular area such as elder abuse would have to make a difference.*

As this group comprised experienced clinical staff that carry out actual assessment and intervention in suspected elder abuse cases at SVHM, not surprisingly the participants were extremely familiar with the concept of elder abuse, even though none of them actually defined the term. It was also evident in the discussion that although many of the staff were familiar with the types of elder abuse, the recognition of the actual signs depended upon

individual professional training and defined role in the organisation. Staff certainly appeared uncertain about their legal responsibilities in acting on suspected elder abuse.

Participant 4: *The most difficult clinical challenge in dealing with abuse is trying to prove it. You don't really want to get it wrong. There are patients who do confabulate stories but you don't want to write people off to suggest that they are making up things. There is a lot of pressure on Social Work to make a professional judgments based on the presenting issues.*

Participant 5: *There's one case in Emergency where we had suspected there was elder abuse happening, whereby there was a lady that was presenting to Emergency on a few occasions with really vague symptoms. And one time, she did actually have a chest x-ray and it was noticed that she did actually have a fractured rib and she said she'd fallen into a doorknob. That just didn't quite add up and I guess we had a few suspicions about what was going on. And she said everything was fine at home. She said she lived with her husband. There wasn't too much more we could do at that point in time. Her son then came to pick her up and he wouldn't let doctors give her any medications, wouldn't allow any intervention. He was saying – "Come on, Mum, we're going home!". The son had very controlling type behaviours. Because she hadn't really given us anything to go by or anything to work with, there wasn't so much we could do in that situation. What we did was flag her, so that if she did come back, we'd be able to keep chipping away. And from my knowledge, I don't think she has been back since that time. We had spoken to her GP about it as well, he had not noticed any behaviours.*

Participant 6: *There's only one memorable elder abuse that I've been witness to and that was a patient who was confused, but at the same time, didn't want to go to a nursing home or a hostel because they had thoughts of their family members kicking them out to obtain money and the most difficult thing about Emergency Department is we don't know whether it's organic, related or legit and most of the times, these sort of issues are unsolved unless they are quite a few days down the track and their medical conditions are solved and that's one of the barriers in the Emergency Department. The disadvantage of that is that it's actually de-skilling the staff because if we suspect something, whether it's psychiatric or elder abuse, we just refer it onto Social Work or ALERT and the nursing involvement is pretty much a handball.*

Participant 7: *If the patient themselves told you that they've been abused, but they're too afraid to turn in a family member because if they do, then they might likely end up in a nursing home…what are we supposed to do?*

This group was well versed with questions about where and how often elder abuse occurred as well as the associated risk factors. There was also a detailed discussion about the difference between elder abuse and other types of family violence, with the participants describing limited knowledge and education on elder abuse, as opposed to the greater public exposure with other kinds of abuse.

Participant 1*: In terms of social work, I think there are certain areas that we'll probably pick up but physical maybe lesser initially because we are not specifically trained in that area.*

Participant 3*: It's not easy, it's never an easy conversation, it's confronting and you have to ask questions that personally make you feel uncomfortable- you don't know what their reaction's going to be but it has to be done. The thing that I probably find most difficult is how you manage the protection of the patient with all of the pressures from working in a busy hospital environment.*

Participant 4*: I guess with child protection issues, there's straightforward processes that we see as social workers. We know that there's a department that we can ring...as well with domestic violence too, often the patient is competent to make that sort of decision in terms of risk...I'd say the assessment changes with the elderly as well. Elder abuse - it's a much more complex issue.*

Participant 6*: I think sometimes there's a blurry line is to what is seen as domestic violence compared to elder abuse. The Emergency Department itself is not the right place to even do that confronting role because how do you put a safety plan in place in a matter of a few hours and have adequate follow up at that point in time which is a real issue because there's definitely issues going on at home but how you balance all of that in such a short time*.

Participant 7: *There's a lot more public exposure on child abuse than the elderly - if a child does come into the Emergency Department, everyone, regardless of what the patient comes in for, there's a tighter threshold for you to assess child abuse than it is for elderly.*

In summary most participants in this group felt that the key challenges that faced them included difficulty in proving and identifying elder abuse, pressure to make a professional judgment with the limited information available, pressure to discharge patient, and the need to skill up staff in departments such as the Emergency Department. They also discussed the need for a standardised documentation processes to facilitate better communication throughout teams and wards.

3. 8 Summary of Results from the Focus Groups

As there was such rich data from the focus groups consideration of how this data could be analysed and presented was considered. The findings of the focus groups were interpreted and summarised according to the Richie and Spencer Framework (1994). This framework includes four categories. These categories are:

- Contextual: Identifying the form and nature of what exists
- Diagnostic: Examining the reasons for what exists
- Evaluative: Appraising the effectiveness of what exists
- Strategic: Identifying new theories, policies, plans or actions

3.8.1 Context – dimensions of attitudes and perceptions.

Focus Group 1 participants' perceptions were based on recall of cases of suspected abuse where they had directly cared for the older person and interacted with the suspected person of concern. An important theme of ambiguity about what constitutes elder abuse was highlighted. For example a participant responded by saying:

In relation to elder abuse I automatically thought it was physical and financial, but it's a bit more than that (participant 1).

Focus Group 2 participants' perceptions were based on recall of cases of suspected abuse in which they had directly been involved or which they had witnessed. Overall, the participants felt a level of ambiguity about the definition and associated signs of elder abuse. For example a participant responded by saying:

I need to make sure that I understand the definitions and the signs (participant 2).

Focus Group 3 participants' perceptions were based on recall of cases of suspected abuse where they had provided guidance or supervised junior staff into taking a course of action. This group was relatively confident in terms of the signs, risk factors and triggers associated with elder abuse. For example a participant responded by saying:

I do feel confident but usually I like to have a guideline even where I think you've got a level of confidence with something (participant 3).

3.8.1.1 Nature of people's experience.

Focus Group 1 perceptions were based on personal interactions with older people, re-telling of experiences of suspected of elder abuse; Media/newspapers; Policy statements (example: experience in the UK); lack of experience or knowledge of recent Victorian government's With Respect to Age guideline document. For example a participant responded by saying:

I think there was even an article again in the paper today about the amount of financial abuse that's actually going on in our community (participant 7).

Focus Group 2 participants recalled the experiences of junior staff; personal interaction with older people; discussion of how staff was/how it should be directed; managing team wide response; bringing about intervention in cases suspected of abuse; key challenges. For example a participant responded by saying:

I need to understand elder abuse signs because the staff will come to me to discuss it (participant 4).

Focus Group 3 participants perceptions were based on personal interactions with older people, re-telling of experiences of co-workers/colleagues; lack of knowledge of recent Victorian government document: With Respect to Age, social workers self-educated on elder Abuse, mainly through government health-based literature and articles.

3.8.1.2 Challenges of population of interest.

Focus Group 1 discussed educational/training needs. Many participants clearly identified lack of training in recognition and handling of suspected elder abuse. Confusion regarding unintentional versus intentional elder abuse from person of concern emerged. For example a participant responded by saying:

A patient had no inside bathroom and the family had made a makeshift commode themselves. I was wondering "are they consciously doing that or are they not understanding that they can go and buy a commode?" Is it just their lack of understanding and knowledge of services? (participant 5).

Focus Group 2 discussed educational/training needs (many participants clearly identified lack of training in recognition and handling of suspected elder abuse). In addition to the need

for a policy, there was also discussion about need for annual training for all staff. For example a participant responded by saying:

I think having a policy to reference is really valuable. I think that's something good to have along with an education campaign (participant 4).

Focus Group 3 discussed the primary need identified was for formalised training/education, including a component on the current legislation on elder abuse as this was the level of staff which carries out intervention in suspected elder abuse cases. Most participants, particularly social work staff depended upon self-education. The participants did not seem 100% confident on how to guide the less experienced staff other than referring to other programs or departments. For example a participant responded by saying:

To be able to have a guideline confirms that "I am on the right track" or "I'm moving in the right direction" (participant 3).

3.8.1.3 Challenges for health professionals.

Focus Group 1 participants had no access to a departmental elder abuse policy. Main sources of information were external/self-initiated readings. None of the participants had undergone formal education/training. For example a participant responded by saying:

I agree that all staff should have training (participant 7).

Focus Group 2 participants had never attended any formal training or education on elder abuse. For those who had attended any formal training or education, it was years since it took place. All participants agreed that there was no policy or any sort of guidelines in their department or ward to assist staff in the area of elder abuse. For example a participant responded by saying:

In the absence of a current hospital policy, I would come to the senior team within Social Work (participant 5).

Focus Group 3 confirmed the need for an organisation-wide elder abuse policy. For example a participant responded by saying:

Child abuse has policies and procedures whereas elder abuse has nothing (participant 1).

3.8.2 Diagnostic.

3.8.2.1 Factors influencing different attitudes and perception of participants.

Focus Group 1 participants described different kinds of personal experience and exposure to cultural norms.

Focus Group 2 participants described different kinds of personal experience. Greater experience has led to greater chances of giving benefit of doubt. Participants felt that intent, ignorance and lack of education also led to elder abuse. For example a participant responded by saying:

We see carer stress or carer burden and there are risks if there are no strategies put in place (participant 2).

Focus Group 3 participants in this group are senior clinicians and specialists at providing a response to suspected elder abuse cases. Their years of experience working in ED, acute and sub-acute as well as their supervisory and problem-solving roles define their attitudes and perceptions. For example a participant responded by saying:

Having clinical champions that are more knowledgeable around elder abuse would make a difference (participant 5).

3.8.2.2 Factors influencing decision making of participants.

Focus Group 1 participants discussed safe discharge from hospital as a priority and evoked as a critical decision-point in decision making for elder abuse. For example a participant responded by saying:

You don't want to be sending someone home to a poor home environment (participant 1).

Focus Group 2 participants described feeling inexperienced and no training in supporting less experienced staff. They feel this contributed to lack of response. They felt that documentation in such cases was time consuming leading to a higher clinical load for staff and for this reason staff may not escalate elder abuse cases to managers. For example a participant responded by saying:

We often get asked for an opinion. I need to need to understand elder abuse signs because the staff will come to me to discuss it (participant 4).

Focus Group 3 participants felt that the nature of the ward/department determined the kind of action taken - in the Emergency Department, due to shortage of time, it was difficult to carry out a complete assessment and work out a safety plan. It was also agreed that the difficulty in confirming and identifying elder abuse contributed to lack of action in this direction. Another factor that was seen as a challenge was patient reluctance to disclose information due to their own shame, fear of safety and relationship with their family. Another factor was the hesitation in delaying discharge in case the signs of suspected elder abuse were ambiguous. For example a participant responded by saying:

The Emergency Department is not the right place. How do you put a safety plan in place in a matter of a few hours and have adequate follow up? (participant 6).

3.8.2.3 Factors influencing the needs of participants.

Focus Group 1 described ambiguity about their role, absence of set policies/guidelines, absence of escalation processes, absence of policy to guide processes like safe discharges/discharge planning. For example a participant responded by saying:

Our managers need to be aware of elder abuse so we can consult and they are able to support us to make sure we are doing the right thing (participant 1).

Focus Group 2 also described an absence of set policies/guidelines, absence of escalation processes, absence of policy to guide junior staff as well as processes like safe discharges/discharge planning can affect their response to elder abuse. For example a participant responded by saying:

Clinical staff need something, managers need something different, social workers need something different again. It really needs to be tiered (participant 1).

Level 3 participants discussed factors such as absence of set policies/guidelines, absence of policy to guide less experienced staff as well as discharge processes such as putting in appropriate safety nets. Often times, assessments have to be made with the limited information available as there is always pressure to discharge the patient in case he/she is medically stable. Also, need for comprehensive documentation was identified by all. For example a participant responded by saying:

The thing I find the most difficult is how you manage the protection of the patient with all the pressures from working in a busy hospital environment (participant 3).

3.8.2.4 Factors influencing the application of a policy to practice.

This was the only question where all three focus groups provided a consistent response.

Focus Groups 1, 2 and 3 confirmed that by having no guidelines/no official policy and lack of awareness of elder abuse contributed to their ability to identify and respond effectively to elder abuse at the study site. For example participants in each level responded by saying:

Having a policy to reference is really valuable because it identifies the overarching ways in which we should deal with a particular situation (focus group 2, participant 4).

3.8.3 Evaluative.

3.8.3.1 How are objectives achieved?

Focus Group 1 did not respond directly to this question.

Focus Group 2 and 3 participants suggested that in the absence of an organisation wide policy or guidelines, most participants said they depended on referring suspected elder abuse cases to social work staff. A high degree of participants agreed that holistic and comprehensive documentation helped achieve objectives. For example a participant responded by saying:

There are people we are suspecting but there's no evidence – people will visit us and you can build up that evidence over time if there is good, solid documentation (focus group 2, participant 6).

3.8.3.2 What affects the successful delivery of program services?

Focus Group 1 did not respond directly to this question.

Focus Group 2 suggested the absence of organisation wide policy and guidelines; absence of organisation wide data collection.

Focus Group 3 proposed that an absence of organisation wide policy and guidelines; absence of organisation wide data collection and standardised documentation template; not having a specialised team to deal with the issue impacted the successful delivery of program services.

3.8.3.3 What barriers exist to systems operating?

Focus Group 1 did not respond directly to this question.

Focus Group 2 participants felt that challenges include factors such as lack of evidence to confirm elder abuse, ambiguity in proving, staff inexperience leading to lack of response and clinician overload were barriers to responding to suspected elder abuse. For example a participant responded by saying:

There was abuse, we all knew there was, but we just couldn't collect the information to substantiate it (participant 5).

Focus Group 3 participants felt that difficulty in proving and identifying elder abuse, pressure to make a professional judgment with the limited information available, pressure to discharge patient, and de-skilling of staff in departments such as ED due to constant referrals to Social Work and nursing, were the main barriers. For example a participant responded by saying:

It's actually deskilling the staff because if we suspect something we just refer it on and the nursing involvement is pretty much a handball (participant 6).

3.8.4 Strategic.

3.8.4.1 What types of services are required to meet needs?

Focus Group 1 suggested case-based debriefing sessions; a coordinator/expert who has cross-institutional reach, teams that consist of various kinds of clinical and allied health staff; 'train the trainer'. For example a participant responded by saying:

I think it's important that staff can share their own experiences (participant 1).

Focus Group 2 participants felt that the implementation of an organisation wide policy which ensures prop improved reporting relationships; annual education refreshers, possibly tiered to meet different needs; hospital orientation programmes; comprehensive documentation and risk assessment guidelines and Clinical Practice Guidelines may help in meeting the needs for vulnerable older people. For example a participant responded by saying:

Clinical staff need something, managers need something different, social workers need something different again. It really needs to be very tiered (participant 1).

Focus Group 3 participants agreed that in addition to an overall SVHM policy on elder abuse, guidelines were also needed. They also raised the need for education on policy, standardised documentation and templates to improve communication, and implementation of standards of care. For example a participant responded by saying:

With child protection issues, there's a straight forward process, we know there is a Department we can ring. With domestic violence, often the patient is competent to make decisions in terms of risk. With elder abuse, it's a much more complex issue (participant 4).

3.8.4.2 What should be included in an elder abuse policy?

Focus Group 1 participants suggested a policy should have guidance for carer education, guidelines for how elder abuse cases should be followed up, guidelines that emphasise safe discharge planning, guidelines that advocate inter-disciplinary team approach and guidelines that clarify legal implications such as duty of care, confidentiality and capacity issues. For example a participant responded by saying:

We need team based education so we don't deal with it in isolation, so we're dealing with it all together (participant 3).

Focus Group 2 suggested a policy should reference organisation wide communication strategies and, knowledge of triggers and key clinical risks for elder abuse. For example a participant responded by saying:

I need to make sure I understand the definitions and the signs (participant 4).

Focus Group 3 suggested that through implementation of policy and guidelines, annual education refreshers - there was agreement that all staff should be trained in elder abuse, specialised team members in each team such as "clinical champion" and mandatory online training should be considered. For example a participant responded by saying:

Having clinical champions in each team who are more knowledgeable around elder abuse would have to make a difference (participant 5).

3.9 Individual Interviews

Semi - structured individual interviews were conducted with key staff across the study site who were unable to attend the focus groups. The semi- structured interviews with the participants involved open ended questions that explored their perspectives on elder abuse. The aim of the interviews was to determine the perceptions and experiences of key staff who were directly involved with older people at the study site.

There are three different types of interviews: structured, unstructured and semi-structured. Structured interviews are based on questions that are asked of each and every participant involved. There is no variation in the question sequence between participants. Unstructured

or informal conversation interviews have no consistency in the set of questions (Crabtree and Miller, 1999).

The semi-structured format for interviews allowed for guided, open-ended conversations that enabled an in-depth understanding of the health professionals' attitudes, perceptions, and viewpoints on elder abuse (Patton, 2002).

Face-to-face interviews may be more time-consuming compared to focus groups. However individual interviews allow rapport to be established which may be critical in discussing a complex issue such as elder abuse. Individual interviews explore in more depth the respondents' perceptions and can allow for clarification if required around certain topics or issues which may be uncomfortable to discuss in large focus groups.

3.9.1 Purpose.

The semi structured interviews identified key issues and provided information that was critical to addressing the research question. It was anticipated that information gained from the interviews would be critical in the development of the training intervention.

3.9.2 Participants.

Participants comprised the Director of Aged Care at SVHM (Geriatrician), Nurse Unit Manager Emergency Department, Nurse Unit Manager Acute General Medical Ward and a Senior Physiotherapist (Team Leader ACAS) who were unable to attend the focus group discussions. The staff were selected because of their experience and designated roles at the study site.

3.9.3 Instruments.

Participant information and consent forms were developed. A mutually agreed time was selected for the interview with each of the participants.

The interviews were semi-structured and conducted to ensure all participants were able to address the key questions in each interview. The questions were loosely based on the same question format as the focus groups. In this research semi-structured interviews allowed the researcher to vary the sequence of the questions as required, explore key themes for further understanding and examine responses in more depth while maintaining the focus on the research objectives.

Prior to the individual interviews each of the four participants were provided with detailed information relating to the research. The participants were also assured that he or she had no obligation to participate and could withdraw from the research process at any time. The researcher followed the interview guide and elaborated on each question which required further exploration. Each interview took approximately 45 minutes. After the individual interviews were completed, the researcher determined if the participant had any issues or questions that needed clarification. The Ecological Framework underpinned the development of the questions used in the inquiry phase.

3.9.4 Procedure.

A purposive sampling approach was used with the participants in the face to face interviews. Prior to the individual interviews each of the four participants were provided with detailed information relating to the research.

3.9.5 Analysis.

The individual interviews were taped and transcribed verbatim and the analysis was facilitated using the Framework method (Ritchie and Spencer, 1994).

3.9.6 Results - individual interviews.

A total of 4 face-to-face interviews were conducted by the researcher with SVHM staff who were unable to attend the focus groups. These included the Director of Aged Care, the Emergency Department Nurse Unit Manager, the ACAS Team Leader and ALERT Manager.

One of the important issues that was discussed during the interview with the Director of Aged Care was the need to consider the cultural factors which can play a key role in what could be done in relation to suspected elder abuse. This respondent believed from his extensive clinical experience, that different cultural backgrounds had different definitions of what was acceptable – and at times there was likelihood that culture and elder abuse are embedded into complex situations. This respondent believed that in such situations, it was difficult to give clinical advice, as it was difficult to determine what the triggers were and to interpret their meanings from the specific cultural perspective. Of interest, this was a theme that had come up during the focus group interviews where the participants had talked about cultural differences and how much this may affect a health professional in responding to suspected elder abuse.

During this interview, the Director of Aged Care at SVHM concluded that medical staff were not that perceptive in regards to the subtle signs of elder abuse and may only respond to obvious signs such as physical abuse. The interviewee believed that nursing staff had more time than doctors and were more able to identify any risk factors during the course of their routine involvements with patients. The interviewee also discussed the high-cost of hospital beds and the importance of weighing up risk factors for older people to ensure that there were not lengthy delays in discharge planning. Another issue that was discussed was the risk of hospital staff not feeling supported. One of the suggestions that was flagged during the course of this interview was strong support for an effective training program on elder abuse - possibly an online module available for SVHM staff. In discussion about individual knowledge of elder abuse policy, there was a suggestion about how things may appear on the 'radar' but may not get detected – due to staff being distracted, not confident to act or due to a lack of resources.

During the interview with the Emergency Department Nurse Unit Manager, it was evident that an emerging theme was the pace of how clinical decisions are made within the Emergency Department (ED) as the ED was essentially involved in ensuring the medical well-being of the patient. This is consistent in with our findings during focus group sessions where it was suggested that the limited time in ED was cited as one of the challenges to identify suspected elder abuse cases.

During the interview with the ACAS team leader, it was evident that one of the biggest challenges facing the staff was a lack of an organisation-wide document on elder abuse. There were a lot of grey areas – dependent on backgrounds of patients – and a lot of confusion about what the 'flags' were and what to do with that information. Nurses may be unclear about who to approach and may not feel confident about the signs of abuse. This is consistent with our focus group findings where the staff concluded that a lack of clinical guidelines on elder abuse acted as a barrier to identification of suspected elder abuse. One of the suggestions during this interview was training the staff not to be afraid to use the term 'elder abuse' as the term is often seen as a taboo. The interview also suggested the introduction of mandatory elder abuse training and need for documentation guidelines, themes that had also come up during focus group interviews.

During the interview with the ALERT Manager, there was emphasis on the need for competency building across the organisation. This was a theme that had been discussed during the focus group sessions. There was also discussion about need for support for staff

during suspected elder abuse cases. Nursing and Medical staff in ED look for support from the ALERT team regarding suspected elder abuse cases. The interviewee was of the opinion that the staff needed education, time as well as sensitivity to handle suspected elder abuse cases. Suggestions for increasing staff confidence to act on elder abuse included targeted training.

3.10 Discussion

This section will now provide a discussion relating to the online survey, focus groups and individual staff interviews.

The confidential online survey was carried out across different campuses at the study site targeting a range of healthcare professionals across the organisation. The survey was designed in 4 parts to capture: staff demographics, experience with elder abuse, self-rating scale and staff education needs.

The total number of respondents was 275 with over 80% or 225 of these staff were female. According to profession, the largest group of respondents with almost half 49% were nursing staff with 136 responses and the lowest response 10 from managers and administration staff. Nursing has always been considered a female dominated profession and in 2011, 90% of nurses in Australia were women (Health Workforce Australia, 2012. This demographic mix of the respondents is representative, to a large extent, of the demographic mix of the health professional sector in Australia.

According to the age of the respondents, the largest group of staff who responded were aged between 25 and 34 years of age being just over 42% or 117 out of 275. The rate of responses were from staff working were in the acute units, followed by the sub-acute and then the emergency department. A high percentage (44%) of the respondents were staff, who had been working between 1 and 5 years.

A high percentage of the respondents to the online survey, over 78% or 215, had never attended a training or workshop session on elder abuse. This forms a key finding in this study as evidence strongly supports that health professionals are unlikely to respond to elder abuse due to a lack training/education and lack of knowledge of appropriate intervention strategies. According to the literature, lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse have been identified as significant barriers to managing elder abuse (Richardson et al., 2002; Cooper et al., 2009; Alt et al., 2011).

One hundred and eight (108) out of the total 275 respondents indicated that they had suspected incidents of elder abuse in the past 12 months. However it could be hypothesised that this may be the tip of the iceberg and there may be many more SVHM staff who did not have the knowledge to identify the signs or risk factors for vulnerable older people who may have presented at risk of elder abuse. Hence, those cases could have gone unreported and the risk may have continued. This is consistent with the review of literature in Chapter 2.

According to O'Keeffe et al (2007), evidence suggests that elder abuse is often unrecognised and under-reported by hospital staff. Boldy (2002) suggests that health professionals frequently put elder abuse in the 'too hard basket'. In some cases, the healthcare professional may fail to act on suspected elder abuse due to lack of knowledge of how and where to report. The review of literature supports this view. According to Bonnie and Wallace (2003), elder abuse may also be undetected due to the failure of professionals to either identify the problem or to be aware that the abuse may have occurred. Halphen et al. (2009) state that reporting and responding to elder abuse may be more complicated due to a lack of knowledge from health professionals about where to report the suspected abuse.

Consistent with the literature relating to incidence of elder abuse, the majority of respondents indicated that they were more likely to suspect financial abuse. Financial abuse is the most common form of reported or suspected abuse relating to older people (Office of the Public Advocate, 2015). Studies estimate that approximately half of all abuse experienced by older people is financial abuse.

Clinical judgment and information disclosure by the older person formed the two highest reasons for suspected abuse as indicated by staff. It could be assumed that a high percentage of staff needed to rely on their clinical judgment, which comes from experience rather than education to identify older people at risk of elder abuse. Hence, less experienced staff who may not have had the opportunity to develop their clinical judgment and who have not had any education or training on elder abuse, can be assumed to be less confident in identifying elder abuse in a hospital setting.

As stated the other most common means of identifying suspected elder abuse is due to direct disclosure by the older person. This means of detecting suspected elder abuse is considered less common as self-reporting by older people is very rare and older people often feel shame and are fearful of the consequences.

The respondents indicated that the three most prevalent actions they followed in cases of suspected elder abuse included referring to another program or team in the hospital, consultation with seniors/managers and referring the case to an external agency. 38% of the respondents or 41 staff said that they would have managed the situation differently had they received any training or education on elder abuse. According to the literature, lack of knowledge regarding appropriate interventions by healthcare professionals is one of the proposed contributing factors why elder abuse remains an ongoing issue in our community.

As described, the online survey had specific questions to determine the knowledge and confidence of the respondents in the area of elder abuse at the study site. The majority of the respondents either strongly agreed or strongly disagreed with the questions in this section of the online survey. In the question regarding what action would the respondent take when faced with a suspected elder abuse, 55 staff responded that they would refer the case to the relevant hospital department.

When asked about what interventions that would assist in the overall understanding and management of elder abuse, the majority of the respondents, 174 staff, suggested education of health professionals would greatly assist in responding. One hundred (100) respondents also mentioned education of older people about their rights could increase the overall understanding regarding the issue. This is consistent with a review of literature which identified education as a critical strategy to assist in the prevention of abuse of older people at risk. According to Walsh et al. (2007), education is essential for understanding and having an awareness of elder abuse.

In response to the question on how they could improve their knowledge, confidence and competence in identifying and acting upon suspicion of elder abuse, the majority of respondents over 62% or 129, indicated that this could be addressed through an organisation wide policy.

The result of the cross-tabulation between the current role of the participants at the study site and the various aspects of elder abuse carried out during quantitative analysis showed that a higher proportion of social workers had received training or education on elder abuse as compared to other participants. It also showed that a higher proportion of nursing staff had exposure to elder abuse compared to respondents in other roles. These results would indicate that social workers have received more training to assist in responding to elder abuse even though the results indicate that nursing staff are more exposed to possible elder

abuse situations. This would suggest that nursing staff have to rely on either intuition or clinical judgment to handle elder abuse cases in the absence of attending education.

A high percentage of respondents indicated that if they had received any training or education on elder abuse, they would have managed the case differently. As mentioned earlier, a significant body of literature points to deficits in awareness, knowledge and confidence among health professionals in relation to elder abuse and documents the limited provision of education and training in the area (McLaughlin & Lavery, 2000; Richardson et al., 2002; Thompson-McCormick et al., 2009; Sugita & Garrett, 2012).

During quantitative analysis, a chi-square test of independence was conducted to explore the relation between having attended a training or workshop on elder abuse and if the participants thought they would have managed the suspected case of elder abuse differently. The results were statistically significant. This means that there is a significant association between the variables 'having attended training/workshop' and 'further education would have helped'. Hence, a significantly larger percentage of staff who had never attended a training or workshop on elder abuse indicated that further education and/or training would have helped them manage suspected elder abuse cases differently. It can be concluded from the results of the survey that the participants who had never received any training or education on elder abuse felt that education or training could have helped them to have the knowledge and confidence to manage cases of suspected elder abuse differently.

Three focus group sessions were carried out using a researcher developed interview instrument. This instrument aimed to explore the participants' perceptions, insights into elder abuse, and suggested themes for further inquiry and research. Each session lasted for approximately an hour and was taped and transcribed.

Level 1 focus group comprised 8 junior staff from nursing and allied health staff. Level 2 focus group was made up of 6 managers and heads of departments. Level 3 focus group consisted of 7 experienced clinical staff from different health backgrounds.

The Ritchie and Spencer Framework (1994) for Qualitative Analysis was used to analyse the data collected as a result of these focus group sessions. The analysis covered four elements – context, diagnosis, evaluation and strategy. These elements were incorporated in form of questions which were answered with the help of the data collected.

In level 1 focus group, there was an overall lack of formal education and training regarding elder abuse. In many instances, the staff acknowledged that they used intuition to identify

elder abuse. There was also evidence of ambiguity pertaining to defining suspected elder abuse suggesting a lack of appropriate training and an organisation wide policy on elder abuse. All participants agreed that the introduction of elder abuse training should be considered for all staff similar to the current mandatory aggression training at the study site.

The participants in this group also suggested a component for interactive, team-based training on elder abuse. The participants from level 1 focus group believed that senior staff and management needed to be trained in elder abuse to assist them to make decisions regarding possible dilemmas pertaining to confirmation and appropriate strategies for discharge planning. The reliance of this group on the use of 'intuition' in identifying suspected elder abuse could be balanced by providing appropriate training and education to improve skills for elder abuse identification.

Responses from the Level 2 focus group supported an overall need for implementation of an organisation wide policy and set of guidelines pertaining to the management of elder abuse. Staff in this group supported the need for appropriate training and education on elder abuse as the majority of them felt an ambiguity when it came to defining elder abuse and the associated signs. The managers and heads of departments in this focus group supported a need for training for less experienced staff in responding to suspected elder abuse. Some of the other challenges identified by participants in this group included ambiguous reporting relationships, communication pathways and lack of standardised documentation. There was unanimous support for the introduction of an overall hospital policy on elder abuse and clinical practice guidelines.

The findings from Level 2 focus group suggests that managers and heads of departments require targeted training on elder abuse - targeted to their level to ensure that they can appropriately support their staff if they identify a case of suspected elder abuse.

Responses from Level 3 focus group, indicated strong support for education and training for all staff. Some of the suggestions that arose out of this focus group included annual refreshers as well as mandatory online training. There were also suggestions for formulating a specialised team to deal with elder abuse cases at the study site. According to these participants in this group, the main challenges that they faced included both identifying and confirming suspected elder abuse, pressure to make a professional judgment with the limited information available, and pressure to discharge a patient.

Level 3 focus group also highlighted the strong need for training and education on elder abuse as well as the need for a standardised documentation process. Since this group comprised of experienced clinical staff who are required to carry out the actual assessments and interventions, their request for overall training and education on elder abuse was critical in the development of the education package which was developed as part of this research project to meet the identified needs of staff.

A total of 4 face-to-face interviews were conducted by the researcher with staff who were unable to attend the focus groups. These included the Director of Aged Care, the Emergency Department Nurse Unit Manager, the ACAS Team Leader and ALERT Manager.

There was emphasis on need for competency building across the organisation. This was a theme that had been discussed during the focus group sessions. There was also discussion about need for support for staff during suspected elder abuse cases. Suggestions for increasing staff confidence to act on elder abuse included targeted training for core groups of staff working in key areas across the organisation.

3.11 Implications for the Development of the Training Intervention

According to Joubert & Posenelli (2009), the hospital provides a unique opportunity for staff to respond if they suspect elder abuse. As already described Australia has an ageing population, and hence, in the coming years, it is anticipated that these people are going to have increased access to healthcare services. According to the WHO (2011) healthcare professionals who routinely interact with older people are in the best position to identify those who are at risk for abuse and also extend support to those elderly who are already experiencing abuse. Hence, it is essential that hospitals in Australia are fully equipped to deal with the greater likelihood of suspected elder abuse cases as estimated prevalence would suggest that 5% of our older population are at risk.

Literature confirms that few studies have been undertaken which have explored responses to elder abuse in a hospital context. Hence, the findings of this phase can actively contribute to the development of the training intervention through this study. The focus groups, feedback has provided a picture of the perceptions of the staff at the study site relating to elder abuse. And as we have seen from the staff responses, training and education of hospital staff on elder abuse is a requirement which has been confirmed by all three focus groups.

This view has been further supported by the online survey, in which it has been identified that many of the respondents believed that they would have managed cases of suspected elder abuse differently had they received training and/or education. In addition, the need for standardised documentation, a hospital wide policy, and a set of clinical practice guidelines have also been emphasised in all three focus groups. Hence, by introducing training and education on elder abuse for all staff, by introducing a formal policy and set of guidelines, this study can begin to address the research question relating to this thesis.

The main themes that emerged from all three focus groups included a need for an overall organisation-wide policy to assist staff in the management of elder abuse, a set of guidelines to guide the staff, standardised documentation procedures, clear guidelines to assist staff in the escalation process as well as a formalised education for targeted staff across the organisation.

There was agreement that the hospital did offer vulnerable older people a 'window of opportunity' to support them if they were being abused or at risk of elder abuse. There was also an agreement that at present, a high degree of staff relied on their own intuition or 'gut feeling' to identify elder abuse in our older patients.

The results of the descriptive analysis for this phase suggest two common themes in relation to health professionals involved in this phase - the need for education and training on elder abuse and an organisation wide policy. Overall, staff felt that they would be more confident to respond if they had received education and/or training on elder abuse and there was strong support for an organisation-wide policy on elder abuse which could include a standardised documentation process and clinical practice guidelines.

CHAPTER 4 – DEVELOPMENT OF TRAINING INTERVENTION

4.1 Introduction

This chapter will describe the rationale and design relating to the development of the training intervention. This includes a justification for the chosen approach and the significance of the ecological framework which guided the intervention for health professionals. In this phase the study focuses on application of the knowledge, analysis and decisions made (synthesis) in previous phases to inform development of the training package to be tested at the study site.

This phase will use the available literature and thematic data analysis from the staff survey, focus groups and interviews to support the transfer of knowledge to health professionals at the study site.

The aim of this chapter is to describe the design of the training intervention taking into account the context of practice and drawing on available literature regarding key components including content, context, targeting specific audiences, strategies and methods. The training intervention will be tested in the next phase (chapter 5) to evaluate its effectiveness in facilitating health professionals' response to suspected elder abuse.

Perspectives and recommendations from the online survey, focus groups and interviews will be drawn upon to further assist in the development. At this point it is important to ensure through discussion in this chapter that the research aims are being met.

4.2 Definition of Training

There is an increasing focus on improving training for health professionals. A definition of training needs to be considered for the purpose of this thesis. Training is a type of activity which is planned, systematic and it results in enhanced level of skill, knowledge and competency that are necessary to perform work effectively (Gordon, 1992). Within a health context, training supports health professionals to acquire and improve knowledge, skills and attitudes towards work related tasks within designated roles and expected responsibilities (Department of Human Services, 2009). The process of identifying barriers and enablers for training health professionals is considered to be an important step in developing tailored, effective training interventions (National Institute for Health and Clinical Excellence, 2007).

4.3 Implications of the Literature Review for the Development of the Training Intervention

Findings from the literature review (chapter 2) will be considered in the development of the training intervention. These will be considered around the four themes that have been proposed:

- the problem of elder abuse
- review of models and approaches for responding to elder abuse
- responding to elder abuse – the role of the health services
- education and training for health professionals in detecting and responding to elder abuse

An examination of the literature in chapter 2 has revealed the complexities of understanding and addressing elder abuse within a health context. This chapter examines the literature using themes which emerged in undertaking the first phase of this study.

A summary of key points follows regarding each of these themes and the implications for the development of the training intervention.

4.3.1 The problem of elder abuse.

- Health professionals need to be aware that elder abuse is a recognised form of family violence and that it can have a devastating impact on an older person and their family.
- Fear of punishment, isolation, shame and guilt often means that the older person may remain silent.
- For many older people at risk of elder abuse, the hospital is the first contact point with the health system and may offer a "window of opportunity" for help and support (Joubert & Posenelli, 2009).
- Health professionals who routinely interact and assess older people are well placed to identify those at risk of abuse and also to provide support to those experiencing abuse.
- Health professionals working with older people need to understand the complexity of elder abuse as well as their own values and attitudes, to minimise contributing factors such as ageism.

- Health professionals need to be aware of the risk factors for elder abuse – both for the older person and the person of concern to assist in minimising the risk. The issues of capacity, vulnerability and dependency need to key factors for consideration within a health context.
- Elder abuse is higher in situations in which there are other contributing factors, such as a history of conflicted relationships, carer stress or mental health issues (Anetzberger 2000).
- Factors affecting under-reporting of elder abuse can be attributed to both the older person and the person of concern such as reduced cognitive capacity, physical disability, mental health issues, restricted mobility leading to dependency, lack of understanding of what constitutes elder abuse, lack of knowledge about rights and legal options, social isolation, stigma or shame, language or cultural barriers; fear of retribution from the person of concern or just a lack of service options available to older people at risk of elder abuse (Bagshaw, Wendt & Zannettino 2007).

4.3.2 Review of models and approaches for responding to elder abuse.

- The need for a multidisciplinary approach to the prevention and response to elder abuse is acknowledged in all Australian state and territory policy and strategic documents.
- The Victorian Government supports older people having a right to self-determination and being empowered to make their own individual choices.
- Australia has preferred to develop individual state protocols and guidelines that emphasise a multi-disciplinary approach and effective cooperation between key stakeholders such as hospitals (Department of Health and Human Services, 2009).
- The focus of the UK adult protection model is on 'safeguarding' and achieving a balance between autonomy and protection for all adults (Phelan, 2009).
- The UK response is based on the premise of providing necessary services to minimise any type of abuse and restore family relationships, rather than punishing the people inflicting the harm to the older person or vulnerable adult (Filinson, 2006).
- An examination of the safeguarding approach in the UK has raised the important issue of governance at the study site and the need for a consistent approach across organisations.
- The approach in Canada draws on collaboration across sectors and increased attention to the impact of family violence on older people.

4.3.3 Responding to elder abuse – the role of the health services.

- Elder abuse may be under reported because of the barriers relating to health professionals having the confidence to identify the problem (Krueger and Patterson, 1997).
- The professional response to elder abuse is often inadequate, services are lacking or non-existent, fragmented, and offer different levels of expertise (Nerenberg 2008)
- Reporting may be complicated by a lack of knowledge about where to report suspicion of elder abuse due to a lack of policy or appropriate education strategies in place for staff (Sugita & Garrett, 2012).
- Barriers to responding to elder abuse include lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse.
- An examination of the literature suggested the following barriers for health professionals are important to consider: lack of confidence in defining, identifying, and reporting abuse; reluctance to report abuse unless there is certainty that abuse had occurred; concern for the therapeutic relationship; potential consequences for the older person ; empathy with the abuser; not having clear definitions of abuse; shortages of available interventions for the older person; a lack of training; a lack of time; the older persons health; absence of clear legislation; not knowing where or how to report; a lack of protocols; ethical dilemmas; the belief that abuse is a private family matter; and insecurity about whether the informant will be protected (Joubert & Posenelli, 2009; Cooper et al., 2009).

4.3.4 Training and education – what, who and how.

- The literature emphasises the need for training to equip healthcare professionals with the knowledge and skills to work effectively as part of a multi-disciplinary team in managing elder abuse.
- The literature underlines the importance of assessing the training needs of healthcare professionals, adapting training content to make it relevant to health professionals' practice and tailoring training programs to the target audience's baseline knowledge.
- Elder abuse training should provide professionals with the information, knowledge and tools to respond appropriately if they encounter an older people at risk of elder abuse or who may disclose to them directly.

- Multidisciplinary input and multi - agency collaboration in the design of elder abuse educational initiatives is critical (Anetzberger et al., 2000; Gironda et al., 2010).
- The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda et al., 2010).
- Professional training has the potential of increasing the knowledge amongst health professionals; however, without a cultural change that allows for education, supervision and support, elder abuse may continue to be under reported.
- In studies involving participants who had a good baseline knowledge of elder abuse, interventions did not appear to be effective, thereby highlighting the importance of tailoring training programs to the target participants' baseline knowledge (Richardson et al., 2002; McCauley et al., 2003).
- Few studies have directly compared different training methods for health professionals and elder abuse. This means that there is insufficient evidence to conclude which training methods are more or less effective.
- Face-to-face delivery of training is more effective as a mode of intervention when compared with dissemination of information through printed educational materials (Nusbaum et al., 2007)
- Using case studies in the delivery of elder abuse training gives participants opportunity for discussion, reflection and feedback (Smith et al., 2010).
- The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda et al., 2010
- The provision of training by an internal member of the organisation or service who is knowledgeable about elder abuse is seen as an important factor in the success of elder abuse education and training for staff (Nusbaum et al., 2007; Nolan et al., 2008).

4.4 Implications of the Survey, Focus Groups and Individual Interviews for the Development of the Training Intervention

A summary of key points follows regarding the survey, focus groups and individual interviews and the implications for the development of the training intervention.

4.4.1 Online staff survey.

- 44% of staff who had never attended a training or workshop on elder abuse indicated that further education/training would have helped them to manage a suspected case of elder abuse differently
- When asked about what interventions that would assist in the overall understanding and management of elder abuse, 63% of participants suggested education of health professionals would greatly assist in responding.
- In response to the question on how they could improve their knowledge, confidence and competence in identifying and acting upon suspicion of elder abuse, 62% of participants, indicated that this could be addressed through an organisation wide policy.

4.4.2 Focus groups.

- Participants felt that some of the key challenges that they faced responding to elder abuse included ambiguous intervention strategies due to various clinical and legal factors, management of risk, communication strategies and lack of standardised hospital documentation
- A strong theme for increasing staff confidence to act on elder abuse included targeted training for core groups of staff working in key areas across the organisation.
- Barriers identified by staff in the inquiry phase include time & staff education
- The need for standardised documentation, a hospital wide policy, and a set of clinical practice guidelines, clear guidelines to assist staff in the escalation process as well as a formalised education for targeted staff across the organisation were emphasised in the focus groups.

4.4.3 Individual interviews.

- There was emphasis on the need for competency building across the organisation
- One of the biggest challenges facing the staff was a lack of an organisation-wide document on elder abuse.
- A theme emerged that there were ambivalence responding to elder abuse — as well as confusion about what the 'flags' were and what to do with that information.
- There was also discussion about need for support for staff during suspected elder abuse cases.

- Suggestions were made about the introduction of mandatory elder abuse training and need for documentation guidelines.

4.5 Factors for Consideration – the Study Site

This study focuses on health professionals working in a hospital setting in the Emergency Department and acute and sub-acute wards. It seeks to improve health professionals' responsiveness to suspected elder abuse, enabling them to move from suspicion to intervention. It does not try to explain the causes of elder abuse or measure prevalence within a health context. Instead the study seeks to address elder abuse training needs and to evaluate the impacts of an elder abuse training intervention. Therefore the training intervention to be developed needed to be specific to the barriers and enablers identified by health professionals' at the study site.

An examination of the literature and feedback from the online staff survey, focus groups and interviews strongly confirmed that there would be little effect in training health professionals in elder abuse unless there was a clearly defined organisation wide Elder Abuse Policy, model of care, Governance structure and support from executive at the study site.

At the time of undertaking this study, the hospital lacked a process to support older people who may be at risk of elder abuse presenting to emergency, acute or sub-acute care. There was no integrated and consistent approach across disciplines, units and streams of care in relation to the suspicion, detection and management of elder abuse. The study site was not yet able to quantify the scale of the problem, the types of abuse, or the range of issues which were presenting across the organisation.

The study site did not yet have in place organisational arrangements to support health professionals identify or respond to elder abuse. There were no available established best practice principles on the management of elder abuse in a hospital setting. Therefore, it was imperative that the study site established a response framework to support health professionals if they suspected elder abuse.

The hospital risk management system on its own was not adequate for responding in this emerging area of practice. The Victorian Government guideline *With Respect to Age (2009)* promotes empowerment of older people and self-determination. At times, competent older people choose to return to situations of risk. For this reason the study site needed to

consider processes to incorporate practice realities and key principles relating to real life elder abuse issues as they presented in day to day practice.

Following success in receiving funding for this ARC Linkage Grant and the launch of the Victorian Government document, '*With Respect to Age (2009*), in early 2011, the study site established an internal working group to develop an elder abuse policy and model of care for the organisation. This group was chaired by Chief Social Worker who was also an investigator on this research. The working group also had a representative from the Victorian Department of Health and a consumer representative. This group consulted with a number of stakeholders in the development of the SVHM Elder Abuse Policy. This included: The Director of Aged Care; the Chief Medical Officer/ Head of General Medicine; Manager, Aged Care Assessment Service; Team Leader, Aged Care Assessment Service; Manager, Assessment, Liaison and Early Referral Team (ALERT); Nurse Unit Manager 8 East; Manager, Treatment Response and Assessment for Aged Care (TRAAC); Manager, Aged Psychiatry Assessment and Treatment Team (APATT) Senior Social Work Clinician, APATT; Nurse Unit Manager Ellerslie (Transition Care) Unit; Social Work/ Elder Abuse Australian Thesis Council (ARC) Linkages Grant (student); Nurse Unit Manager Residential Services; Nursing Education; Senior Aboriginal Liaison Officer; Social Worker, Sub-acute Ambulatory Care Services; Manager, St Vincent's at Home; Consumer Representative; Clinical Risk Manager /Clinical Practice Improvement Nurse; Director of Mission; Group Manager Allied Health.

Following nearly 20 months of work, the policy was formally endorsed by SVHM Executive in March 2013. The title of the Elder Abuse Policy at SVHM is the 'Protection of Vulnerable Older People' Policy (See Appendix 5)

Following ratification of the policy, this working group was replaced by a new Governance Group called the 'Vulnerable Older Persons' Coordination and Response Group (VOP C&RG). This governance group was comprised of health professionals with relevant experience and knowledge in elder abuse.

4.5.1 Vulnerable older persons coordination and response group (VOP C&RG).

The SVHM response to Vulnerable Older People (VOP) aimed to minimise elder abuse while respecting the autonomy and decision-making rights of older people. The response to elder abuse is a shared responsibility across departments and programs. The SVHM Model of Care for the Protection of Vulnerable Older People (VOP) strives for an integrated and

consistent approach to the detection and management of suspected elder abuse, at both clinical and organisational levels. The following key steps act as a pathway to ensure a consistent approach for all staff. The SVHM Model of Care which can be found in the SVHM Protection of Vulnerable Older People policy.

- Alert/trigger for elder abuse - this can be alleged, disclosed, witnessed or suspected.
- Immediate risks are identified and addressed.
- Consultation and referrals - a multidisciplinary team approach occurs.
- Liaison with relevant senior staff/line managers
- Early notification of a Vulnerable Older Person notification form is completed (for reference to this notification which can be found in the SVHM Protection of Vulnerable Older Person policy)
- Location of patient - consider referral to sub-acute if the patient is in the acute setting and more time is needed for further assessments
- Assessment – this step requires a comprehensive assessment by at least two SVHM staff. This may also include review by a geriatrician or geriatric registrar. The patient's capacity needs to be determined at this time.
- Decision - can elder abuse be confirmed? Or is further assessment needed?
- Plan - a care plan needs to be implemented following the outcome of assessment processes.
- Monitoring – Should a safety net discharge plan be activated? Do community referrals need to take place?
- Review – follow up and monitoring.

Training of health professionals at the study site is a core element of the governance approach to elder abuse and provided a strong foundation to the development and testing of the training intervention. In summary to support the training intervention for this study, the study site was required to implement a clinical governance approach to the management of elder abuse. Heyrani, Maleki & Marnani (2012) confirm that it is necessary in a health setting to pay attention to firm foundations of the structure, including equipment, staffing arrangement, supporting specialties, and staff training for effective governance.

4.6 Development of and Rationale for the Training Intervention

The Ecological Framework which underpins this thesis invites healthcare professionals to use the instrument of education to empower and challenge individuals and families at risk of abuse by identifying and reducing risk factors in their own environment. This can be achieved through staff education and training targeted at specific interventions for vulnerable older people. The study also examined available literature to guide the development and design of a training intervention for health professionals. An examination of the literature did not clarify which educational approach may be most effective in maximising the knowledge and skills of health professionals working in a hospital context in the recognition and management of elder abuse.

Ecological theory was applied to this study to examine interventions from the perspective of the older person as well as the environmental, social and cultural systems in which the individual is situated. This framework underscored the need to consistently be mindful of the hospital and policy contexts in developing the training intervention.

In developing the training intervention it was seen as important that this should be congruent with current frameworks and approaches to delivering training in hospital settings and consistent with policy directions in education in health care in Victoria.

The actual delivery of the elder abuse education was critical in the next stage of this research. As there was no standard elder abuse policy or education package already available for hospital staff, a unique and site specific training package needed to be designed to meet the training needs of staff at the study site. Combining different forms of learning, and choosing an approach that 'best fits' a particular context, provides an effective approach to workforce skill development (Misko, 2008).

Across all developed countries, health professionals are moving toward adopting competence and competency standards relating to core areas of clinical practice. (Department of Human Services, 2009). The role of competency appears to be a strong theme in the literature relating to training of health professionals. The development and use of competency standards has been identified as an emerging factor in supporting health professionals' education and training, particularly around health workforce development. A thorough review of health professional education literature reveals that little attention has been given to the competencies needed for health professionals in relation to elder abuse.

A review of the literature resulted in the decision to develop a Competency Framework as part of this research at the study site. The two key frameworks on workforce development and clinical governance which informed the development of the training intervention were the Victorian Allied Health Competency Framework (2014) and the Victorian Clinical Governance Policy Framework (Department of Human Services, 2009). The literature suggests that it is important for organisations such as hospitals to establish clinical competencies to ensure a safe and efficient health service (Victorian Department of Human Services, 2009).

In addition to the Competency framework outlined above, the Victorian Clinical Governance Policy Framework (Department of Human Services, 2009) provides four domains of quality and safety: consumer participation, clinical effectiveness, effective workforce and risk management as a construct for strategies to enhance the delivery of clinical care. Within each domain there are a number of quality and safety management functions that require direction and oversight by governing bodies.

In line with the Victorian Clinical Governance Policy Framework (Department of Human Services, 2009) this study aims to build the capacity and capability of health professionals at the study site to identify and respond to elder abuse. The World Health Organization (2006) suggests that giving the right training to the right people creates an effective workforce. Building effective workforce practices requires effective clinical governance.

4.7 Application of a Competency Framework

The role of competency appears to be a strong theme in the literature relating to the training of health professionals. The development and use of competency standards has been identified as an emerging factor in supporting health professional education and training, particularly around health workforce development. A thorough review of health professional education literature reveals that little attention has been given to the competencies for health professionals in relation to elder abuse. This appears to be a significant gap needing further consideration in addressing the research aims in this thesis. The consideration of what competencies are critical for different levels of staffing roles and experience needs further consideration.

In addition to providing training in recognising and responding to elder abuse there is a suggestion that training programs should also focus on the competencies required for protecting older people from abuse (DeHart et al., 2009).

The study has sought to be informed by evidence in developing the training intervention. In line with the ecological approach it has, as already noted, been important to consider the policy context in the development of the training, to ensure congruency, or 'fit.' In 2014 the Victorian government released a document: Allied Health: credentialing, competency and capability framework. The key purpose of the framework is to support health professionals to respond to the demands and opportunities which currently exist in a changing health environment to achieve optimal patient-centered care. In addition to providing training in recognising and reporting elder abuse the literature confirms that training programs should also focus on the competencies required for protecting older people from abuse (DeHart et al., 2009).

Across all developed countries, health professionals are moving toward adopting competence and competency standards relating to core areas of clinical practice. (Department of Human Services, 2009). Competency is the consistent application of knowledge and skill to the standard of performance required in the workplace. It embodies the ability to transfer and apply skills and knowledge to new situations and environments' (National Quality Council 2014, p. 4).

A competency framework is a model that provides a blueprint for 'excellent' performance within an organisation or sector such as a hospital. The framework should refer to a number of competencies, which can be applied to a number of different roles within an organisation (Victorian Department of Health, 2014).

As already identified training on elder abuse prevention, recognition and response is essential for all sectors that provide care and services to older people. Education and training must be designed to reach different individuals/groups, and the educational process should be ongoing to address staff turnover. An understanding of the respective roles and intersections among the roles of all those involved in responding to elder abuse, is crucial for an effective response. Any local legislation must be continuously reviewed to ensure it supports individuals and organisations in protecting older adults.

In addition to providing training in recognising and reporting, elder abuse, the literature suggests that training programs should also focus on the competencies required for protecting older people from abuse (DeHart et al., 2009). Although many educational interventions discuss the importance of elder abuse awareness and knowledge, it appears that such improvements do not necessarily translate into improved practice (Cooper et al.,

2012). This research therefore aims to evaluate the confidence and knowledge of staff who have received specific training to act on suspected elder abuse. In reviewing the definitions of confidence and knowledge, there are some writings which help to understand these terms in a health context in the area of elder abuse.

Confidence can be examined in four components: namely affect (feelings associated with action), reflection (thoughtfully examine one's actions and intentions), higher cognitive functioning (which includes aspects such as learning and integration of concepts, decision making, attention, motivation and memory) and action (Holland et al., 2012).

Knowledge can be defined as "(1) the fact or condition of knowing something with familiarity gained through experience or association; (2) acquaintance with or understanding of a science, art, or technique (Holland et al., 2012).

Confidence and knowledge are useful terms for expressing beliefs about the staff's ability to perform their job. In this thesis, 'knowledge' refers to expertise, and skills acquired by a person through experience or education. 'Confident' will refer to health professionals' willingness or not to undertake an activity.

The literature suggests that it is important for organisations such as hospitals to establish clinical competencies to ensure a safe and efficient health service (Victorian Department of Human Services, 2009). It is generally accepted in the literature that the definition of competency can be applied to individuals who can demonstrable a skill, or observable actions in their work (Hoffman, 1999). Importantly, it encompasses more than just knowledge and competency can include an individual's values, attitudes and skills (White & Evan, 1991).

Furthermore, professional practice refers to elements which are embedded into clinical practice policies that help health professionals to achieve competent, compassionate and collaborative care which should be provided to individuals or clients and their families through an evidenced based commitment in care, education, and research (Victorian Department of Health, 2014). The commonalities for health professionals should include: maintaining client centered care at all time, maintaining baseline or professionally recognised levels of knowledge and skills, recognising gaps in knowledge and skill and being proactive to engaging in professional development to address areas requiring further development and ensuring that existing professional standards can be met with the

introduction of new developments and responsibilities (Victorian Department of Health, 2014).

Clinical governance is defined by the Australian Council on Healthcare Standards as: 'the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers (Australian Council on Healthcare Standards, 2004).

Clinical governance is a key aspect of the governance arrangements within health care settings to ensure safe, high quality health services are delivered to consumers (Australian Council on Healthcare Standards, 2004). The increasing acuity of clients requires a strong platform for the provision of health care services as the foundation of an effective health care system (NHHRC 2009:6).

The Victorian Clinical Governance Policy Framework states that, "all staff employed within health services must have the appropriate skills and knowledge required to fulfill their role and responsibilities within the organisation. Support is required to ensure clinicians and managers have the skills, knowledge and training to perform the tasks that are required of them and that they understand the concept of governance" (Victorian Department of Human Services 2009).

In Victoria, the location of the study site, all health services are mandated to address the four domains of quality and safety: consumer participation, clinical effectiveness, effective workforce and risk management as part of their funding guidelines that underpin the Statements of Priorities and Victorian Health Service Agreements (Department of Human Services, 2009).

Each health service is required to: review its own clinical governance structure to ensure consistency with the statewide framework, report annually on clinical governance structures and activities and ensure adequate internal documentation in compliance with the framework.

The Victorian Clinical Governance Policy Framework (2014) aims to address effective workforce by encouraging strategies for health services. The following strategies are considered as relevant for this thesis in relation to workforce and improving responses to elder abuse:

- workforce development provides for a health workforce with appropriate skills
- expectations and standards of performance are clearly communicated
- the workforce is supported through training, development and mentoring
- the health workforce is fulfilling its roles and responsibilities competently
- workforce competence is sustained, innovation is fostered and knowledge is passed on
- multidisciplinary teamwork is fostered and supported

The rationale for the competency framework was consistent with the UK safeguarding approach recognising that health professionals working within a health care environment play different roles when acting on suspected elder abuse. Three levels were developed for staff training at the study site (See Appendix 6). Each of the three levels includes a breakdown of requirements that need to be met as part of supporting staff to undertake certain role and responsibilities in acting on suspected elder abuse. Epstein & Hundert (2002) define professional competence as: "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served".

- Level 1 – Awareness raising for staff (junior or less experienced clinical staff)
- Level 2 – Clinical Governance /statutory – Managers or Heads of Departments
- Level 3 – Experienced clinical staff that have direct involvement in the assessment and intervention with vulnerable older people at risk or those experiencing elder abuse.

For the purposes of containing the scope of this study, agreement was reached between the Principal Investigators that the training intervention which was to be developed and tested would focus on the clinical needs of staff from Level 3. This would support the aims of the study to support health professionals improve their responsiveness to act on suspected elder abuse. Therefore, the training content needed to be more advanced, clinically-based and targeted at specific roles within the organisation. An understanding of the respective roles and intersections among the roles of all those involved in responding to elder abuse, is crucial for an effective response (Cooper et al., 2012).

The seventeen core competencies which were developed and guided the development of the training intervention for this study needed to be included in the training package. These competencies supported staff move from identifying elder abuse to providing an effective

response. The following competencies were developed for this study and were informed from the previous phases of this study.

These competencies are:

1. Understand what is meant by the term elder abuse
2. Understand the 5 main types of elder abuse
3. Recognise signs and indicators of elder abuse
4. Recognise risk factors associated with abuse
5. Understand the principles and values that underpin the protection of vulnerable older people (e.g. self-determination)
6. Understand duty of care and legal responsibilities if elder abuse is suspected
7. Report any incidents of suspected abuse in line with appropriate SVHM policies
8. Complete education to ensure familiarity with elder abuse and to build knowledge regarding how to act on suspicion
9. Have a robust working knowledge of the SVHM Protection of Vulnerable Older People Policy and the SVHM model of care
10. Have sound knowledge of the SVHM reporting framework including the SVHM Response and Coordination Group
11. Understand the different roles and responsibilities of key stakeholders involved in cases of suspected elder abuse
12. Know what organisational resources are available to support staff who report concerns of abuse.
13. Able to undertake appropriate assessment of suspected elder abuse situations involving SVHM patients and the alleged person of concern
14. Have knowledge of principles of intervention and ensure that these are actioned in a timely manner (confidentiality, client safety, duty of care, client focus)
15. Demonstrate advanced knowledge regarding decision making capacity and how this impacts the pathway for intervention
16. Demonstrate sound knowledge of the resources available to older people, to ensure that a "safety net" is in place
17. Demonstrate advanced written and communication skills

Staff training was the critical element which was identified to support a more effective response to suspected elder abuse. To meet the aims of the research, it was identified and

supported by the literature that the training intervention needed to consist of a number of key elements:

- A comprehensive face to face PowerPoint presentation and key articles which would be informed by phase 1 of the study and the Ecological Framework
- Inclusion of the newly developed SVHM Policy, model of care and a summary pathway for the management of elder abuse (Appendix 7)
- Case discussions

4.8 Development of the Training DVD

Originally it was felt that the training package should be designed to be comprehensive and aimed at applying different education techniques supported by the literature: lecture format, reading materials, written materials and case discussion. An opportunity was identified to develop and include a unique resource for the study. This was the decision to focus considerable effort and attention on developing an audio visual approach to training health professionals at the study site – that is, to identify the risk factors (or red flags), types of elder abuse, interview techniques and importantly strategies for identifying and responding.

At the time of developing the training intervention for this study there was no existing elder abuse training DVD which was specifically designed for health professionals to support inpatients within a hospital context. In 1995, a New South Wales Advisory Committee produced a training package called 'Behind Closed Doors: Abuse of Older People in their Homes'. This package contained a video, a handbook for staff who come in contact with older people to assist them assessing and responding to elder abuse, case scenarios, information on legal interventions and a template to assist in the establishment of an Inter-Agency Protocol. Unfortunately, this video was very out-dated and focused on professionals who may come into contact with older people at risk of elder abuse in their own homes. This includes staff from local councils and programs including Aged Care Assessment Teams. The training video is still used by the community sector across Australian as a teaching tool.

The training DVD developed as part of this research is comprised of 5 hospital-based scenarios. Evidence confirms that researchers have used vignettes for decades to encourage discussion of topics that respondents might find particularly difficult. Vignettes have also been used in the field of elder abuse to find out about doctors' experiences of a range of suspected elder abuse situations. As described in chapter 2 the literature suggests

that vignette-based instruments are useful in identifying the areas of knowledge that improve following an educational intervention (Hazel, 1995). The value of case studies is that they present the complexities of elder abuse cases and enable participants to actively engage in and explore approaches and solutions in the context of best practice, policy and legislation (Day et al., 2010). Case studies also give participants opportunity for discussion, reflection and feedback (Smith et al., 2010).

There was extensive research undertaken reviewing content of existing training DVDs which already developed on elder abuse. The DVD which was developed for this study targets training for health professionals working with older people within a hospital context and they are scenario based.

The script for the DVD includes hospital based scenarios and effort was made to ensure that all five recognised types of elder abuse were included (See Appendix 8). The scripts for these scenarios were assessed for face and content validity by a panel of experts (internal and external to the study site) using Lynn's two-stage approach (development and judgement quantification). These experts were multidisciplinary and ensured content relevance and validity. According to Lynn (1985), using a two stage approach to determine and quality content validity is fundamental to the validation of all instruments.

In this study, validity was taken into consideration. For example, because the scenarios were constructed by the research student, they were designed to meet the research aim of this thesis. Descriptive, interpretative, and theoretical validity were taken into consideration. An exhaustive literature review in the study area was conducted carefully before developing the scenarios. This enabled the inclusion of the conceptual frameworks to be included. The content and interaction between the health professional and the older person was well supported by the findings from the literature and the survey, focus groups and interviews. The scripts for the scenarios were designed taking into consideration the issues related to the problem and aims of the study and available literature on the subject. It is therefore believed that the content of the scenarios is reliable.

$16,500 from the Australian Research Linkage Grant was available for the production of the DVD. The research student was fortunate to have a family member who could actively assist in the production of the DVD. There was considerable work done in the lead up to the production. This included meetings with the Production Company - Gorgeous Films. The director developed a run sheet in conjunction with the researcher to assist in preparation for

the development of the DVD.

The director from the Production Company used many of his contacts to generate interest across the acting community in Melbourne. There was a particular focus on gaining interest from people in theatre groups across Melbourne. Auditions were held over 2 days in Melbourne in June 2012. Actors were selected from the auditions to appear in the training DVD. Over 30 people attended the auditions. Ten actors were selected for the five scenarios to play either the older person or the health professional. Table 4 describes the summary of the older person and the health professional needed in each scenario.

Table 4: Scenario actors

Scenario	Older person	Health professional
1	Aged female (distressed/confused looking, late 70s)	Nurse
2	Aged male (unkempt) – short term memory issues	Social Worker
3	Aged female (well presented)	Physiotherapist
4	Female (tired/worn out looking)	Nurse Unit Manager
5	Aged female (bruises)	Doctor

One actor was also selected to be the narrator. The training DVD was made over 2 days in September 2012 in a simulated hospital environment at Box Hill Technical School. A number of meetings and negotiation needed to occur to support the DVD being filmed at Box Hill Technical School. We were also fortunate to have the generous support of a family friend who assisted with professional make-up and hair on the day. There was also significant editing to assist in the final version of the DVD. The DVD runs for approx. 15 minutes (See Appendix 9). This DVD is a critical element of the training intervention that was developed as part of this research. The following chapter will describe in detail the methodology relating to the intervention.

In recent years, there has been a number of new training DVDs which launched as part of the elder abuse training for community workers in Victoria. However, these training tools provide baseline education for frontline staff. To date, there is no training DVD available

which is specific to hospital-based scenarios. The DVD developed as part of this research remains unique to elder abuse education for health professionals because it is aimed at targeting health professionals improve their responsiveness in situations where they suspect an older person may be at risk of abuse.

4.9 Educational Theories

An initial examination of the literature was targeted at reviewing approaches in training health professionals in identifying and responding to elder abuse. In developing the training package for this phase a gap was identified in understanding educational theories for the target audience. This was not an exhaustive exercise but a brief review of the literature was undertaken to ensure that the rationale, design and delivery were evidenced informed. This enabled the training intervention to address the themes outlined earlier - who, why and how.

Educational approaches adopted include adult learning theories such as problem based learning and learning styles. The underlying assumption of these theories is that change occurs as a result of an individual striving for competence. The emphasis is motivation to learn. These theories were relevant for consideration as part of this thesis. The resultant training intervention included strategies such as small group interactive learning and problem-based learning.

To facilitate learning within the study site, it was important to understand the specific needs and attributes of the core group of staff who were all considered to be adult learners. Adult learning principles place attention on the value of experience in the learning process, the adult learner's self-concept and motivation to learn and the importance of self-directed learning. According to (Brookfield, 1998) the principles that were considered for adult learners as part of the development of the training intervention included:

- The need to be respected, valued and acknowledged for their past experience and to have the opportunity to apply this experience to their current learning
- Adult learners learn best in environments that provide support for change and development
- Adult learners learn more effectively through experiential techniques (e.g. discussion and problem solving)

Importantly all health professionals have a responsibility to engage in lifelong learning, to keep up to date with the changing work environment and current evidence-based practice,

and to ensure they invest time in their own professional development (NSW Health, 2005). Clinicians can facilitate not only their own learning, but the learning of others through the sharing of knowledge, resources and information, and harnessing opportunities to engage in professional networks and communities of practice (NSW Health, 2005).

4.10 Chapter Summary

This chapter has outlined the elements which informed the training intervention as part of this research. In this phase the study focused on application of the knowledge, analysis and decisions made (synthesis) in previous phases to inform development of the training package to be tested at the study site.

This phase used the available literature and thematic data analysis from the staff survey, focus groups and interviews to support the development of the training intervention. The intervention has been informed by the UK 'safeguarding' approach - No Secrets legislation (2000) which focuses on person led principles, organisation wide policy and a competency framework. This phase has required the development of core competencies for health professionals to respond to suspected elder abuse. Importantly these competencies have underpinned the content of the training package. Likewise the Ecological Framework has been applied to guide the understanding of elder abuse for an older person in their individual environment or context.

The Ecological Framework suggests that elder abuse is a complex issue, embedded in individual, relationship, community and societal factors. This thesis draws on the ecological framework for consideration in understanding the impact of elder abuse. This framework was relevant for this study because it helps to identify, categorise and evaluate interventions that take into account the multiple, yet interlinking, levels and approaches in responding to elder abuse (O'Donnell et al., 2015).

The role of competency appears to be a strong theme in the literature relating to the training of health professionals. The literature suggests that it is important for organisations such as hospitals to establish clinical competencies to ensure a safe and efficient health service (Victorian Department of Human Services, 2009). This chapter provided the rationale and application of a competency based framework to the development of the training intervention.

An examination of the safeguarding approach in the UK raised the important issue of governance at the study site. An examination of the UK approach required the study site to consider how training of health professionals was going to be undertaken within a large health care environment in relation to governance. Halligan et al., (2001) supports the view that effective leadership, effective use of data, trained staff and effective workforce, being patient-centered and evaluation of services are key features in hospitals to successful implement clinical governance. The next chapter will describe the feasibility of developing and testing the training intervention to support health professionals at the study site to respond to suspected elder abuse.

Chapter 7 will describe in more detail the outcomes of the knowledge transfer and the sustainability of the elder abuse governance framework that was established as part of this study which is still in existence at the study site.

CHAPTER 5 – EVALUATION

5.1 Introduction

Health professionals are uniquely positioned to make a difference in the lives of older The purpose of this study was to determine whether a training intervention had an effect on health professionals' perceived level of suspicion and level of confidence to act on suspected elder abuse. This study adopted varying research designs at different stages. Given the sequential approach and multiple phases of the study this was required to meet the objectives of the research. The research question was as follows: can a training intervention improve the responsiveness of health professionals to suspected elder abuse? A quasi-experimental method was used with a pre-test and post-test design (Creswell, 2013) for this phase of the study. This design was used to identify differences between the intervention and control groups in an attempt to understand change.

Findings from the literature indicate that health professionals often believe themselves to be ill-equipped to identify and provide a response to suspected elder abuse. This study employed a training intervention and assessed its effectiveness as measured through perceived change in health professionals' confidence and knowledge. A variety of learning strategies were used in the delivery of the training intervention designed for this study. These have been described in chapter 5.

5.2 Aims and Objectives of this Phase and Research Design

The overall aim of this phase is to demonstrate the effectiveness of a newly developed elder abuse training package for health professionals at the study site using quantitative data collection.

The objectives are:

1. To present the demographic characteristics of the participating sample by group membership (i.e. control vs. intervention).
2. To gain insights into the experience of health professionals in relation to elder abuse
3. To establish if there are any statistically significant differences between the average level of suspicion and average level of confidence to act between the control and intervention groups and between times T1 and T2.

To test the training intervention a quasi-experimental design was adopted. This design seeks to study the effects of the newly developed elder abuse training intervention on the group experiencing it. The assumption is that the group experiencing the training intervention will demonstrate a change, as opposed to the group not experiencing the intervention. Therefore two groups, an experimental or intervention group and a control group, were required. The changes relate to health professionals perceived level of suspicion and level of confidence to act on suspected elder abuse. Burns and Grove (2003) indicate the purpose of quasi-experimental research is to "determine the effect of one variable on another" (p. 28).

5.3 Ethical and Practice Considerations

The ethical aspects of this thesis were approved by the Low Risk Thesis Sub-Committee of Human Thesis Ethics Committee –A (HREC-A) of St Vincent's Hospital, Melbourne. This research was carried out using two separate applications based on the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia for confirmation of two Ethics Approval received for this research – LR 067/11 (phase 1) and LR 132/12 (See appendix 10).

5.4 Participants

A convenience sample of staff from the Social Work Department and ALERT Program were invited to test the effectiveness of the newly developed elder abuse training package. To be eligible, staff needed to have a core clinical role in the Emergency Department (ED), Acute or Sub acute wards at the study site - not in the community or undertaking outreach work. Managers or senior staff not directly involved in clinical work were ineligible. The Social Work Department does not provide a clinical service to the Emergency Department. For this reason, staff from the ALERT program were invited to participate.

The ALERT program is a Hospital Admission Risk Program (HARP) service that provides coordinated care for patients who present to the Emergency Department (ED) with complex psychosocial and medical needs and it has the capacity to manage patients back into the community. ALERT screens for clients presenting to ED with the following risk factors: substance abuse, aged care, homelessness, assault and violence, disability, mental health, chronic disease and clients who are of Aboriginal and/or Torres Strait Islander descent. ALERT is a multidisciplinary team of clinicians comprised of registered nurses, occupational therapists, physiotherapists, dieticians and social workers.

Information was provided to potential participants via their staff/team meetings. The research student provided background to this research and outlined what this research would require from potential participants. The research student then invited social work and ALERT staff to participate.

The health professionals involved in this phase of the research equated to 75% of total SW and ALERT staff eligible to participate at the time. In line with the composition of the teams, these staff consisted of clinical staff from different disciplines and across different steams of care. The staff who participated needed to have clinical responsibility to complete assessments for patients in the ED, acute and or sub-acute wards at the study site. Managers from both Social Work and ALERT were in agreement with this method of recruitment.

The research student knew many of the staff involved in a professional capacity. However, there was no dependent or unequal relationship existing between anyone involved in the recruitment and the potential participants. No ethical issue arose during the course of this research. In the event that a participant did experience any psychological events during participation in this research, consultation was available with an agreed nominated person (Chief Social Worker) at St Vincent's. In the event of any adverse events relating to the management of information or breach of patient confidentiality, these would be reported to HREC-A by the principal investigator within 24 hours.

Participants in this research who completed the pre and post-test design evaluation of the training package in the were provided with an Information Sheet and also asked to sign a Consent Form (Appendix 11), in line with SVHM Human Research Ethics Committee Guidelines. Participants were informed that participation was voluntary and they could withdraw from the research at any time without implications.

5.5 Instruments

An initial questionnaire was developed as part of this phase to understand the demographics of the study sample participating in this evaluation phase.

A subsequent data collection tool was developed to test the change before and after the training intervention to compare the participants' reported changes in their suspicion of elder abuse and their confidence to respond. This tool was aligned with the case scenarios'

presented in the training DVD. All participating staff selected their own confidential unique identifier.

The participants involved in this phase completed the initial questionnaire online prior to commencing this phase of the research. This questionnaire asked eleven questions in part A and 12 questions in Part B. These questions were informed by the literature review and staff perspectives from phase 1: including the online survey, focus groups and interviews (n =300) and the conceptual frameworks underpinning this thesis.

Part A of the questionnaire was developed to understand the demographics of the sample population in the evaluation phase. Additional questions (Part B) were added by the research student to elicit further data from the respondents regarding personal perceptions on elder abuse prior to the testing of the training intervention.

The questions for Part A:

1. What is your unique identifier/ allocated number?
2. Please select your sex
3. Please select your age range
4. Please select your employment status.
5. What is your current role at St. Vincent's?
6. In which area of the hospital do you mainly work?
7. How many years have you been employed at St. Vincent's?
8. Have you ever attended a training workshop or education session on elder abuse?
9. During the last 12 months have you suspected any incidents of elder abuse for an older person in hospital? (Suspected in your judgment you have reason to believe that abuse may have occurred)
10. If you have suspected elder abuse for an older person in hospital, what did you do?
11. From your most recent situation in which you suspected abuse, do you believe you would have managed the case differently if you had received any/further education and training on elder abuse?

The questions for Part B focus on a self rating scale: staff rating 1 lowest and rating 10 the highest in your self-rating around your knowledge and competence in the area of elder abuse.

1. Please rate your level of understanding regarding the definition elder abuse.
2. Please rate your understanding of the different types of elder abuse
3. Please rate your knowledge associated with the signs of elder abuse.
4. Please rate your knowledge of the risk factors which are associated with elder abuse
5. Please rate your confidence in knowing what you would do if you suspected abuse or if a patient disclosed to you they were being abused.
6. Please rate your level of understanding regarding SVHM expectations on the management of elder abuse?
7. Please rate your level of understanding regarding the Victorian Government Elder Abuse Prevention Strategy and the principals associated with their "empowerment model"?
8. How confident do you feel you would know your individual responsibilities and duty of care in relation to suspected elder abuse?

5.6 Pre – Post - Test Intervention Methodology

The methodology used to guide this phase of this research was a pre- post-test design. Two key variables were considered in relation to testing the intervention: level of suspicion relating to elder abuse within the case scenarios and the confidence to act. As already noted, an intervention and control group were selected to test the training intervention. Quantitative data were collected from the tool that was developed for the evaluation phase.

5.7 Procedure

Time 1 - After viewing the DVD developed for the research all staff completed a research-based response which determined their individual clinical knowledge about elder abuse and their response to each of the 5 scenarios. This survey required all participants to rate each of the 5 scenarios on the basis of their perception about whether they suspected abuse was evident and what pathway they would follow regarding their individual assessment and intervention. The main purpose of the survey was to determine if staff had the confidence to act upon suspected elder abuse for hospital patients.

The staff had already selected a unique identifier for the purposes of matching and analysis. After one week of completing the online survey, all twenty two staff watched the newly developed SVHM elder abuse training DVD. Due to the small size of the training room, staff were divided into two separate groups to maximise their viewing potential.

One week after viewing the DVD and completing the research -based response survey, the staff were sorted into two groups. Group A and B (n = 11 for each group).

Two weeks after viewing the DVD, Group B (intervention group) was presented with the comprehensive elder abuse training intervention which had been developed as part of this research.

Time 2 - Both groups repeated the survey- 4 weeks after the educational intervention presented to Group B. It was important to determine if staff from Group B had more confidence and knowledge to act on suspected elder abuse. It should be noted that elder abuse education was offered to Group A after a number of weeks, but no data collection occurred**.**

5.8 Delivery of the Training Intervention

The development of the training intervention has been described in chapter 5. However, it is important to briefly describe the delivery of the training intervention as part of this study, as well as establishing the desired responses in relation to the DVD scenarios.

The elder abuse training was directly provided by the research student. An examination of the literature highlighted the following key element that was considered in the delivery of the training for this study: the provision of training by an internal member of the organisation or service who is knowledgeable about elder abuse is seen as an important factor in the success of elder abuse education and training for staff (Nusbaum et al., 2007; Nolan et al., 2008). The delivery of the training was just as critical as the contents of the training package itself.

Prior to the delivery of the training, agreement needed to be reached regarding the established response for each of the 5 scenarios depicted in the DVD. This agreement was developed using an Inter-rater Agreement framework. The purpose of this was to establish levels of agreement with an established response protocol to the assessment and management of elder abuse at the study site.

This methodology was used to assess the degree to which different observers give consistent estimates of the same phenomenon. A team of clinical experts was used to establish an agreed response based on a consensus approach. These experts reviewed newly developed case vignettes which consisted of the 5 hospital based scenarios in the training DVD. These scenarios (as outlined in Chapter 5) were developed by the research

student and were a snapshot of an interaction between an older person and a health professional. The experts were familiar with the newly endorsed organisation wide policy for the Protection of Vulnerable Older People.

The actual delivery of the elder abuse training was a critical consideration in this phase of the research. As there are no standard guidelines or education package already available for hospital staff, a unique, evidenced informed training intervention was developed and delivered to meet the needs of health professionals working at SVHM. The "correct pathway/gold standard" relating to the elder abuse scenarios and the using the competency framework as the foundation, the training package was delivered over 6 hours using different education techniques, supported by a review of the evidence regarding the value of a lecture format, reading materials, workshops, and by clinical practice**.**

5.9 Data Analysis Techniques

Data analysis undertaken is described in the following sections. The frequency distributions (counts and percentages) were tabulated for all questions with a categorical response (nominal or ordinal). Descriptive statistics (Mean and Standard Deviation or Median and Interquartile Range as appropriate) were tabulated for all questions with a continuous response.

The trends in responses were summarised, based upon whether the majority (more than 50% of the participants) agreed or disagreed with the questions. The trend of the distributions (e.g. whether the highest frequencies were located at the agreement or disagreement end of the scales) was recorded where applicable. Only the instances where all the assumptions of the chi-square test were met have been reported.

5.10 Key Dependent Variable Scoring

The average level of suspicion score, measured through the scenario survey, and the average level of confidence scores, measured through the self-report survey, were computed for all participants from their responses to the five scenarios at times T1 and T2. These average scores have a range between 1 and 10, where 1 indicates a low level and 10 indicates a high level.

MANOVA has been used to explore the effect of the intervention on the average levels of suspicion and confidence between times T1 and T2 for the control and intervention groups. A MANOVA is used to test the effect of factors on more than one dependent variable considered at one time.

Prior to conducting parametric statistical analyses, the assumptions required to be met were inspected. The Kolmogorov-Smirnov (K-S) test was used to check the statistical significance of normal distribution of the variables at alpha = .001. Parametric statistical tests were not used with variables that did not meet the test of normality

5.11 Results – Pre Intervention

The results will now be described prior to the evaluation of the training intervention.

5.11.1 Participants.

A convenience sample of twenty-two staff 22 staff took part in this phase. Although the number of staff who participated in the pre and post design of the education was small, it was balanced in that the groups represented different clinical experience and disciplines working in the targeted areas across SVHM. The research student sought guidance from the University of Melbourne Statistical Consulting Centre to determine the power analysis and to determine the number of staff to be recruited into this phase of this thesis. The research student followed his recommendations based on the aims and thesis design. Descriptive statistics, "used to describe and summarize the data" were used to describe the study sample (Polit & Beck, 2008 p. 792).

The control group, Group A had 2 males and 9 females. As per employment status, Group A had 6 full time and 5 part time employees. There were 2 nursing staff, 6 employees from Social Work, 1 Physiotherapist, 1 Occupational Therapist (OT) and 1 from speech therapy. In group A, there were 3 employees from Acute, 4 employees from Emergency, 1 employee from Sub-Acute and 3 employees working in more than one area.

In the intervention group, Group B, had 1 male and 10 females. Group B had 10 full time employees and 1-part time employment status. In the intervention group, there were 9 employees from Social Work, 1 Physiotherapist, and 1 Occupational Therapist. In group B, there were 4 employees from Acute, 2 employees from Emergency, 2 employees from Sub-Acute and 3 employees working in more than one area. The largest group of employees in both control and intervention groups had 1 to 5 years of experience working at SVHM.

The demographic characteristics of the groups are presented in Table 5 below. A Fisher's test found no significant differences between the proportion of males and females by control/intervention group (p=1.000).

Table 5: Sample characteristics (n= 22)

			Control or Intervention Control	 Intervention	Total
Gender	Male	N	2	1	3
		%	18.2%	9.1%	13.6%
	Female	N	9	10	19
		%	81.8%	90.9%	86.4%
Age range	25 – 34	N	7	6	13
		%	63.6%	54.5%	59.1%
	35 – 44	N	2	3	5
		%	18.2%	27.3%	22.7%
	45 – 54	N	0	2	2
		%	0.0%	18.2%	9.1%
	55 - 64	N	2	0	2
		%	18.2%	0.0%	9.1%
Employment status	Full-time	N	6	10	16
		%	54.5%	90.9%	72.7%
	Part-time	N	5	0	5
		%	45.5%	0.0%	22.7%
	Other	N	0	1	1
		%	0.0%	9.1%	4.5%
Current role at St. Vincent's	Nursing	N	2	0	2
		%	18.2%	0.0%	9.1%
	Social Work	N	6	9	15
		%	54.5%	81.8%	68.2%
	Physio	N	1	1	2
		%	9.1%	9.1%	9.1%
	OT	N	1	1	2
		%	9.1%	9.1%	9.1%
	Speech therapist	N	1	0	1
		%	9.1%	0.0%	4.5%
In which area of the hospital do you mainly work?	Acute	N	3	4	7
		%	27.3%	36.4%	31.8%
	Emergency	N	4	2	6
		%	36.4%	18.2%	27.3%
	Sub-Acute	N	1	2	3
		%	9.1%	18.2%	13.6%
	More than one area	N	3	3	6
		%	27.3%	27.3%	27.3%
How many years have you been employed at St. Vincent's?	Less than one year	N	1	2	3
		%	9.1%	18.2%	13.6%
	1 – 5 years	N	5	7	12
		%	45.5%	63.6%	54.5%
	6 – 9 years	N	3	2	5
		%	27.3%	18.2%	22.7%
	Over 10 years	N	2	0	2
		%	18.2%	0.0%	9.1%

5.11.2 Prior experience with elder abuse.

The participants were also questioned about their experience with elder abuse prior to the intervention being delivered. Nearly two-thirds of respondents in the intervention group reported they had attended training or a workshop in the past 12 months compared with one-third in the control group, however the different was not statistically significant $\chi 2$ (1, N = 22) = 1.636, p=.201 > .05 using the chi-square test. Evidence confirms that the difference in group participants can be tested for statistical significance using the Chi-square test of independence (Smith, Gratz, & Bousquet, 2009). There difference between the control and intervention groups with respect to having suspected incidents of elder abuse in the last 12 months approached significance ($\chi 2$ (1, N = 22) = 2.933, p=.087 > .05) with 64% of the control group saying they had suspected incidents compared with 27% of the intervention group.

Respondents in the control and intervention groups reported taking similar action to each other in response to suspected cases of elder abuse, with the majority saying they would consult their senior manager. Similarly, in both groups, half the respondents said they thought they would do something differently if they had had training, or more training.

Table 6: Prior experience of elder abuse (pre intervention)

			Control or Intervention		Total
			Control	Intervention	
Have you ever attended a training workshop or education session on elder abuse?	No	N	7	4	11
		%	63.6%	36.4%	50.0%
	Yes	N	4	7	11
		%	36.4%	63.6%	50.0%
During the last 12 months, have you suspected any incidents of elder abuse for an older person in hospital?	No	N	4	8	12
		%	36.4%	72.7%	54.5%
	Yes	N	7	3	10
		%	63.6%	27.3%	45.5%
Action suspected abuse	Consulted with my senior/manager	N	6	3	9
		%	85.7%	75.0%	
	Referred to ACAS	N	2	1	3
		%	28.6%	25.0%	
	Referred to another team/program within St. Vincent's	N	2	2	4
		%	28.6%	50.0%	
	Referred to an external agency – VCAT, OPA	N	4	2	6
		%	57.1%	50.0%	
	Followed up – abuse confirmed	N	4	1	5
		%	57.1%	25.0%	
	Followed up – abuse could not be confirmed	N	2	1	3
		%	28.6%	25.0%	
	Other	N	0	1	1
		%	0.0%	25.0%	
From your most recent situation in which you suspected elder abuse – do you believe you would have managed the case differently if you had received any/further education and training on elder abuse?	Yes	N	6	6	12
		%	54.5%	54.5%	54.5%
	Would not have done anything different	N	2	0	2
		%	18.2%	0%	9.1%
	Unable to answer/not sure	N	1	1	2
		%	9.1%	9.1%	9.1%
	Not applicable – have not suspected abuse	N	2	4	6
		%	18.2%	36.4%	27.3%

5.11.3 Responding to elder abuse.

The responses of the control and intervention groups with regards to the specific questions about knowledge and confidence in the area of elder abuse are summarised in table 7 below.

An independent sample t-test found no significant differences between the mean control and intervention scores for any of the questions at alpha=.05. The relation between these variables was not significant, $\chi 2$ (1, N = 22) = 1.636, p=.201 > .05. This indicates that there are no significant differences between the knowledge and confidence between the control and intervention groups in the area of elder abuse prior to the delivery of the training intervention.

A chi-square test of independence was performed to examine if there are statistically significant differences between the control and intervention groups with respect to having suspected incidents of elder abuse in the last 12 months. The relation between these variables was not significant, $\chi 2$ (1, N = 22) = 2.933, p=.087 > .05. There are no statistically significant differences between the control and intervention groups with respect to having suspected incidents of elder abuse in the last 12 months. Please see table 7: Knowledge and confidence in the area of elder abuse (pre intervention)

Table 7: Knowledge and confidence in the area of elder abuse

Question	Control or Intervention	Mean	SD	t	df	Sig.
Please rate your level of understanding regarding the definition "elder abuse"	Control	7.55	1.57	.848	15.184	.410
	Intervention	7.09	0.83			
Please rate your understanding of the different types of elder abuse	Control	7.82	1.33	.898	18.809	.381
	Intervention	7.36	1.03			
Please rate your knowledge associated with the signs of elder abuse	Control	6.55	1.29	-.809	19.973	.428
	Intervention	7.00	1.34			
Please rate your knowledge of the risk factors which are associated with elder abuse	Control	6.45	2.07	.323	19.838	.750
	Intervention	6.18	1.89			
Please rate your confidence in knowing what you would do if you suspected abuse or if a patient disclosed to you they were being abused	Control	6.36	2.11	.598	17.194	.557
	Intervention	5.91	1.38			
Please rate your level of understanding regarding St. Vincent's expectations on the management of elder abuse	Control	5.55	2.42	-.196	18.932	.847
	Intervention	5.73	1.90			
Please rate your level of understanding regarding the Victorian Government Elder Abuse Prevention Strategy and the principles associated with their "empowerment model"	Control	3.45	2.66	-.544	18.570	.593
	Intervention	4.00	2.00			
How confident do you feel you would know your individual responsibilities and duty of care in relation to suspected elder abuse?	Control	5.64	2.34	.209	18.246	.837
	Intervention	5.45	1.69			
How well do you feel you understand the term capacity or competency when referring to older people?	Control	7.45	1.86	-.837	16.174	.415
	Intervention	8.00	1.10			
Please rate your level of confidence in being able to effectively assess an older person at risk of abuse. For example, would you know what questions to ask the older person? Would you know how to determine the level of risk?	Control	5.64	1.63	-.707	19.451	.488
	Intervention	6.09	1.38			
How confident do you feel you would know the different types of resources available to you in relation to cases of suspected elder abuse? For example, in the hospital and in the community?	Control	4.64	2.62	-.957	17.465	.352
	Intervention	5.55	1.75			
How confident do you believe you could develop an appropriate action plan in relation to suspected elder abuse?	Control	5.45	2.34	.000	16.625	1.000
	Intervention	5.45	1.44			

5.12 Results – Post Intervention

As previously described in the procedure section of this chapter, this phase sought to test the effectiveness of heath professionals' to determine their level of suspicion and level of confidence to act on elder abuse in relation to the 5 scenarios presented in the training DVD.

One week after viewing the DVD and completing the response survey, the staff were sorted into two groups. Group A and B (n = 11 for each group). Two weeks after viewing the DVD, Group B (intervention group) was presented with the comprehensive elder abuse training intervention which had been developed as part of this research.

Both groups repeated the survey at Time 2 i.e. 4 weeks after the intervention presented to Group B. It was important to determine if staff from Group B had more knowledge and confidence to act on suspected elder abuse. As already noted elder abuse education was offered to Group A after a number of weeks, but no data collection occurred.

After the delivery of the intervention, all participants were asked to view the 5 case scenarios and to self rate their level of suspicion regarding evidence of elder abuse and their level of confidence to act upon the suspicion.

5.13 Impact of the Intervention and Time on Levels of Suspicion and Confidence to Act

The two dependent variables created to test the impact of the educational intervention were accurate recognition of potential elder abuse (suspicion) and confidence to act on suspicion of elder abuse. The distributions of the variables were normal at T1 prior to the educational intervention and at T2 after the intervention group had received the education (based on Kolmogorov-Smirnov test of normality).

The summary statistics for the above variables at both time points are given in table 8. The variables were not individually determined for each of the individual case scenarios. The sample included the response from the health professionals to all scenarios as a collective.

Table 8: Summary statistics for suspicion and confidence at T1 and T2

	N	Min	Max	Mean	SD
T1 Level of Suspicion Average Score	22	5.20	8.80	7.0818	.93739
T2 Level of Suspicion Average Score	22	6.80	9.80	8.2636	.84939
T1 Level of Confidence to Act Average	22	2.60	7.40	5.7545	1.15294
T2 Level of Confidence to Act Average Score	22	3.60	9.20	6.8727	1.31590

As outlined MANOVA was used to examine the main effects of time (T1 and T2) and group membership (control vs intervention), and the interaction between time and group membership, on the latent variables of average level of suspicion and average level of confidence scores.

There was a main effect for time, with a significant increase in the average level of suspicion from T1 to T2 for the whole sample, and a significant increase in the average level of confidence ($F (2, 39) = 14.282$, $p < .001$; Wilk's $\lambda = .577$).

There was also a significant main effect of group membership with a significant difference in the average level of suspicion of respondents from the control group compared with the intervention group ($F (2, 39) = 3.79$, $p = .031 < .05$; Wilk's $\lambda = .837$).

The interaction of time and group membership was also significant for suspicion and confidence ($F (2, 39) = 4.079$, $p = .025 < .05$; Wilk's $\lambda = .827$). The intervention group had a significantly greater increase in the average level of suspicion score compared to the control group ($F(1, 40), = 5.827$, $p=.020<.05$).

Similar findings were observed with respect to the average level of confidence score, but the findings are significant at .1 level of significance as opposed to .05 level of significance ($F(1, 40)=3.687$, $p=.062<.1$).

Table 9: Descriptive statistics

	Control or Intervention	T1 or T2	Mean	SD	N
Level of Suspicion Average	Control	T1	7.15	0.75	11
		T2	7.73	0.60	11
		Total	7.44	0.73	22
	Intervention	T1	7.02	1.13	11
		T2	8.80	0.72	11
		Total	7.91	1.30	22
	Total	T1	7.08	0.94	22
		T2	8.26	0.85	22
		Total	7.67	1.07	44
Level of Confidence to Act Average	Control	T1	5.69	1.38	11
		T2	6.15	1.21	11
		Total	5.92	1.29	22
	Intervention	T1	5.82	0.93	11
		T2	7.60	1.00	11
		Total	6.71	1.31	22
	Total	T1	5.75	1.15	22
		T2	6.87	1.32	22
		Total	6.31	1.35	44

5.14 Scope of Post Intervention Results

The tables presented in this phase demonstrate preliminary results from the testing the effectiveness of the training intervention. The raw data is extensive for the sample size and analysis of the considerable variables is beyond the scope of this study. The findings of this phase as outlined indicate the benefits of implementing evidence informed training intervention to targeted health professional's specific to address the study aims. However this study is suggestive that a training intervention on its own will not increase the confidence of staff to act on suspected elder abuse. This will be discussed in further details in chapter 7. Recommendations for further research include studying the effect of the training intervention across disciplines and responsiveness to the different types of elder abuse. It would be useful to determine the effects of the elder abuse training intervention on health professionals over time.

5.15 Summary

In summary, this phase used a quasi-experimental design to determine change in health professionals' level of suspicion and confidence to act on suspected elder abuse after participating in a training intervention. Data was analysed using descriptive analysis. The intervention designed for this phase was informed by previous phases of the overall study which utilised a sequential mixed methods design.

The health professionals selected in this phase were experienced clinicians who were expected to identify and respond in suspected elder abuse cases as part of their clinical caseload. The sample size was 22 and all of the participants completed a baseline survey before moving on to this phase of the study. Participants were later divided into two equal groups of 11 each, a control group and an intervention group.

After all the participants watched the newly developed DVD at T1, participants completed a response survey in order to determine their clinical knowledge on elder abuse and their chosen responses to each of the 5 scenarios portrayed in the DVD. The participants had to rate each of these scenarios on the basis of their perception if they suspected that abuse was evident. The purpose was to assess if the staff had the confidence to act upon suspected elder abuse in the 5 hospital based scenarios.

One week later, these respondents were divided into 2 groups of 11 each – Group A and Group B. Group B, the intervention group, was given the education that had been

developed, two weeks after initially viewing the DVD. After this time, both groups discussed the scenarios and watched the DVD again. Then the survey was repeated at T2, which was 4 weeks after Group B had been presented with the educational intervention. This was aimed at determining if Group B had more confidence in acting upon suspicion of elder abuse.

A MANOVA test was carried out to examine the effect of variables such as effect of time (T1 and T2), group membership (control and intervention), interaction between time and group membership as the factors on the latent variables of average level of suspicion and average level of confidence scores. The results demonstrated that there was a statistically significant effect of time (T1 and T2) on, of group membership (control or intervention) on and of the interaction of time and group membership on the average level of suspicion and confidence. Perhaps the most important finding is that the intervention group indicated a significantly higher increase in the average level of suspicion score when compared to the control group. Similarly, the intervention group also indicated a higher increase in the average level of confidence score when compared to the control group.

The estimated marginal mean of average level of suspicion was higher for the intervention group as compared to the control group. The estimated marginal mean of the average level of suspicion was higher for T2, when compared to T1. The estimated marginal mean of the average level of suspicion was higher for the intervention group at T2 as compared to the control group at T2. At T1, the estimated marginal mean of the average level of suspicion was higher for the control group when compared to the intervention group.

The estimated marginal mean of the average level of confidence to act was higher for the intervention group when compared to the control group at T2 when compared to T1. The estimated marginal mean of the average level of confidence to act was higher for the intervention group at T2, when compared to the control group at T2. At T1 as well, the estimated marginal mean of the average level of confidence to act was higher for the intervention group when compared to the control group.

These findings can be explained by the fact that the intervention group had received comprehensive education on elder abuse. This education on elder abuse changed their confidence to improve their level of suspicion as well as their level of confidence to act on suspected elder abuse cases. The level of suspicion and the level of confidence to act were also higher at T2 when compared to T1. The next chapter will provide the discussion for the thesis.

CHAPTER 6 – DISCUSSION & RECOMMENDATIONS

6.1 Introduction

In this chapter, the findings from the thesis will be interpreted and discussed. The discussion will pay close attention to the significance of the study and the relevance of applying a sequential approach which meant that each phase informed subsequent phases. The convergence of the quantitative and qualitative data obtained from this research has produced a number of key findings which will be described. The study has also provided an opportunity for significant knowledge translation to extend beyond this research study. These important translational outcomes will be described in Chapter 7.

To address the research aims, the following question was posed: *can a training intervention improve the responsiveness of health professionals in responding to suspected elder abuse.* The thesis has described and examined the phases that were used to facilitate the development and testing of a training package to enable health professionals working at the study site, a major metropolitan hospital in Melbourne, to respond to elder abuse. No such comparative work appears to have been undertaken before in a hospital context. This chapter summarises the findings, conclusions and recommendations of the study.

This chapter determines if the aims of this project have been achieved, through discussion of the key findings from each of the four phases of the study. There will be consideration given to the research methodology used and a review of the strengths and limitations of the study will be provided. The chapter will also discuss lessons learned through this study, some of the implications and the recommendations regarding future directions.

In summary the chapter will highlight the role that a training intervention can play in supporting health professionals respond to elder abuse.

6.2 Significance of this Research

This study provides a unique opportunity to reflect on current practice within one health care setting in Victoria in relation to health professionals' response to elder abuse. The findings of the study make an important contribution to confirming the value of training for health professionals to facilitate their improved response to elder abuse within a hospital setting. The topic is of significance because Australia will face a major demographic shift with a majority of its population aged over 65 years by 2030. The resulting challenges will require innovative and collaborative approaches to dealing with chronic health care issues and other

issues that will face our ageing population, including elder abuse. The current estimates of elder abuse within Australia suggest that 5% of our older population are at risk. This may increase as the changes in our ageing population occur in the coming years.

This study has identified the gaps and barriers for health professionals in responding to elder abuse. It has examined the literature and importantly gained feedback from health professionals working at the study site highlighting the strategies that would support health professionals to respond. Two critical findings emerged in this study: the need for targeted training for health professionals working with older people in relation to elder abuse and the importance of the training being supported by a governance framework, particularly an organisation policy as a reference point for hospital staff.

Literature suggests that few studies have been undertaken which have explored the response by hospital based health professionals to elder abuse. Hence, the findings of this study could serve as a guide for other hospital settings in Victoria, and possibly Australia. Chapter 8 of this thesis will describe the translation of these findings within the study site, beyond the study period and for the wider hospital and policy context within Victoria through partnership collaborations with the Department of Health and Human Services.

The research supports the view that the hospital does offer a 'window of opportunity' for older people at risk of elder abuse but it is critical that health professionals are educated to enable them to be more confident in providing support for older people at risk. This education needs to be targeted to meet their specific roles and clinical responsibilities. This can be achieved through the introduction of a competency framework which proposes that one type of training package cannot meet the required needs of all health professionals in relation to responding to elder abuse For example staff involving in the assessment and management of older people at risk require different competencies when compared to line managers who are not directly involved in the clinical care of patients.

6.3 Importance of the Findings

This section of the chapter will discuss the intended aim and outcomes from each of the four phases of the study. The key findings from this study are as follows:

- Findings from the online survey, suggested that many of the staff would have managed cases of suspected elder abuse differently if they had received training and/or education.

- Feedback from the focus groups provided a picture of the perceptions of the staff at the study site relating to elder abuse and confirmed that staff identified training as a critical factor to improve confidence to act on suspected elder abuse
- An unexpected finding from this study identified that targeted training was important at the study site to support health professionals to achieve the required competencies to match their roles and responsibilities. A 'one size fits all' training package on elder abuse will not facilitate the response by health professionals to suspected elder abuse. The literature and findings from each phase of this study confirmed the importance of this.
- The findings highlighted the need, in developing a training package, to take into account governance considerations – in this case an organisation wide policy and model of care.
- A further finding related to the importance of including information and approaches that reflect the 'macro' system or policy directions within a training package, to ensure that staff are trained to understand the broader implications of elder abuse beyond the hospital walls.

It is important in this chapter to review the aims of this study which guided the research design and approach and whether these aims were achieved.

6.4 Aims

The aims of the research were:

- To identify the barriers to health professionals' identifying and responding to suspected elder abuse
- To examine current knowledge on elder abuse and to describe models, approaches and frameworks for identifying and/or responding to elder abuse, including the education and training of health professionals
- To develop an elder abuse evidence informed training intervention in relation to responding to elder abuse for health professionals working with older people in an acute, sub-acute and Emergency Department setting
- To implement the training intervention and evaluate its impact on the awareness, knowledge and confidence of health professionals working at the study site, in facilitating their responsiveness to suspected elder abuse

A brief review of the findings of each phase in relation to the aims will follow.

6.5 Discussion - Phase 1 Inquiry and Descriptive Analysis

Phase 1 comprised a literature review, online survey, 3 focus group sessions and 4 face-to-face interviews. A mixed methods approach was used to analyse the data collected using both qualitative and quantitative methods. The aims of phase 1 were to extensively examine both peer reviewed and grey literature to scope key themes and to identify barriers for health professionals in responding to elder abuse and how these might be addressed as part of this study. A descriptive design was used and included feedback from health professionals at the study site to obtain their perspectives via a staff survey, focus groups and in-depth interviews. Key findings will now be discussed from the literature review.

6.5.1 Literature review.

Joubert & Posenelli (2009) suggest that the hospital provides a unique opportunity for staff to respond if they suspect elder abuse. According to WHO (2011), healthcare professionals who routinely interact with older people are in the best position to identify those who are at risk for abuse and also extend support to those elderly who are already experiencing abuse. Hence, it is essential that health professionals are fully equipped to deal with the greater likelihood of suspected elder abuse cases as estimated prevalence would suggest that 5% of our older population are at risk. The literature confirms that health professionals have an important role in identifying, managing and preventing elder abuse.

Elder abuse is often undetected, but nonetheless emerges as a critical social problem in an ageing society. Fundamentally elder abuse is a human rights issue and responses to the management and prevention of elder abuse sit within a range of complex policy and practice structures across different levels of government, and various justice system frameworks within the private sector and across non-government organisations. Importantly, the hospital system and health professionals have been recognised from the literature as offering a valuable contribution to the management of elder abuse for vulnerable older people.

Key findings from the literature review are:

- the literature underscores the importance of assessing the training needs of health care professionals and adapting training content to make it relevant to their practice

- the development of an elder abuse training package needs to understand elder abuse within the overall context of the relationship between the older person and the person of concern (the micro system).
- reasons for under-reporting by health professionals' in relation to elder abuse include a lack of knowledge on how to identify and respond to suspected elder abuse
- the literature emphasises the need for an organisation policy to support health professionals in responding to elder abuse.
- a key finding from the literature suggests that crafting a training intervention requires that the training incorporates models and approaches supported in the local context.
- the response to elder abuse requires a multidisciplinary understanding and a coordinated, multiple service system response to support vulnerable older people, the person of concern and the social network surrounding the family.
- previous studies do not provide conclusive evidence as to whether training health professionals has been effective in demonstrating changes in health professional' awareness and response to elder abuse.
- recognising, and responding to elder abuse is a complex issue for health professionals which requires well-coordinated protocols, policies and clinical guidelines to assist staff navigate the magnitude of clinical and ethical dilemmas
- the response to elder abuse requires a multidisciplinary understanding and a coordinated, multiple service system response to support vulnerable older people, the person of concern and the social network surrounding the family.

6.5.2 Online survey.

A confidential online survey was carried out across different campuses at the study site targeting a range of healthcare professionals across the organisation. The survey was designed in 4 parts to capture: staff demographics, experience with elder abuse, self-rating scale and staff education needs.

The total number of respondents was 275 with over 80% or 225 of these staff were female. The rate of responses were from staff working were in the acute units, followed by the sub-acute and then the emergency department. In relation to the aim of this study, significant findings from the online survey were critical in understanding the core components which needed to be considered in the development of the staff training package:

- 78% or 215, of the respondents had attended a training or workshop session on elder abuse.
- 39% or 108 of the total 275 respondents indicated that they had suspected incidents of elder abuse in the past 12 months
- 38% of the respondents or 41 staff said that they would have managed the situation differently had they received any training or education on elder abuse
- 63% or 174 staff, suggested education of health professionals would greatly assist in responding.
- 62% or 129 staff indicated that an organisation wide policy could improve their knowledge and confidence in identifying and acting upon suspicion of elder abuse
- Clinical judgment and information disclosure by the older person formed the two highest reasons for suspected abuse as indicated by the survey respondents

These results form a key finding in this study as the literature suggests that health professionals are unlikely to respond to elder abuse due to a lack of training/education and lack of knowledge of appropriate intervention strategies. An important and unexpected finding from the survey is that the other key reason for identification or suspicion of elder abuse was due to direct disclosure by the older person. It may be that hospitalisation affords a 'window of opportunity' not only for health professionals to respond, but also for a vulnerable older person, the opportunity in a safe environment, to disclose abuse.

An important finding of this phase is that participants confirmed, in line with the literature, that specific elder abuse guidelines and protocols are needed to assist health professionals identify and responding to elder abuse (Fulmer et al., 2004). It is important to recognise that elder abuse protocols are required in organisations working with older people, to provide an appropriate pathway for staff to respond to suspected cases of elder abuse. There was overwhelming support (62%) for an organisation wide approach to assist staff in supporting vulnerable older people presenting to the study site.

6.5.3 Focus groups.

Three focus group sessions were carried out using a researcher-developed interview instrument. This instrument aimed to explore the participants' perceptions, insights into elder abuse, and suggested themes for further inquiry and research.

Level 1 focus group comprised 8 junior staff from nursing and allied health staff. The Level 2 focus group was made up of 6 managers and heads of departments. The Level 3 focus group consisted of 7 experienced clinical staff from different health backgrounds.

The Ritchie and Spencer Framework (1994) for Qualitative Analysis was used to analyse the data collected as a result of these focus group sessions. The method followed has been described in detail in Chapter 3.

The key findings from the focus groups include:

- in the Level 1 focus group, there was an overall lack of training regarding elder abuse. All participants agreed that the introduction of elder abuse training should be considered. The participants from Level 1 focus group believed that senior staff and management needed to be trained in elder abuse to assist them to make decisions regarding possible dilemmas pertaining to confirmation and appropriate strategies for discharge planning.
- responses from the Level 2 focus group supported an overall need for appropriate training and education on elder abuse as the majority of them felt an ambiguity when it came to defining elder abuse and the associated signs. There was unanimous support for the introduction of an overall hospital policy on elder abuse and clinical practice guidelines. The findings from Level 2 focus group suggest that managers and heads of departments require individualised training on elder abuse targeted at their level to ensure that they can appropriately support their staff if they identify a case of suspected elder abuse.
- responses from Level 3 focus group indicated strong support for education and training for all staff and support for targeted training and education on elder abuse was critical in the development of the education package to meet the required clinical responsibilities for different health professionals.

The results of the framework analysis for the three focus groups suggest two common themes across the various levels of staff at the study site - the need for targeted education and training on elder abuse and an organisation wide policy in relation to elder abuse.

6.5.4 Face-to-face interviews.

A total of 4 face-to-face interviews were conducted by the researcher with staff who were unable to attend the focus groups. These included the Director of Aged Care, the Emergency Department Nurse Unit Manager, the ACAS Team Leader and ALERT Manager.

The key finding was the emphasis on need for competency building across the organisation. This was a theme that had also been discussed during the focus group sessions. There was also discussion about need for support for staff during suspected elder abuse cases. Suggestions for increasing staff confidence to act on elder abuse included targeted training for core groups of staff working in key areas across the organisation.

6.6 Discussion – Phase 2

This phase entailed conceptualisation and decision-making in relation to the knowledge, ideas and insights generated by the findings of Phase 1 to inform the development of the training intervention which was one of the aims of the research. This phase was important in achieving focus around the training in that decisions were made regarding the content, the targeting or selection of trainees and effective strategies or methods for delivering the training.

This phase confirmed the need to consider the application of conceptual frameworks to support a training intervention designed to meet the clinical needs of health professionals at the study site. Phase 1 findings required further consideration in this phase to how the training package was going to address the aim to improve responsiveness for those staff involved in responding to elder abuse. An examination of the literature outlined in phase 1 confirmed the importance of the core elements relating to health care professionals' roles and responsibilities in addressing elder abuse. The role of competency development emerged as a strong theme in phase 1 relating to the training of health professionals. The application of the Ecological Framework in this phase provided an understanding of the narrative in understanding how healthcare professionals in a hospital context can improve their responsiveness to suspected elder abuse.

This phase was able to meet the desired aim to conceptualise and make decisions to inform the development of the training intervention through the application of knowledge inquiry and knowledge synthesis.

6.7 Discussion - Phase 3 Development of the Training Intervention

This phase was informed by Phase 2, enabling development and trial of the tools and products for the training package to be used at the study site. This phase was characterised by knowledge synthesis into policy and practice. The outcomes achieved at the study site included a governance framework relating to the protection of vulnerable older people which was identified as a key factor to support the training intervention. This phase examined the findings from earlier phases regarding effective intervention and service delivery for the management of elder abuse by health professionals' working in a hospital context.

As seen in the literature, the role of interactive education and training is very important when it comes to generating understanding and raising awareness about elder abuse. Hence, the development of the training package related to elder abuse for health professionals at the study site needed to be informed by previous phases of this study. In line with the literature it was also important to consider the policy context in the development of the training, to ensure congruency, or 'fit' for the study site.

In addressing the research aim of developing an evidence informed training package perhaps the most significant aspect of the research, has been the development of a unique training package. The package which was informed by the literature and findings from the previous phases has incorporated key considerations which had emerged as consistent barriers for health professionals in responding to elder abuse. Those considerations have included:

- The development of a competency based training framework for health professionals at the study site which comprises 3 levels of understanding and response to elder abuse within a hospital setting
- Development of a policy and model of care for the study site to facilitate health professionals' responding to suspected elder abuse within a governance framework

The training package which was developed contains a training DVD specifically designed for hospital staff, including a PowerPoint presentation, information on the newly developed SVHM Policy, Model of Care and Governance Structure and a clinical pathway for management of elder abuse. As described in Chapter 5, no such training DVD, specific to hospital staff, has been generated elsewhere to date. Hence, the development of this DVD has been unprecedented. The actual process of the development of this DVD, along with its contents, has been discussed in detail in Chapter 5.

6.8 Discussion Phase 4 – The Evaluation Phase

The findings from this phase confirmed that training package delivered to targeted health professionals at the study site improved their knowledge and confidence to respond to suspected elder abuse.

A key finding from this phase supported the research aim which was to determine if health professionals could improve their responsiveness to suspected elder abuse, the findings of this phase confirmed that of the sample of participants involved in the intervention group were able to increase their level of suspicion and level of confidence to act on suspected elder abuse cases.

6.9 Discussion Summary

The rationale, design and contents of the education package were based on a review of the literature and from the findings from the quantitative and qualitative data analysed from previous phases of this study. One of the most important outcomes from the research, in line with the research aims, has been the development of an effective, evidenced informed comprehensive training package for targeted health professionals working in Emergency, acute and sub acute care settings at the study site.

There have been several unintended outcomes of this research in terms of a multidisciplinary approach to the training. Multi-disciplinary educational forums supported collaborative learning and exchange. The clinical issues faced by participants of the research were of common interest. The examination of these issues enabled differences in disciplinary perspectives to be discussed openly and respected. While the training package was developed to meet a local educational need at the study site, the package has already evoked widespread interest from a number of key organisations across Victoria and within Australia. The translational outcomes of this research will be discussed in chapter 7.

6.10 Methodology of the Study

The findings of this study support the mixed methods sequential design was used to assist in addressing the research aims and question posed at the commencement of the study. The training intervention which was developed as part of this study was evaluated by measuring changes in knowledge and confidence to act on suspected elder abuse in a hospital setting for a targeted group of health professionals. This phase used a quasi – experimental design to test the effectiveness of the training intervention. This study aimed to explore the

perceptions, and knowledge of health professionals regarding the issue of elder abuse. It also described the main requirements identified by staff in relation to the management of suspected elder abuse cases. The application of a mixed methods sequential design has allowed one type of data to provide a basis for collection of another type of data. This has been evidenced through the order of the phases from the literature review through to the online survey, focus groups, face-to-face interviews, education package design and pre and post testing. Each phase has informed subsequent phases of this study.

Overall, the methodology used for this study has been successful in distilling the perceptions of staff regarding management of suspected elder abuse cases at the study site. It has been successful in generating the findings that the research aims and question set out to explore. Not only has the study been able to identify the specific training and education needs of health professionals in relation to facilitating their responsiveness to suspected elder abuse, it has also been able to provide a clear picture of the knowledge gaps and experiences regarding elder abuse within a particular hospital setting in relation to suspected elder abuse. Furthermore, the application of this methodology has identified the barriers raised by those staff and addressed them as part of the study sequence.

6.11 Lessons Learned

This research acknowledges that while elder abuse is not a new phenomenon, the speed of population ageing in Australia will lead to its increase in higher numbers of older people at risk. This thesis confirms the barriers for both older people and health professionals in relation to elder abuse which contribute to the under-reporting of this problem.

The main lesson learnt as a result of this study is that the education and training needs of hospital staff need to focus on improving staff knowledge and confidence in relation to identifying elder abuse and then knowing how to respond. This training needs to include specific information which is consistent to the local policy context and be supported by a robust governance framework. It needs play close attention to the competencies of the health professional being trained and address the role and responsibilities of individual staff. There is no one size fits all package that will ever meet the requirements of all health professionals in a hospital context.

As a result of the methodology used for this study it was possible to apply a sequential approach to understand and address the comprehensive range of requirements which should be considered as part of an education package to increase the knowledge and

confidence of health professionals working in hospital settings in responding to suspected elder abuse.

Another lesson learnt from this study is that there is indeed a 'window of opportunity' for health professionals working in hospital settings to respond to older people at risk of elder abuse and that effective training can increase capacity to respond. The findings from the study confirm that health professionals at the study site who received the training intervention had improved confidence and knowledge regarding elder abuse interventions.

6.12 Limitations

There are a number of limitations to this study that need to be considered. This research did not analyse a range of different health settings. It was focused specifically on health professionals working in a hospital context. In terms of the scope of the research the focus was on health professionals working in a hospital setting in the Emergency Department and acute and sub-acute wards. It did not focus on health professionals working in community or ambulatory settings within a health context.

The training itself was focused on health professionals who were in direct clinical roles supporting older people who were inpatients at the time of involvement. Therefore, conclusions drawn have relevance for older patients within a specific health care context.

This study aimed to improve health professionals' responsiveness to suspected elder abuse, enabling them to move from suspicion to intervention. It does not try to explain the causes of elder abuse or measure prevalence within a health context. Instead the study seeks to address elder abuse training needs and to evaluate the impacts of an elder abuse training intervention for health professionals working in key programs at the study site who were in a position to both identify and respond to elder abuse within their core roles.

An additional limitation has been that following the post test application, no further, specific evaluation has been undertaken at the study site. Few studies have measured the long-term retention of knowledge as a result of training programs. Hence, there is a need for further evaluation to determine the longer term effectiveness of education and training on elder abuse prevention and management. The challenge also remains to determine the most effective way of delivering training in terms of cost and resources without an injection of funds to support this work. For the study site long-term retention of knowledge and the application of knowledge to practice for those who receive the training remains an unanswered question. Chapter 8 does provide an overview of the translation of this research

into practice and interesting data on cases of suspected abuse reported over a four year period since the training was first introduced. It is worth noting that the training package developed for the research has underpinned ongoing training at the study site in that four year period.

Another limitation is that the study does not feature the voice of older people themselves in terms of their views regarding what they might expect from health professionals working in hospital settings in relation to the issue of elder abuse. This was beyond the scope and aims of the study. To date there has been limited work done regarding elder abuse where the voices of older people who have been abused have been represented. This is a crucial gap in elder abuse research which needs to be addressed. In health care patient centred care and partnering with consumers is required under accreditation standards. In spite of some limitations the study provides insights on key considerations for designing and evaluating a training intervention and governance framework to assist health professionals respond to suspected elder abuse in a hospital setting.

6.13 Sustainability of the Training at the Study Site

Translating the findings of this study into clinical practice at the study site is the most significant achievement of this study. This research highlights that elder abuse is a socially constructed phenomena requiring a myriad of different responses to assist health professionals improve their confidence and knowledge to respond to suspect elder abuse

The development of a SVHM Vulnerable Older Persons' Policy and Model of Care which needed to be incorporated into the training intervention provided staff with a framework and clear pathway to assist them step-by-step in understanding their responsibilities. These important initiatives have fostered a cultural and attitudinal shift to support innovative efforts to prevent harm to older people.

Building on the foundations that the research project has provided, the study site continues to build capacity to systematically respond to elder abuse in a climate of increased attention to issues of family violence. Interface with peak bodies and policy makers continues to grow. There has been an expansion of effort in strengthening the organisation's policy and advocacy voice in relation to elder abuse. SVHM's ongoing interface with the Victorian Department of Health and Human Services (DHHS) has provided an opportunity to contribute to a new elder abuse pilot project which will enable the sharing of knowledge, resources and strategies with other Victorian hospitals. Other new collaborations to improve

the health and wellbeing of older people at risk of elder abuse include Seniors Rights Victoria (SRV) funded Health-Justice Partnership between SVHM and Justice Connect/Seniors Law. These outcomes are described in Chapter 8: Post Script.

6.14 Summary

Elder abuse is a complex phenomenon. Despite advancements in elder abuse research it has remained largely under recognised and under- reported in our community. The literature highlights the barriers and at the same time underscores that health professionals are in a strong position to recognise and respond to signs of elder abuse. The themes reported by staff at the study site are consistent with findings from the literature that staff are not confident to respond unless they receive training which is supported by an organisation wide policy and is relevant to the local policy context. The survey, focus group and interview data confirm the required careful consideration of the what, who and how regarding the development of the training intervention. It needs to be relevant in relation to content, selection of those health professionals to receive the training and attention to strategies and mode of delivery.

Healthcare professionals who routinely interact and assess older people are best placed to identify those at risk of elder abuse and provide support to those experiencing abuse (WHO, 2011). However, evidence confirms that lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse can be a significant barrier in addressing elder abuse for older people (Cooper et al., 2009). Reasons for lack of response by healthcare professionals includes factors such as lack of knowledge about elder abuse signs and symptoms, elder abuse risk factors, assessment principles and intervention options appropriate for older people (Joubert & Posenelli, 2009).

Education is a critical strategy to assist in the minimisation for older people. It is essential for understanding and having an awareness of elder abuse (Walsh et al., 2007). The importance of providing specific elder abuse education to targeted health professionals such as social workers is becoming well recognised as we become more aware of the impact of elder abuse on older people (Walsh et al., 2007).

This Australian Research Council (ARC) Linkage Project between SVHM and the School of Social Work, the University of Melbourne has focused on developing an evidenced informed training intervention for health professionals at the study site to support older people at risk of harm. The Australian Council on Healthcare Standards confirms the importance of clinical

governance for effective care in hospitals to maximise our work with patients. The study conducted at SVHM approach has focused on the importance of differing training needs and competency levels for health professionals and the significance of the training being underpinned by an elder abuse governance framework.

The involvement of multidisciplinary and multi-program key stakeholders at the study site led to the establishment of an organisation-wide Protection of Vulnerable Older Persons' Coordination Response and Coordination Policy and Governance Group. This group continues to aim to minimise clinical risk and improve safety of care for older people attending the health service, using a systems approach.

This study has highlighted the significance of the UK safeguarding approach which balances the rights of older people while striving to maintain their safety and dignity and which promotes clinical and organisational accountability in this area of health care practice.. This is achieved through education, interagency collaboration and effective policies and procedures for staff which is targeted at specific roles and based on a competency framework. This approach is consistent with the policy context in Victoria and this approach has enabled the aims of the research to be met. This research has been able to show that the training package developed as part of this project has improved the knowledge and confidence of health professionals working at the study site to respond to suspected elder abuse.

6.15 Recommendations

St Vincent's Hospital Melbourne has a long standing vision and commitment to excellence in service delivery, teaching and research. The work to date in improving responsiveness to elder abuse is well recognised. Strong networks and partnerships have begun to build a foundation in which the organisation can profile the work undertaken to date regarding the protection of older people at risk of harm or abuse which has been spearheaded by the research.

Healthcare professionals are faced with more complex issues on a daily basis within their clinical work than ever before. Elder abuse has become an issue of growing prominence due to increasing societal awareness of family violence and abuse towards vulnerable populations, linked with issues raised by the ageing of the population (Cooper et al., 2009). It is hoped that the results of this research will provide some insights into the issue of elder abuse, the role of hospitals and the effectiveness of a training approach, to facilitate

improved responsiveness by health professionals working in Emergency, acute and sub acute settings.

The recommendations for addressing the problem of elder abuse which have arisen from this study are:

- support a coordinated national approach to elder abuse which will go along way in creating consistent practices for health professions' in hospitals across Australia.
- increased efforts to improve education among health care professionals and service providers about what constitutes elder abuse, how to act on it and how to support at risk older people
- clear procedures and pathways for health professionals, regular case reviews for complex patients where suspected elder abuse is a factor and staff education which is targeted according to roles and responsibilities within an organisation
- improved coordination of services in order to provide more support and oversight of elder abuse and to ensure continued training based on the SVHM framework
- using evidenced informed approaches to establish and implement elder abuse policies and procedures in key agencies across Australia. Also seeking clinical champions to help progress such an agenda
- to strengthen awareness by older people themselves about their rights and legal options in situations of harm or abuse through information provision
- providing older people with free services that may prevent future abuse, such as legal and financial advice and resources for retirement planning
- expansion of Health Justice Partnerships across Victorian hospitals to support older people at risk of abuse
- a national strategy with increased collaboration and resources to support consistency and best practice principles
- finally, the need to address a crucial gap in elder abuse research is the voices and views of older persons themselves about what they want and need from health professionals in relation to issues of safety and risk.

6.15.1 Recommendations for Australian hospitals.

As already evidenced in this research, Australia does not have a national strategy for the response and prevention of elder abuse. The thesis provides an overview regarding responses from the different state and territory governments in relation to elder abuse. These greatly vary in response to their training and education packages, funded services and policies and protocols (Kurrle & Naughtin, 2008). This has led to differences in intervention practices and programs within Australia that operate across various levels of government and community service sectors such as hospitals.

Without a national approach to elder abuse in Australia a useful strategy may be to increase the profile of elder abuse within the family violence framework, to ensure that all health professionals receive the appropriate education and training to provide effective support and responses to older people at risk.

Key recommendations for Australian health services would be to:

- Implement consistent evidenced informed policies and processes to facilitate health professionals working in Australian hospitals to improve their response to suspected elder abuse.
- Consider opportunities to expand the response by health services in relation to family violence across the lifespan
- Provide funding to support workforce development (particularly in social work) to address the psychosocial needs of the ageing population
- Staff should be supported by managers within their organisations to receive education on elder abuse which is specific to their role and experience. This is a critical step in ensuring that every older person at risk of elder abuse can receive appropriate help and support.
- Hospitals across Australia need to recognise that there is a 'window of opportunity' to support older people who interface with the health system.
- Use findings from this research to inform elder abuse both training and clinical practice in relation to elder abuse response for hospitals across Australia.
- Continue to foster collaborations with university partners to build the evidence in understanding and responding to elder abuse

6.15.2 Recommendations for policy development.

There is agreement across a number of sectors that elder abuse is now firmly on the agenda in Australia. However, this research has confirmed that elder abuse awareness, research, policy and practice is still years behind compared to other areas of family violence including child abuse and domestic violence. In terms of elder abuse there is lack of agreement regarding definitions, prevalence, risk factors, intervention strategies and there is no national approach. Elder abuse is an issue that is going to become more evident in an ageing society and the challenge for all levels of government is to ensure that there are adequate resources are available to respond effectively.

From a policy perspective, Commonwealth, state and territory governments have intersecting responsibilities in relation to ageing, aged care and health. Local governments in Australia have responsibility for the delivery of services to older people. Currently each division of government is working in isolation and there is little collaboration. From this perspective, to date there has been the lack of an agreed approach in various legislative, policy and practice frameworks is seen to inhibit the development of a coherent approach from the perspectives of both measurement and response.

Furthermore, evidence about prevalence in Australia is lacking. Based on estimates it is likely that between 2% and 10% of older Australians experience elder abuse in any given year (SRV, 2015). The statistical evidence on Australia's age profile in the coming decades suggests that we will see unprecedented proportions of Australia's population being aged. In 2050, just over a fifth of the population is projected to be over 65 (compared with 15% in 2015), and those aged 85 and over are projected to represent about 5% of the population (compared with less than 2% in 2011). Further added to this is that estimates predict that three in ten people over 85 are likely to have dementia which has been identified as a major risk factor for elder abuse.

6.15.3 Academia and future research.

This research has highlighted complexities relating to elder abuse within our society. In order to progress responsiveness to elder abuse, it is important to identify and reduce existing gaps in research and current policy responses.

This research has raised a gap in service delivery for health professionals' in Australia. These are no consistent policies or a best practice model of care for responding to elder

abuse across Australian states and territories. There is widespread recognition among experts in the field that both the existing knowledge base concerning elder abuse and approaches to preventing, identifying and addressing elder abuse has significant limitations (Clare et al., 2011; Wainer et al., 2010). Community concern is also increasingly evident, reflected in the NSW Parliamentary Inquiry into elder abuse currently underway, the Victorian Royal Commission into Family Violence and the Australian Law Reform Commission Inquiry into Elder Abuse.

The WHO (2011) has observed that there is limited knowledge on prevention approaches, and a number of recent Australian studies have called for a greater focus in this area (Clare et al., 2011). A crucial gap in elder abuse research relates to the voices, opinions and recommendations of older persons themselves.

Future research related to elder abuse needs to recognise the complete life experiences of an older person in the context of family relationships (Ecological Framework), vulnerability, ageism and the valued contribution that they make to our society.

The translation of the knowledge gained from this study will be described in chapter 7.

CHAPTER 7 – POST SCRIPT

7.1 Introduction

This chapter will describe several outcomes which have occurred in the last few years at the study site which have directly resulted from the translation of the knowledge from this research. St Vincent's Hospital Melbourne is building capacity within the organisation to respond systematically to suspected elder abuse. Social Work has developed an important academic-practice research partnership in the area of elder abuse and this research has already evidenced strong translational components.

The organisation has set in place an effective structure, policy and processes based on what was developed for this research including the education resources. Staff commitment to the area of elder abuse has remained high however sustainability and expansion of the work were ongoing considerations. Efforts to refine, expand and develop the model of care, training and data collection in relation to elder abuse have resulted in collaboration with key external stakeholders, in particular policy makers.

7.2 The Royal Commission into Family Violence

The debate about the inclusion of elder abuse as a form of family violence has reached partial resolution in the state of Victoria in Australia. An important outcome from the recent Royal Commission into Family Violence (RCFV) in Victoria confirmed that abuse and harm towards an older person is now a recognised form of family violence (RCFV March, 2016).

In early 2015, the Governor of Victoria appointed two Commissioners to the Royal Commission into Family violence. In March 2016 The Commission provided 227 recommendations on how Victoria should respond to family violence moving forward based on the evidence provided by key experts in the field. The Victorian Government pledged to enact all the recommendations made in the Commission's report, indicating an overhaul of family violence services and response within the state.

In 2015, St Vincent's Health Australia & St Vincent's Hospital Melbourne completed a submission and provided verbal evidence to the Victorian Royal Commission into Family Violence confirming the role that health services can and should play in the responding to elder abuse. The Royal Commission endorsed St Vincent's Hospital Melbourne's framework

for addressing elder abuse, concluding: “the Commission notes and supports initiatives such as the St Vincent’s Hospital model. A model such as this should be adapted for use in other hospitals and other environments such as aged care.”

While the recommendations specific to elder abuse are limited, the content of the RCFV’s chapter ‘Older People’ RCFV provides a solid basis for future reform and consideration by St Vincent’s Hospital in future endeavours in this area of practice.

The Commission believes that responses to older people who have experienced family violence should be informed by key principles, which recognise the particular experiences and needs of older victims. These key principles are (Victorian RCFV report, Chapter 27: Older People, p 89):

- Public awareness of family violence against older people must increase, so that family and friends can identify abuse and provide support.
- Older victims should be encouraged to seek help and know where it can be found.
- All service providers who may come into contact with older victims should be able to identify when family violence is occurring and know what to do in response. Aged care and health care workers should be able to obtain advice and support to resolve the ethical tension between patient/client wishes and protecting their safety.
- Older victims should be supported to remain in their homes. If they choose to leave, they should be supported to obtain appropriate accommodation.
- Older victims from Aboriginal or Torres Strait Islander backgrounds should be able to receive culturally safe services.
- Older victims from particular communities – including culturally and linguistically diverse communities (CALD), lesbian, gay, bisexual, transgender communities and people with disabilities should be able to access services that understand and can respond to their different experiences and needs.
- When responding to family violence against older people, the response should be sensitive to their choices about family relationships; for example, instead of relying on a criminal justice response, greater support could be given to parents who are carers of adult children with mental health issues.
- Responses between various sectors (and particularly aged care, health and family violence services) should be coordinated and collaborative.

The research conducted at SVHM and the ongoing work has been influential in placing the organisation in a strong position to meet these expectations.

7.3 National Elder Abuse Conferences, Australia – 2014 and 2016

A presentation on the early outcomes from this study were presented at the 3rd National Elder Abuse Conference, Perth WA, September 2014. The paper was titled: *'It takes more than a policy: safeguarding vulnerable older people by building clinical and organisational capacity.'* This presentation attracted a great deal of interest from the wider field (legal, health, community, statutory organisations and government). This led to specific approaches by a number of key stakeholders, for example Seniors Rights Victoria; the Office of the Public Advocate Victoria, the NSW Elder Abuse Prevention Unit and contact from Seniors' Programs & Participation, Ageing & Aged Care Branch, Department of Health and Human Services, Victoria.

A further presentation occurred at the 4th National Elder Abuse Conference, Melbourne, in February 2016. The paper was titled: *"So you want to do better in responding to elder abuse: then review your data!"* Both of these opportunities provided St Vincent's Hospital with valuable experience to profile and showcase the work being undertaken in the area of elder abuse we are at a national level.

7.4 Establishment of a Health Justice Partnership at SVHM

In May 2015, based on the ongoing practice innovations in the area of elder abuse the Social Work Department received an offer to establish a new Health Justice Partnership (HJP) between SVHM and Justice Connect: Seniors Law, to improve health outcomes for vulnerable older people who are at risk of harm or are experiencing elder abuse. This was a significant outcome of the ongoing work (and the sharing of knowledge about the work) which flowed from the research.

A literature review by the National Centre for Medical Legal Partnership (NCMLP) in the Unites States (2013) demonstrated that HJPs have a positive impact in three areas: 1) financial benefits to clients and partnering organisations; 2) improved health and wellbeing of clients; and 3) increased knowledge and confidence of health professionals to address legal issues. There is a significant social return on investment from integrating legal services into a health care setting. The SVHM HJP is aligned with SVHM values of compassion, justice, integrity and excellence and reflects the organisation's Mission and abiding commitment to

person centred care and social responsibility. It supports St Vincent's Health Australia's (SVHA) Vision that we lead through research driven, excellent and compassionate health and aged care and strategic commitment to enabling partnerships *(enVision, 2025).*

The proposed partnership commenced in January 2016 and includes the incorporation of a senior lawyer to strengthen current work on preventing and responding to suspected elder abuse at SVHM. Pro bono services, consultation and training are funded by Senior Rights Victoria (SRV) at 3 days a week for an indefinite period as long (as they continue to receive funding from the Victorian Department of Health and Human Services). The lawyer is based at SVHM Fitzroy and is linked to Social Work, whilst also working with key programs across the organisation that interface with older people. Outreach is also provided to other SVHM campuses/locations and programs, in particular those based at St George's Health Service.

The role of the HJP lawyer is to:

- Provide secondary consultations to support staff at SVHM in the work of managing elder abuse.
- Provide staff training regarding the interface with and referrals to the SVHM HJP
- Develop resources and tools to support staff to identify and respond to elder abuse and identify legal issues.
- Assist the SVHM Vulnerable Older Persons' Coordination and Response Group to strengthen existing policy and processes
- Develop information and resources for patients
- Attend case work and clinical review meetings to support staff to identify potential legal, duty of care issues and appropriate legal referral pathways.

7.5 Data on Suspected Elder Abuse Notifications

The most important outcome of the ongoing work has been the increased ability both recognise and respond to suspected elder abuse presentations to the hospital and to describe and quantify what his occurring in that regard. Building on the introduction of the Elder Abuse Governance Framework and the earlier findings from this study, new systems were introduced at SVHM around data collection. The implementation of the SVHM hospital wide policy for the Protection of Vulnerable Older People (VOP) introduced a new Model of Care and response framework to improve the quality of care for vulnerable older people. Processes were established to collect data about this patient population and to educate and empower clinicians to work with vulnerable older people within an organisational framework.

The data obtained from ongoing auditing has provided a clear picture of this patient population, the vulnerabilities and complexities and how clinicians are working with them and their families.

Data collection on suspected elder abuse notifications has been occurring since December 2012. This data has enabled SVHM to examine prevalence, types of abuse, risk factors, adherence to policy and pathways of care, implement safety planning and also to identify opportunities to improve practice. Using data analysis, SVHM has also in a preliminary way begun to gauge the resource implications of this work.

Hence measures that can inform the ongoing work have been developed, introduced and utilised. Through the establishment of the high level governance group, the key steps achieved include: 1) establishment of a program of routine auditing; 2) piloting of a specific audit tool; 3) comparison of audit findings with data from comparable settings; 4) review of outcomes and performance in relation to patient assessment and care planning, and 5) the identification of opportunities for improvement in processes which include the model of care, practice, training and data collection.

Audits of VOP notifications made at SVHM since the inception of the new policy and related case information, have been based on the Richie and Spencer Framework (1994), which was used in the research. SVHM Quality Assurance Ethics approval was obtained to undertake data mining analysis (Epstein, 2002) of existing records (n = 315) for the period December 1st 2012 to November 30th 2016.

Data was collated using patient files via Medical Records On-line (MRO) for the corresponding episodes of care i.e. the episodes during which a VOP notification was received. Qualitative and qualitative data was collected in Survey Monkey format. All data collection was non-identifying. Using the Ritchie & Spencer (1994) framework, as already noted, analysis of the data was largely descriptive covering four main categories: contextual, diagnostic, evaluative and strategic. Based on these categories, questions were framed which were answered using the data (n=315) which had been collected.

7.5.1 Demographic data.

- The patient population is predominantly female (67.3%)
- The highest notification rate is for patients between 75 and 84 years of age (41.9%), followed by that for the very old (85+) at 26.3%

- 72.4% of the sample was born outside of Australia and 46.0% required an interpreter.
- Overall, in the vast majority of situations, an immediate family member of the older person was suspected of the abuse – son (38.4%), spouse/partner (21.6%) and daughter (15.9%)
- 63.8% of vulnerable older people are living with the suspected person of concern

7.5.2 Types of abuse.

- Suspicions of financial abuse (55.9%), psychological (52.7%), physical (38.7%) and neglect (27.9%) were strongly evident within the sample.
- Two types of abuse were suspected in 31.4% of cases, and three or more types of abuse were suspected in 20.6% of cases. Therefore, in just over half of the cases, more than one type of abuse was suspected

7.5.3 Confirmation of abuse.

- In 75.2% of cases, the suspicion of elder abuse was confirmed. This may suggest that in the vast majority of cases, clinicians' initial suspicions were accurate

7.5.4 Triggers and risk factors.

- In relation to the person of concern, mental health issues (33.3%), a history of family violence (31.1%) and substance abuse issues (20.6%) were the highest indicators as to why the suspected abuse may be occurring.
- For the vulnerable older person, dementia/cognitive impairment (37.8%), isolation (36.2%) and a history of family violence (31.7%) were consistently the highest indicators as to why the suspected abuse may be occurring.

7.5.5 Level of assessed risk.

- Overall, in 71.7% of cases, a high level of assessed risk was evident and an immediate and timely response was required for assessment and intervention.
- In 82.5% of cases, clinicians were required to put an intervention/safety plan in place. Comprehensive information as to the nature and reasoning of these intervention plans in future data collection would be beneficial.

7.5.6 Findings related to SVHM policy and processes.

- Clinicians are reliably documenting their concerns regarding suspected abuse in patient files (95.2%).
- In 67.9% of cases, clinicians documented that they consulted with their line manager/supervisor and, in 69.8% of cases, clinicians documented that assessment/consultation by two clinicians occurred.

In October 2014 the SVHM Elder Abuse Governance Framework was a joint winner in the Category Exceptional Care: Effective Clinical Governance for 'Safeguarding vulnerable older people: building capacity" at the SVHA Quality Awards 2014. This submission was based on the data collected on suspected elder abuse cases at SVHM, but more importantly on the systems and processes which had been introduced.

7.6 Strengthening Hospitals' Response to Family Violence (SHRFV)

In April 2014, The Royal Women's Hospital and Bendigo Health commenced a partnership to develop and implement a model for identifying and responding to family violence within a hospital setting that was sustainable and transferable to other hospital settings. This Project was funded by the Department of Health and Human Services. During this period, two modules of training were developed for the purpose of building the capacity and capability of staff to respond to family violence. A discussion paper was also developed outlining the issues and opportunities associated with data capture within hospitals. The pilot project was evaluated by Our Watch, an organisation set up to drive nationwide change to reduce violence against women and children.

In October 2015, the SHRFV service model was further developed along with a toolkit of resources and supporting communication materials, designed to guide and support other health services to implement the model. Four demonstration sites (two metropolitan and two regional services) joined the project in January 2016 and began implementing and adapting the service model to suit their health care setting.

In August 2016, Stage three of the SHRFV project officially commenced with the announcement of funding by the Minister of Health on the 17th August 2016 bringing the total number of hospitals and services participating in the project up to fifteen. The announcement of funding was accompanied by an event hosted by the Women's at which a

suite of communication materials developed to support the project were launched, as well as a new-look website featuring the suite of SHRFV project resources and also providing a communication hub for participating hospitals. Stage Three of the SHRFV Project is governed by a Project Advisory Group (PAG), chaired and administered by the Women's and Bendigo Health on an alternative basis. The group has been established to oversee the project's progress and provide expert advice and support. The group will meet quarterly and formally report to DHHS on planning, progress and emerging risks. SVHM Social Work is now a member of the SHRFV Project Advisory Group.

7.6.1 SHRFV project - St Vincent's Hospital

On 17th August 2016 Minister for Health, Jill Hennessy, announced that funding for the Strengthening Hospitals Response to Family Violence (SHRFV) Project would increase from $250,000 to more than $1.2 million in the 2016/2017 financial year. The initiative will provide training to help 15 Victorian health services to better support patients who have experienced family violence. St Vincent's Hospital Melbourne (SVHM) received new funding to:

- Implement a 'whole-of-hospital' service model within SVHM. This is a staged roll out which requires SVHM to identify areas within the health service where health professionals are likely to come into contact with patients experiencing family violence. SVHM Social Work Department has been funded as the SVHM SHRFV Project Lead role from November 2016.
- Importantly additional funding has been allocated to the SVHM Social Work as part of an established agreement between the Royal Women's Hospital and SVHM for the development of a module guiding health services to identify and respond to elder abuse - as a key part of the current SHRFV service model. This module will be launched in August 2017.

SVHM has established a SHRFV Steering Committee which includes wide representation from a number of stakeholders across the organisation. Terms of Reference have been endorsed. The SHRFV Steering Committee proposes a plan for initial implementation of education in responding to family violence in 2017 in the SVHM Emergency Department and the Neurosurgery Unit.

7.7 The Victorian Government Elder Abuse and Prevention Unit

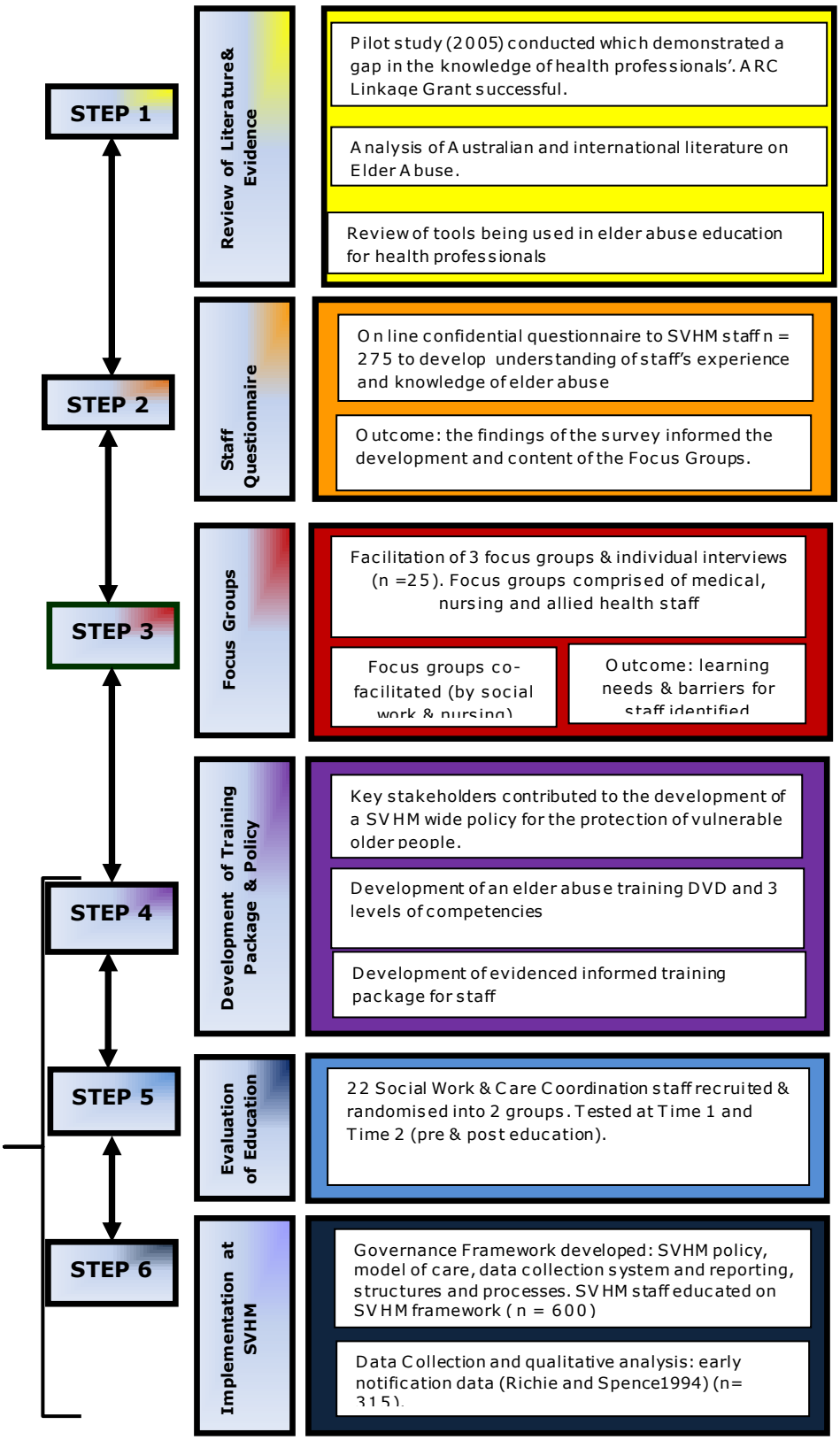
In 2016 the Victorian Government's Elder Abuse and Prevention Unit released funding to trial an integrated model for the management of elder abuse across a number of Victorian Hospitals. St Vincent's Hospital Social Work Department received funding to work with the Bouverie Centre [1]and Seniors Rights Victoria on this initiative. SVHM are contributing our learning's from the research in relation to training health professionals to respond to suspected elder abuse. This integrated model is going to be trialed in three Victorian Health commences commencing June 2017.

7.8 Summary Diagram and Comments

It is useful to show, through the use of the following flowchart the steps that occurred at the study site in relation to the research and system and process changes.

[1] The Bouverie Centre, Victoria's Family Institute combines clinical family therapy, academic teaching, research, workforce development and community education into one integrated service.

Figure 1: Research Summary Diagram – Inquiry to Intervention



It is also important to underscore that the research has continued to lead, as noted above, to ongoing achievements and outcomes in relation to knowledge development and the translation of that knowledge to strengthen practice, training initiatives, to strengthen innovation and to inform policy. These efforts mean that a meaningful, ongoing contribution to the problem of elder abuse can be made.

REFERENCES

Adamson, L. and P. Noble (2011). "Healthy dose of legal advice: Legal services play their part in helping to ensure the health of the socially disadvantaged." Law Institute Journal

Acierno, R., Hernandez-Tejada, M., Muzzy, W., Steve, K. (2009). National elder mistreatment study. Washington DC: National Institute of Justice

Acierno, R., Hernandez, M., & Kilpatrick, D. (2010). Prevalence and correlates of emotional, physical, sexual and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health, 100(2), 292-297.

ACT Government, (April 2010) ACT Elder Abuse Prevention – Dealing with Abuse of Clients and their Carers. A Training Kit

Age Concern New Zealand (2009) Elder Neglect. A qualitative study of neglect cases referred to Aged Concern Elder Abuse and Neglect Prevention Services during the period 1 July 2002 to 30 June 2006. Family Centre Social Policy Research Unit.

Al-Baho, A.K. (2003) “Epidemiology of Self-Dependence among Kuwaiti Elderly Population of Abdullah Al-Salem Area” Kuwait Medical Journal, vol 35 no 2 pp 98-104

Alt, K. L., Nguyen, A. L., & Meurer, L. N. (2011). The effectiveness of educational programs to improve recognition and reporting of elder abuse and neglect: A systematic review of the literature. Journal of Elder Abuse and Neglect, 23(3), 213–233

Alves, L. and Wilson, (2008) S.R. “The Effects of Loneliness on Telemarketing Fraud Vulnerability Among Older Adults” Journal of Elder Abuse and Neglect, vol 20, no 1 pp 63-82

Alzheimer’s Disease International (ADI), World Alzheimer Report (2015): The Global Impact of Dementia – An Analysis of Prevalence, Incidence, Costs and Trends

Anetzberger, G. (1997). Elderly Adult Survivors of Family Violence: Implications for Clinical Practice. Violence Against Women, 3(5), pp. 499–514.

Anetzberger, G, Palmisano, B et al (2000) A Model Intervention for Elder Abuse and Dementia, The Gerontologist, Vol 400, No 4 pp 492-497

Anetzberger, G (2005) The Clinical Management of Elder Abuse, Hapworth Press, New York

Anetzberger, G (2012) An Update on the Nature and Scope of Elder Abuse Generations; Fall 2012, Vol. 36 Issue 3, p12

Angus, J and Reeve, P (2006). "Ageism: a threat to "Aging Well" in the 21st Century", in Journal of Applied Gerontology, Vol. 25, No. 2, pp. 137-152

Andrew, S. & Halcomb, E. J. (2012) Mixed Method Research. In Borbasi, S. & Jackson, D. (Eds.) Navigating the Maze of Research: Enhancing Nursing & Midwifery Practice. 3rd ed. Marrickville, New South Wales, Elsevier

Arksey, H. and O'Malley, L. (2005) Scoping studies: towards a methodological framework, International Journal of Social Research Methodology, 8, 1, 19-32.

Australian Association of Gerontology. (2015). Inquiry Into Elder Abuse in New South Wales: Submission to Legislative Council Inquiry Into Elder Abuse in New South Wales (Submission No. 23). Sydney: NSW Legislative Council.

Australian Bureau of Statistics. (2012a). Personal Safety Survey 2012 (Cat. No. 4906.0). Canberra: ABS.

Australian Bureau of Statistics. (2012b). Who are Australia's older people? (Cat. No. 2071.0; Reflecting a Nation: Stories from the 2011 Census, 2012-2013). Canberra: ABS.

Australian Bureau of Statistics. (2013a). Disability, ageing and carers, Australia: Summary of findings 2012 (Cat. No. 4430.0). Canberra: ABS.

Australian Bureau of Statistics. (2013b). Population projections, Australia, 2012 (base) to 2101 (Cat. No. 3222.0). Canberra: ABS.

Australian Bureau of Statistics. (2013c). Where and how do Australia's older people live? (Cat. No. 2071.0; Reflecting a Nation: Stories from the 2011 Census, 2012-2013). Canberra: ABS.

Australian Bureau of Statistics (2013) "Population Projections, Australia, 2012 (base) to 2101."

Australian Bureau of Statistics (ABS) (2013) – Causes of Death, Australia,

Australian Bureau of Statistics. (2015a). Australian demographic statistics, March 2015 (Cat. No. 3101.0). Canberra: ABS.

Australian Government. (2014). Royal Commission into Institutional Responses to Child Sexual Abuse Terms of Reference 1(d). Canberra: Australian Government.

Australian Government (2013) Productivity Commission Report

Australian Institute of Health and Welfare (2007). Older Australia at a glance: 4th edition. Canberra, Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare (2012). Dementia in Australia. Canberra, Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare (2013). Australia's Welfare 2013. Australian Institute of Health and Welfare's Australia's Welfare series. Canberra, Australian Institute of Health and Welfare.

Australian Law Reform Commission. (2014). Equality, Capacity and Disability in Commonwealth Law. Melbourne: Justice Connect

Australian Law Reform Commission (2016) Elder Abuse, ALRC Issues Paper 47

Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld: University of Newcastle and the University of Queensland.

Australian Securities and Investments Commission. (2014). National Financial Literacy Strategy 2014-17. Melbourne: ASIC.

Australian Securities and Investments Commission. (2015). Submission to the Queensland Parliamentary Inquiry: The Adequacy of Existing Financial Protections for Queensland Seniors. Brisbane: Queensland Government.

Australian Society of Geriatric Medicine. (2004), ASGM Position Statement No.1 Elder Abuse. Australasian Journal on Ageing, 23(1): 38-41.

Bagley, E (2011) Insights into elder abuse; Dublin: Centre for Ageing Research and Development in Ireland.

Bagshaw, D, Wendt, S & Zannettino, L (2007), Our Actions To Prevent The Abuse Of Older South Australians, Action plan (based on research), prepared for the Office for the Ageing, Department for Families and Communities, South Australia

Bagshaw, D, Wendt, S & Zannettino, L (2009), 'Preventing the financial abuse of older people by a family member: Designing and evaluating older-person-centred models of family mediation'. An Australian Research Council (ARC) Linkage Grant (2 years) with the Office for Ageing, Department for Families and Communities (SA), Relationships Australia (SA), Alzheimers' Association Australia, Office of the Public Advocate and the Guardianship Board

Bagshaw, D., Wendt, S., & Zannettino, L. (2009). Preventing the abuse of older people by their family members (Stakeholder Paper 7). Sydney: Domestic Violence Clearing House.

Bagshaw, D., Wendt, S., Zannettino, L., & Adams, V. (2013). Financial abuse of older people by family members: Views and experiences of older Australians and their family members. Australian Social Work, 66(1), 86-103.

Baker, A. A. "Granny-battering", (1975) Modern Geriatrics, vol 5, pp 20-24

Baker, M. W., LaCroix, A. Z., Wu, C., Cochrane, B. B., Wallace, R., & Woods, N. F. (2009). Mortality risk associated with physical and verbal abuse in women aged 50 to 79. Journal of the American Geriatrics Society, 57(10), 1799-1809

Baker, C., & Gilding, M. (2011). Inheritance in Australia: Family and charitable distributions from personal estates. Australian Journal of Social Issues, 46(3), 273-289.

Baker, M & Heitkemper, P (2005) The roles of nurses on interprofessional teams to combat elder mistreatment, Nurse Outlook, Vol 53 pp253-259.

Barnett, M., & Hayes, R. (2010). Not seen and not heard: Protecting elder human rights in aged care. University of Western Sydney Law Review, 14, 45-83.

Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd ed.) Thousand Oaks, CA: Sage.

Beaulaurier, R.L., Seff, L.R. and Newman, F.L. (2008) "Barriers to Help-Seeking for Older Women Who Experience Intimate Partner Violence: A Descriptive Model" Journal of Women & Aging, Vol 20 nos. 3 / 4 , pp 231-247

Bennett, G & Kingston, P. (1993). Elder abuse: concepts, theories and interventions. London: Chapman & Hall.

Berg, B. L. (2009). Qualitative research methods for the social science (7th ed.). Boston:

Biggs, S, Manthorpe, J et al (2007) UK Study of Abuse and Neglect of Older People, Kings College London National Centre for Social Research

Biggs, S. Phillipson, C. & Kingston, P. (1995) Elder Abuse in Perspective. Buckingham: Open University Press.

Biggs, S., Manthorpe, J., Tinker, A., Doyle, M. and Erens, B. (2009) "Mistreatment of Older People in the United Kingdom: Findings from the First National Prevalence Study" Journal of Elder Abuse and Neglect, vol 21, pp 1-14

Birrell, B., & McCloskey, D. (2015). The housing affordability crisis in Sydney and Melbourne: Report one. The demographic foundations. Melbourne: Australian Population Research Institute.

Black, B. (2008), The Human Rights of Older People and Agency Responses to Elder Abuse, Centre for Human Rights Education, Division of Humanities, Curtain University of Technology, pp. 1-59.

Blundell, C (2015) Elder abuse: an under-recognised phenomenon: Community Care Review

Boldy, D., Horner, B., Courchley, K., Davey, M. & Boylen, S. (2005). 'Addressing Elder Abuse: Western Australian Case Study' in Australian Journal on Ageing, Vol.24, No.1, pp.3-8.

Bowers, B., Cohen, L. W., Elliot, A. E., Grabowski, D. C., Fishman, N. W., Sharkey, S. S., Zimmerman, S., Horn, S. D. & Kemper, P. (2013) Creating and supporting a mixed methods health services research team. Health Services Research, 48, 2157-2180.

Bronfenbrenner, U. (1979). The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press

Brozowski K., & Hall D. R . (2010). Aging and risk: Physical and sexual abuse of elders in Canada . Journal of Interpersonal Violence, 25, 1183 – 1199

Bryman, A. (2006) Integrating quantitative and qualitative research: How is it done? Qualitative Research, 6, 97-113.

Buchwald D, Tomita S, Ashton S, Furman R, Manson SM. (2000) Physical abuse of urban Native Americans. Journal of General Internal Medicine; ;15:562–564

Budd, J. (2010), Prevention of Elder Abuse Project, accessed 24-6-12 at respectforseniors.org

Burns, N., & Grove, S. K. (2009). The practice of nursing research (5th Edition). Philadelphia: W.B. Saunders Company.

Burston GR. (1975) Granny battering. BMJ ;iii:592.

Caracelli, V. J., & Greene, J. C. (1997). Crafting mixed-method evaluation designs. In J. C. Greene, & V. J. Caracelli (Eds), Advances in mixed-method evaluation: The challenges and benefit of integrating diverse paradigms (pp. 19-32). San Francisco: Jossey-Bass.

Carr, K et al (1986) An elder abuse assessment team in an acute hospital setting. Gerontologist, Vol 26. No 3, pp115-118

Chesterman, J. (2013). Responding to violence, abuse, exploitation and neglect: Improving our protection of at-risk adults (Churchill Fellowship Report 2013). Canberra: Winston Churchill Memorial Trust.

Chesterman, J. (2015a). Taking control: Putting older people at the centre of elder abuse response strategies. Australian Social Work, 1-10.

Chesterman, J. (2015b). Submission to the Parliamentary Inquiry Into Elder Abuse in New South Wales. Sydney: Parliament of New South Wales.

Choo, W. Y., Hairi, N. N., Francis, D. P., & Baker, P. R. A. (2013). Interventions for preventing abuse in the elderly (protocol): John Wiley & Sons, Ltd, 2013.

Clare, M., Blundell, B., & Clare, J. (2011). Examination of the extent of elder abuse in Western Australia: A qualitative and quantitative investigation of existing agency policy, service responses and recorded data. Crawley, WA: Crime research Centre

Clare, M (1992). Working with the aged – beyond common sense? Australian Social Work, 45(3), p. 3-11.

Cohen, S., Janicki-Deverts, D., & Miller, G.E. (2007). Psychological stress and disease. Journal of American Medical Association, 298, 1685-1687.

Cohen, M., Levin, S. H., Gagin, R. and Friedman, G. (2007), Elder Abuse: Disparities Between Older People's Disclosure of Abuse, Evident Signs of Abuse, and High Risk of Abuse. Journal of the American Geriatrics Society, 55: 1224–1230.

Comijs, H.C., Pennix, B.W., Knipscheer, K.P., & Van Tilberg, W. (1999). Psychological distress in victims of elder abuse: The effects of social support and coping. J Gerontol Psychol Sci Soc Sci, 54, 240-245.

Communities, Disability Services and Domestic and Family Violence Prevention Committee. (2015). Inquiry Into the Adequacy of Existing Financial Protections for Queensland's Seniors (Parliamentary Committees Report No. 2, 55th Parliament). Brisbane: Queensland Parliament.

Connolly, M., Brandil, B., & Breckman, R. (2014). Elder justice roadmap: A stakeholder initiative to respond to an emerging health, justice, financial and social crisis. Alhambra, CA: National Center on Elder Abuse.

Cooper C. Manela M. Katona C., & Livingston G. (2008). Screening for elder abuse in dementia in the LASER-AD study: Prevalence, correlates and validation of instruments. International Journal of Geriatric Psychiatry, 23, 283– 288

Cooper, C, Selwood, A & Livingstone, G (2009). Knowledge, Detection, and Reporting of Abuse by Health and Social Care Professionals : A systematic Review. American Journal of Geriatric Psychiarty, October 2009 – Volume 17- Issue 10 (pp 826-838).

Corbin J., Strauss A. (2015). Basics of qualitative research: Techniques and procedures for developing grounded theory (4th ed.). Thousand Oaks, CA: Sage.

Cotterell, E., Leonardi, S., Coward, D., Thomson, J., & Walters, A. (2015). Elder abuse in the ACT: A literature review. Canberra: Council on the Ageing ACT.

Council of Australian Governments. (2012). National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services. Canberra: Council on Federal Financial Relations.

Cox, P. (2015). Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey 2012 (Horizons No. 1). Sydney: Australia's National Research Organisation for Women's Safety.

Cramer, E., & Brady, S. (2013). Competing values in serving older and vulnerable adults: Adult protective services, mandated reporting and domestic violence programs. Journal of Elder Abuse and Neglect, 25(5), 453-468.

Creswell, J.W., V.L. Plano Clark, M. Gutmann, and W. Hanson. (2003). Advanced mixed methods research designs. In Handbook on mixed methods in the behavioral and social sciences, ed. A. Tashakkori and C. Teddlie, 209-240. Thousand Oaks, CA: Sage.

Creswell, J.W., V.L. Plano Clark V (2007) Designing and conducting mixed methods research. Thousand Oaks, CA: Sage.

Creswell J (2013) Qualitative inquiry and research design Choosing among five approaches (3rd ed.)Los Angeles, C.A :Sage

Culo, S. (2011) Risk assessment and intervention for vulnerable older adults. BCMJ, Vol. 53, No. 8, October, page(s) 421-425

Darzins, P., Lowndes, G., & Wainer, J. (2009). Financial abuse of elders: A review of the evidence. Melbourne: Faculty of Medicine, Nursing and Health Sciences, Monash University.

Davidson, S., Rossall, P., & Hart, S. (2015). Financial abuse evidence review. London: Age UK.

Davis DA, Mazmanian PE, Fordis M, Van Harrison R, Thorpe KE, Perrier L. (2006) Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. JAMA;296(9):1094-102

Day, M.R., Bantry-White, E. and Glavin, P. (2010) 'Protection of vulnerable adults: An interdisciplinary workshop'. Community Practitioner, 83 (9): 29–32.

DeHart, D. D., Webb, J., & Cornman, C. (2009). Prevention of elder mistreatment in nursing homes: Competencies for direct-care staff. Journal of Elder Abuse & Neglect, 21(4), 360-378.

Denzin N., Lincoln Y., Giardina M. (2006). Disciplining qualitative research. International Journal of Qualitative Studies in Education, 19, 769–782.

Department of Communities QLD (2009), 'Cross-Government Project to Reduce Social Isolation of Older People: Best Practice Guidelines for Projects Aiming to Reduce

Department of Health and Home Office (2000). No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. London

Department of Health, UK, (2005) Safeguarding Adults, A National Framework of Standards for good practice and outcomes in adult protection work

Department of Health, Victoria. (2012). Elder abuse prevention and response guidelines for action 2012-14. Melbourne: Department of Health.

Department of Health. (2014). Care and support statutory guidance issued under the Care Act 2014. London: Department of Health.

Department of Social Services. (2013). Living longer, living better: Aged care in Australia is changing. Canberra: DSS.

Department of Victorian Communities (2005), 'Strengthening Victoria's Response to Elder Abuse: Report of the Elder Abuse Prevention Project', Office of Senior Victorians, Victorian Government, Melbourne.

Dixon, J., Manthorpe, J., Biggs, S., Mowlam, A., Tennant R, Tinker, A., and McCreadie, C. (2010). Defining elder mistreatment: reflections on the United Kingdom study of abuse and neglect of older people, Ageing and Society, 30(2), p. 403-420.

Doe, S.S., Han, H. K. and McCaslin, R.,(2009) "Cultural and Ethical Issues in Korea's Recent Elder Abuse Reporting System", Journal of Elder Abuse and Neglect, vol 21, pp 170 – 185

Dong, X (2005) Medical Implications of Elder Abuse and Neglect, Clinics in Geriatric Medicine, Vol 21 pp 293-313

Dong X, Simon M, de Leon CM et al. (2009) Elder self-neglect and abuse and mortality risk in a community-dwelling population. JAMA ;302:517–526.

Dong X, Simon MA (2013) Elder self-neglect: Implications for health care professionals. Can Geriatr Soc J 2013;3:25–28.

Dong X, Simon MA.(2014) Vulnerability risk index profile for elder abuse in a community-dwelling population. J Am Geriatr Soc ;62:10–15.

Dong, X. (2012), Culture Diversity and Elder Abuse: Implications for Research, Education, and Policy. Journal of the American Society on Aging.

Dong, X., Simon, M.A., Odzwazny and Gorbien, M (2008) “Depression and Elder Abuse and Ngelect Among a Community-Dwelling Chinese Elderly Population” Journal of Elder Abuse & Neglect, vol 20, no 1, pp 25-40

Dong XQ, Simon MA, Beck TT ,et al. Elder abuse and mortality: the role of psychological and social wellbeing .Gerontology -549:(6)57;2011 .

Dong X, Chang E-S, Wong E et al. (2014) Association of depressive symptomatology and elder mistreatment in a US Chinese population: Findings from a community-based participatory research study. J Aggression Maltreatment Trauma ;23:81–98.

Dow, B., Hempton, C., Cortes-Simonet, E. N., Ellis, K. A., Koch, S. H., LoGiudice, D., Mastwyk, M., Livingston, G., Cooper, C. and Ames, D. (2013), Health professionals' and students' perceptions of elder abuse. Australasian Journal on Ageing, 32: 48–51

Dunn, P. F., Sadler, P. M. (1993), 'Claim making about elder abuse in Australia'. Australian Journal on Ageing, 12(4): 42-46.

Dyer, C & Rowe J (1999) Elder Abuse, Trauma, Vol 1 pp 163 -169

Dyer, C.B., Pavlik, V.N. and Murphy, K.P. (2000) ‘The high prevalence of depression and dementia in elder abuse or neglect’. Journal of the American Geriatrics Society, 48 (2), pp. 205–208.

Earl, J., Gerrans, P., Asher, A & Woodside, J. (2015). Financial literacy, financial judgement, and retirement self efficacy of older trustees of self-managed superannuation funds. Australian Journal of Management, 40(3), 435-458.

Elder Abuse Prevention Unit. (2006). Position statement on mandatory reporting of elder abuse. Queensland: EAPU.

Elkins, T. and O’Neill, C.(2009) “Strategic Review of the Elder Abuse Prevention Program. Final Report” v.2, pp 1-36

Employment and Social Development Canada. (2015) Government of Canada announces project promoting social inclusion of seniors and marks World Elder Abuse Awareness Day (media release). Ottawa: Employment and Social Development Canada.

Epstein RM, Hundert EM. (2002) Defining and assessing professional competence. JAMA Jan 9;287(2):226-35.

Erlingsson C, Carlson S, Saveman B (2006) Perceptions of elder abuse: voices of professionals and volunteers in Sweden – an exploratory study. Scandinavian Journal of Caring Sciences . 20, 2, 151-159.

Faye, B., and M. Sellick (2003). Advocare's speak out survey, "S.O.S" on elder abuse. Perth, Advocare Incorporated.

Featherstone, M. and M. Hepworth (1990) “Images of ageing” J. Bond and P. Coleman (eds.) Ageing in Society, Sage Publications, London.

Federation of Ethnic Communities Councils of Australia (2015) Review of Australian Research on Older People from Culturally and Linguistically Diverse Backgrounds

Field, S., Matkovic, L., & Bhatia, S. (2015). Final report: The policies and practices of financial institutions around substitute decision making. Sydney: Cognitive Decline Partnership Centre.

Filinson, R. (1989). Introduction. In R. Filinson & S. R. Ingman (Eds.), Elder abuse: Practice and policy. New York: Human Sciences Press.

Fitzgerald, G., Blake, D., and Thurlow, R. (2009). Response to the consultation on the review of No Secrets: Action on Elder Abuse, London.

Fulmer, T (2004) Elder Abuse and Neglect Assessment, Dermatology Nursing, Vol 16, Issue 5

Fontanarosa PB, DeAngelis CD (2002) Basic science and translational research. Journal of the American Medical Association; 287(13): 1728

Fulmer, T., Guadagno, L., Dyer, C., & Connolly, J.D. (2004). Progress in elder abuse screening and assessment instruments. J Am Geriat Soc, 52, 297-304.

Glogowska, M. (2011) Paradigms, pragmatism and possibilities: Mixed-methods research in speech and language therapy. International Journal of Language & Communication Disorders, 46, 251-260.

Gibbs, A. (1997) ‘Focus Groups’, Social Research Update, 19, Winter, Department of Sociology, University of Surrey

Gil, A., Kislaya, I., Santos, A., Nunes, B., Nicolau, R., & Fernandes, A. (2015). Elder abuse in Portugal. Journal of Elder Abuse and Neglect, 27, 174-194.

Gironda, M.W., Lefever, K., Delagrammatikas, L.,Nerenberg, L., Roth, R., Chen, E.A. and Northington, K.R. (2010) ‘Education and training of mandated reporters: Innovative models, overcoming challenges, and lessons learned’. Journal of Elder Abuse & Neglect, 22: 340–364.

Government of Canada. (2014). Action for seniors report. Ottawa: Government of Canada.

Graham ID, Logan, J., Harrison MB, Straus, S., Tetroe, JM, Caswell, W. et al. (2006). Lost in knowledge translation: Time for a map? Journal of Continuing Education in Health Professions, 26, 13-24.

Graham ID & Tetroe, JM (2007). How to Translate Health Research Knowledge into Effective Healthcare Action; Healthcare Quarterly, 10(3) May 2007: 20-22

Graham ID & Tetroe, JM (2010). The Knowledge to Action framework. In J.Rycroft-Malone & T. Bucknell (Eds.), Models and Frameworks for Implementing Evidence-Based Practice: Linking Evidence to Action (pp. 207-222). Oxford: Wiley-Blackwell, Sigma Theta Tau International Honor Society of Nursing

Grainger, A. (2009) 'Raising concerns of abuse'. British Journal of Healthcare Assistants, 3 (1): 39–42.

Grenade L, Boldy D. (2008) Social isolation and loneliness among older people: issues and future challenges in community. Australian Health Review ; 32:468-478.

Halligan A, Donaldson L. (2001) Implementing clinical governance: turning vision into reality. BMJ ;322 (7299):1413-7 4.

Halphen J. M., Varas G. M., Sadowsky J. M. (2009). Recognising and reporting elder abuse and neglect. *Geriatrics*, 64(7), 13-18.

Hayslip, B., Reinberg, J., & Williams, J. (2015). The impact of elder abuse education on young adults. Journal of Elder Abuse and Neglect, 27(3), 233-253.

Hazzard, W (1995) Elder Abuse: Definitions and Implications for Medical Education, Academic Medicine Vol 70, No 11

Hawranik, P., & McKean, E. (2004). The abuse of older adults: Issues and prevention strategies. In C. A. Atea, and J. Mirwaldt (Eds.), Within our reach: Preventing abuse across the lifespan (pp. 90–104). Winnipeg, Canada: Fernwood.

Health Service Executive Elder Abuse Services. (2013). Open your eyes: There is no excuse for elder abuse. Dublin: HSE Elder Abuse Services.

Heath, J, Dyer, M et al (2002) Four Models of Medical Education and Elder Mistreatment, Academic Medicine, Vol 77, Issue 11 pp 1101-1106

Hempton C, Dow B, Cortes-Simonet EN *et al.* (2011) Contrasting perceptions of health professionals and older people in Australia: What constitutes elder abuse? International Journal of Geriatric Psychiatry *;* 26*:* 466–472*.*

Heyrani A, Maleki M, Marnani AB (2012) Clinical governance implementation in a selected teaching emergency department: a systems approach. Implement Sci 2012; 7(1):84.

Holland K, Middleton L, Uys L. (2012) Professional confidence: a concept analysis. Scandinavian Journal of Occupational Therapy Mar;19(2):214-24.

Hoover, R. M., & Polson, M. (2014). Detecting elder abuse and neglect: Assessment and intervention. American Family Physician, 89(6), 453-460.

House of Representatives Standing Committee on Legal and Constitutional Affairs. (2007). Older people and the law. Canberra: Parliament of Australia.

Hudson, M., & Carlson, J. (1988). Elder abuse: Expert and public perspectives on its meaning. Journal of Elder Abuse and Neglect, 9, 77-97.

Jackson, L. (2009), The Cost of Elder Abuse In Queensland: Who Pays and How Much, Elder Abuse Prevention Unit, Department of Communities, QLD, pp. 1-14.

Jackson, S., & Hafmeister, T. (2015). The impact of relationship dynamics on the detection and reporting of elder abuse occuring in domestic settings. Journal of Elder Abuse, 27(2), 121-145.

James , M. , & Graycar , A. (2000) . Preventing crime against older Australians , Research and Public Policy Series, No. 32 . Canberra , ACT : Australian Institute of Criminology

Jaye, C. (2002). Family Practice. 'Doing qualitative research in general practice: methodological utility and engagement'. 19:557-62.

Jogerst, G.J. and Ely, J.W. (1997) 'Home visit program for teaching elder abuse evaluations'. Family Medicine, 29: 634–639.

Johannesen, M., & LoGiudice, D. (2013). Elder abuse: a systematic review of risk factors in community-dwelling elders. Age and Ageing, 42(3), 292-298.

Joosten, M., Dow, B., & Blakey, J. (2015). Profile of elder abuse in Victoria: Analysis of data about people seeking help from Seniors Rights Victoria. Summary report. Melbourne: National Ageing Research Institute & Seniors Rights Victoria.

Joubert L & Posenelli, S (2009) Responding to a 'Window of Opportunity": The Detection and Management of Aged Abuse in an Acute and Subacute Health Care Setting, Social Work in Health care, Vol 48 pp702-714

Kahan, F & Paris, B (2003) Why Elder Abuse Continues to Elude the Heath Care System, The Mount Sinai Journal of Medicine, Vol 70. No 1

Kaspiew, R., Gray, M., Weston, R., Moloney, L., Hand, K., Qu, L., & the Family Law Evaluation Team. (2009). Evaluation of the 2006 family law reforms. Melbourne: Australian Institute of Family Studies

Kaspiew, R., Carson, R., & Rhoades, H. (2016). Elder abuse: Understanding issues, frameworks and responses. Canberra: Australian Institute of Family Studies.

Kaye, L. W., Kay, D., & Crittenden, J. A. (2007). Intervention with Abused Older Males: Conceptual and Clinical Perspectives. Journal Of Elder Abuse & Neglect, 19(1–2), 153–172.

Kennedy, R (2004) Elder Abuse and Neglect: The Experience, Knowledge, and Attitudes of Primary Care Physicians, Annual Scientific Assembly, Vol 37, No 7

Kennelly S, Sweeney N, O'Neill D (2007) Elder abuse: knowledge, skills, and attitudes of healthcare workers. Irish Medical Journal . 100, 1, 326-327.

Keys, F. and Brown, M.(1992) "Elder Abuse and Fear of Crime Among Older People" Report on an Australian Conference and New Zealand Initiatives

Kielva, S.L. et al. (1992). Abuse in old age: Epidemiological data from Finland. Journal of Elder Abuse and Neglect, 4, 1-18.

Kingsley, B. (2001). Elder abuse; protocol and policy guidelines to prevent the abuse of elderly people in community and residential care. Perth, Western Australia: Curtin University of Technology.

Kingston P & Penhale B (1995) Elder abuse and neglect: issues in the Accident and Emergency Department, Accident and emergency Nursing Vol 3, pp 122 - 128

Kingston P & Penhale B (1997) Issues in the sphere of elder abuse and neglect: the role of education, Nurse Education Today, Vol 17 pp 418 – 425

Kissal A, Beser A. Elder abuse and neglect in a population offering care by a primary health care center in Izmir, Turkey. Soc Work Health Care. 2011;50(2):158–75

Kitzinger, J. (1995) 'Introducing Focus Groups', British Medical Journal, 311, pp.299-302.

Koch, R. and de la Cruz, F. (1999), Historical aspects and overview of research on phenylketonuria. Ment. Retard. Dev. Disabil. Res. Rev., 5: 101–103

Kosberg, J., & Garcia, J. (1995). Common and unique themes on elder abuse from a worldwide perspective. In J. Kosberg & J. Garcia (Eds). Elder Abuse: International and Cross Cultural Perspectives (pp. 183-198). Binghampton, New York: Haworth Press.

Krueger, P., and Casey M. (2000). Focus groups: A practical guide for applied research. Thousand Oaks, CA: Sage

Krueger, P & Patterson, C (1997). Detecting and managing elder abuse: challenges in primary care. Canadian Medical Association, October 1997, Vol 8 pp 1095- 1110

Kurrle, S. (2004). 'Elder Abuse' in Australian Family Physician, Vol.33, No.10, October 2004.

Kurrle, S., Naughtin, G. (2008), 'An overview of elder abuse and neglect in Australia'. Journal of elder abuse & neglect, 20(2): 108-25.

Kurrle, S.E., Sadler, P. M. and Cameron, I.D.(1992) “Prevalence and Patterns of Elder Abuse”, The Medical Journal of Australia, vol 157 pp 673-676

Kurrle, S.E., Sadler, P. M., Lockwood, K. and Cameron, I.D (1997) “Elder Abuse: prevalence, intervention and outcomes in patients referred to four Aged Care Assessment Teams”, The Medical Journal of Australia, vol 166 pp 119-122

Kurrle, S. (2013). Australia. International Perspectives on Elder Abuse. A. Phelan, Routledge.

Kyle, L. (2012). Assets for care: A guide for lawyers to assist older clients at risk of financial abuse. Melbourne: Seniors Rights Victoria.

Lacey, W. (2014). Neglectful to the point of cruelty? Elder abuse and the rights of older persons in Australia. Sydney Law Review, 36, 99-130.

Lachs, M.S., L. Berkman, T. Fulmer, and R. Horwitz (1994) A prospective community-based pilot study of risk factors for the investigation of elder mistreatment. Journal of the American Geriatrics Society 42(2):169-173.

Lachs, M.S. & Pillemer, K. (1995) Abuse and Neglect of Elderly Persons, The New England Journal of Medicine, Vol 332. No7

Lachs, M.S. & Pillemer, K. (2004). Elder abuse. Lancet, 364, 1263-1272.

Lachs M, Berman J. (2001) Under the radar: New York State elder abuse prevalence study. Prepared by Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, and New York City Department for the Aging

Lavelle E, Vuk J & Barber C (2013) Twelve tips for getting started using mixed methods in medical education research, Medical Teacher, 35:4, 272-276

Lee M & Kolomer S (2009) Design of an Assessment of Caregivers Impulsive Feelings to Commit Elder Abuse, Research on Social work Practice, Vol 17, No 6 pp 729-735

Levine, J.M. (2003). Elder neglect and abuse: A primer for primary care physicians. Geriatrics, 58, 37-44.

Lowenstein A. Eisikovits Z. Band-Winterstein T. , & Enosh G . (2009). Is elder abuse and neglect a social phenomenon? Data from the first national prevalence survey in Israel. Journal of Elder Abuse & Neglect, 21 , 253 – 277

Lynn M. R. (1985) Determination and Quantification of Content Validity. Nursing Research. Vol (6):pp 382-5.

Mandiracioglu A, Govsa F, Celikli S & Yildirim G (2006) Emergency health care personnel's knowledge and experience of elder abuse in Izmir, Achives of Gerontology and Geriatrics Vol 43, pp 267 - 276

Mann, R., Horsley, P., Barrett, C., & Tinney, J. (2014). Norma's Project: A research study into the sexual assault of older women in Australia (ARCSHS Monograph Series No. 98). Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Mariam, L., McLure, R., Robinson, J., & Yang, J. (2015). Eliciting change in at-risk elders (ECARE): Evaluation of an elder abuse intervention program. Journal of Elder Abuse and Neglect, 27(1), 19-33.

Matlaw, J & Spence D (1994) Hospital Elder Assessment Team: A Protocol for Suspected Cases of Elder Abuse and Neglect, Journal of Elder Abuse and Neglect, Volume:6, Issue 2 pp 23 -37

McCallum, J. (1993), "Elder abuse: The 'new' social problem?", Modern Medicine of Australia, September, pp.74-83.

McCreadie, C. (1991). Elder abuse: an exploratory study. King's College, Age Concern Institute of Gerontology, London

McCreadie, C., Bennett, G. & Tinker, A (1998) Investigating British general practitioners' knowledge and experience of elder abuse: report of a research study in an inner London borough. Journal of Elder Abuse and Neglect, 9(3), p. 23-39.

McCreadie, C., Bennett, G., Gilthorpe, M, Houghton, G & Tinker, A (2000) Elder abuse: do general practitioners know or acre, Journal of the Royal Society of Medicine, Vol 93

McDonald, L. (2011). Elder abuse and neglect in Canada: The glass is still half full. Canadian Journal on Aging, 30(3), 437–465.

McDonald, L., & Collins, A. (2000). Abuse and Neglect of Older Adults: A Discussion Paper.

McGaghie WC, Bordage G, Shea JA. (2001) Problem statement, conceptual framework, and research question. Acad Med;76:923–4.

Minichiello, V., Browne, J. and Kendig, H. (2000) Perceptions and consequences of ageism: Views of older people. Ageing and Society, 20, 253-278

Miskovski, K. (2014). Preventing financial abuse of people with dementia. Sydney: Alzheimers Australia NSW

Missing voices: views of older persons on elder abuse, (2002) Geneva, World Health Organization

Monash University, Medicine, Nursing & Health Sciences (2009) Financial Abuse of elders: a review of the evidence, Protecting Elders' Assets Study

Monash University, Medicine, Nursing & Health Sciences (2010) Prevalence of Financial Elder Abuse in Victoria, Protecting Elders' Assets Study

Monash University, Medicine, Nursing & Health Sciences (2011) For love or money: intergenerational management of older Victorians' assets, Protecting Elders' Assets Study

Morgan, D.L. (1998) The Focus Group Guidebook, Focus Group Kit 1, Sage, London.

Naughton, C. et al. (2010). Abuse and Neglect of Older People in Ireland. Dublin, Ireland: NCPOP

Natan M.B., Lowenstein A. & Eisikovits Z. (2010) Psycho-social Factors Affecting Elders' Maltreatment in Long-term Care Facilities. International Nursing Review 57, 113–120

National Ageing Research Institute (2016). Australian elder abuse policies

National Ageing Research Institute in partnership with Seniors Rights Victoria. (2015). Profile of elder abuse in Victoria: Analysis of data about people seeking help from Seniors Rights Victoria Melbourne: NARI.

National Centre for the Protection of Older People (2010) Abuse and Neglect of Older people in Ireland, University College Dublin

National Centre on Elder Abuse. (2000) A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services. The National Centre on Elder Abuse: Washington.

National Centre for Social Research (2007). UK Study of Abuse and Neglect of Older People. London: King's College London,

NSW Elder Abuse Helpline and Resource Unit. (2015). Submission to the Parliamentary Inquiry into Elder Abuse in New South Wales. Sydney: Parliament of New South Wales.

Nusbaum, N.J., Mistretta, M. and Wegner, J. (2007) 'An educational intervention for police and firefighters for elders at risk: Limits of education alone as a strategy for behavior change'. Educational Gerontology, 33 (10):801–809.

O'Brien, J.G. (2010) A physician's perspective: elder abuse and neglect over 25 years. Journal of Elder Abuse & Neglect, 22(1-2), 94-104.

O'Brien JG, Riain AN, Collins C et al. Elder abuse and neglect: A survey of Irish general practitioners. J Elder Abuse Negl 2014;26:291–299.

O'Donnell, D., Treacy, M. P., Fealy, G., Lyons, I., Phelan, A., Lafferty, A. et al. (2012). Managing elder abuse in Ireland: The senior case worker's experience. Dublin: National Centre for the Protection of Older People, University College Dublin.

O'Dwyer, L. A. (2001). The impact of housing inheritance on the distribution of wealth in Australia. Australian Journal of Political Science, 36(1), 83-100.

Office of the Public Advocate, (2006). Elder Abuse in Culturally and Linguistically Diverse Communities. Office of the Public Advocate: Perth.

Office for Senior Citizens. (2015). Towards gaining a greater understanding of elder abuse and neglect in New Zealand. Wellington: Office for Senior Citizens.

Office of Senior Victorians Elder Abuse Prevention Project (2005) The Mismanagement & Misappropriation of Older Peoples Assets: How can the Financial Service Sector Help?

Office of Senior Victorians Elder Abuse Prevention, Consultation Paper August 2005

Office of the Public Advocate (Qld), & Queensland Law Society. (2010). Elder abuse: How well does the law in Queensland cope? Qld: OPA (Qld) & Queensland Law Society.

Office of the Public Advocate, & University of South Australia. (2011). Closing the gaps: Enhancing South Australia's response to the abuse of vulnerable older people. Adelaide: Australian Guardianship and Administraton Council.

Office of the Public Advocate. (2003). Elder Abuse: The Hidden Problem. Submission to the Minister for Aged Care. 8th September 2003. Office of the Public Advocate (Victoria): Melbourne.

Ogg, J., & Bennett, G.C.J. (1992). Elder abuse in Britain. British Medical Journal, 305, 998-999.

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R. et al. (2007). UK Study of Abuse and Neglect of Older People: Prevalence survey report. London: National Centre for Social Research.

Olsberg, D., & Winters, M. (2005). Ageing in place: Intergenerational and intrafamailia housing transfers and shifts in later life (AHURI Final Report, Vol. 88). Melbourne: Australian Housing and Urban Research Institute.

Ozanne, E (2009) , 'Negotiating identity in late life: Diversity among Australian baby boomers', Australian Social Work, vol. 62, no. 2, p. 132 — 154.

McCauley, J., Jenckes, M., & McNutt, L.-A. (2003). The effectiveness of a continuing medical education video on knowledge and attitudes about interpersonal violence. Academic Medicine, 78(5), 518-524.

McCreadie, C., (2002). A review of research outcomes in elder abuse. Journal of Adult Protection, 4, 2, 3–8.

McLaughlin, J, Lavery, H.(1999) Awareness of elder abuse among community health and social care staff in Northern Ireland: an exploratory study. J: Elder Abuse Negl.;11:53–72.

Meeks-Sjostrom DJ (2013) Clinical Decision Making of Nurses Regarding Elder Abuse. J Elder Abuse Negl 25: 149-161.

Norris, D, Fancey P, Power E, and Ross P (2013) The critical-ecological framework: advancing knowledge, practice, and policy on older adult abuse. Journal of Elder Abuse and Neglect; V 25(1):40-55

Pavlou M, Lacks M (2006) Could self-neglect in older adults be a geriatric syndrome? Journal of the American Geriatric Society. – 54: 831–842.

Pelotti, S., D'Antone, E., Ventrucci, C., Mazzotti, M. C., Salsi, G., Dormi, A., & Ingraavallo, F. (2013). Recognition of elder abuse by nurses and nursing students: evaluation by the Caregiving Scenario Questionnaire. Aging Clinical and Experimental Research, 25(6), 685-690

Penhale, B. & Kingston, P. (1997). 'Elder abuse, mental health and later life: steps towards an understanding' in Aging & Mental Health, Vol 1, Issue 4, pp.296-304.

Penhale, B. (1993) The abuse of elderly people: Considerations for practice, British Journal of Social Work, April 1993, p.97-111.

Penhale B. (2008) Elder abuse in the United Kingdom. Journal of Elder Abuse & Neglect ;20:151–68

Peri, K., Fanslow, J., & Hand, J. (2009). Keeping older people safe by preventing elder abuse and neglect. Social Policy Journal of New Zealand, 35, 159-172.

Phelan, A (2008) Elder abuse, ageism, human rights and citizenship: implications for nursing discourse

Phillips, L.R. (1986) Theoretical explanations of elder abuse: Competing hypotheses and unresolved issues. In K.A. Pillemer & R.S. Wolf (Eds.), Elder Abuse: Conflict in the Family. Dover, MA: Auburn House Publishing, pp. 197 – 217).

Pico-Alfonso M. A. Garcia-Linares M. I. Celda-Navarro N. Blasco-Ros C. Echeburúa E. Martinez M . (2006). The impact of physical, psychological, and sexual intimate male partner

violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. Journal of Women's Health , 15, 599– 611.

Pillemer, K., & Finkelhor, D. (1988). The prevalence of elder abuse: A random sample survey. Gerontologist, 28, 51-57.

Pillemer, K., Burnes, D., Riffin, C., & Lachs, M. S. (2016). Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. [Article]. Gerontologist, 56, S194-S205.

Ploeg, J., Fear, J., Hutchison, B., MacMillan, H., and Bolan, G. (2009). A systematic review of interventions for elder abuse. Journal of Elder Abuse and Neglect, 21(3), 187-210.

Podnieks, E. (1992). National survey on abuse of the elderly in Canada. Journal of Elder Abuse, 41, 5-58.

Podnieks E, Penhale B, Goergen T, Biggs S, Han D. (2010) Elder mistreatment: An international narrative. Journal of Elder Abuse and Neglect ; 22: 131–163.

Polit, D.F. and Hungler, B.P. (2013). Essentials of Nursing Research: Methods, Appraisal, and Utilization (8th Edition ed.). Philadelphia: Wolters Kluwer/Lippincott Williams and Wilkins

Qu, L., & Weston, R. (2010). Parenting dynamics after separation: A follow-up study of parents who separated after the 2006 family law reforms. Canberra: Attorney-General's Department.

Qu, L., Weston, R., Moloney, L., Kaspiew, R., & Dunstan, J. (2014). Post-separation parenting, property and relationship dynamics after five years. Canberra: Attorney-General's Department.

Radensky, L., & Parikh, D. (2008). Developing a "train the trainer" program to identify elder abuse and neglect: the Jewish home life care system model. Home Health Care Management & Practices, 20(3), 254–259.

Richardson, B, Kitchen, G & Livingstone, G. (2002).The effect of education on knowledge and management of elder abuse: a randomised controlled trial. Age and Ageing, British Geriatrics Society. Vol 31 pp 335 – 341.

Rinker, A (2009) Recognition and perception of elder abuse by prehospital and hospital-based care providers, Archives of Gerontology and Geriatrics, Vol 48, Issue 1, pp110-115

Ritchie J, Spencer L. (1994) Qualitative data analysis for applied policy research. In Bryman A, and Burgess, R G. Analysing Qualitative Data, Chapt 9, Routledge

Rodriguez, M, Wallace, S, Woolf, N & Mangione, C (2006) Mandatory Reporting of Elder Abuse: Between a Rock and a Hard Place, Annals of Family Medicine, Vol 4, No 5 p p403-409

Royal Commission into Family Violence (2016) : Summary and recommendations, Parl Paper No 132 (2014–16).

Schiamberg, L. B., & Gans, D. (2000). Elder abuse by adult children: An applied ecological framework for understanding contextual risk factors and the intergenerational character of quality of life. The International Journal of Aging and Human Development, 50(4), 329-359.

Schmeidel, A. N., Daly, J. M., Rosenbaum, M. E., Schmuch, G. A., & Jogerst, G. J. (2012). Health Care Professionals' Perspectives on Barriers to Elder Abuse Detection and Reporting in Primary Care Settings. Journal of Elder Abuse & Neglect, 24(1), 17-36.

Schofield, M.J., & Mishra, G.D. (2004). Three year health outcomes among older women at risk of elder abuse: Women's Health Australia. Quality of Life Research, 13, 1043-1052.

Seamon, J. P., Jones, J. S., Chun, E., & Krohmer, J. R. (1997). Identifying victims of elder abuse and neglect: a training video for prehospital personnel. Prehospital and Disaster Medicine, 12(4), 269–273

Selwood, A, Cooper C & Livingstone, G, (2007) What is elder abuse – who decides?, Department of Mental Heath Sciences, University College, London. International Journal of Geriatric Psychiary, pp1009 -1012

Simons, L. & Lathlean, J. (2010) Mixed Methods. In Gerrish, K. & Lacey, A. (Eds.) The Research Process in Nursing. 6th ed. London, Wiley-Blackwell.

Smith, L. F., Gratz, Z. S., & Bousquet, S. G. (2009). The Art and Practice of Statistics. Belmont: Cengage Learning.

Sparkes, D., & Jackson, L. (2011). Elder abuse: Effectiveness and outcomes of an awareness campaign. Fortitude Valley, Qld: Elder Abuse Prevention Unit.

Spike, C. (2015). The EAPU helpline: Results of an investigation of five years of call data. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015. Chermside Central, Qld: Elder Abuse Prevention Unit, UnitingCare Community.

Srivastava, A. & Thomson, S. B. (2009). JOAAG. 'Framework Analysis: A Qualitative Methodology for Applied Policy Research'. Vol. 4. No. 2.

Stanley, N. And Manthorpe, J. (eds): 2004 The Age of the Inquiry, Abingdon: Routledge

Stiegel, L. A. (2005). Elder abuse fatality review teams: A replication manual. Washington, DC: Office for Victims of Crime & American Bar Association.

St Vincent's Hospital Melbourne, (2015) Annual Report

Sugita JA, Garrett MD. (2012) Elder abuse and oral health care providers: an intervention to increase knowledge and self-perceived likelihood to report. J Elder Abuse Neglect ;24(1):50-64

Teaster P. B. Nerenberg L., & Stansbury K. L. (2003). A national look at elder abuse multidisciplinary teams. Journal of Elder Abuse & Neglect, 15, 91–107

Teaster, P. B. (2003). A response to the abuse of vulnerable adults: The 2000 survey of state adult protective services. Washington, DC: National Center on Elder Abuse.

The Beth Israel Hospital Assessment Team (1986) An Elder Abuse Assessment Team in an Acute Hospital setting, The Gerontologist Society of America, Vol 26, No 2

Thompson-McCormick J, Jones L, Cooper C, Livingston G. (2009) Medical students' recognition of elder abuse. International Journal of Geriatric Psychiatry; 24: 770–777.

Thomson A, Beavan J, Radcliffe L, McCracken L & Myint P (2010) Training in elder abuse: The experience of higher specialist trainees in Geriatric Medicine in the UK, Achives of Gerontology and Geriatrics, Vol 51, pp 257 - 259

Tilden, V, Schmidt T, Limandri B et al (1994) Factors that Influence Clinicians' Assessment and Management of Family Violence, American Journal of Public Health, Vol 84, No4

Tilse, C., Rosenman, L., Peut, J., Ryan, J., Wilson, J., & Setterlund, D. (2006). Managing older people's assets: Does rurality make a difference? Rural Society, 16(2), 169-185.

Tilse, C., Wilson, J., Setterlund, D., & Rosenman, L. (2005). Older people's assets: A contested site. Australasian Journal on Ageing, 24(Supplement), 51-156

Tilse, C., Wilson, J., White, B., Rosenman, L., & Feeney, R. (2015). Will-making prevalence and patterns in Australia: Keeping it in the family. Australian Journal of Social Issues, 50(3), 319-338.

Tornstam, L. (1989). Abuse of the elderly in Denmark and Sweden: Results from a population study. Journal of Elder Abuse and Neglect, 1, 35-44.

Treasury. (2015). 2015 intergenerational report: Australia in 2055. Canberra: Commonwealth of Australia.

Trevitt, C. & Gallagher, E. (1996). 'Elder Abuse in Canada and Australia: implications for nurses' International Journal of Nursing Studies. Vol.33, No.6, pp.651-659.

Twomey, M, Quinn, M & Dakin, E (2005) From Behind Closed Doors: Shedding Light on Elder Abuse and Domestic Violence in later life, Journal of the Centre for Families, Children's and the Courts

United Nations Department of Economic and Social Affairs. (2013). Neglect, abuse and violence against older women. New York: United Nations.

Vandsburger, E., Curtis, V. S., & Imbody, B. A. (2010). Professional preparedness to address abuse and neglect among elders living in the rural south: Identifying resiliency where stress prevails. Ageing International, 37, 356-372.

VicHealth. (2007). Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria. Melbourne: VicHealth.

Victorian Community Council Against Violence – Preventing Elder Abuse Through the Health Sector. A Background Paper by the Victorian Community Council Against Violence. November 2005

Victorian Department of Planning and Community Development, Office of Senior Victorians – Victorian Government Elder Abuse Prevention Strategic Implementation Plan 2006 – 2009

Victorian Department of Planning and Community Development, Office of Senior Victorians, (2007) Implementation of Elder Abuse Prevention Strategies. Consultation Paper-Community Education and Older Persons Legal Service

Victorian Department of Human Services. (2009) With Respect to Age – 2009. Melbourne: Victorian Department of Human Services

Victorian Department of Health and Human Services (2014) Allied Health: credentialling, competency and capability framework. Driving effective workforce practice in a changing health environment

Victorian Government (1995) - With Respect to Age. A Guide for Health Services and Community Agencies Dealing with Elder Abuse. An Aged Care Services Publication, Health and Community Services

Victorian Government, Elder Abuse Prevention Strategy (2010) Victorian University, Workshop Manuals 1 & 2

Victorian Government. (2015).Royal Commission into Family Violence Terms of Reference. Melbourne: Premier of Victoria.

Victorian Law Reform Commission, Review of Family Violence Laws: Consultation Paper (2004), 14 ff; Stephen Fisher, 'From Violence to Coercive Control: Renaming Men's Abuse of Women' (Research Series – No 3, White Ribbon Campaign, 20111)

Vinton, L. (1993). Educating case managers about elder abuse and neglect. Journal of Care Management, 2(3), 101-105.

Wainer, J., Darzins, P., & Owada, K. (2010). Prevalence of financial elder abuse in Victoria: Protecting Elders' Assets Study. Melbourne: Monash University.

Wainer, J., Lowndes, G., Owada, K., & Darzins, P. (2010). Staying safe with money: The experience of older English speakng Victorians. Protecting Elders' Assets Study. Melbourne: Monash University.

Wainer, J., Owada, K., Lowndes, G., & Darzins, P. (2011). Diversity and financial elder abuse in Victoria: Protecting Elders' Assets Study. Melbourne: Faculty of Medicine, Nursing and Health Sciences, Monash University.

Walsh, C., Ploeg, J., Lohfeld, L., Horne, J., MacMaillan, H., & Lai, D. (2007). Violence across the lifespan: Interconnections among forms of abuse as described by marginalised Canadian elders and their caregivers. British Journal of Social Work, 37, 491_514.

Weiner A. A community-based education model for identification and prevention of elder abuse. Journal of Gerontological Social Work 1991;16(3-4):107–19

Western Australia, Office of the Public Advocate. (2005). Mistreatment of older people in Aboriginal communities project: An investigation into elder abuse in Aboriginal communities. Perth: OPA.

White, B., Tilse, C., Wilson, J., Rosenman, L., Purser, K., & Coe, S. (2015). Estate contestation in Australia: An empirical study of a year of caselaw. University of New South Wales Law Journal, 38(3), 880-910.

WHO/INPEA (2002). Missing voices: views of older persons on elder abuse. World Health Organisation, Geneva.

Wiglesworth A, Mosqueda L, Mulnard R et al. (2010) Screening for abuse and neglect of people with dementia. J Am Geriatr Soc;58:493–500

Wilkins, N., Tsao, B., Hertz, M., Davis, R., & Klevens, J. (2014). Connecting the dots: An overview of the links among mutliple forms of violence. Atlanta, GA: National Centre for Injury Prevention and Control, Centers for Disease Control and Prevention

Wilkinson, S. (2004). Focus group research. In D. Silverman (ed.), Qualitative research: Theory, method, and practice (pp. 177–199). Thousand Oaks, CA: Sage

Wilson, J, Tilse, C, Setterlund D & Rosenman, L (2009) Older People and Their Assets: A range of Roles and Issues for Social Workers, Australian Social work, Vol 62, No 2 pp155-167

Wilson, J., Tilse, C., Setterlund, D., & Rosenman, L. (2009). Older people and their assets: A range of roles and issues for social workers. Australian Social Work, 62, 155-167.

Wolf, R & Pillemer, K, (1994) What's New in Elder Abuse Programming? Four Bright Idea's. The Gerontologist, Volume 34, Issue 1

Wong, C & Marr, S (2002) Factor Influencing Health Care Professionals in Identifying and Managing Elder Abuse: A Preliminary Report. Geriatrics Today, 5, 34 – 37.

Wong, L.P. (2008). Singapore Medical Journal. 'Focus group discussion: a tool for health and medical research'. 49:256-60; quiz 261.

World Health Organisation (WHO). (2002). World Report on Violence and Health. World Health Organisation: Geneva.

World Health Organization. (2002a). Missing voices: Views of older persons on elder abuse. Geneva: WHO.

World Health Organization. (2002b). World report on violence and health. Geneva: WHO.

World Health Organization (2004) World report on knowledge for better health: strengthening health systems. Geneva: World Health Organization

World Health Organization, (2005) Public Health Agency of Canada. Preventing chronic diseases: a vital investment. Geneva, World Health Organization

World Health Organization. (2008). A global response to elder abuse and neglect: Building primary health care capacity to deal with the problem worldwide. Geneva: WHO.

World Health Organization. (2011). European report on preventing elder maltreatment. Geneva: WHO.

World Health Organization. (2014). Global status report on violence prevention. Geneva: WHO.

World Health Organization. (2015). World report on ageing and health. Geneva: WHO

Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) Journal of Elder Abuse & Neglect. 2008;20(3):276–300

Yaffe, M. J., Wolfson, C., & Lithwick, M. (2009). Professions show different enquiry strategies for elder abuse detection: Implications for training and interprofessional care. Journal of Interprofessional Care, 23(6), 646-654.

Yan E & Tang C. (2001). Prevalence and psychological impact of Chinese elder abuse. Journal of Interpersonal Violence , 16, 1158–1174

Yon, Y., Wister, A. V., Mitchell, B., & Gutman, G. (2014). A national comparison of spousal abuse in mid- and old age. Journal of Elder Abuse and Neglect, 26(1), 80-105.

Zannettino, L., Bagshaw, D., Wendt, S., & Adams, V. (2015). The role of emotional vulnerability and abuse in the financial exploitation of older people from culturally and linguistically diverse communities in Australia. Journal of Elder Abuse Neglect, 27(1), 74-89.

APPENDICES

Appendix 1 Ethics Approval Letter

Appendix 2 Elder Abuse Staff Survey – Introduction and Information

Appendix 3 Focus Group Instrument

Appendix 4 Focus Group Consent and Information Sheet

Appendix 5 SVHM Vulnerable Older Persons Policy

Appendix 6 SVHM Elder Abuse Competency Framework

Appendix 7 SVHM elder abuse Pathway Tool

Appendix 8 Elder abuse training DVD Script

Appendix 9 Training DVD

Appendix 10 Ethics Approval Letter

Appendix 11 Elder abuse Evaluation Consent