AGE Concern Scotland

They put up with it what else can they do?

Mistreatment of black and minority ethnic older people and the service response

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Executive Summary

Aims and objectives

The central aim of the research was to identify the impact of cultural diversity on understandings of elder abuse, and to explore the implications of diverse understandings for the provision of services to older people and their carers in an ethnically diverse society. Specific objectives were:

- To identify, across a broad range of black and minority ethnic (BME) communities, what understandings of elder abuse exist;
- To explore the implications of these understandings for appropriate preventative and support measures;
- To audit service delivery relevant to addressing elder abuse in BME communities;
- To produce appropriate good practice feedback for service professionals and voluntary groups encountering elder abuse in BME communities.

Research methods

An initial literature review and consultation exercise identified key questions for inclusion in interview schedules. The consultation exercise identified that, for people in BME communities, especially those speaking minority languages, the term 'mistreatment' was more appropriate than 'abuse'. Interviews were conducted with

- 28 exemplary service providers with expertise in work on mistreatment, older people's issues and BME issues about the services they provided and their views about good practice;
- 58 people from a wide range of BME communities about their understandings and experiences of mistreatment of old people, and where they felt services could help.

A series of seven focus groups involving community members and one, service providers, then explored the 'fit' and gaps between the service providers views and the community experiences. Data analysis focused on identifying principles for good practice in services.

Key findings

Service providers' perspectives

All the service providers interviewed agreed that mistreatment of older people was an issue in BME communities

They perceived the main strengths of the services they provided to be

- Connection with local BME communities;
- Cultural competence;
- Involvement in multi-agency working.

Some of the challenges for services were

- Persistence of a 'colourblind' approach to service provision;
- Funding and resourcing issues, especially in the voluntary sector;
- Building further links with BME communities, especially for non-BME organisations.

In discussing mistreatment of older people, service providers tended to emphasize mistreatment within families and only a minority considered mistreatment by services or wider society. Service providers used 'official' language when speaking about mistreatment and most were familiar with adult protection developments.

Practice development was in progress, and services were increasingly addressing elder abuse and adult protection issues.

However, there was evidence that the BME organisations were finding this more challenging.

Good practice exemplars identified by service providers included

- The need to recognize and respond to mistreatment of older people;
- The importance of links with BME communities;
- The need for services to be flexible and responsive to diversity;
- The need for staff training in issues of elder abuse in BME communities;
- The importance of collaboration between agencies, especially between statutory services and the BME voluntary sector.

Obstacles to effective service development included

- Lack of services for older people experiencing mistreatment;
- The need for, and in some cases, a lack of confidentiality;
- Services which were not accessible for people from BME communities.

Community understandings and experiences

36 (62 per cent) of people interviewed from BME communities felt that older people are not treated well in today's society, both within families and more widely.

They perceived that older people in BME communities are experiencing mistreatment, and 40 of them (69 per cent) knew of specific examples, which had occurred within families and outside.

The most common type of mistreatment identified was lack of respect, named by 43 (74 per cent) of respondents.

These views and experiences differed very little between ethnic categories, and our respondents were very willing to speak about this 'taboo' topic.

A wide range of reasons given for mistreatment of older people included difficulties in families, pressure on carers and the position of older people in society, with the most likely abusers being family members and care staff.

Stress on carers emerged as a significant factor in mistreatment of older people.

Responses to mistreatment

46 people (81 per cent) interviewed from BME communities said that an older person from a BME community experiencing mistreatment would 'do nothing' about it.

Reasons for this included cultural factors, shame, dependency, fear, lack of alternatives and wider social exclusion.

32 people (55 per cent) had directly encountered an older person experiencing abuse and 24 people (41 percent) had tried to help them. Where people had obtained support from outside the family, this had particularly come from the BME voluntary sector.

It was widely agreed that more services were needed, which would be more responsive to cultural diversity.

Principles of good practice

The following principles of good practice emerged from the study:

- Mistreatment cases should be considered as involving the whole person, within their family and community context;
- Mistreatment within services has to be covered, even though BME community members may not see this as an issue;
- Issues of shame and confidentiality are important, but should not become obstacles to developing and offering services;
- There is a need to develop appropriate outreach work, which can enable mistreatment of older people to be discussed and addressed, drawing on the experience of services which have tackled other very sensitive issues;
- Service developments need to be aware that mistreatment may not be the 'up-front' issue for clients from BME communities;
- Improved, diversity sensitive support for carers and families could prevent mistreatment from developing;
- Non-BME service providers need to be alert to the needs of older BME people service users and to prevent potential mistreatment by care staff who may lack knowledge of minority cultures or who, at worst, may reflect negative attitudes towards minorities;
- Effective, collaborative work, involving the BME voluntary sector has potential to be vital in this area;
- Whilst specialist services for particular ethnic groups have done much valuable work, there is a need to be alert to differences within communities, shared experiences across communities, and the relevance of diversity competence for all service providers;
- Education and raising awareness of mistreatment of older people and how they can get support has to continue BUT there is little point in raising awareness if the support is not there;
- Training needs to ensure that BME issues are integral to discussion of adult protection, and older people's issues need to be part of training focused on race.

Table of contents

Executive Summary....2

Chapter One: Introduction and background....7

Aims and objectives....8

Background literature and other research....8

Research methods and design....10

The report....12

Chapter Two: Service provision....13

The service providers and their organisations....14

Perceptions of mistreatment....19

Working with BME older people....20

Overviews of elder abuse service provision....22

Collaboration with other service providers....25

Conclusion....26

Chapter Three: Understandings and experiences....27

Older people in today's society....31

Mistreatment of older people....33

Why are older people mistreated?....39

Who mistreats BME older people?....42

Conclusion....44

Chapter Four: Responses to mistreatment....45

What do older people do when they are mistreated?....46

Helping older people experiencing mistreatment....50

Services for older people experiencing mistreatment....52

Conclusion....54

Chapter Five: Principles of good practice....55

Understanding mistreatment dynamics....57

Recognising mistreatment....58

The role of the voluntary sector....59

Education about abuse....59

Conclusion....60

Chapter Six: Conclusions and implications....61

Understandings....62

Implications....63

The state of services....63

Good practice....63

References....64

Appendices....66

Appendix 1: List of organisations interviewed for the study....66

Appendix 2: Interview schedules....66

List of tables

Table 1.1: Stages of research....10
Table 2.1: Organisations included in the study....15
Table 2.2: Activities of organisations interviewed....16
Table 2.3: Interpreters used by service providers....18
Table 3.1: Summary of respondent characteristics....29
Table 3.2: Structure of sample by ethnicity, gender, generation, age, Carstairs scores and education....30
Table 3.3: Types of mistreatment....33
Table 3.4: Reasons for mistreatment of older people....39
Table 3.5 The most likely to mistreat older people....42
Table 4.1: Responses to experiencing mistreatment....46
Table 4.2: Sources of support received by older people experiencing mistreatment....51
Table 4.3: What other services are needed to support BME older people experiencing mistreatment....53

1

Chapter One

Introduction and background

In previous research on elder abuse, the experiences and understandings of black and minority ethnic groups have been little considered, not least because of the great sensitivity of this topic. This research project has worked in partnership with Age Concern Scotland and the Black and Minority Ethnic Elders Group (BMEEG) Scotland to address the omission of black and minority ethnic concerns from both research and service development and delivery. The project has a UK-wide remit and aims to inform national developments, whilst being Scotland-based.

Aims and objectives

The central aim of the project was to identify the impact of cultural diversity on understandings of elder abuse, and to explore the implications of diverse understandings for the provision of services to older people and their carers in an ethnically diverse society. The specific objectives of the research were:

- To identify, across a broad range of black and minority ethnic (BME) communities, what understandings of elder abuse exist;
- To explore the implications of these understandings for appropriate preventative and support measures;
- To audit service delivery relevant to addressing elder abuse in BME communities;
- To produce appropriate good practice feedback for service professionals and voluntary groups encountering elder abuse in BME communities.

Background literature and other research

In recent years, a significant body of research on elder abuse has been published. Since Eastman's (1983,1984) pioneering work, elder abuse has been a recognised issue, though commentators such as Biggs *et al* (1995) and Slater and Eastman (1999) have noted that the impact of this recognition on service development and delivery remains rather limited. Similarly, Rowlings' (1999) interviews with social workers in Scotland in the nineties revealed only a very gradual developing awareness of the issue among professionals. They considered that the issue remained extremely sensitive, suggesting that increasing awareness had to come from grassroots activity, in the form of the work of professionals in close contact with communities. More recently, the topic has gained greater public recognition (Hussein et al 2007) and received increasing research attention, nationally and internationally. In the UK, a major prevalence study (O'Keefe et al 2007) was funded, but did not specifically cover BME perspectives.

Research on elder abuse has involved much definitional debate. Moving on from the initial focus on 'granny bashing', commentators have identified that abuse can take many forms. Johnson (1991), who reviews the definitional debate, proposes a broader focus on 'mistreatment' generally. Biggs et al (1995) suggest that this is a useful approach, which should prompt questions about events and behaviour perceived as inappropriate, covering types of behaviour, precipitating factors, victim and perpetrator and location. This terminology has gained increasing currency, alongside the term 'maltreatment' widely used in the North American literature (e.g. Nadien 2006). In addition, there is debate as to whether elder abuse is usefully distinguished as a particular phenomenon, or whether it is part of a lifespan phenomenon of abuse (e.g. Walsh et al 2007).

From the point of view of professionals, identifying that elder abuse has occurred is a sensitive process. Rowlings' (1999:184) respondents spoke of 'gut feelings', 'a sort of unravelling', and noted that matters were seldom straightforward, particularly in terms of the interpersonal relationships that might be linked with the abuse. They described difficulties in taking action, especially where evidence was limited or where the abuse remained unacknowledged. Wilson (2002) found that social workers were often reluctant to address cases, as local systems did not support action, and effective remedies were difficult to find. The research literature also identifies limited service responses to elder abuse (e.g. Walsh et al 2007), and there is evidence of continuing debate about the nature of elder abuse, how to recognise it and who is considered responsible, whether the wider society, the perpetrator or, in some cases, the victim. Victim blaming was significant in Erlingsson et al's (2006) Swedish study. Recognition of elder abuse (Selwood et al 2007) has been shown to vary between different professionals, caregivers, older people themselves and the public (Helmes and Cuevas 2007; Morgan et al 2006) and alongside these differing perspectives there is disagreement about appropriate remedies.

There is increasing emphasis in the literature on elder abuse as a phenomenon which extends beyond the interpersonal level. Abuse may occur in families, in communities and in institutions. It is clear therefore that explanations of and remedies for elder abuse have to engage with family structures, communities and institutions. Malley-Morrison (2004) and Patterson and Malley-Morrison (2006) argue these points particularly strongly in relation to international comparative research in over 20 countries. Elder abuse and, particularly, the low priority it has had on some policy and practice agendas, is also linked with attitudes towards older people and their roles in society, in which they tend to lack power and control over their own lives.

In the light of these arguments, it is not difficult to see how elder abuse in BME communities is a particularly complex issue. Taking first the definitional issue, notions about the appropriate 'treatment' of older people are subject to cross-cultural variation, and notions of 'mistreatment' must also therefore vary. Secondly, the general difficulties experienced by professionals in tackling elder abuse must be compounded where they represent services which have repeatedly been found lacking in their responses to ethnic diversity (Butt and Mirza 1996, Bowes and Dar 2000). Thirdly, family structures and communities are ethnically diverse, and the context of and explanations for abuse likely to vary. Fourthly, people from BME communities frequently experience additional exclusion through racism, which may compound the effects of ageism in the case of older people from these communities.

Yet, until recently, relatively little attention has been paid to the issue of elder abuse in BME communities. Blakemore and Boneham (1994:83) make only passing reference to possible abuse in isolated Asian families; Biggs et al (1995) refer to racism as an additional form of elder abuse, and note that migration, which may affect previously accepted family relationships and traditions, may increase the possibility of abuse within families. Their discussion however remains extremely limited. Similarly, Slater and Eastman's (1999) discussion of elder abuse and responses to it in different countries does not address minority issues or possible cultural variation. Scott's work (1998) in bringing together professionals from a selection of BME communities indicates that elder abuse is an issue for BME communities and begins to indicate how some of the relevant cultural and other factors may come into play. This work indicates that for BME communities, experiences of, explanations for and appropriate service responses to elder abuse are likely to differ from those currently available. These differences are partly to do with experiences of minority ethnic groups themselves, their particular cultural beliefs and preferred family structures, but they are also related to wider social processes and practices, including racism, the marginalisation of minority groups and the limited way in which service providers have managed to respond to diversity.

Some researchers are now looking at elder abuse using approaches which take account of different cultural values, and Kosberg et al (2003) have argued that more cross-cultural research is needed. Yan and Tang (2003) for example identify literature on elder abuse in Chinese communities, and link increasing abuse with a breakdown in traditional values of filial piety. Tsukada et al (2001) examine knowledge and perceptions of elder abuse among Japanese older people, finding evidence of both. Neikrug (2003) shows that fear of abuse is amongst the worries of older workers in Israel, linking these fears with economic uncertainty and a weakening welfare state. Patterson and Malley-Morrison's (2006) international comparative work demonstrates, they argue, that older people are universally susceptible to abuse, and that this can be explained by a range of individual and society wide factors. Other work looks at domestic abuse more generally, highlighting culturally specific issues which interact with experiences of exclusion such as racism (e.g. Harvie 1991,

Samad and Eade 2003). However, there is significant debate concerning the extent to which particular cultural factors affect experiences and understandings of elder abuse. Whereas some researchers, as we have noted, make connections between particular cultural ideals and particular experiences of abuse, others have found that the central influences are poverty and marginalisation of older people. For example, Rabi (2006) finds little cultural variation in one of the most ethnically diverse societies, Israel.

The research reported here addresses a significant gap in knowledge concerning the perceptions and experiences of elder abuse in BME communities in the UK. It considers the implications of these perceptions and experiences for service responses to elder abuse. A UK-wide audit of available services has been conducted to identify examples of good practice, in which a sensitive response to elder abuse takes account of cultural diversity. We explore the perceptions of BME people themselves about elder abuse, and examine the 'fit' or lack of it between the perspectives of exemplary service providers and their potential clients. Our focus is very much 'on the ground' and at the community and service front line. It is not our aim to consider wider policy frameworks or legal remedies.

Research methods and design

The research design was founded on a partnership between Age Concern Scotland and researchers from the University of Stirling, with inclusion of the Black and Minority Ethnic Elders Group (BMEEG) Scotland. There were five stages in the research, listed in table 1.1.

Table 1.1: Stages of research

Stage 1:	literature review, consultation exercise
Stage 2:	collection and analysis of data on perceptions and experiences of elder abuse
Stage 3:	audit of services
Stage 4:	focus groups of older people
Stage 5:	writing up and dissemination activities

Stage 1: Literature review, consultation exercise

A literature review was conducted, using on-line database resources to identify and systematically audit recent research related to elder abuse, other forms of abuse, cultural aspects of abuse and service responses. This review provided a benchmark for the current state of knowledge, drawing on published academic and professional thinking.

A consultation exercise was conducted, involving a small and varied selection of service providers known to be addressing issues of elder abuse among minority ethnic groups, to ensure that current service provider thinking informed the research from the outset.

Findings from these two tasks were reviewed by the researchers with BMEEG Scotland to identify key questions for stage two, and to inform the design of appropriate and culturally sensitive research instruments.

Stage 2: Collection and analysis of data on perceptions and experiences of elder abuse

Interviews on perceptions and experiences of elder abuse were conducted with a sample of 58 people from a range of BME communities. In sampling, quotas were set to ensure coverage of an appropriate range of communities. We did not seek to cover all minorities. Instead, the design of this sample reflected diversity, and included people from South Asian (self-identified as Bangladeshi, Indian and Pakistani), Chinese and African Caribbean backgrounds and several European minorities (self-identified as German, Italian, Jewish, Polish and Ukrainian). Thirty nine of these interviewees self- identified as 'older people' and 19 as 'middle generation'. The inclusion of people who are not elders reflects the need to perceive elder abuse not only as an issue for older people, but as affecting and involving families and communities in complex ways.

Interviewees were recruited through a network of personal contacts, using so-called 'snowball sampling'. Contacts were made through BMEEG Scotland, and BME community groups. Care was taken to ensure that the network of contacts was wide-ranging and not restricted to certain interest groups. Most interviewees were located in Scotland, though African Caribbean and Chinese respondents were more widely spread.

In conducting the fieldwork, it was important to be aware at all times that any interviewee might be a victim or a perpetrator of abuse – the fieldworkers undertook training in how to respond to disclosure, and to point people towards effective support, should this be needed.

Interviews were qualitative, using a semi-structured schedule (summarised in Appendix 2) whose design was informed by the outcomes of the consultation exercise. Interviews were conducted in the language of the respondents' choice, with the research team using their own language skills.

Analysis of data was thematic, allowing themes identified by the respondents as well as those precipitated by the interviewer to emerge. Data were managed using SPSS and NVivo7, which enabled quantitative and qualitative findings to be linked.

Stage 3: Audit of services

Interviews with 28 service providers working with older people, carers and people experiencing abuse produced an account of their experiences and perceptions of elder abuse in BME groups and appropriate service responses. The sample also reflected diversity; in particular it included service providers involved in specialist minority work and others with a more generic remit.

Since much previous research had already identified a rather poor response by service providers to diversity among older people, there was little point in repeating this predictable finding for services relating to elder abuse. Accordingly, our interviews with service providers focused on those identified as positively taking forward both a diversity agenda and issues of elder abuse and other abuse. Respondents were identified through networking, starting with the consultation in stage one. Services across the UK, acknowledged by others to be doing effective work with older people from BME groups, particularly in relation to elder abuse, were identified. They included statutory and voluntary sector providers, covering both services for individuals, and work with communities on, for example, harassment or community safety. The organisations are listed in Appendix 1.

These interviews were conducted face to face or by telephone. The data were subjected to thematic analysis, with a particular emphasis on identifying good practice in addressing elder abuse, from the points of view of service providers. The interview schedule is summarised in Appendix 2.

Stage 4: Focus groups of older people and younger adults

The purpose of the focus groups was to explore the 'fit' between the perceptions and experiences of people from BME communities and those of the exemplary service providers, and to seek ways forward in identifying good practice and developing effective services on a wider front. These focus groups drew on the findings of the previous stage of work, as well as on the experiences and views of the participants.

Seven focus groups of BME people were held. In all, they included 51 people, 36 older people and 15 middle generation people. One of the groups consisted of BMEEG Scotland members, and the others were 'natural groups', generally attached to community based organisations. They covered a range of ethnicities and religions and there were 14 men and 35 women. Thus the focus groups echoed the full range of groups involved in the earlier data collection (though participants were not drawn from the group of phase two respondents). They were conducted in a variety of languages, including Punjabi, Chinese (Hakka) and Polish as well as English. In one case (Polish), a professional interpreter assisted and in others, a bilingual assistant supported the research team.

In addition to the focus groups, we also held an evening phone-in on Radio Awaz, an Urdu language radio station, to publicise the study.

One focus group was held with service providers, to consider outstanding issues from the service audit. Participants are listed in Appendix 1.

The focus groups were guided by a schedule (summarised in Appendix 2) which drew on early findings from the community-based interviews The focus group data analysis concentrated on the identification of good practice, the development of services which are responsive to diversity, and the impact of diversity on understandings and experience of elder abuse.

A note on terminology

As we noted, there is terminological debate in the research literature and in policy approaches. Advice from BMEEG Scotland, supported by the research literature, suggested that in the community interviews, the term 'mistreatment' was most appropriate, as it could be translated into relevant languages, and was a term which people would understand and be more willing to discuss than other alternatives, which would translate in many languages into extreme expressions. In the case of the service provider interviews, the terms 'abuse' and 'adult protection' were used more freely, generally reflecting the interviewee's own usage, though in every case, the interviews commenced by using the term 'mistreatment'. Our account reflects the terms that respondents themselves used.

The report

In the next chapter, we explore the perspectives of the exemplary service providers included in the service audit. They identified good practice in service provision from their points of view, as well as a number of difficulties in developing services for BME older people experiencing mistreatment. We commence with the service providers' perspectives because of our focus on improving services – their views provide a baseline of existing practice which is then interrogated by the findings from the community based interviews and the focus groups.

Chapters three and four then consider the views and experiences of people from BME communities about mistreatment of older people and about service provision to support people experiencing it. We consider the diversity of views, and the factors which influence diversity. Chapter three focuses on people's experiences and views about mistreatment, and chapter four concentrates on responses to mistreatment by those experiencing it and by service providers.

Chapter five focuses on the identification of good practice, considering the 'fit', or lack of it, between the views of the service providers and the people from BME communities. In this chapter, we also draw on the focus group findings, which tested out some of the issues identified in initial data analysis of the service provider and community interviews.

In conclusion, chapter six draws together the key findings of the research and considers issues for good practice in service provision for BME older people experiencing mistreatment, their families and carers.

2

Chapter Two

Service provision

Key points

- All the service providers interviewed agreed that mistreatment of older people was an issue in BME communities;
- They perceived the main strengths of the services they provided to be
  – Connection with local BME communities
  – Cultural competence
  – Involvement in multi-agency working;
- Some of the challenges for services were
  – Persistence of a 'colourblind' approach to service provision
  – Funding and resourcing issues, especially in the voluntary sector
  – Building further links with BME communities, especially for non-BME organisations;
- In discussing mistreatment of older people, service providers tended to emphasize mistreatment within families and only a minority considered mistreatment by services or wider society;
- Service providers used 'official' language when speaking about mistreatment and most were familiar with adult protection developments;
- Practice development was in progress, and services were increasingly addressing elder abuse and adult protection issues;
- However, there was evidence that the BME organisations were finding this more challenging;
- Good practice exemplars identified by service providers included
  – The need to recognize and respond to mistreatment of older people
  – The importance of links with BME communities
  – The need for services to be flexible and responsive to diversity
  – The need for staff training in issues of elder abuse in BME communities
  – The importance of collaboration between agencies, especially between statutory services and the BME voluntary sector;
- Obstacles to effective service development included
  – Lack of services for older people experiencing mistreatment
  – The need for, and in some cases, a lack of confidentiality
  – Services which were not accessible for people from BME communities.

The service providers and their organisations

The service providers interviewed for the research were those recommended and recognized by others as offering particularly good services for older people from BME communities. We commenced with an initial list drawn up as a result of the consultation exercise, and selected others based on recommendations made during interviews. We aimed to interview representatives of a wide range of organisations, covering the whole UK, different service sectors and different types of services. In recruiting organisations to participate, we found a general welcome for the research, which contrasts with the tendency for research participants to feel that BME issues are 'over-researched' at the expense of action (Butt and O'Neill 2004). However, the recruitment process did reveal some important background information. Firstly, it became clear that provision supporting older people from BME groups who may experience mistreatment is very patchy, with some regions (including Scotland) offering minimal support and others being more developed, notably in large BME communities in parts of England. The organisations included cover areas of greater and lesser experience. Secondly, during the recruitment process, we approached several organisations which declined to participate, on the grounds that mistreatment of older people was not an issue they had dealt with. Whilst recognizing that, especially in the voluntary sector, organisations may be wary of devoting resources to unfamiliar topics, it was a pity that, for example, some local domestic abuse forums did not feel that mistreatment of older people was relevant to their activity.

Twenty eight interviews were conducted, with one focus group held at a later stage to discuss the topics which arose from preliminary analysis (this involved four participants) and one interview was also held at this stage. The service providers included in the study are listed in Appendix One. In each case, the interviewee was an individual with an overview of the organisation, generally a member of senior staff. Characteristics of the organisations are listed in Table 2.1

Table 2.1: Organisations included in the study

		Number
Area covered	England	12
	England and Wales	2
	Northern Ireland	2
	Scotland	9
	Wales	2
	UK	1
Sector	Statutory	11
	Voluntary	17
Specifically for BME communities		17
Providing services		24
Campaigning or other activity		4

The organisations interviewed came from voluntary (17) and statutory (11) sectors. Most provided services, though four organisations with a more general remit than service provision were included, as they were recommended as having an overview of relevant issues and/or a strategic role in work on elder abuse. Nine operated in Scotland, 12 in England, two each in Northern Ireland and Wales, one was a UK-wide organisation and two covered England and Wales. They varied between relatively new organisations (six had been in operation for less than six years) to long standing organisations, one of which had been in operation for more than 100 years. Table 2.2 indicates their remits:

Table 2.2: Activities of organisations interviewed

Activity	Mentioned by (n=28)
Working at strategy level	18
Counselling and support	15
Campaigning/awareness raising	15
Befriending and volunteering	12
Community development	11
Research	9
Training	8
Telephone help-line	7
Day centre services	7
Residential care	5
Offering refuge space	2

Note: all potential activities mentioned by each organisation were recorded

Seventeen of the organisations had specific funding and/or remits to work with BME groups, and this varied from a full remit to do nothing else to small projects attached to a wider general remit. Specific, BME targeted activities were more limited with, for example, several organisations focusing on day- centre services only. Eight organisations had remits exclusively covering older people's issues, and four, a primary focus on abuse. It soon became clear that there were differences between the views and experiences of the ten organisations which were grounded in BME communities and others, whether or not these had specific BME remits. In presenting our findings, we refer respectively to 'BME organisations' and 'non-BME organisations' when reporting these differences.

Organisations were funded by a range of sources and it was notable that the voluntary sector ones often had 'cocktails' of funding, subject to regular re-application. This was frequently described as a difficulty, as the constant need to make funding applications consumed significant time and effort.

Sixteen organisations employed bilingual staff, speaking local minority community languages, and this had generally been a deliberate strategy. Twenty two kept ethnic monitoring records, especially of the ethnic origins of service users and languages spoken.

Promoting services

Organisations promoted their services to BME communities in a wide range of ways, and many organisations used several methods. There was a sense that strenuous efforts were being made by both BME and non-BME organisations to link with local BME communities, and that these were having results, in that services were generally well used. However, these information channels related to the general remit of the services, and did not necessarily cover issues relating to mistreatment of older people. Only two organisations (one BME and one non-BME) reported specific information activity on mistreatment of older people for BME communities. However, an organisation that specialised in work on domestic violence related how important the spread of information had been to their development and their ability to support women, despite some local resistance:

I think a lot of the events we've had are not encouraged [by local community leaders]… but at least we made the women aware that there is something out there, there's somewhere that they can go. (2106[1])

The existence and use of effective communication channels was not, for most of these organisations, in any doubt. Methods of promotion included the widespread use of leaflets translated into minority languages and made available in a range of settings, such as community centres and GP surgeries. The media was also widely used to promote service availability and to conduct campaigns, and this included minority ethnic media, such as radio stations and magazines in minority languages. Many groups emphasised the importance of word of mouth and their local reputations in bringing clients to use their services, and spoke of the importance of winning the trust of local communities. It was clear that in many cases, this had been done, in that there was a steady flow of clients using the services.

Acquiring clients

For BME specialist services, acquiring clients did not seem to present difficulties – indeed some were under significant pressure from high demand. One of these stated that they were not currently promoting their service because they could not meet the demand. For non-BME services, bringing in BME clients was in some cases more challenging. There was evidence of some innovative practice – for example, one police force was working with local community based groups to support people who wanted to report crimes but were reluctant to contact the police directly. Another reported regularly setting up a stall at local community events.

Strengths of services and their challenges

We wanted organisations to speak about the perceived strengths of their services and about some of the challenges they faced.

For the BME voluntary sector organisations, there was a perception that connection with the local BME communities was a key strength. Some of these organisations had operated locally for many years and built up a fund of goodwill and trust. It was noteworthy that the links and consultations were presented as being with the BME communities in general. There was little evidence that groups had specifically set out to engage with older people themselves. Even in the cases of those groups which provided services for older people, much of the outreach, information-providing work had been done with carers of older people rather than older people themselves.

Their cultural competence was emphasised by the BME groups – their ability to understand minority cultures and the ability of their staff to engage with people in their own languages. One local authority representative noted that older people were treated better in BME communities. The BME groups had not always had the full support of community leaders (as in the domestic violence service above), and the process of raising awareness of a new issue could be lengthy. The domestic violence group had used events like Summer play schemes or health events, as people did not necessarily want to hear 'full on' about sensitive issues such as domestic violence. A local Council of Mosques reported that special groups and events had been set up for women, as much of the Mosques' activities tended to involve men. A Chinese service reported that they were able to supply traditional Chinese cuisine, and that this was especially important for their clients at day centres and in care homes. A Polish group reported that their awareness of Polish culture of the 1940s was essential for their work.

1 Organisations are identified only by their interview number for reasons of confidentiality.

For non-BME organisations, the strengths identified included working with other organisations. Multi-agency working was seen in many cases as improving coordination of effort and having the potential to address issues more fully. In some cases, organisations such as local authorities emphasised that they tried to include local BME organisations in this joint working process, though others had found this more difficult. This was especially reported where local BME communities were small, or where the local authority had only recently commenced its work with BME communities (probably following the Race Relations (Amendment) Act 2000).

Where successful links with local BME communities were reported, these included well established links to translation services, specific attention to BME issues on joint working panels, and successful recruitment of volunteers from BME communities. In addition, several organisations spoke about working with older people, consulting them about how to raise issues of mistreatment and about how to address them. Only one non-BME organisation however spoke about involving older people from BME communities in a process of this kind.

There was evidence that some non-BME organisations were taking a 'colourblind' approach to services, and had failed fully to consider issues for BME groups. They claimed to offer services regardless of ethnicity and in describing their services did not comment on BME issues until prompted to do so. In some cases, the services had only recently started to work on elder abuse, and had only just begun to raise the issue locally. One Adult Protection team member however highlighted the additional difficulties of reaching BME communities, suggesting that speaking only a minority language could be a factor putting someone into the 'vulnerable' category, as it put people at a disadvantage.

Organisations also spoke of the particular challenges they faced. For the voluntary sector, the main issue was funding, especially the need to devote resources to regular funding applications. Among non-voluntary organisations, challenges included the need for some to increase their connections with BME communities. It was clear that these connections had not always been considered fundamental, and that several organisations had much work to do in appealing to diverse communities. This seems to be a persistent issue, especially in areas where BME communities are smaller.

Interpreting was mentioned as a challenging issue by three groups. Two were concerned that their access to interpreting services was not efficient enough, and one reported that, in their view unfortunately, family members were still being used as interpreters. They considered this particularly inappropriate in relation to mistreatment of older people, pointing out that the interpreter could also be the perpetrator of mistreatment. In all, 24 groups used interpreters. Table 2.3 shows who was used as interpreters.

Table 2.3: Interpreters used by service providers

Interpreters	Mentioned by (n=24)
Qualified interpreters	15
Workers from within organisation	14
From other agencies	6
Family members	5
Volunteers	4

Note: all potential interpreters mentioned by each organisation were recorded

The table suggests that the use of family members as interpreters was, overall, not extensive, and that more professional approaches were more widespread.

Perceptions of mistreatment

All those interviewed agreed that mistreatment of older people was an issue both locally and nationally. All of them felt that mistreatment of older people happens within BME communities. They generally felt that such issues faced everyone, and were not specific to one or other kind of community:

Elder abuse happens across the board. (2102)
I think it happens across all communities. (2103)
I would say it happens in all communities. (2108)

Nevertheless, several people noted that communities did not always want to recognise this, and that it could be a sensitive issue:

We don't buy into this fantasy that, for example Asian families ….have a different cultural or value base and… an older Asian woman is less likely to be abused, because there's this notion that 'they look after their own don't they?' (2109)

For the majority of respondents, the focus of their comments was on intra-familial mistreatment, though four spoke of mistreatment in institutions and by care staff, in hospitals, care homes and domiciliary care. Mistreatment by services was linked with lack of cultural sensitivity, for example in failing to identify a person's needs, failing to consider cultural preferences and also racism on the part of service providers. These were, however, minority perspectives.

Their comments on types of abuse frequently reflected 'official' formulations of abuse, for example listing 'financial, sexual, physical, verbal, psychological' and so on – two respondents explicitly referred to guidance which included such a list. They referred to neglect of the needs of the older person, behaviour that challenged the rights of the older person and to lack of respect in care settings. A small number of respondents wanted to develop the 'official' formulations to include additional factors – one mentioned 'institutional abuse', whereby people did not receive appropriate services and one other mentioned 'discriminatory abuse' based on a person's individual attributes, which, they explained could include ethnicity and/or age. Another minority view (five respondents) moved away from the classifications of abuse and spoke of the violation of trust, to distinguish the phenomenon from other kinds of harm. Clearly, there was something of a definitional debate occurring, but our respondents did not appear to have been diverted from their action by this.

They identified a range of factors which would cause them to suspect or identify mistreatment including physical signs such as bruises, behavioural changes ('going quiet' was cited several times), crying, weight loss, facial expression and phoning a help-line, but not leaving a number.

Some described elder abuse as something that emerged when people had contacted them about other issues – they said it was very unusual for someone to present with the issue up-front. For example, a local BME voluntary sector group related:

We start realizing when they come and say 'I'm looking for housing' and initially, they don't say why. They say 'There's less space in the house – it's better if I move out'. Then you start going through the process of getting housing for them – that's when it starts coming out…how they are getting all the verbal and mental abuse, and that's why they want to move out, and they don't want to talk about it to anybody. (2105)

Similarly, one of the police respondents described how officers have been trained to notice quite subtle signs that an older person may be being mistreated, such as behavioural changes, the behaviour of carers, and older people being accompanied to banks consistently by the same people and withdrawing large sums.

An advocacy group reported subtle signs of potential mistreatment:

If we're going to visit them – somebody that says repeatedly things like 'my son's in the house at the moment and he doesn't like me to see people.' Or people that phone saying 'I really need some help' and you arrange a date and then they call up and say 'I've changed my mind', but then they'll phone you back. If we're doing an assessment and you're asking them questions, but they're not engaging with you, or they're looking round to see if people are listening… (2111)

One organisation with a helpline specifically dedicated to abuse had received very few calls from BME people. This is potentially explained at least partly by the view, particularly expressed by the BME organisations, that people were unlikely to report mistreatment directly, or to come to a service with it as the first difficulty mentioned. It was more likely, they reported, for mistreatment to be revealed subtly or indirectly.

The subtlety of signs of abuse however implied for this organisation a need for particular alertness by professionals. Whilst urging service providers not to 'see abuse everywhere', this respondent said:

I worry too often about those occasions where somebody stumbles on abuse and then says 'oh, he's in his seventies, or she's in her eighties – couldn't possibly be happening', and walks away. And that could be the one and only time that older person has a chance to escape from what's happening to them, because people don't want to believe that older people can be abused. (3118)

However, organisations had also encountered cases in which people did not want help, however apparently clear the mistreatment had become:

And it came to a stage where even the neighbours called the police and then she didn't want to press charges because what would the community say? And they [social services] wanted her to go into sheltered accommodation and then she refused to go. It was all sorted and set up for her and she refused to go. She said 'No, no, what would the community say. I've got so many children but [they] are not looking after me'. She didn't want a slur on her family. They can use her and abuse her and treat her abominably, that's OK. She tolerated that until she died (3121)

Working with BME older people

Of those who provided services (24), 18 reported that they saw BME older people who said they had suffered mistreatment. They were able to list specific examples of various kinds, but many stated that they did not have figures. Two organisations (both in local authorities) were able to give precise figures. One of these stated that they had dealt with 15 cases from BME communities over the last year out of a total of 448 cases of abuse, but was unable to break down the figures to indicate how many cases involved BME older people. The second identified that cases of mistreatment of older people had increased from 57 in 2003-4 to 147 in 2005-6 though, again, were unable to differentiate how many of these involved BME people. These organisations appeared to have relatively effective record keeping systems – other organisations did not appear to have clear reporting in this way. One of these authorities reported that the split between mistreatment by care staff or other professionals and family members was about even, whereas other organisations tended to emphasise mistreatment by families.

There was a general feeling (18) that awareness of elder abuse was increasing, but that awareness needed to be raised further (22).

I think older people sometimes find it very difficult to identify the situation that they're in as abuse. (3122)

Linked with lack of awareness, unwillingness to report mistreatment was identified:

I think everybody knows, but the thing is, people don't talk about it. If you ask a woman, you know, who is getting abused at home, she will say yes this is happening in our community, but not happening to me. So they don't want to tell. (2105)

They never lived a life when they're alone and they don't speak the language… some of them would rather sleep on the sofa, sleep on the floor…[than report abuse] (3120)

Respondents felt that the more information there was about elder abuse, the more public education, the better trained and more aware professional staff were and the better the recording systems, the more likely people were to recognize it and perhaps more likely to have the confidence to come forward for help. Organisations working specifically on elder abuse issues were more confident in saying that reporting of mistreatment was increasing.

Service users were reported to be predominantly women (14), or equally men and women (nine). There were no services which reported only male service users. Where more women were said to be users, reasons cited included domestic violence, the subordinate position of women, especially in South Asian cultures, and greater poverty of women.

Men have a place to go. They can go to the mosque and things like that. Women don't have anything. Women don't have anything. (2105)

Men were felt by some to be less vulnerable, more likely to speak English, more able to get out of the house, and to manage in public spaces. However, others felt that older men were disempowered and likely to need support as much as women. There was a feeling that greater age increased the possibility of mistreatment, with more people from these older age groups using services.

Many services (17) had changed in recent years in their responses to older people reporting abuse. In many respects, changes had been stimulated from elsewhere, particularly by changes in policies on adult protection which had occurred recently and rapidly. This was particularly and unsurprisingly the case for the non-BME organisations, such as local authorities and healthcare providers. The organisations had designated officers specifically responsible for adult protection, and had developed teams locally which were coordinating multi-agency work (see below). It remained the case, however, that many of the BME organisations were not involved in such initiatives and had little awareness of them. BME organisations were much less likely to refer to legislative and policy frameworks, or to use the developing language of adult protection.

There was some evidence that increased awareness of elder mistreatment issues had produced demand for support. However, it was also clear that members of BME communities needed support to raise issues, and several of the BME organisations described work they had done to bring people together, to provide events such as health information talks, which they felt enabled people to discuss things if they wanted to. A parallel was made with work on domestic violence, which had also been (and remains) a difficult topic. It was noted that women had started to come forward and report domestic violence and seek support in dealing with it, and

that one of the main ways they had found out how to do this was through events such as those just described. People preferred to attend events which did not carry the titles of difficult issues, but nevertheless provided opportunities for them to be discussed.

Fifteen respondents reported that staff had received training in work with older people from BME communities experiencing abuse. They felt that training had resulted in staff being more aware of the issue, more aware of the potential signs of mistreatment and therefore more likely to address it if it emerged. However, discussion of these responses revealed ambiguities about the training issue. It emerged that training on elder abuse was available in many organisations. And training on race issues was also available – generic antiracism training, or training in issues of diversity and cultural competence. What was noticeably missing however was training which addressed issues of elder abuse with specific reference to BME communities. Organisations in their training programmes seemed to be separating off BME issues into the anti-racism training, and not necessarily considering them when other issues were addressed. BME organisations had in some cases received training on elder abuse, but it was noted that there were a number of difficulties with this. BME organisations were felt to be reluctant to take up training opportunities; in some cases, lack of financial resources was an issue for BME groups; in others, as the training did not exactly match the remit of the organisation, people found it difficult to justify taking time to participate.

It was unusual for organisations to report training for staff to help them avoid unintentional abuse of people with whom they worked. However, one local authority did highlight this aspect:

Sometimes the cultural issues have been ignored and that is abusive, because it shows….people that are working … need to be mindful of every aspect of what they're doing when they're in somebody's home or when they're providing care. It's not just about the physical, its about, you know, not allowing somebody to pray when they want, or not taking account of their particular time of year when they're celebrating different festivals and things. (3129)

It became clear that certain organisations are developing training programmes focused on mistreatment of older people and BME issues, some of which are made available to e.g. adult protection teams or voluntary sector organisations. One was particularly interesting for the holistic approach it took:

We talk about human rights…we look at advocacy stories and within that there are … stories about abuse, and we look at the …cycle of oppression and stereotyping …there's an Age Concern piece on caring for ethnic minority elders and so we look at some misconceptions about ageing, tips for working with BME groups, and within those, we talk about abuse. (2111)

However, it was also clear that there are significant areas where BME issues have not been considered in work on elder abuse and/or adult protection, and in which organisations are unaware of the availability of appropriate training.

Overviews of elder abuse service provision

Twenty respondents reported that they could identify examples of good practice in this kind of work. Again however, few of the examples were actually about mistreatment, but tended to be about issues for BME older people, or more general aspects of work with BME communities. Despite this, some useful general principles emerged. It should be noted at this point that these ideas about good practice were given from service providers' points of view. Later in the report, we will consider the views of potential service users.

One principle was simply that of recognition – understanding that mistreatment of older people does take place, and needs a response. As we have noted, for some of these exemplary providers, who did recognize elder abuse, this had been a key step, and the BME groups in particular had found that the communities they served did not necessarily share this understanding. One respondent emphasised particularly eloquently why organisations needed to understand and respond to issues of mistreatment:

If somebody gets the courage and the nerves up to disclose to you, your initial response is hugely important, and I think anybody who's providing sort of frontline services who are directly in contact with older people needs to be in a position to respond to any disclosures of abuse in an appropriate and safe way for that older person. (3122)

Some of the BME groups felt that singling out mistreatment of older people as a specific issue, and attaching specific procedures to it, could be unhelpful. They explained that they would prefer to look at cases in a more holistic way, and if elder mistreatment emerged as part of a case, to consider it in the context of other issues. In this, they retained the emphasis on mistreatment of older people as something occurring within families.

It was clear from the interviews that those organisations with effective links with local BME communities had a clearer understanding of BME views and experiences, even though there was not necessarily much they could actively do – as we have noted, there was significant resource pressure, especially on the BME organisations. Some of the non-BME organisations had engaged in proactive work contacting local BME communities and this had paid off. Also, some of the BME organisations had used their effective community links to raise discussion of difficult issues and to make people aware of potential service support. There was particular emphasis on the effectiveness of outreach work and word of mouth communication with local communities, including activities such as running stalls at community events; linking information about mistreatment of older people with other issues (such as women's health) which people felt able to discuss more freely; and in one case, the use of theatre workshops to explore difficult issues.

Basic good practice measures, such as the availability of appropriate translation and interpreting and the exercise of cultural sensitivity applied here as they do in all service provision for BME groups. In this connection, it was noted that a 'colourblind' or 'one size fits all' approach to service provision was not necessarily inclusive for BME communities, and was perceived to be persistent in some non-BME organisations:

They have their set criteria and procedures which are very standard, and they are not willing to bend it for ethnic minorities. (2105)

Services, respondents suggested, needed to be more flexible, so that they could respond holistically to individual needs. Opinions differed on whether ethnically specific services were needed – those BME organisations which were set up to cater for one particular sector of the population tended, unsurprisingly, to suggest that separate services were needed. But service providers with a generic remit recognized the difficulties of delivering very specific services, and saw a need to apply the principles of responsiveness and sensitivity to diversity in all services.

With the tendency to emphasise mistreatment of older people as primarily a family concern, respondents spoke at length about the stresses and strains on family relationships in BME communities, emphasizing ideologies of family life which could lead people to try to cope with difficult situations on their own and keep any problems within the family. Respondents emphasized that strong family ideologies were positive, not least for supporting a higher value accorded to older people, even though, at the same time, they could make raising issues of mistreatment and taking action especially difficult for the older person. They suggested

that in working with families, a holistic, family-centric approach was appropriate, rather than necessarily an exclusive focus on the individual experiencing abuse.

As we have already noted, the need for training of staff emerged as an element of good practice, with the limitation that some of the training provided was not sufficiently 'joined up' and tended not to integrate BME issues into training on adult protection, or to consider adult protection as an issue to be considered within generic diversity training.

Interviewees were generally aware of strategies and documents addressing mistreatment of older people and felt that they would know where to find out information about organisations that could help with the issue. There were several descriptions of how organisations had reviewed their practice in response to policy documents. However, some of these accounts were rather general, and it was not clear that they would actually be effective. In some cases, organisations were perhaps commenting in ways that they were aware were appropriate, rather than giving evidence of real, embedded effort.

Many gaps were identified in services for people from BME communities experiencing abuse, and improvements were suggested. Some organisations suggested that gaps were particularly extensive:

The gaps are limited resources, educating the external providers, educating the voluntary groups and educating the community – that's a massive gap…And I think sometimes people deal with it without fully acknowledging the complexities of adult protection and I think that's probably a gap nationally…..There are some teams [locally] that have never reported an adult protection issue. (2103)

There is a lack of support services both for the person who's experiencing abuse and also for the person who's perpetrating it, and I think there are issues around counselling…both to…come to terms with the abuse and ….start to heal, but also…for the perpetrator. (2104)

One local authority noted:

I think there will always be people who will be failed by the system, because I think that the nature of abuse is by definition complex, and I don't think we can always be assured that every complex situation can be dealt with satisfactorily, and I think that at times we have to accept there are things we just can't resolve….we can't make things better for everybody. (2107)

Confidentiality emerged as a potential problem. BME groups argued that confidentiality was of the utmost importance, especially since they felt that mistreatment of older people was seen as particularly shameful in the communities in which they worked. They also noted that whilst services such as lunch clubs existed, people would be unlikely to raise issues of mistreatment in a forum of that kind. However, some of the statutory providers were concerned that parts of the BME voluntary sector (none of the organisations included in the study) were less than effective at maintaining confidentiality, and that local community workers could be too personally involved with clients they were trying to support.

Lack of accessibility of services to BME communities was raised particularly by the BME organisations. There was a widespread concern that, if people from BME communities did raise problems with mistreatment of older people, they would have difficulty finding appropriate support. This had led, they reported, to BME community organisations trying to deal with intractable problems, and produced unsatisfactory outcomes:

We actually don't know when we are referring somebody on, or encouraging them to do something, whether we can guarantee that the response is going to be appropriate and sensitive and pitched at the right level. (3118)

One group reported having tested out a helpline that had advertised that people could call in, state the language they needed, and someone speaking that language would be connected to the call. Their 'test' person, a Bangladeshi woman making a fictitious enquiry in Bengali, had waited after the initial call on the line for twenty-five minutes, and received no response. For the BME organisation, this confirmed their view that there was little point approaching general (i.e. non-BME specific) services. Clearly, there is work to be done to improve links between general services and specialist projects.

Collaboration with other service providers

Some of the more successful work reported on mistreatment of older people occurred where organisations were working together, and it was clear that there was more scope for this to be done to the benefit of BME people. Twenty four organisations worked with other organisations to provide services to people from BME communities, though many of these were not explicitly related to mistreatment of older people. Those involved in collaboration included both statutory and voluntary agencies, with many collaborations being cross- sector. Some organisations were involved with local adult protection committees, which promoted inter-agency working, and these were reported as working well. The BME groups generally reported that they worked with others: it was however notable that some of the groups had rather limited links outside their local communities. Collaboration involved activity such as work on local adult protection strategies; developing more 'joined up' working; forging links with local BME communities; delivering and receiving training; consultations with local communities; and referring clients for services.

Some limits to collaboration emerged. New organisations for example saw collaboration as something to do in the future, suggesting that they did not perhaps see a need to learn from the experiences of others from the outset. A small number of respondents mentioned examples of organisations with which they would actively not collaborate, specifically for reasons including a failure to engage effectively with BME communities.

Referrals to other groups were frequently made as part of collaborative working – 17 organisations reported doing this. Six of these reported that making referrals presented some difficulties. In some cases, older people did not wish to be referred on, even though it was clear that they needed help. In other cases, organisations hesitated to refer as they were not confident that other agencies could provide appropriate services, as 3118's comments (above) indicated. Such caution applied both to mainstream services which were not diversity responsive, and voluntary sector organisations which did not have the capacity or remit to tackle issues of elder abuse. One area of particular concern with the voluntary sector was that of confidentiality. One service in particular as previously noted contrasted what they saw as their 'professional' and therefore confidential approach with that of some local BME projects. Most organisations tracked referrals, and were aware of what had subsequently happened in cases they had referred elsewhere, so these comments were clearly based on real experience.

Conclusion

All the service providers we interviewed were recommended as exemplars of good practice. It was clear that many were working hard, often under constrained circumstances to address issues of adult protection and the mistreatment of older people, and working with local BME communities. Some were actively involved in campaigning and public education on the issue. Many organisations, both BME and non-BME, presented clear understanding of the problems they faced in providing adult protection services to BME communities. We would not wish to deny any of the efforts that were clearly being made, nor the good work being done.

However, it was clear that the service providers perceived gaps in the work they themselves were doing, and in the national picture. These gaps suggested that service support for people from BME communities experiencing mistreatment remains limited, and that there is significant work to be done to improve its effectiveness. In the next chapter, we move on to consider the perspectives of BME community members themselves, and will particularly focus on their understandings and perceptions of mistreatment of older people, as well as their views about and experiences of the services that might support those experiencing it.

3

Chapter Three

Understandings and experiences

Key Points

- 36 (62 per cent) of people interviewed from BME communities felt that older people are not treated well in today's society, both within families and more widely;
- They perceived that older people in BME communities are experiencing mistreatment, and 40 of them (69 per cent) knew of specific examples, which had occurred within families and outside;
- The most common type of mistreatment identified was lack of respect, named by 43 (74 per cent) of respondents;
- These views and experiences differed very little between ethnic categories, and our respondents were very willing to speak about this 'taboo' topic;
- A wide range of reasons given for mistreatment of older people included difficulties in families, pressure on carers and the position of older people in society, with the most likely abusers being family members and care staff;
- Stress on carers emerged as a significant factor in mistreatment of older people.

In this chapter, we examine community members' views and experiences of the mistreatment of older people. As previously explained, we used the term 'mistreatment' in preference to 'elder abuse' because of translation issues and following consultation with our reference group (BMEEG Scotland).

Table 3.1: Summary of respondent characteristics

Characteristics		Number (N=58)	Percent
Gender	Female	36	62
	Male	22	22
Generation (self defined)	Older people	39	67
	Middle generation	19	33
Households	Living with spouse (of whom 15 older people)	22	38
	Living alone 19 (of whom 16 older people)	19	33
	Living with other relatives	15	26
	Care home residents	2	3
Ethnic catergory	South Asian	18	31
	White European	17	29
	Chinese	12	21
	African-Caribbean	11	19
Religion	Christian	26	45
	Muslim	13	22
	Buddhist	5	9
	Jewish	5	9
	No religion	4	7
	Hindu	3	5
	Sikh	2	3
Employment status	Currently employed or self-employed	21	36
	Not employed or self-employed (of whom 35 older people)	37	64
	Retired	37	64
Carers	Caring for someone else - of whom:	17	29
	Looking after a spouse	7	12
	Looking after older relatives or neighbours	5	9
	Looking after younger relatives, including grandchildren	5	9
Gender of carers	Female	13	76
	Male	4	24

Table 3.1 shows the demographic characteristics of the 58 community based interviewees. They were a heterogeneous group of people, deliberately selected to have a wide range of potential experience and views. In analyzing their responses, we explored systematically whether the various aspects of difference among them were linked with differences of views and experiences. We examined generational differences (between the older people and the middle generation), gender, religion, ethnic category, Carstairs scores (Index of Social Deprivation), and educational level. Table 3.2 indicates the variability in the sample across the four broad ethnic categories. It should be noted that people's own ethnic identifications, whilst placing them within these broad categories, were very varied.

Table 3.2: Structure of sample by ethnicity, gender, generation, age, Carstairs scores and education

Characteristics	South Asian	South Asian	African Caribbean	White European	Total
Gender					
Male	8	5	4	5	22
Female	10	7	7	12	36
Generation					
Older	12	8	7	12	39
Middle	6	4	4	5	19
Age group					
Under 50	5	2	1	2	10
50-59	3	2	3	3	11
60-69	8	1	1	0	10
70 and over	2	7	6	12	27
Carstairs					
scores*					
1 and 2	7	3	0	8	18
3 to 5	6	7	6	7	26
6 and 7	4	2	4	2	12
Education					
Primary or less	3	4	0	1	8
School only	4	4	3	6	17
HNC/HND or equivalent	4	1	2	2	9
Degree or above	7	3	6	8	24

*2 missing values (1=most affluent, 7=most deprived)

In the discussion of findings which follows, we highlight where responses varied according to any of these criteria – where such variation is not mentioned, we found a range of views across the diverse respondents, and no systematic variation. In general, we found a remarkable consistency of views, with a spread of opinion throughout the sample.

Older people in today's society

We wanted to explore the wider context in which mistreatment of older people might occur, and began therefore by asking people to explain how they saw the treatment of older people in today's society. Thirty six people (62 per cent) felt that older people are not treated so well, referring to a wide range of negative factors, such as the lack of power and influence of older people and stereotypes about them, risks to older people in the street and lack of government funding for older people's services. One emerging theme, that of lack of respect, was identified by 27 (47 per cent) people. This was particularly reflected in comments concerning the role of younger generations, although both older people and middle generation expressed such views equally. There was a widespread view that formerly, people used to care for those from older generations, but that this had changed in recent times. Various explanations were offered for this, including the busy lives of the younger generation, a disdain for the life experience of older people and the provision of government support so that older people no longer needed to rely on their families.

There were many comments on generational differences, both in general and within families:

People feel that once they become old, your own children are the first people who tell you that father, mother, you don't know that because this is new fashion, this is a new age and they are the first people to tell you that you are too old, you are not useful in the society. (2204 Indian)[2]

The thing that amazes me about ageism is the way that we treat people who have survived long enough to get old, you know, and this awareness that just like they're a different species or a different planet and that younger people are not going to get old themselves. It's almost like there's no connection. (2206 African Caribbean)

Today's generation does not help anyone, there is no empathy, no justice. The people who are from the past generation used to care about each other. Today everybody is too busy in their lives and work. If someone makes a mistake, other people need to tell them they are making a mistake. Today the so called educated people don't want to listen to their elders. Before, there was a sense of sharam [modesty]. When women got married they were quiet and respectful in front of their parents and parents-in-law. (2207 Pakistani)

2215: Older people should be asked what they want to do with their lives. They should be given more creative things to do as well, apart from looking after children.

I: Do you think they're used a lot for looking after children, yes?

2215: Yes, babysitters until they can't do that any more because you know, because of ill health…. and then when they can't do that any more, then they're no good for them any more and that happens in the Indian community quite a bit. (2215 Pakistani)

Others felt that other social structural factors were important, including the world of work and the education system:

Now I'll tell you one thing you're working there now and everything is OK, because you can mix with people and you can just pass [by] who you think haven't got a good idea inside them or that. But when you're sick like me, it's bloody terrible because with people out there you would be surprised…. people handle you as if you're dirt or something like that or just they think you're stupid. (2223 African Caribbean)

2 Respondents are identified by a number and their self-defined ethnicity is indicated. Where relevant 'I' is the interviewer (GA or SM).

On my opinion in this country the older people are not treated well. …The main point is the children….The children are not brought up to and educated to honour and to have esteem…..If you are not respecting your elders, you cannot expect to be respected by your children. (3254 Polish)

Some people related stories of direct experiences of bad treatment. In some cases, this was at an interpersonal level, either in public or in the family:

And today, [I was] trying to get on the bus with two big bags of shopping and this young man behind me was swearing at me saying 'get up, get up the steps woman, get up', that sort of attitude. (2228 African Caribbean)

I am never in the right. He is always right but if I am right, it is not allowed. Only he can be right. I can never be in the right. I have to 'worship' [=give into] him every time, and each time I have to 'carry his legs' [=curry favour and say he is right]. (3235 Chinese)

Others related stories of perceived bad treatment or unfairness from agencies and institutions:

I think the state could treat old people better by increasing pensions. (3238 German)

If I go in a home at my age, if I've got to go in a home, it'll cost me an arm and a leg and the ones who hasnae [has not] done anything or they've drunk their money, they've never saved a penny, they get everything free. (3239 Italian)

I think what older people are needing is time spent explaining things to them and … people are far too busy to spend that time. And if they've not got a member of their family to speak up for them they're lost. I think they suffer…. it doesn't matter whether you're black and minority ethnic or, or what, that the care isn't there, the care and the understanding isn't there. (3243 Caribbean)

They live in [care] homes, they are charged. At [the] moment they are like means tested - if people they do have a house they have to sell it before they qualify for this kind of benefit. So even that is quite injustice, unjust, yes. (3244 Chinese)

Others, however, felt that older people are treated well, and referred both to family and community support and services for older people including pensions and free medical care, focusing (as had the more negative views) on wider social structures and relationships:

When I look at the elder people in Scotland I mean, I think they get treated better than everywhere, because they get benefit and pension. (3246 Chinese)

People are well treated with pensions in this country. (3250 Ukrainian)

The last respondent however contrasted treatment by the state with treatment within families:

However, people in the family are not really supportive of one another, especially when one gets older. People here live in separate homes. In Ukraine or Poland, families live together and there is care support for the older members even though families may not be well off. (3250 Ukrainian)

Mistreatment of older people

We asked people to explain what 'mistreatment of older people' might be. Table 3.3 summarizes their answers.

Table 3.3: Types of mistreatment

	Mentioned by	
	Number	Percent
Lack of respect	43	74
Psychological	42	72
Other	38	56
Verbal	37	64
Financial	32	55
Gaps in services	31	53
Physical	24	41
Racism	15	26
Neglect	6	10
Sexual	3	5

Note: all types of mistreatment mentioned by each individual were recorded

Other factors mentioned included comments on the general position of older people in society, including being ignored and isolation.

Generally the middle generation respondents were more likely to name each of the types of mistreatment than were the older people. Men were more likely to refer to racism, physical abuse and gaps in services than women. Those who lived in families (as compared with those who lived alone) were more likely to mention psychological abuse, as were those with more education. No South Asians or White Europeans identified sexual abuse as a potential type of abuse.

When they spoke about mistreatment, it was common for people to link mistreatment with their comments about the way older people are treated in today's society, and they picked up on the themes of interpersonal, intrafamilial and society-wide behaviour. It was clear that they saw 'mistreatment' as being a broad ranging category of behaviour. So for some people, interpersonal mistreatment might be receiving fewer visits from their grandchildren than they might have wished, and at the other extreme, it meant physical and other violence, financial cheating, and severe neglect. In reality, people found difficulty in distinguishing sharply between categories of behaviour, and clearly perceived behaviours as ranging along a continuum of good and bad treatment. This is important, because it emphasises the lack of clear cut distinctions in people's experiences and behaviours. These make the definition of mistreatment more difficult, but they also suggest possibilities to change problematic behaviours to other parts of the continuum.

This woman expressed her horror at the extreme potential of mistreatment of older people:

Abuse on a number of levels,mistreatment, denying people food and not giving them the dignity of caring for them if they're incontinent or if they have bowel incontinence and leaving them in their mess or not changing them or physical attacks and, you know, hitting people and striking them. I've seen the ad campaign and, you know, some of the pictures are quite shocking really (2206 African Caribbean)

These respondents spoke about the range of mistreatment:

I think at a basic level would be even jokes and comments and maybe even name calling. At extreme level it's about abuse either at home or in the streets or crime against elderly people, attacks. (2212 African)

Of course there are the rare cases where you hear of older people being you know, victimised and actually being brutalised in instances but I think those are the minority rather than the rule. (2228 African Caribbean)

Society-wide mistreatment which related to structures and institutions was also exemplified:

Well I would say mistreatment would be the lack of appropriate services and the poor quality of services for older people. (2202 Indian)

An emerging theme in the discussion about the nature of mistreatment was one of abuse of power on the one hand and the relatively weak power position of older people on the other. Examples of this included a physically disabled man who stated:

We aren't strong and then they take advantages (2223 African Caribbean)

Similarly, this woman was concerned about giving another person control of her financial affairs:

Once you've signed this piece of paper, they can abuse the privilege of having that. (2225 Jewish)

And a middle generation woman spoke of the disempowerment of older people once a family business had passed to the new generation:

Well, see the elderly, if they can walk and their health-wise is OK and if they get better and have better income, the children seem to treat them better, that's what I feel. Even like when they pass the business to their family, know what I mean, they seem to treat them different……They feel like I don't have to – 'm sai tai nei ge min hou' [don't' have to look at your face] because I am the owner now, all this…Like it used to be like the children depended on their dad, but when they pass the business, it seems to be like the parents depend on the child now. (3246 Chinese)

The lack of power in the hands of older people made them vulnerable to threats, as this woman described:

I know of a case where one has been to ask for an extravagant amount of money because they want to go and buy different type of materials for clothes or parties, they want to …. travel and they know their grandfather, grandmother has the money you see and she said 'well some months ago we gave you a lot, what did you do with all this money?' and then they started to become nasty with it and so it was 'oh well, fair enough, we're not going to feed you'. It is the little violent things. (2230 African Caribbean)

Although most people represented older people as vulnerable to abuse, there was a minority view that identified unreasonable behaviour by older people. For example, speaking of a friend, a woman related:

Well she was complaining always about her daughter, wasn't phoning, wasn't coming to see her and I used to say 'look', I says, 'she's very far and she's working, her husband's working and she's working, she's got two kids. You've got to allow for that. You phone her.' See now she would say she would be maltreated because her daughter wasn't constantly phoning. (3239 Italian)

We asked whether respondents felt older people could make choices in their lives – more than half (31 people, 53 per cent) felt they generally could not, and positive answers were frequently qualified with phrases such as 'as long as they have their health' or 'it depends on their financial position' or 'if you are blessed with a good mind'. There were several older respondents who clearly felt themselves to be without power, relating this to their economic position, their age, and their labour market position:

I feel I don't have any value, as I am not wealthy (2210 Bangladeshi)

For one so old, what more is there to ask? (3233 Chinese)

And so if you are, when you're working, right, you're more up-to-date … other people are talking to you, you're hearing things more and, and no matter what anybody says word of mouth is a way people learn everything, most things. You're out there, you know what I mean?...I think the older you get you're not so much in mainstream…And you're less informed yes, yes and not aware of your choices. I've found that even being unemployed, I just seem to be missing out. (3243 Caribbean)

Again, there were minority views. For example, this respondent identified decision making in older age as two sided:

When you are older, you are not thinking so fast and you are not so alert, but you are able to make decisions and you are wiser to make decisions. On one hand you are wiser but on the other hand you don't think so quick. (3250 Ukrainian)

Experience of mistreatment

Only three respondents felt that mistreatment of BME older people did not happen. Nine were unsure, and 46 (79 per cent) stated that it happened.

They discussed the extent and form of this mistreatment. Forty people (69 per cent) said they knew about specific examples of people being mistreated, most referring to small numbers of examples (five or fewer). Five people explicitly disclosed that they had themselves experienced abuse, four having been resolved before the time of interview, and one continuing[3]. People who lived alone were less likely to know about mistreatment than those living in families or couples. Those with higher levels of education were more likely to be able to talk about particular cases – this most likely reflects the types of employment they had experienced, as many had worked in the voluntary sector or public service. The direct experience of mistreatment uncovered here appears particularly high in relation to the 2.6 per cent one year prevalence rate identified

3 In this case, the person concerned was given information about where to get help by the interviewer.

by O'Keefe et al (2007). We identified a different set of experiences, i.e. not necessarily direct ones, and we did not operate such a rigorous definition of mistreatment, i.e. our interviews permitted people to define mistreatment for themselves, rather than fitting pre-set criteria, such as dependency on others for performing daily tasks to qualify as neglected when they did not receive help with these (O'Keefe et al 2007:42). Nevertheless, the specific cases which were described included many which would undoubtedly have qualified as 'abuse or neglect' under the O'Keefe criteria. There are reasons in our study to suggest that rates of mistreatment may be somewhat higher than those identified by O'Keefe et al (2007). One is the level of explicit disclosure of personal experience of mistreatment: five people identified experiences of mistreatment, even though they had not been directly asked about personal experience. A second is the comments about the shame attached to mistreatment; the third is the discussion about how people would react to mistreatment, and the consequent potential for much of it to remain hidden (discussed below); and finally, there is the difficulty of leaving an abusive situation, which is only partly related to availability of services, as we will discuss below. We would not suggest that the higher levels of mistreatment are particular to BME communities, though some issues are distinctive. We would suggest that it is likely that hidden mistreatment is widespread.

Respondents described a wide range of specific cases. These included comments relating to the continuum of mistreatment highlighted above. For example:

Even with the best will in the world children tend to do this with older people, they make decisions for them, 'you'd be better here', do you know what I mean, or 'you'd be better staying here' or this or that without saying to them 'what would you like?' It can be very subtle and they're not even aware that they're doing it. (2224 Jewish)

The same respondent related how abuse could emerge – for example, an older person might wait for a family to arrange accommodation for them, and suffer in the meantime as the family had difficulty doing this. In another case, a respondent described a situation they had tried to help with:

I have seen it happening where the wife is suffering from dementia and the husband just can't understand…what's happening to his wife and, you know, ordinarily when they go out together she walks along beside him and he walks ahead...He just couldn't understand when the nurse was saying to him no, when you take her out you now have to hold her arm…to make sure she's going to come along beside you, you know, because he was getting so angry that he'd turn round and she goes off in a different direction. (3243 Chinese)

This case highlights the potentially detrimental outcomes of lack of understanding.

In other cases, the mistreatment described appeared to have been more deliberate. These examples relate to interpersonal relations within families:

A neighbour in my street, I often have to pick her up at the bus stop, because she just wanders around because they leave her alone in the house. I suppose they go to work and leave her alone so she gets out and walks around and often doesn't know where she is. (2228 African Caribbean)

There is this financial and economic abuse. Whilst I myself have not had this happen to me, I have seen two of my friends in Edinburgh being mistreated at the end of their lives and one of them has since died. Both cases had to do with taking finances and property without really considering the older person's welfare. (3250 Ukrainian)

I never got an education because in those days it never really happened for women. When I came to my husband's house, I put up with the good and bad. They said to me you are stupid, uneducated and mad….all my life I have heard this and it has felt like a beating. (2207 Pakistani)

My brother's wife is mistreated, her daughter-in-law doesn't like her because she is too old and she talks too much and they don't like her and they are taking her money. The way she sits, the way she eats – they don't like her. (2210 Bangladeshi)

Most of the cases described related to family situations. A small number were focused on mistreatment within institutions:

She has a mother-in-law who had a stroke and you know what the people there say in the … nursing home, a nursing home they have to pay a lot of money? They say she won't drink and she won't eat. Is it true? Not true. They have no patience. (3245 Chinese)

Here, the family had tried to place the older person in a good care home, which was costly, but the care home had not been satisfactory. In another case, hospital care was felt to have been problematic – this respondent related a long story of attempting to get appropriate care for her grandmother in hospital. The main issue was that the hospital appeared unable to provide female staff to assist her grandmother with toileting. The respondent had become frustrated and angry, especially when one nurse appeared to refuse to attend to her grandmother because of her presence:

I went mental and I said to her 'look, you either provide a female staff for my gran or we're going to do it from home, we're not going to let you do it. She's too weak to go to the toilet herself otherwise you wouldn't have any of this'…I had to sit on a chair, a hard chair. That was my punishment for, for actually for staying the night, a hard chair all night long but it didn't matter to me it was just that I wanted someone to be with my gran and I tell you honestly after that I would never let neither my mother, my father or anyone old go into hospital on their own. All night these patients right, were screaming for help… and they didn't bother with them. Sometimes they, I know sometimes that old people want the attention but sometimes that pain could be genuine, then what would they do? (2215 Pakistani)

UK compared with other countries

In comparing their experiences in the UK with those in other countries, including their countries of origin, respondents tended to see both good and bad treatment of older people as being widespread. There were references to different ideals about caring for older people, with family support being seen as a feature of former times in South Asia, East Asia and Eastern Europe in particular, but many people felt that these countries were changing, and that economic changes in particular were breaking up formerly joint family households, and worsening the position of older people. In general, the UK was seen to have a positive advantage because of the availability of services as a safety net. Changes in ideologies about caring for older people were occurring, but these were perceived as related to different generations, and were occurring everywhere. There was little nostalgia for the 'home country', as it was often called, in terms of the treatment of older people.

However, Muslims stood out as more likely to say that mistreatment of older people was worse in the UK than in their home countries. Respondents identified a number of reasons for this, including the smaller households in the UK, and the fact that people no longer lived surrounded by a whole community of relatives, who would know what was being done in a household and thus prevent mistreatment, and who could also support older people more generally, rather than

leaving care to one daughter-in-law. Furthermore, there was some evidence that Muslims felt particularly excluded from white society in the UK, and were in some cases more willing to challenge discrimination – the woman who challenged hospital treatment above was one example of this. Others described how older Muslims might be more conspicuous in the street and therefore potentially more liable to attack. By contrast, Chinese respondents were more likely to say that it was difficult to get help because of language issues, and they would rather keep themselves to themselves, referring in some cases to the 'red haired devils' (white people) who neither understood nor supported them.

Frequency of mistreatment

Most people felt that mistreatment of older people was either increasing (33 per cent) or had stayed the same (19 per cent) in recent years, with a minority identifying increased awareness as important. Some felt that increased awareness meant that more cases of mistreatment would come to light, while others felt that increased awareness would reduce levels of mistreatment as people had a better understanding of its nature and consequences. Generally, people felt that increases in mistreatment were likely because of the societal changes already identified, and added that as the size of the older population increased, so would levels of mistreatment.

Gender issues

Women were believed by 22 people (38 per cent) including 17 women to be more likely to experience mistreatment, although 22 (38 per cent), 12 men and ten women, felt that this was the same for both men and women. Women's lower status in society was cited as putting them at greater risk, as well as their longer life, their tendency to spend more time in the home and their inability to defend themselves.

Interestingly, six people felt that older men were more likely to experience mistreatment, referring to the greater shame potentially experienced by a man, the loss of influence of older men and older men being less independent and more reliant on the care of others, thus potentially at greater risk of mistreatment. Linked with this was the feeling that as women cared for their children, they would be more likely to receive reciprocal care in their older age, at least within the family.

Hidden mistreatment – the role of shame

A key reason for suggesting that rates of abuse may be higher than previously reported is the widespread discussion of shame, which appeared throughout our interviews.

Certain things happen to you, you take it to the grave with you, you don't tell anyone, you're too ashamed and all that. (2223 African Caribbean)

Other respondents spoke about keeping private matters within the family, and not being concerned with others:

I know very little of what is happening in other people's family. These things, I hear in one ear and let it out the other. I don't care about other people's issues. I normally don't listen to other people's issues, I don't get involved. (3235 Chinese)

The theme of shame was very significant, and will be discussed further in the next chaper.

Why are older people mistreated?

Reasons for the mistreatment of older people mentioned are listed in Table 3.4.

Table 3.4: Reasons for mistreatment of older people

Reason	Mentioned by	
	Number	Percent
Financial problems	29	50
Older person has poor health	29	50
Older person has disability	25	43
Lack of culture	23	38
Older person has mental health problems	22	38
Pressure on carer	22	38
Cannot speak English	20	34
Racism	18	31
Living in extended family	16	28
Lack of religion	13	22
Older people are not valued	12	21
Alcohol misuse	10	17
Gambling	8	14
Older people are vulnerable	6	10
Drug abuse	5	9
Other reasons	3	5

Note: all reasons mentioned by each individual were recorded

In these explanations, there is an element of victim blaming, with the reasons characteristics of the older people themselves. One respondent saw fault in himself:

Because your brain becomes less and the older person makes mistakes. I get angry at small things, I wasn't like that before. It's not the old person's fault – it's age. I take it out on the children and my wife and the children have less patience [with me]. (2209 Bangladeshi)

However, most of the explanations referred to the situation within families and households, often influenced, as people saw it, by changing experiences and values.

A tension emerged between on the one hand continuing ideals of respect for older people and a desire to support and care for them, and on the other hand the pressures of modern life and the real difficulties of caring for a dependent older person. This respondent was debating with herself how she would cope, and exploring some of these tensions:

I keep saying to myself if my mother had to suffer from Alzheimer's or something like that, how would I cope, because I think it puts an awful strain on the family to have someone to look after like that going from being the, the child of a parent to parent of parent. (3243 African Caribbean)

She had been asked by her daughter-in-law to babysit, and expressed some of the conflicts that produced in her:

It's funny how you look at things like that eh, because I keep thinking to myself 'I don't want to be a burden on my child', you know what I mean? You just don't want her to feel she is responsible for your care. And they [son and daughter-in-law] don't even realise they're doing this and giving me that responsibility at this moment in time. They don't even realise it. (3243 African Caribbean)

Middle generation respondents were more likely to refer to cultural changes ('lack of culture' or 'lack of religion') than were older people. Muslims were more likely to say that mistreatment was due to religion. Sometimes, this referred to the failure of people to live up to their religious values of respecting older people, and in a few cases, it referred to older people being more conspicuous in the street due to their skin colour or dress and therefore more vulnerable to public attack.

Muslims and Christians were more likely to mention pressure on carers as a factor in abuse, echoing the continuing focus on family relationships, though others also identified this:

If people get impatient with them and … they need a lot of care and attention and that reduces the person who's caring for them…I think impatience might come into it… I think people almost feel that they have a right to their parents' money or properties and if their parents deny them what they want, then they might abuse them to take that…But if, if the parent needs a lot of care and attention, then just the frustration of how that curtails your life might mean that people will lash out. (2206 African Caribbean)

Sometimes it's circumstantial, neglect. The carer gets exhausted; they leave the older person at home. Older people slow down and are very needy and people [carers] get tired and frustrated. Also mistreatment happens because of lack of respect and knowledge of old age. If an older person is disabled they are more likely to be mistreated. (2205 Bangladeshi)

It's just a straw that breaks the camel's back, do you know what I mean, I don't think there's any particular reason. I would say stress, stress and pressures….Oh the people that care the most, because they always say that a good daughter is the one that bashes - the bad daughter walks away … (2224 Jewish)

Mistreatment of older people was also linked with their general position in society, as older people, as men or women and as members of minority communities. Considering minority status, and noting that many people did not know their rights and did not claim them, one respondent noted:

I am startled by the number of people who are still apologetic about being here – even those who were born here. (2212 African)

This view was echoed by a Polish man who felt that less confident people were more likely to be mistreated:

We have a saying that everybody will jump on the tree which is not straight … you can easy bend it down and destroy this tree. You know when it's straight you need force, but when it's not straight… you jump on it and you can break it…. This weakness is kind of tempting quite a lot of people to mistreat it. Confident persons are less mistreated. (3254 Polish)

There was discussion of fractured families and fragmented communities, in which the pressures of coping without effective support from services had promoted individualism and militated against mutual support both within the family and across communities:

Old people are not valued; they are not good for anything. Even if they help they are told that 'you don't know what you are doing, just leave it'. Old people are seen as useless, they are just a burden, they are costing us money, they are given bad bedding, 'our place would be better if they weren't here', or 'this room would be free if they weren't here' or 'we would have less to do if the older person was not here'. This is despite the fact that when they are out, the old person is left at home to look after and guard their house. (2216 Pakistani)

In a small number of cases, mistreatment of older people was said to be linked with negatively perceived cultural norms. For example:

Some grannies, their husbands die and then they are left some property but the children are also eyeing the property. That is to say, when they see the granny have the money, they do not see the granny as a close family [member]. This is the Chinese thing…the granny is not willing to spend her money on food nor buy any new clothes…She only always remembers to buy new things for the young children [grand-children]. Therefore, treatment towards the granny is not just. (3236 Chinese)

A lot of people are from rural areas, women are dominated and kept down by men and they are not 'trained' to make decisions. It's women that suffer, even women that are working are dominated by their husbands. Women make sacrifices and compromises and men generally exploit women, that's all men know. (2213 Pakistani)

A particular issue that emerged in the case of Chinese respondents was that of the Chinese enjoyment of gambling. This respondent linked it with other causes of mistreatment:

Racism, institutional racism in society, mental health or health problems…general problems, lack of support from family or extended family, disability, or living in isolation. Another thing is you know, talk about, you talk about economic hardship or even gambling families you know, that's another thing you know. (3244 Chinese)

There will be some who spend their money gambling and do not give them [their spouses] money to spend and these can cause clashes. Yes, I have heard of such things. A lot of people gamble and some Chinese, a lot of them love to gamble. (3241 Chinese)

This respondent (3241) however related a history of abuse from racists, including court appearances which had resulted from attempts to fight back physically. Although people cited gambling as a potential source of problems therefore, it would be incorrect to see it in isolation from other issues, and, particularly to cite it as a single cause of mistreatment.

Who mistreats BME older people?

Table 3.5 summarises responses on those considered most likely to carry out mistreatment

Table 3.5 The most likely to mistreat older people

Likely abusers	Mentioned by	
	Number	Percent
Children-in-law	39	67
Older person's children	37	64
Care staff	31	53
Male spouses	25	43
Other relatives	24	41
Female spouses	21	36
People on the street	5	9

Note: all potential abusers mentioned by each individual were recorded

These figures indicate a particular perception of cross-generational mistreatment, with children and children-in-law as being the most likely to mistreat older people. Spousal mistreatment was also significant and in these responses, there was reference to mistreatment from outside the family, particularly from care staff. Whilst fewer people mentioned abuse on the streets, those who did mention it spoke extensively on this topic.

Middle generation respondents and Christians were more likely to highlight abuse by care staff than were older people or those of other religions, who tended to see abuse as occurring within families or, in a few cases, on the streets.

The large majority of respondents, as the figures suggest, focused on mistreatment within the family. It was clear however that mistreatment was not seen as a prerogative of 'bad' individuals. Many people spoke of pressures generated by family relationships, living circumstances, role expectations and social and economic position.

One respondent spoke of the difficulty of living up to an ideal to which she aspired:

We value, because it goes back to the Quran that we should honour thy mother and father - … your mother especially you know. 'The heaven lies in the feet of your mother', so you know…. that you shouldn't say when they reach an old age, you shouldn't even say 'oof' to them which means that … even no matter how hard you think that they're making your life, if you bear that with patience then you will be rewarded for that. And we believe that totally. I believe that totally so I'm as guilty as the next person of like saying 'oh but mum you know, I've told you a million times it's not like this', but the thing is then you calm down and think 'oh my God' you know, 'oh my God I shouldn't have said that' and you feel so bad about it …. and then you just wind down and apologise you know, because we are all guilty of it. (2215 Pakistani)

Family tensions were reflected by a number of respondents who saw these as an outcome of people living together:

It's not fair to blame the daughter-in-law as she has children as well to look after and other responsibilities too. Sometimes old couples, man and woman together in the house scream and shout at each other. (2211 Bangladeshi)

Partners but it could be either male or female…Yes they're closer, so there's more frustration and again I think it's because eventually there's just a straw that I can't take any more. (2224 Jewish)

For those that live together, there tends to be more quarrelling and verbal abuse. When there are many people living together, there is close proximity, more words, each one has a word …. and if they disagree, there will be 'noise' [=quarrelling and disagreements]… Those that do not live together, there will be less disagreements. (3235 Chinese)

Others referred to relationship norms and expectations, and how these could produce tensions

You know, if the father-in-law and the mother-in-law and the son and the daughter-in-law all live in the same house you know, two families are competing with each other for decision making…. You know, the mother tells you to do this and the wife tells you to do that and it's very difficult, we find it a lot, a lot of times - tension you know. (3244 Chinese)

It is most likely to be the daughter-in-law because she marries the son [of the granny] and because there is love between granny and son and that is why she [daughter-in-law] will not be on good terms with the granny. Before [the marriage] it would be agreed that the granny will look after the children. (3236 Chinese)

This respondent felt that looking after the children was often seen as the 'price' paid by a grandmother for food and accommodation.

Intergenerational differences were not necessarily perceived as mistreatment however – this is further illustration of the continuum of behaviours being discussed:

It is the older generation who are not prepared to change and the younger generations also. They've got their own lives so they become also in certain ways 'look I've got my different outlook, my dad has got different outlook so be it' and then it becomes into some sort of, oh, people think it's a mistreatment. I do not consider them as mistreatment or abuse at all. (2209 Indian)

In discussing mistreatment by care staff, respondents raised a number of issues, including the idea that people who were not family members would be more likely to mistreat service users, suggesting a deep mistrust of care workers:

If people are in institutions, then I think the carers probably don't, they don't care. They don't have that same sense of duty really, if there's no blood connection. (2206 African Caribbean)

I think basically they go in there just to make money and they just want the shift over and done with and not all of them, because I know that my ….cousin she … works in a care home and she's really caring and they love her to bits and that is because she treats them like she would treat her own mother and father. I think not all of them are like that. (2215 Pakistani)

A friend of mine who they put her in a home, the daughter was so upset sometime when she go to see, she's wet herself and all smelly and not washed properly….And then they were paying, she was paying she and her brother was joining up and I don't know how

much a week for the woman to be looked after. So old people …. haven't got a chance: they stay home they mistreat them; they put them in a home where the families pay and they mistreat them, they slap the food on the…desk, if they eat it fine if they don't eat it well don't eat it, you know. (2228 African Caribbean)

Conclusion

The discussion in this chapter has demonstrated that people from BME communities have significant knowledge and experience of mistreatment of older people. Our interviewees emphasised mistreatment within the family predominantly, though they also identified mistreatment in the formal care system and in the street. The extent of mistreatment appeared to be greater than that reported in other research, and this was at least partly explained by the difficulties of bringing mistreatment into the open. We discuss this further in the next chapter.

In general, we found a marked degree of consensus among our respondents, with minimal variation in terms of ethnicity. There were some generational differences and gender differences, though these were not great. The causes of mistreatment, it was widely agreed, were in part the general place of older people in society and their lack of influence and respect accorded and in part the stress of life within families, particularly stress on carers.

4

Chapter Four

Responses to mistreatment

Key Points

- 46 people (81 per cent) interviewed from BME communities said that an older person from a BME community experiencing mistreatment would 'do nothing' about it;
- Reasons for this included cultural factors, shame, dependency, fear, lack of alternatives and wider social exclusion;
- 32 people (55 per cent) had directly encountered an older person experiencing abuse and 24 people (41 percent) had tried to help them;
- Where people had obtained support from outside the family, this had particularly come from the BME voluntary sector;
- It was widely agreed that more services were needed, which would be more responsive to cultural diversity.

This chapter continues the discussion of the community members' responses, and turns to their perceptions of responses to mistreatment by individuals and services, their experiences of helping people being mistreated, and their suggestions about how responses could be improved.

What do older people do when they are mistreated?

The overwhelming trend in responses to this question was that older people would do 'nothing'. Older people from BME groups were believed to be more likely to do 'nothing' than were those from other groups as Table 4.1 indicates:

Table 4.1: Responses to experiencing mistreatment

Response	Older people generally*		BME older people*	
	Number	Percent	Number	Percent
Do nothing	39	68	46	81
Speak to someone	7	12	6	11
Get help from a service provider	11	19	5	9

*One person did not want to answer

These figures for non-reporting contrast very significantly with those reported by O'Keefe et al (2007). In their survey, 70 per cent of those reporting an experience of mistreatment had reported it. Help had mainly been sought from family or friend (31 per cent) or from social workers (30 per cent). Whilst, as we have previously noted, their methods differed from ours, this very large difference is indicative of particular issues in reporting for BME communities. We will suggest in this chapter that lack of access to appropriate services is of particular significance for BME communities.

We explored people's explanations for doing nothing, and again found that these referred to a complex array of factors, including cultural factors; issues of shame; dependency; fear; lack of alternatives; and more general social exclusion.

Cultural factors and issues of shame were linked, and shame related particularly to strong family ideologies, whereby people did not want to bring dishonour to families. This view applied across all ethnic categories. For example, an African woman reported:

It's also they don't want to, [for] the shame of it and they don't want to expose again to the community. We have already given this impression of a close knit community. We have family, extended family; we care for each other [laughs]. It's a myth that then when it's destroyed, you don't want to admit that that can happen. (2212 African)

In another example, a Chinese woman described the case of an acquaintance who had been assaulted by her son in whose house she was living at the time. She was hospitalised for some time, and friends and supporters tried to persuade her to move in with her daughter instead. She refused to do so, in the view of the storyteller because of the higher cultural value attached to a son, and the importance of being in the son's house.

Nineteen people, from across the ethnic categories spoke explicitly of the shame attached to reporting mistreatment:

Our people really worry about what the community will think. They don't want their son's or daughter's or their whole family's honour to be tarnished in any way. They can't go to anyone else's house as it would be a great insult to the family. People will also say that 'this older person has been thrown out of the house and what was the reason for this, they must have done something'. People will just accept the abuse, they will remain silent, they will internalise it. They will just keep taking the abuse but won't tell anyone. (2216 Pakistani)

[It's shameful] to talk about with other people; it's a shameful thing, especially something to do with domestic abuse you know, so they just keep quiet, yes. (3244 Chinese)

Actually some people are ashamed to complain. (3256 Polish)

In some cases, shame was linked with self-deprecation, whereby the older person would take some responsibility for mistreatment:

Sometimes the old ladies, the old people themselves think that they're a burden so you know, they put up with it, they think well this is their lot, what else can they do. (2228 African Caribbean)

Respondents referred back to earlier comments about how older people became dependent on others, and that this could make it more difficult for them to report mistreatment. Older people, they suggested, were dependent in a variety of ways, including for care; for relationships; and financially. Dependency for care was seen as placing the older person in a powerless position:

They are in the hands of the carers. (2208 Bangladeshi)

But when you get to the stage you can't do it yourself, that's when the problem comes in. You're supposed to get your meal and you can't go get it and somebody is supposed to take it to you and they don't there's nothing you can do about it. (2223 African Caribbean)

Family relationships were widely valued, as we have noted, and respondents felt that the need to maintain these relationships could deter people from reporting mistreatment:

Keep quiet or else the relationship with the family member might be lost. (3250 Ukrainian)

For many older people, financial dependence was also seen as significant – poverty in older age, lack of pensions, and a widespread practice of handing over property and income to the younger generation were all factors promoting financial dependence. Cases were reported in which family members had gone as far as cheating older relatives out of money, and in

which the older person was unable to resist, having no independent advice. These dependent relationships were linked with a fear of worsening mistreatment, if a complaint were made. For example:

If you're scared, you'll not tell anybody – you don't do anything. (3239 Italian)

This woman went on to explain that abusers would put up a front in public, and the older person would come to fear that if they reported the mistreatment, they would not be believed.

There was also a fear that outsiders might make difficult situations worse. For example:

3248 You'll not talk to social workers nowadays because they're frightened in case the social workers will maybe yes, take whatever it is away and redo or you know…..

I: Rearrange everything?

3248: Yes exactly yes. …You've heard about social workers, because somebody has been doing this and doing that, [and] they've rearranged them all. (3248 Ukrainian)

A very strong theme was that older people lacked alternatives to the family life in which they were deeply embedded. Thus reporting abuse would not only damage the family reputation, but would also leave the older person with nowhere to go:

The trouble is that they keep suffering in silence. That is the real trouble and if they raise their voice somebody will be upset and their family reputation will go down and they also dread living alone, could be much more trouble than living in a suffocation in the family home. Living alone, they don't know English, they don't know where to go, what to do. (2204 Indian)

A woman living in an abusive relationship with her husband stated:

I really don't have any way out. I don't really care if he is dead or alive. (3235 Chinese)

She went on to explain that she had no choice but to stay with her husband, as leaving him would damage their reputations, and there was in any case nowhere for her to go. Her sentiments were echoed by others:

[They have] this feeling that they were brought to the United Kingdom by their son or daughter so they feel obliged and under that obligation they keep suffering from the mistreatment…. Sometimes there is threatening behaviour but if you keep doing or if you raise your voice 'I'm going to send you back to Pakistan'….And that is a shame for them once they go back, they have another problem of social stigma, people will laugh at him or her. 'You went to the UK to live with your son or daughter, now they have thrown you like fly out of the milk'. (2204 Indian)

What's the point of going [for help] because, you know, they think that we look after our community. (3231 Chinese)

The lack of alternatives was seen as not only due to families and their importance, but also to the wider community, including service providers, who were widely seen not to be offering services for BME people. Thus, even if people thought of reporting mistreatment, doing so was perceived to be fruitless. For example, this woman had felt unable to report problems with her husband because she had no access to people speaking her language:

There was not a single Chinese and all of them were 'guai' [whites]. These people from the West – how do you speak to them? It is like the chicken and the duck talking. (3233 Chinese)

There was also some evidence of mistrust of BME voluntary sector organisations, whether as service providers or as gatekeepers to other services. This woman who attended a day care centre felt she could not trust staff to keep confidentiality

Other people will come to know about your family affairs. They will talk. For example, if you have any issues, people will know and will tell the other person. Therefore the worker will know your problems. Even the interpreter can talk about you. (3235 Chinese)

In discussing non-reporting of mistreatment of older people, our respondents returned to the theme of the position of older people in society, the lack of respect accorded to them, and their own desires to maintain their dignity and respect. There was an implication that by accepting support, both inside and outside the family, they were accepting their own subordination:

I also think there is a proudness in it which is another side of it because they want to say ah, in this country so many times I was told that I'm this and that no good and I don't want to show that I am weak or I don't want to show that somebody could have used me or mistreated, mistreat me or something. They just don't want to show it, especially men which is proudness is quite a nature for them anyway. (3253 Ukrainian)

Old people try very hard to be involved in what's going on, even though they are not welcome. What older people tend to do is that even if certain things are done and said which they don't approve of, they will pretend to agree so they are accepted. They just say 'yes' to a lot of things, they flatter the people that they are living with. This is done just to keep their own respect in front of everybody. They do this so that the people they live with let them sit with them and talk to them and respect them. They try to speak respectfully with others so that they are also treated with respect. (2216 Pakistani)

This case also showed the difficulties an older person might face in seeking help, for reasons of a need to maintain their dignity:

He served in the Polish army, he's ninety-five or six and he's a very proud man, very, very proud man and you know he can't admit that he can't do what he could. You know until a year ago he could run round this whole place ten times …. Now he can't and he can't admit to it that he needs it but I know he needs assistance at home and I know that he needs … but he just doesn't want to accept it. He won't let people into his house. (2221 Jewish)

This man's family had tried to persuade him to accept help, but had found it very difficult to negotiate. Our respondent felt that whilst it would be wrong to impose help on someone who did not want it, at the same time, there was an obligation to support someone in need. Again, this illustrated some of the difficulties of identifying at what point a situation could become potentially abusive, and the complexities of family and other relationships.

Some older people themselves felt that they could not resist their subordinate position. For example, this man felt his family were more capable than himself in interacting with the community:

My language is not on level with them. (3252 Polish)

He explained that he had no choice but to defer to his family in matters on which they had greater knowledge due to their greater language skills. His comments were echoed thus:

That goes for Poles, that goes for any white minority, it goes for the black, for the Asian and everybody, the common thing for all of those communities it is not knowing sufficient the language of the country they're in, and if you do not know and they are using children or grandchildren to translate for them and so on, if you don't know the language you cannot feel safe. You don't get information about different things and you are vulnerable. It causes the vulnerability, the lack of knowledge of the language. (3254 Polish)

Another respondent felt that it was inevitable that older people would defer to younger people:

What is the point of challenging with her? One is older and the other is younger, so it must as well be that we give in. Of course, the older person will have to give in. The young will not give in to you, the older one. See? The young are more healthy and time for the old is not much more [i.e. they do no have much life left], isn't that so? (3233 Chinese)

Thus, many reasons were given as to why an older person was unlikely to report mistreatment, and instead continue to live with it. Much of the explanations focused on the nature of family relationships, but also there were references to a lack of availability of appropriate help from outside the family. Expectations of being able to stop or get away from mistreatment appeared low throughout the sample of respondents. The barriers to seeking help appeared very significant, echoing the views of the service providers, but magnifying the assessment of difficulties.

Helping older people experiencing mistreatment

Thirty two respondents reported that they had 'come across' an older person experiencing mistreatment. Most of these people told specific stories of cases they had known – there was a great variety of these, suggesting the reality of this knowledge, which went beyond the general. We consider this specific experience, and then explore how people had reacted to it, despite the barriers identified above. Knowledge of mistreatment related to families, to public arenas and to services. Examples of the stories told were wide ranging and included the following relating to families: a family dispute about property in which an older woman was 'kicked out' of the house when her husband died, with the property being divided between the children (2204 Indian); a woman who neglected her husband who had dementia (2205 Bangladeshi); reference to a relative being mistreated (2210 Bangladeshi, quoted on p41); and a reference to a friend ill-treated by her nephew's wife:

[She] used to swear at her own grandmother and her father, and [my friend] used to cry so much. All the relatives could hear and they said 'come and stay at our house' but she said 'no, I won't leave because this is my brother's daughter-in-law…it is his honour and I have stayed here for so long and when I die, my body must be lifted from here'. (2216 Pakistani)

There were far fewer reports of mistreatment by services or paid carers. Again, this may reflect the distance of some groups from services, or the view that mistreatment of older people does not concern services. However, respondents reported, amongst others, a case of poor treatment in hospital, which included lack of interpreting, and a 'tea lady' being asked to help; the failure of services to consider mobility difficulties of older people in making appointments; and a case in which a person had cancelled a hip operation, as they had not understood the letter from the hospital. These were attributed to the failures of the services to be sensitive to the needs of older people generally, as well as older people from BME communities in particular.

In 18 cases, the older person concerned had obtained support, with various sources of this being identified, as Table 4.2 shows

Table 4.2: Sources of support received by older people experiencing mistreatment

Source of support received	Mentioned n=38	
	Number	Percent
Organisation	14	24
Family	8	14
Friends	7	12
Religion/God	3	5
Volunteer	2	4
Police	1	2

Note: all sources of help mentioned by each individual were recorded

Organisations clearly had a significant role to play in providing support for those experiencing mistreatment. Specific organisations mentioned were mostly (ten) specialist BME voluntary sector organisations. In addition, three people mentioned help from the local Social Work Department and one explained that they had helped with a financial difficulty through approaching statutory pension providers.

Only seven people felt that the needs of the person they had helped had been fully met. Eleven said that some had been met and two, that needs had not been met at all. Where needs had not been fully met, explanations focused on the lack of knowledge of the older people (eight), concerns that others might find out about the mistreatment (three) and belief that nothing could be done (two). There was a strong sense that issues of mistreatment persisted, as people continued in their relationships and living arrangements from which it was difficult, and in many cases they did not wish, to escape. Thus, half (16) of those whom respondents had 'come across' were said still to be in the same situation – this resonates with the earlier reports of people feeling unable to act and the difficulties that faced them. In addition, there was some evidence that people had sought help, but found it unsatisfactory. This included two reports of interpreters who had revealed information and a reference to members of the Chinese community who had little trust in the police – this came from experiences of having called for help with incidents in their businesses with abusive customers and not having received it.

Twenty four people reported that they had themselves assisted an older person who was being mistreated. Here, we were asking people about their direct experience and this again supports the finding that they had direct knowledge and experience of mistreatment. Much of this assistance involved listening, or providing information, or talking with the person concerned. In seven cases, the assistance had been more practical, involving for example assistance with claiming benefits or applying for re-housing, with eight people reporting that they had sent the person on to someone else, usually a professional such as a Social Worker or voluntary sector organisation. In some cases, money, food, personal care or transport had been offered. It is notable that rather few people had sent those they had tried to help on to contact professional help. In many cases, this seemed to be because the issues were seen as personal or because the older person only wanted to talk about the situation and did not want take action. In two cases, the helper had not known where else to go for help.

Whilst there was evidence of mutual help on an interpersonal basis, for some respondents, this had proved difficult, as others had resented what they saw as interference in private matters. This respondent's experience illustrates how difficult helping someone could be:

Instead of listening to what I am trying to say the son has shown me the list of things that he believes the old woman has done, and now he also thinks that I am trying to interfere in their family and I am trying to take the side of his nephew and older brother. (2204 Indian)

And in this case, a woman spoke of her reluctance to interfere for her friend, who had come to her own accommodation with her situation:

She was afraid of losing the relationship with her son……On the one hand, she hated the situation of being in a wheelchair…and not able to help others as she had done in the past. Now she is dependent on others for her care and physical needs and on her son for management of her finances. She is frustrated at the situation, but she could not do much about it. To me, she is not admitting to being mistreated. She is afraid of losing her son. (3250 Ukrainian)

Services for older people experiencing mistreatment

More than half (32) said that they were aware of services for older people experiencing mistreatment. Six people mentioned Age Concern, although this may have reflected their knowledge that the research involved Age Concern Scotland. However, other voluntary sector organisations were listed, including community based groups for BME older people, some specialist services and statutory bodies including the Social Work Department (mentioned by seven people) and the police (three mentions). However, it was clear that these services were mentioned because of knowledge of their general activities, not necessarily because they were thought to have any specific expertise in supporting older people experiencing mistreatment. No-one mentioned any specialist organisation. This is not surprising in the light of the lack of such specialists.

Seventeen people felt that existing services were meeting people's needs, with 22 saying they were not, and 19 unsure. There was clear doubt here. Several accounts were given of services which had proved helpful, but these were frequently qualified with comments such as 'they do their best' (2223 African Caribbean) 'this is a very difficult issue' (2213 Pakistani) followed by identification of shortcomings such as uncompleted work, and continuing need. Shortcomings identified included lack of cultural appropriateness in mainstream services, including lack of understanding of minority cultures, lack of bilingual staff and 'workers from our own community' (2213 Pakistani); overstretched voluntary sector groups, which could not respond effectively due to lack of resources; lack of staff training, which meant that staff did not know how to respond to reports of mistreatment; and a general lack of responsiveness to diversity:

Service providers should be able to have the flexibility to provide a range of services that reflect the diversity of society in relation to age (2202 Indian)

In addition, respondents referred to the reluctance of older people to approach services, which we have already identified, and the widespread lack of knowledge about services in many communities.

Where people felt that services were not meeting people's needs, we asked what improvements they felt were needed. The suggestions are listed in Table 4.3.

Table 4.3: What other services are needed to support BME older people experiencing mistreatment

Services	Mentioned n=38	
	Number	Percent
Raising awareness of elder abuse	21	36
Community member training	15	26
More bi-lingual training	12	21
Staff training	10	17
Counselling services	4	7
More police intervention	4	7

Note: all services mentioned by each individual were recorded

The emphasis on greater awareness and knowledge, including the need to educate community members, was marked. Middle generation respondents were more likely to suggest a need for increased awareness.

Elaborating on their suggestions for further services and improvements to services, many respondents highlighted what they saw as general issues with service provision for people from BME groups. So, for example, they spoke about insecure funding of community-based groups and failures in mainstream services to provide interpreting and/or bilingual staff. Others considered aspects of the place of older people in society and the need for them to be valued and respected. They spoke of the need for older people to have better knowledge of places to go for help, safe places to go and get it, or the possibility of phoning a helpline. In general, there was a strong focus on the whole person and the whole situation, including aspects of the wider environment. Thus, in discussing this topic, respondents ranged widely through issues of ageism and social exclusion, as well as the stresses on family carers and the widely perceived failure of services to be accessible and appropriate for older people experiencing mistreatment. For example. in suggesting a 'one stop shop' for services, this respondent said:

It takes time for people to know they have confidence in a drop-in centre to talk about what is happening in their home. Over a period of time, people will go to a focal point. There needs to be some focal point – an institution …. where people can go to for all sorts of problems – life is like that, it is general. A one stop approach/centre for general advice because when people are asking for something there may be other things behind it. (2205 Bangladeshi)

At the same time however, others were less optimistic. This respondent reflected the more pessimistic responses:

What can you do? Is there anything you can do? Expectations are very low. (2210 Bangladeshi)

Only one person said they knew of work done by existing services with perpetrators of mistreatment – they thought perhaps the Social Work Department might be doing something. We asked what work could be done with perpetrators. There was a strand of punitivism in the answers – for example, a 'short sharp spell in prison' was suggested, and a minority of respondents suggested legal remedies were needed:

They should be punished by the law and the law should be tightened so that it becomes clear to people that they can't abuse older people.... You could say that maybe not feeding somebody or not changing them if they've messed themselves is not seen as abusive but I think it is actually because it's about denying people their dignity and their right to dignity and I think that, that should be targeted within the law as much as if you strike somebody, because the ultimate intent is to deny them their rights and to be treated with dignity as a human being. (2206 African Caribbean)

However, this was not the main response. More typically, there was recognition of some of the pressures faced by family carers and their need for support to prevent a situation of mistreatment arising.

I think it's probably most common that such mistreatment as occurs are because carers are sometimes just stretched to breaking point. (2220 Jewish)

The theme of the need for carer support was reiterated, and some of the responses referring to improved information made explicit comment on the importance of this as part of support for family carers.

In thinking about work with abusers, nine respondents interestingly spoke more fully about careworkers involved in abuse, moving away from the predominant emphasis on mistreatment within the family. They saw clear possibilities for care homes to be more carefully monitored and for the regulation of services to have a role in preventing or addressing mistreatment. By contrast with the complexities perceived in family relationships, paid work activities appeared relatively simple, and to have the possibility of being addressed by a regulation regime.

Conclusion

The strongest and most disturbing of our findings from this set of interviews is undoubtedly the report that older people in BME groups experiencing mistreatment would do nothing about it, but would continue to live with it, often for years at a time. At the same time, people were critical of service provision that is available and felt that there was little point in older people from BME communities seeking help from services. They were in many cases attempting to provide support for older people seeking it, but their efforts were not necessarily effective. There was support for improvements in services to make them more accessible for people experiencing mistreatment.

People's difficulties in seeking help when mistreated and their lack of faith in services in particular present potentially serious problems for service providers attempting to develop and deliver services. There is a potential for the low expectations and lack of faith in services to perpetuate mistreatment and to reinforce the notion that there is no point seeking help. Given the commitment of the service providers we interviewed, and their efforts to be more responsive and to tackle issues of mistreatment of older people, there is a need to identify good practice lessons which can begin both to raise people's expectations of getting help and deliver appropriate, accessible and effective services.

5

Chapter Five

Principles of good practice

Key points

The following principles of good practice have emerged:

- Mistreatment cases should be considered as involving the whole person, within their family and community context;
- Mistreatment within services has to be addressed, even though BME community members may not see this as an issue;
- Issues of shame and confidentiality are important, but should not become obstacles to developing and offering services;
- There is a need to develop appropriate outreach work, which can enable mistreatment of older people to be discussed and addressed, drawing on the experience of services which have tackled other very sensitive issues;
- Service developments need to be aware that mistreatment may not be the 'up-front' issue for clients from BME communities;
- Improved, diversity sensitive support for carers and families could prevent mistreatment from developing;
- Non-BME service providers need to be alert to the needs of older BME people and to prevent potential mistreatment by care staff who may lack knowledge of minority cultures or who, at worst, may reflect negative attitudes towards minorities;
- Effective, collaborative work, involving the BME voluntary sector has potential to be vital in this area;
- Whilst specialist services for particular ethnic groups have done much valuable work, there is a need to be alert to differences within communities, shared experiences across communities, and the relevance of diversity competence for all service providers;
- Education and raising awareness of mistreatment of older people and how they can get support has to continue BUT there is little point in raising awareness if the support is not there;
- Training needs to ensure that BME issues are integral to discussion of adult protection, and older people's issues need to be part of training focused on race.

The service providers we interviewed were recommended as being particularly effective in supplying services for older people experiencing mistreatment, including in many cases older people from BME communities. These services made various suggestions, as we discussed in Chapter Two, for ways in which services could be improved. In addition, we also identified some areas where improvements were needed. The interviews with people from BME communities were striking for the finding that older people experiencing mistreatment, if they were looking for help, would not look to service providers, at least partly because they did not believe that service providers would/could help them. There is thus a gap between the efforts of even the best service providers and older people experiencing mistreatment. In some respects, this gap exists because mistreatment of older people is a relatively newly recognized issue, and one which service providers have only recently begun to consider. However, in terms of providing support to BME communities, services appear to be even less developed than they are for the general population. And many of the BME organisations were finding it difficult to engage with adult protection developments because of resource constraints in particular. In this chapter, drawing on both sets of interviews, as well as the focus group findings, we consider areas of good practice which link the concerns of both service providers and potential service users.

The focus group schedule (Appendix 2) presented to BME community members some of the suggestions for good practice that the service providers had identified, with a view to explicitly testing out the 'fit' or lack of it between the service providers' perspectives and those of the community members. We also re-considered these suggestions with a small group of service providers – this was important because, during the course of the research, new legislation had been promulgated in Scotland, and there had been a number of high profile media campaigns relating to elder abuse. It was important to see whether these had shifted thinking: in general for the service providers, they had not, although there was a more explicit focus on the potential of legislation.

Understanding mistreatment dynamics

Both sets of interviews had identified the complexity of family relationships involved in situations of mistreatment of older people and indicated the importance of taking these into account when considering cases. There was a clear message from the community interviews that mistreatment cases should be considered as involving the whole person, within their family and community context. In general, the service providers agreed with this, especially the BME service providers. The non-BME service providers did perhaps focus more clearly on the policy imperatives of choice for the older person, considering their individual rights and preferences. There is certainly a need to be aware of the sensitive balances between the needs of the older person and the carers.

Cases of mistreatment of older people by employed carers were relatively little discussed by community members. This may in part reflect the limited engagement of many people with formal services from outside the home. However, people's lack of recognition of these issues cannot in any sense suggest that they are unimportant. Some of the service providers undoubtedly recognized the importance of training front line staff, conducting Criminal Records Bureau/Disclosure Scotland checks and referring to Protection of Vulnerable Adults (POVA) registers, though it was not clear if they had considered whether there might be particular issues relating to work with BME communities. The lesson here is that attention needs to be given to mistreatment by care workers, even though local BME people may not perceive this as an issue.

Both sets of interviews identified the great sensitivity of addressing mistreatment of older people, and noted that issues of shame and confidentiality were possibly more acute for members of BME communities than for the general population. It emerged that ideologies of the family were especially strong in some communities, and that these could increase people's sense of shame if mistreatment occurred, and their tendency to 'save face' by tolerating mistreatment. Confidentiality issues were partly concerned with keeping family business within the family, and with maintaining the reputation of families as caring for their parents. Both older people and middle generation people were involved in maintaining these reputations. However, there were also some concerns about confidentiality within the community in relation to community based organisations which were 'close to the ground' and whose staff were locally known. We found very little evidence that BME community groups were not confidential – rather, worries that they might find this difficult because of their location and often extensive integration into local communities. The key lesson here seems to be the need to be aware of these sensitivities, but at the same time, given the real experiences of mistreatment and the needs of people for support, not to react to them in ways which make offering support difficult. BME community groups need to ensure they have established a reputation for absolute confidentiality, and they also need places where they can refer BME people who need support but who prefer not to seek it locally.

It emerged that older people in BME groups, partly because of the strong family ideologies and the care practices which followed from them and partly because of the lack of support from outside the family were in a particularly dependent relationship with their families. In addition,

many lacked independent financial means, or had surrendered control of these means to their families. Greater dependency made it particularly difficult for people to seek support from outside the family, in case they should be cut off from the only source of support they had. The potential for seeking support to make things worse was clearly important for many. However, there are precedents for delivering services which can prove acceptable and support people who need to leave their families – the key precedents here are the activities of, for example, successful services for women experiencing marital violence, also a 'taboo topic'. In this field, experienced service providers have used careful outreach work to make women feel that they can safely disclose and that they will indeed get help. Similarly, lessons from mental health or advocacy services suggest that effective support can be developed.

Recognising mistreatment

Training in recognizing potential signs of mistreatment of older people was widespread among statutory services, and some of our service provider respondents were actively involved in delivering it. In the BME voluntary sector, training was less prevalent, though some had had access to it, and were conscious of noting potential signs in their daily work. It was clear from the service providers' interviews that, in their experience, people rarely came to a service with a direct complaint of mistreatment – they were much more likely to come with other problems, and mistreatment could emerge, either implicitly or explicitly. A range of professionals may acquire knowledge of mistreatment situations, and it is important that they are alert to this. It is also important that professionals are prepared to take appropriate action. In some cases, this may be no action, if the person disclosing wishes this and has the capacity to make such a decision. If people are to be offered assistance, this has to be appropriate assistance. There are particular obstacles in delivering this, given the constraints against disclosure for BME people in the first place and in the second, their widespread perception that services cannot help them.

Another dimension of recognizing abuse relates to the need for raising awareness in BME communities of the possibility of mistreatment of older people. We found that people were aware that it could occur, but were not necessarily prepared to speak about it or to share their experiences with others, including service providers. We spoke with many people who were aware of particular cases and of a need for support to older people and family carers. More often than not, real cases of mistreatment were linked with pressure on family carers. Whilst we recognize that support for carers is an important element of Government policy and of service provision, it was evident that for BME communities, the quality and quantity of services was perceived as insufficient. Additionally, there was evidence of some reluctance to accept support from outside the family for reasons of honour and pride. We note that in other areas, where this principle equally applies, progress has been made in developing acceptable and confidential services, such as in the domestic violence services mentioned in the report and also in mental health services amongst others.

It was striking that a view was taken of mistreatment of older people which saw it as an extreme of a continuum of behaviours. Families could be pushed, by circumstances into situations of mistreating older people. This implies that with support, they could move back along the continuum, and mistreatment could be alleviated. Although there were some examples of deliberate cruelty, these were few. They would be the situations in which legal remedies might be appropriate, but our evidence suggests that a rush to use legal remedies would in many cases be unwise.

Although our BME respondents spoke rather little about mistreatment by formal care staff, there is a need to be alert to this possibility. Whilst people from BME communities are using services to a limited extent, this may be perceived as 'not a problem'. However, there is no reason to suppose that, if BME people used services more, they would be any less at risk of mistreatment by formal carers than would non-BME people. Indeed, there are reasons to expect that such mistreatment might be more common, given language differences and the persistence of racist attitudes which were indeed reported by some of our respondents – notably those whose activities took them more into the public sphere outside the home. An important good practice lesson therefore is the need to be alert to minorities who use mainstream services, and the need to ensure that these are inclusive in the sense of applying adult protection measures appropriately, as would be done for non-BME people.

The role of the voluntary sector

Our service provider interviews included a number (ten) of voluntary sector organisations specifically grounded in local BME communities. These organisations had important strengths in terms of their close engagement with, knowledge of and sensitivity to local BME communities. At the same time however, nearly all of them reported being under severe pressure, notably due to insecure funding. They differed from most of the non-BME service providers interviewed in that they tended to be non-specialist, and to take a more holistic view of people's needs than non-BME specialist services did. Whilst in some cases there was evidence that the BME organisations were not well networked with other services locally, some examples demonstrated the particular potential that exists for such organisations to work collaboratively with statutory services, to the mutual benefit of both kinds of organisations and particularly to the benefit of clients. Where local links between services were effective, it appeared more likely that people seeking support were going to get it. On the negative side, voluntary sector groups that were working in isolation, trying to offer a comprehensive local service for which they were not necessarily fully funded, were under severe strain. In many respects, therefore, a good practice implication of our work would be the need for effective, collaborative work with grassroots organisations, to build on the knowledge and skills they have in terms of community engagement and delivery of appropriate support. This implication is becoming increasingly appropriate: the BME voluntary sector has developed significant strength, and it is in this sector that the most difficult and sensitive of issues (not only mistreatment of older people, but also e.g. forced marriage and domestic violence) are likely to be raised and discussed. The best of voluntary sector activity widely enjoys the confidence of local people, as well as the confidence of local authorities (who commission such organisations to provide services). At the same time, it is important to recognize that voluntary sector groups still have work to do in building their reputations for confidentiality and appropriate services, as we have already noted.

One vexed question is that of the extent to which different ethnic groups need separate service provision. Our respondents varied in their responses to this issue. Several of the BME organisations described themselves as 'multicultural' and appeared to have found ways of working with a range of communities. Others were specifically targeted at particular BME groups. They made the same arguments about the need to be sensitive to cultural diversity and to be aware of particular issues, such as language provision. The non-BME organisations spoke much less about cultural diversity – their comments were in response to our raising the issue, and there was little evidence that the issues had been proactively addressed. Our conclusion from this material is that all services need to be culturally aware, and that many have some work to do in this regard. Clearly, the provision of services targeted to particular communities has a place, but these also have to be aware of the diversity of views and needs within particular communities: this is evidenced by our identification of differences of view between generations in 'the same' communities.

Education about abuse

Our research has identified that there are good practice lessons to be drawn from existing provision and a need for exchange of information and intelligence, especially in the light of the current development of provision of adult protection services. There remains a gap

between adult protection developments and those service providers who are grounded in local communities, and local community members do not appear to have engaged at all with adult protection idioms. At this local level, the first need is to raise awareness of mistreatment of older people, and to find ways in which people experiencing mistreatment can get support. Agencies, we have argued, need to be able to recognize it, to raise issues, to talk about it and to facilitate disclosure as well as providing remedies.

There is relevant experience which can be drawn on to ensure that these good practice lessons are passed on, and that there is continuing development and dissemination of work. No small, local BME organisation should feel the need to operate without knowledge or training on issues of mistreatment of older people – though even some of our exemplary groups had done so and were doing so. Training is an important element of possible action, though there is a need for training to improve so that BME issues are integrated into discussions about adult protection and mistreatment of older people, as well as older people's issues being linked with training focused on race issues. In their day to day work, organisations need to be aware of mistreatment as an issue, recognize signs of it and find ways of addressing it.

Conclusion

The discussion here identifies a set of principles for good practice, listed in the 'key points' at the start of the chapter. One of our important findings is that there are no clear recipes for addressing the issue of mistreatment of older people from BME communities, and that there are few precedents that organisations can follow. However, there are lessons that can be drawn from wider experience of service provision, as well as from our research findings, and we will summarise these in our concluding chapter.

6

Chapter Six

Conclusions and implications

We set out in the research with these aims:

- To identify understandings of elder abuse across a broad range of BME communities;
- To explore the implications of these understandings for preventative and support measures;
- To audit service delivery relevant to addressing elder abuse in of BME communities;
- To produce good practice feedback.

In this concluding chapter, we draw together the key findings of the research and onsider issues for good practice in service provision for BME older people experiencing mistreatment, their families and carers.

Understandings

Contrary to some views that the issues were too sensitive for BME community members to wish to discuss, we found that our respondents were most willing to speak about the mistreatment of older people. They spoke eloquently about their perceptions of the treatment of older people in today's society and of the possibilities for older people of being mistreated. Their analysis focused in particular on difficulties within families and the pressures on family carers, but also identified mistreatment of older people in service contexts and in the wider society. Our comparison with the O'Keefe et al (2007) prevalence study suggested a possibly higher incidence of experience of mistreatment, but most likely significant under-reporting and hidden mistreatment in BME experiences. Many of those involved in the study had real experience of mistreatment of older people, whether through cases they had encountered during their lives or, in a small number of cases, having experienced it themselves.

All this material provides evidence that mistreatment of older people does occur in BME communities, that people are aware of it and that they are willing to speak about it, given a safe and confidential means of doing so. It is likely that much mistreatment remains hidden, as people lack opportunities to disclose it, or may prefer not to disclose it as they perceive no available remedies and consider putting up with mistreatment to be their 'least worst' option.

We found a very widespread view that, whilst mistreatment occurred and people knew about it and talked about it, if they experienced it directly, their most likely response would be to do nothing. This was partly due to older people's embeddedness in family relationships, their dependency on their current living arrangements, the potential shame of disclosure and a real lack of alternatives. Our respondents perceived that there was little available service support appropriate for them which they could trust and rely on.

Where people did identify or seek support, the BME voluntary sector was of particular significance. Generally, our respondents took the view that more support for older people experiencing mistreatment was needed, and that services outside the home could provide this.

It is particularly notable that we did not find systematic cross-cultural variation in views, but a range of perspectives which cross-cut ethnic boundaries. This is in keeping with other recent research findings, which have shown that ethnic differences and other differences, such as social class, cross-cut one another. Thus we found for example some cross generational differences, such as greater awareness of and engagement with services among younger people; some religious differences, with Muslims feeling more vulnerable to abuse when out in public; language issues whereby speaking English improved access to information; indications that poverty increased dependence on family; gender issues, with some women having experienced lifelong abuse in violent marriages.

Implications

The community based views and experiences suggest that there is indeed a place for services to provide support for older people experiencing mistreatment. They also suggest that the current service response has limitations and is not widely perceived to provide an effective response. In part, these perceptions are linked with more generally negative views about the lack of cultural appropriateness of services, which we have characterized as a lack of responsiveness to diversity – these are widely evidenced elsewhere, and contrast with the clearer (though still limited) engagement with services found in the prevalence study (O'Keefe et al 2007). However, there are some additional factors which have emerged particularly in relation to issues of mistreatment. These include the need for services to recognize mistreatment and to be able to respond to it as an issue; the sensitivity of mistreatment and at the same time the need to find ways for people to raise it and to make choices about any action to follow; the great need for confidentiality about mistreatment and people's lack of confidence that this will be maintained. Furthermore, it could be argued that there is a marginalization of mistreatment in services which are used by BME communities in the sense that BME voluntary sector services already have wide remits and have difficulties taking on, as they see it, additional work for which they have neither funding nor training. At the same time, mainstream services are not perceived as satisfactory alternatives.

The state of services

Although perceptions of services among our community based respondents were frequently somewhat negative, and few people saw existing services as being able to respond to mistreatment of older people, we did identify principles and examples of good practice which were in tune with the community perspectives. Of course the services that were included in the study were examples which had been identified by reputation as being especially good, and the people interviewed in the communities were speaking about the general run of services. There does appear to be something of a gap between the best of service provision and the general experience of community members, and our research suggests an urgent need for the dissemination and implementation of the good practice principles on a much wider front.

Many of the very good services that took part in the study were under considerable pressure in terms of funding, from pressure of demand for their services, pressure to increase the range of provision they offered, difficulties of referring clients to appropriate more specialist support and so on. Thus services could reasonably hesitate to embark on raising awareness of mistreatment of older people in case this produced demand for services which could not be met.

Good practice

Most of the good practice principles which emerged from the study were principles that could be applied across the board of service provision. They emphasise the need for recognition of and response to mistreatment of older people to be embedded within services of many kinds, rather than the possibility of separating it out from other issues that are brought to services. The community interviews grounded mistreatment of older people in family, community and wider social life. Understanding of and responsiveness to mistreatment of older people needs to be grounded across the spectrum of services in a similar way.

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Appendices

Appendix 1: List of organisations interviewed for the study

Action on Elder Abuse
Advocacy for Older People in Greenwich
Age Concern Scotland
Akwaaba Ayeh mental health advocacy project, Leicester
Bradford Council for Mosques
Bradford Teaching Hospital Foundation Trust
Burnbank Residential Care Home (Dundee)
Cardiff Adult Services
EKTA Project (Asian Elders), London
Essex Police
Grandparents Association
Hanover Scotland
Help the Aged Northern Ireland
Hounslow Social Services
Jewish Care Scotland
Kiran Women's Aid
Leicestershire Alzheimer Society
Leicestershire Ethnic Elderly Advocacy Project
London Borough of Tower Hamlets
Lothian and Borders Police
Merseyside Chinese Community Development Association
Minority Ethnic Carers of Older People (Edinburgh)
Nari Kallayan Shangho women's welfare group (Edinburgh)
Northern Ireland Regional Vulnerable Adult Forum
Polish and Ukrainian Support Service (Edinburgh)
Practitioner Alliance against Abuse of Vulnerable Adults/Better Government for Older People
Vale of Glamorgan Council
West Lothian Council

Organisations who took part in the service providers' focus group and follow up interview were:
EKTA Project (Asian Elders), London
Help the Aged Scotland
Stirling Council
Scottish Independent Advocacy Alliance
Scottish Government

Appendix 2: Interview schedules

Note: full copies of the schedules may be requested from the authors at **a.m.bowes@stir.ac.uk.**

Service providers interview schedule - summary

Organisational details
Name, type of organisation, location, job title of respondent and managerial responsibilities, how organisation was identified for inclusion in the study;

Background to organisation
When established, description of activities, any funding for BME work, any bilingual staff and what languages spoken, whether and what ethnic monitoring carried out;

Work of organisation
Strategy/policies for working with BME adults and older people; services provided for BME adults and older people; how services promoted; perceived strengths and weaknesses of services; whether and what interpreters used;

Perceptions of mistreatment of older people
Whether it occurs in BME communities; what is understood by mistreatment; how they recognise signs of mistreatment; whether it is an issue locally and/or nationally;

Experiences of working with mistreated BME older people
Whether they see older people who are mistreated; what kinds of mistreatment they see; any changes in awareness locally; who is most likely to experience mistreatment (gender and age);

Responses to mistreatment of BME older people
What can the organisation do; any recent changes in numbers presenting; any recent changes in organisation's response;

Understandings of mistreatment in BME communities
How BME people view elder mistreatment; any training received; whether training beneficial;

Good practice
Any good practice examples; what gaps exist in services for older people experiencing mistreatment; how services might be improved; how improvements can take BME people's needs and be appropriate for them; awareness of documentation and strategies on elder mistreatment; awareness of existing service provision;

Collaborative working
Whether and how working with other organisations that provide services to BME adults and older people; if not doing so, why not; experience of referrals of clients experiencing mistreatment; tracking referrals;

Anything else
Finally, is there anything else you would like to add?

Community members interview schedule – summary

Participants
How identified; location; gender; age; household composition; housing tenure; marital status; disability; ethnic origin (self defined); religion; how they spend their time; employment; housework; any help; any caring responsibilities; education;

Treatment of older people
How are older people treated; what would 'mistreatment' mean; whether and mistreatment of older people happens in BME communities; whether older people can make choices;

Experiences and perceptions of mistreatment
Whether heard about or come across mistreatment; extent of mistreatment; compared with country of origin; any changes over time; who is more likely to experience mistreatment – gender, age; reasons for mistreatment; most likely perpetrators and reasons;

Responses to mistreatment
How will older people generally and older BME people respond to mistreatment; whether they know of particular cases; description of particular cases and their outcomes; what support people got, if any, and how good it was; whether they personally gave support and how; whether they directed the person elsewhere and where;

Awareness of services
Whether aware of services, and which ones; whether existing services meet needs; what other services needed; services for perpetrators; whether person has been consulted about services;

Anything else
Finally, is there anything else you would like to add?

Focus group schedule – summary

Talking about mistreatment of older people
Why is this difficult? How to promote more discussion and better awareness and understanding.

Occurrence of mistreatment
Involvement of families, staff at home or in organisations and institutions, general public; relationships between mistreatment and ideas about older people generally; any recent changes.

Responses to mistreatment
Why do some older people just accept mistreatment as 'part of life' and put up with it; what alternatives are there.

Role of services
Whether more services could help; whether they should be especially for BME people; what other non-services developments might be helpful; possible impact of more general service improvements.

Perpetrators
Support for perpetrators and its potential benefits; relationship between mistreatment and stress.

Good practice in services
Review of good practice suggestions from service providers and community interviews including awareness raising; staff training; promoting discussion of issue; sensitivity in services and whether it is a reality; whether services might be part of the problem; cultural awareness; role of advocacy; potential usefulness of legal remedies; lessons from other services, such as domestic violence services.

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