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Contents

Editorial

Rosette Farrugia-Bonello 74

Articles

Measuring and Modelling Demographic Trends in Malta: Implications for Ageing Policy 78

Marvin Formosa

Pathways to Residential Respite Care in Malta: A Qualitative Study 91

Roberta Sultana and Andee Agius

Communication Training for Informal Caregivers of Persons with Dementia in a Rehabilitation Hospital 108

Roberta Said

Elder Abuse: An Evaluation of Criminal Act XXX1 (2014) 122

Rene Darmanin

The Adequacy Pension Income Conundrum 133

David Spiteri Gingell

Elder Abuse: International and Polish Perspectives 145

Marvin Formosa and Jolanta Maćkiewicz

Book review

Buffel, T., Handler, S. & Phillipson, C. (eds). (2018). *Age-friendly Cities and Communities: A Global Perspective*. UK: Policy Press, 312pp. 156

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Reviewed by Datin Jacqueline Wong

Editorial

Rosette Farrugia-Bonello¹

Introduction

Countries are experiencing one of the greatest demographic disruptions in history - the rapid ageing of their populations. Longer lifespans and reduced birth rates will drive an unprecedented growth in the proportion of the population aged 60 plus. As people age, their need for both health and social care is likely to become increasingly multifaceted. Governments around the World are beginning to experiment with new policies to address these challenges and hence become prepared and well-equipped to secure the needs of population shifts.

Malta, like any other country is also ageing. Malta's population is expected to reach 461,100 persons by 2035 and to reach 476,700 persons by 2060. Life expectancy at birth during 2015-2060 period is projected to increase by 6.4 and 6.3 years from 78.7 to 85.1 and 82.8 to 89.1 for males and females respectively. The fertility rate for the same period is projected to increase only from 1.44 to 1.79. All this makes Malta, one of the fastest ageing countries in the European Union.

This volume of the *International Journal of Ageing in Developing Countries (IJADC)*, with the exception of the last paper, basically focusses on the realities of ageing and the related upcoming and needed policies to face these challenges in Malta. The editorial board have selected three papers, to be published in this peer-reviewed, on-line journal, from the book 'Active and Healthy Ageing in Malta: Gerontological and Geriatric Inquiries' (Formosa, 2018). This book is a timely addition in providing a broad ranging view of the challenges and responses to the increasing age and its implications amongst the Maltese population. The papers chosen to be published in this volume addresses 'Communication training for informal caregivers of persons with dementia in a rehabilitation hospital' (Roberta Said), 'Elder Abuse: An evaluation of Criminal Act XXXI(2014)' (Rene Darmanin) and 'The Adequacy Pension Income Conundrum' (David Spiteri Gingell). The authors of all the papers include academics and policy professionals, and as such bring a range of expertise and insights to the issue. This issue contains also one book review on 'Age-Friendly Cities and Communities: A Global Perspective' (Buffel, Handler & Phillipson, 2018), reviewed by Jacqueline Wong.

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The first article on 'Measuring and modelling demographic trends in Malta: Implications for ageing policy' by Marvin Formosa sets the background for all the following three papers. This article reviews demographic changes relating to population ageing that took place in Malta and future population projections which anticipate even higher numbers and percentages of older persons. Population projections indicate clearly that Malta will be one of the fastest ageing countries in the European Union. Moreover, Formosa writes about the ageing-related challenges that the Maltese government is currently facing through three key overlapping areas of policy boundaries, namely the labour market, health care and long-term care. Formosa concludes his article by putting forward other policy issues which will need to be addressed in the foreseeable future. These are policy relating to ethnic minorities, LGBTIQ ageing, palliative care and capacity building.

Roberta Sultana and Andee Agius explore 'Pathways to residential respite care in Malta: A qualitative study'. In this contribution, Sultana and Agius found that the decision for informal caregivers to apply for such a service very often involves conflicting perceptions and ambivalent judgements. This paper reports on a qualitative study exploring the underlying factors that steer informal caregivers to seek publicly-funded residential respite in Malta. The major finding was that the majority of the caregivers who resorted to residential respite were taking care of older persons with relatively high dependence and while some caregivers referred to respite as the only solution to enjoy privacy for a brief period of time in their own home, others perceived respite as filling the gap, until their care recipient was admitted permanently to a long-term care facility. Moreover, this study found also that there is a lack of co-operation from care recipients and limited trust in formal care systems, both of which were the key factors that hindered the possibility that caregivers use the service more frequently or at all.

The third paper in this volume, by Roberta Said focuses on 'Communication training for informal caregivers of persons with dementia in a rehabilitation hospital'. In Malta, the number of people living with dementia in 2015 was estimated to be 6,071, equivalent to 1.5 per cent of the population. This number is predicted to rise to around 10,000 persons in 2030, making up 2.3% of the Maltese population and to about 12,955 persons by the year 2050, making up 3.3% of the Maltese population. Communication impairment in individuals with early to moderate dementia becomes more prominent as the condition progresses and this makes the caring process stressful due to the difficulties encountered. In this article, Said explains the various difficulties encountered by the caregivers and the challenges that they are faced with. Moreover, the study - through purposive sampling, shows that the challenges brought about by the communication difficulties, affects the caregivers' and persons living with dementia's physical and emotional health. The article concludes that necessary and timely information is imperative to be provided to the caregivers so as to facilitate communicative interactions between them and their care recipients.

'Elder abuse: An evaluation of Criminal Act XXX1 (2014)' is discussed in the fourth paper of this volume. This study by Rene Darmanin, examines the legal provisions enacted by the Maltese Act XXXI of 2014 (Ministry for Justice, Culture and Local Government, 2014) whilst contrasting them to the former provisions of the Criminal Code regulating elder abuse. The

article shows that several studies reveal that older persons are less inclined to report abuse to the police, but are more likely to report abusive behaviour to members of the clergy. In long-term care settings, an office has been set up whereby residents in care homes and long-term care facilities including their relatives, could report any form of elder abuse. Such a service is also required in the community as till the present, older persons suffering from abusive behaviour in their own home may only report such abuse to the executive police. The article concludes by suggesting the idea of introducing an offenders' register. This would create a sense of security for the general public and employers could use this register to search the names of potential employees and hence determine whether prospective employees were at some point in time convicted of any abuse against older persons or otherwise.

The fifth and last contribution by Marvin Formosa and Jolanta Maćkowicz is on 'Elder abuse: International and Polish perspectives'. This paper shed insights into the realities of elder abuse. Elder abuse is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair. The paper gives a clear definition of elder abuse and goes on to explain the five dominant types - physical abuse, material and financial abuse; psychological or emotional abuse; sexual abuse; spiritual abuse and neglect. The paper then goes on to mention the key international policy frameworks that targets the issue of elder abuse. The United Nations (2002) *Madrid International Plan of Action on Ageing* (MIPAA) This plan of action addressed elder abuse and offers several recommendations. It calls for changes in attitudes, policies and practices at all levels and in all sectors in order to ensure that people everywhere are able to age with security and dignity, as citizens with full rights. The authors in this paper refer also to the World Health Organisation (WHO) which also recognises the need to establish a global strategy for the prevention of the mistreatment of older people. Moreover, the United Nations Economic Commission for Europe's (UNECE) urges member states to safe guard the dignity of older persons. The paper than focuses on a study carried out in Poland. The findings demonstrate that legislation is urgently required in order to enact and implement programmes to safe guard older persons from abuse and hence maintaining their dignity.

The topics researched, findings and analyses presented in the first four papers, show that whilst ageing is increasingly evident on policy agendas in Malta, there are still significant challenges and obstacles ahead as we strive to build an active and healthy ageing society for all. Moreover, the last paper demonstrated clearly that legislation on elder abuse is needed in Poland. The messages from all papers are relevant to all policy makers particularly in low-income countries and for countries with economies-in-transition, where by 2050, 80% of people aged older than 60 years will live. It is crucial that research findings in these studies be translated into action. It is imperative that countries need to adapt their own systems so as to answer local needs. As the main editor for this volume, I am delighted to commend to you the collection of these five papers as an important contribution to an active and healthy ageing policy.

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Measuring and Modelling Demographic Trends in Malta: Implications for Ageing Policy

Marvin Formosa¹

Abstract. Malta's population experienced a sharp ageing transition due to increasing and decreasing levels of life expectancy and fertility rates respectively. This article reviews demographic changes relating to population ageing that took place in Malta, and future population projections which anticipate even higher numbers and percentages of older persons. At end of 2017, 18.8% of the total population, or 89,517 persons, were aged 65-plus. The largest share is made up of women, with 53.4% of the total. The sex ratios for cohorts aged 65-plus and 80-plus in 2013 numbered 83 and 60 respectively. Population projections indicate clearly that Malta will be one of the fastest ageing countries in the European Union. the (Maltese) percentage of children (0-14) of the total population is projected to increase slightly from 14.5% to 15.4% (+0.9%), whilst the working-age population (15-64) will experience dramatic decrease, from 68 to 56.1% (-11.9%). On the other hand, the older population segment will incur extraordinary increases. The 65-plus/80-plus population will reach 28.5%/10.5% of the total population in 2060, from 17.5%/3.8% in 2013 (+11.0/6.7%). The ageing-related challenges that the Maltese government that is currently facing traverse three key overlapping areas of policy boundaries and include the labour market, health care, and long-term care. There will also be policy issues which, if not immediate, will certainly need to be addressed in the foreseeable future. These include policy relating to ethnic minorities, LGBTIQ ageing, palliative care, and capacity building.

Keywords: Malta; demography; ageing; population; welfare policy; long-term care.

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Introduction

The Maltese archipelago (Malta) is a European Union Member State. It consists of three islands - Comino, Gozo and Malta - at the heart of the Mediterranean Sea, 93 kilometres south of Sicily and 290 kilometres north of Libya. Comino is uninhabited, and with Gozo having a mere population of 31,446 persons, leaves Malta as the major island of this archipelago state, with as much as 393,938 residents (2013 figures) (National Statistics Office, 2015a). Malta gained independence from Britain in 1964 when it also joined the Commonwealth, and became a Republic in 1974. Its form of government is one of a legislative house, with parliament representatives elected by universal suffrage for a term of five years. Malta joined the European Union in 2004, and adopted the Euro as its currency in 2008. In line with other countries, Malta's demographical scenario was traditionally characterised by a young population (Formosa, 2017; , 2019; Formosa & Cassar 2019). However, this changed abruptly at the beginning of the second half of the 20th Century as an aggressive emigration policy was launched in the wake of the rundown of British colonial rule. In the 1950s and 1960s, no less than 140,440 persons - half of Malta's population at the time - emigrated from Malta (Formosa & Scerri, 2015). As a result, Malta's population experienced a sharp ageing transition, to the extent that in 1968 the Government was the first nation to table a motion before the United Nations Assembly to discuss the global trend in population ageing (Formosa, 2015a). In subsequent decades, Malta experienced a notable increase and decrease in its life expectancy and fertility figures respectively, to evolve out of a traditional pyramidal shape to an even-shaped block distribution of equal numbers at each cohort except at the top. This article reviews the demographic changes relating to population ageing that took place in Malta, and future population projections which anticipate even higher numbers and percentages of older persons. Data was sourced from published censuses for 1995, 2005, and 2011 (Centre of Statistics, 1997; National Statistics Office, 2007, 2012, 2014), supplemented by annual demographic reviews (National Statistics Office, 2015a, 2015b, 2016a, 2016b), European Commission (2015, 2016a) publications, and academic demographic analysis (Camilleri, 1993; Formosa, 2014, 2015a, 2015b, 2016a, 2017, 2018a, 2018b; Miljanic Brinkworth, 2015).

Population growth

On average, censuses in Malta were taken every ten years between 1842 and 2011 (table 1) (National Statistics Office, 2014). Between the first census carried out in 1842 and the last Census in 2011, the population of Malta increased 3.6 times, from 114,499 to 416,055 persons, and nearly doubling from 211,564 to 417,432 persons in the 1911-2011 period. Between the first two censuses held in 1842 and 1851, the population increased by an average of 0.9% every year. The population underwent a similar rate of growth between 1851 and 1861, but between 1861 and 1881 the average annual rate of growth decreased marginally to 0.6%. This was followed by a period of acceleration when the population increased significantly so that in 1911 Malta's population reached 211,564. The decade 1911 to 1921, which included the First World War, was characterised by insignificant population growth that averaged no change in the annual growth rate. This translated into an increase of just 694 persons during this period.

Table 1: Intercensal change: Total population and sex ratio (1842 - 2011)

Census	Enumerated population			Intercensal change (%)		
	Total	Males	Females	Total	Males	Females
1842, March	114,499	55,168	59,331	--	--	--
1851, March	123,496	60,456	63,040	7.9	9.6	6.2
1861, October	134,055	66,270	67,785	8.6	9.6	7.5
1871, May	141,775	69,952	71,823	5.8	5.6	6.0
1881, April	149,782	73,430	76,352	5.6	5.0	6.3
1891, April	165,037	81,316	83,721	10.2	10.7	9.7
1901, March	184,742	91,994	92,748	11.9	13.1	10.8
1911, April	211,564	105,601	105,963	14.5	14.8	14.3
1921, April	212,258	102,745	109,513	0.3	-2.7	3.4
1931, April	241,621	117,457	124,164	13.8	14.3	13.4
1948, June	305,991	150,665	155,326	26.6	28.3	25.1
1957, November	319,620	153,108	166,512	4.5	1.6	7.2
1967, November	314,216	150,598	163,618	-1.7	-1.6	-1.7
1985, November	345,418	169,832	175,586	9.9	12.8	7.3
1995, November	378,132	186,836	191,296	9.5	10.0	8.9
2005, November	404,962	200,819	204,143	7.1	7.5	6.7
2011, November	417,432	207,625	209,807	2.7	3.2	2.3

Source: National Statistics Office, (2014)

The 1921-1930 decennium saw a substantially higher average annual growth rate of 1.4%, with the population rising to 241,621 in 1931 (Camilleri, 1993). The next census was carried out in 1948 after the end of the Second World War. Herein, the population exceeded the 300,000 mark to stand at 305,911. Between 1948 and 1957, the population increased by 13,629 persons, of whom 11,186 were females, but due to high emigration trends the average rate of population increase remained less than 0.5% per annum. After 1962, the Maltese population slowed its long history of rapid growth due to a renewed emigration spurt in the wake of the rundown of British Government employment. This emigration drive caused a marked tendency for the birth-rate to decline, and hence, brought about a reduction of 5,404 persons (-1.69% of the population) between the years 1957 and 1967. The population stood at 314,216 in 1967. A span of eighteen years elapsed until the next census. In 1985, the population comprised 345,418 persons implying an increase of 31,202 persons that, calculated from 1967, represented an average annual increase of 0.6%. During this period the population was affected by onward migratory flows. The subsequent censuses were carried out in 1995 and 2005 (Centre of Statistics, 1997; National Statistics Office, 2007). During this period, a steady increase was experienced, with the population going up to 378,132 in 1995, and exceeding the 400,000 mark in 2005 to reach 404,962. In terms of growth rates, an average expansion rate of 0.9% was experienced between 1985 and 1995, slowing down to 0.7% in the ensuing decade. This deceleration in population growth is attributed mainly to a decline in the birth rate which has contributed to an ageing population. In the last census held in 2011, the population grew by 2.7% to 417,432, indicating a slowdown in population growth with an average annual increase of 1,849 compared to nearly 2,700 evidenced in the previous decennium (National Statistics Office, 2014).

Population ageing

In 1901, 34.1% and 5.4% of Malta's population were in the 0-14 and 65-plus age groups respectively (table 2). As the 20th Century progressed, the proportional representation of these segments changed by very narrow margins, reaching 37.4% and 6.8% in 1957 respectively. However, during the second half of the 20th Century the 0-14 and 65-plus age groups decreased and increased significantly to the extent of reaching 13.9% and 18.8% in 2017 respectively, whilst the 15-64 cohort remaining relatively stable (67.3%) (National Statistics Office, 2018a, 2018b). The median age in the year 2011 stood at 40.5 years, up from 38.5 years in 2005 (*ibid.*).

Table 2: Percentage distribution of population by age groups (1901-2011)

Census Year	0-14	15-64	65+
1901	34.1	60.5	5.4
1911	33.6	61.3	5.1
1921	31.8	62.6	5.6
1931	32.1	62.1	5.8
1948	34.9	59.4	5.7
1957	37.4	55.8	6.8
1967	29.4	61.8	8.4
1985	24.1	66.0	9.9
1995	22.1	62.0	15.9
2005	17.1	69.2	13.7
2011	14.8	68.9	16.3
2017	13.9	67.3	18.8

Sources: Camilleri, (1993); Centre of Statistics, (1997); National Statistics Office, (2007, 2014, 2018a, 2018b).

Such fluctuations were largely the result of a declining birth rate together with an increasing life expectation for both men and women. On one hand, whilst the crude birth rate in Malta was relatively stable over the first half of the Twentieth Century, at around 38 annual births per 1,000, it has declined steadily since, reaching 9.6 births per 1,000 population in 2015 (National Statistics Office, 2016). Indeed, whilst in 2017 France had the highest fertility rate of 1.9 babies per woman, Malta was at the very bottom of the list with 1.32 babies born on average for every woman (Eurostat, 2019). However, it is noteworthy that due to an increase in migrant workers the number of live births increased from 4,466 in 2008 to 7,712 in 2017 (The Independent, 2018). On the other hand, at the end of the World War II, life expectancy in Malta was around 43 and 46 years for males and females respectively (National Statistics Office, 2016). However, in 2016 life expectancy at birth stood at 80.6 years for males and 84.4 years for females, while life expectancy at age 65 stood at 19.7 years for males and 22.1 years for females (National Statistics Office, 2018c). Such extensions in life expectancy have been reached due to the significant developments in modern medicine, higher overall level of education and hygiene. The 'healthy life years' statistic refers to the number of years spent free of long-term activity limitation, equivalent to disability-free life expectancy, and constitutes an important indicator to monitor whether the extra years of life are lived in

good health (Organisation for Economic Co-operation and Development / European Union, 2018). The average life expectancy was 81.9 years in 2015, up from 78.4 years in 2000 and the sixth highest across the European Union. The average life expectancy across European Union Member States was 80.6 years. This means that Maltese men were found to, on average, live 72.6 healthy years, with women spending an average of 74.6 years in good health. At end of 2017, 18.8% of the total population, or 89,517 persons, were aged 65-plus (National Statistics Office, 2018a, 2018b) (table 3). The largest share is made up of women, with 53.4% of the total. In fact, the sex ratios for cohorts aged 65-plus and 80-plus in 2013 numbered 83 and 60 respectively.

Table 3: Total population by age (31 December 2017)

Age	Males	Females	Total	% of total pop.	Sex ratio
All ages	240,599	235,102	475,701	100	102.3
60+	55,697	63,853	119,550	25.1	87.2
65+	40,606	48,911	89,517	18.8	83.0
80+	7,474	12,465	19,939	4.2	60.0
60-69	29,495	29,840	59,335	12.5	98.8
70-79	18,728	21,548	40,276	8.5	86.9
80-89	6,648	10,507	17,155	3.6	63.3
90+	826	1,958	2,784	0.6	42.2

Source: National Statistics Office, (2018a, 2018b)

The coupling of increasing life expectancy and decreasing fertility rate re-shaped Malta's population structure from a long-held pyramidal shape - characteristic of low income developed countries - to an even-shaped block distribution of equal numbers at each cohort except at the top, and where older women outnumbering their male peers. The advantage of women over men in life expectancy tables also means that, similar to international statistics, married men and widowed women are over-represented in later life. This has clear and serious implications for social/health care policy. Whilst by the age of 70 the majority of women are widows, most men are still in married relationships. Older women also tend to be in possession of lower levels of social and financial capital when compared to male peers (National Statistics Office, 2017). Many find themselves constrained in a 'caring' straightjacket as they tend to marry men older than themselves who generally need various levels of social and health support, whilst also caring for siblings and, many times, even for a number of grandchildren (Formosa, 2016a). Malta's 'old age' dependency ratio (measured as the proportion of persons aged 65-plus as a percentage of the working-age population of persons aged 15 to 64) has been experiencing a steady increase in recent decades. In 2013, this figure stood at 26 percentage points, compared to 28 percentage points across the European Union, when this percentage measured 17 and 19 percentage points in 1995 and 2005 respectively (European Commission, 2015). As pointed out in the forthcoming section, projections foresee Malta's old age dependency ratio to increase further, and even exceed the European Union average in the coming decades.

Population projections

There is no doubt that the current population ageing trend is a demographic movement to be taken with certainty, and indicators, both absolute and positive, point at its future continuation. Moreover, projections indicate clearly that Malta will be one of the fastest ageing countries in the European Union. During the 2013-2060 period, life expectancy at birth is projected to increase by 6.4 and 6.3 years for males and females, from 78.7 to 85.1 and 82.8 to 89.1 respectively (European Commission 2015). For the same period, the fertility rate will increase 1.44 to 1.79. As a result, Malta's population is expected to reach 463,200 and 476,700 persons by 2040 and 2060 respectively, since from 2015 onwards the number of deaths will be outnumbered births, and hence, population growth due to natural increase will cease (National Statistics Office, 2016b). Indeed, from present-day onwards positive net migration will be the only population growth factor, though it was projected that as from 2035 this positive net migration will no longer counterbalance the negative natural change, and the population will become increasingly aged (European Commission, 2015). On one hand, the (Maltese) percentage of children (0-14) of the total population is projected to increase slightly from 14.5% to 15.4% (+0.9%), whilst the working-age population (15-64) will experience dramatic decrease, from 68 to 56.1% (-11.9%). On the other hand, the older population segment will incur extraordinary increases. The 65-plus/80-plus population will reach 28.5%/10.5% of the total population in 2060, from 17.5%/3.8% in 2013 (+11.0%/6.7%). As regards the percentage of the population 80-plus of the 65-plus cohort, statistics predict an increase from 21.7% to 36.7% in the 2013-2060 period (+15.1%). The 2013-2060 period will see the 'old age' dependency ratio in Malta increase from 26 to 51 percentage points, one percentage point higher than the European Union average. This means that Malta would move from having four working-age people for every person aged 65-plus to a ratio of two to one. The Maltese 'total' dependency ratio (people aged 14 and below and aged 65-plus, as a percentage of the population aged 15-64) is also projected to increase, from 47 to 78 percentage points, again one percentage point higher than the European Union average.

Policy implications

The demographic trends presented herein consider the age-structure of the Maltese population in today, and how it could look in the coming decades. It is clear that there requires no added emphasis on the fact that Malta is 'turning increasingly grey' in the coming decades. In terms of drivers of population changes two issues stand out (Formosa, 2015b). On one hand, although the total fertility rate is projected to increase, it will nevertheless remain below the natural replacement rate. On the other hand, the expected large and sustained increases in life expectancies in life expectancy at birth will result in an unprecedented boom of older persons, especially persons aged 80-plus. The resulting explosive growth of older adults - suffice to state that by the year 2020, about one in five Maltese are projected to be over age 65 (National Statistics Office, 2016b) - will result in a mix of opportunities and challenges. Whilst an ageing population presents itself as an opportunity to communities because many older adults are committed, long-time residents, who contribute their time and energy to local issues, at the same time supporting the needs of older persons represents a hard-hitting challenge. Ideally, older adults should not feel

forced to move to a supportive environment, so that the 'ageing-in-place' ideal - referring to individuals growing old in their own homes with the help of environmental modifications to compensate for personal limitations - remains a realistic possibility. The ageing-related challenges that the Maltese government that is currently facing traverse three key overlapping areas of policy boundaries.

Labour market

The long-term sustainability of public finances in Malta remains a challenge. Demographic projections anticipate increases in overall participation rates in the labour market, but in particular for older workers aged 55-plus (Formosa, 2014). However, labour supply will decline and the total number of employed persons will diminish since anticipated increases in employment rates will be slower than at present as trend increases in female employment will be less pronounced. Hence, both the working-age population and the numbers of actively employed persons are expected to start falling following the year 2025. This scenario impelled the European Commission to issue the following recommendation to the Maltese government:

The pension system faces the double challenge of achieving sustainability while ensuring adequate retirement incomes. Pension expenditure was lower than the EU average in 2013, at 9.6 % of GDP, but it is projected to increase to 12.8 % by 2060, one of the highest in the Union...In order to improve the adequacy of the system, the contributory national minimum pension continues to evolve in 2016, with a view to reaching 60% of median income by 2027, and to extend its coverage. (European Commission, 2016a : 106)

The effectiveness of reform towards sustainable public pensions depends on safeguarding the employability of the older cohorts. Most specifically, restructurings should include more effective and fairer policies, rather than stand-alone measures and generic statements in policy documents, and include pragmatic interventions that improve education opportunities, access to medical care, and a lower exposure to various risk factors that generally function to push workers from lower socio-economic groups towards earlier exits from the labour market.

Local research on older workers found that whilst males tend to be inactive due to early or mandatory retirement policies, females generally cite family responsibilities (Formosa, 2014). The reasons driving older workers towards labour exit are complex, comprising a mix of positive and negative factors that include retirement schemes, caring commitments and good financial assets on the one hand, and poor health, redundancy, and unfriendly working conditions on the other. Mitigating against such a state of affairs, Malta's *Strategic Policy for Active Ageing* (Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2013) encourages older individuals to remain in the labour market as part of the European Union's 'active ageing' agenda. However, this shift from 'passive' to 'active' welfare policies for older persons will not happen on its own, but only in conjunction with age-friendly labour policies. As the Council Declaration on *European year for active ageing and solidarity between generations (2012): The way forward* (Council of the European Union, 2012) underlined, policies may range from removing incentives for early exit from the labour

market to specific policies that create job opportunities for older workers. In this respect, Malta's *Strategic Policy for Active Ageing* (Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2013) includes a two-pronged response. On one hand, it advocates that general policies should include the removal of fiscal and social disincentives to stay in employment, adaptation of workplaces to older workers' needs and general difficulties to work shifts, and the changing of the work environment to meet the needs of older employees. On the other hand, it supports specific policies should cater for the possibility of gradual or flexible retirement, allowing older workers better access to vocational training and professional education to upgrade their skills, transforming employers' negative mentalities about older workers, and the promotion mixed-age working teams. The level of employment and social security systems is especially crucial. Flexible levels of employment with parallel adjustment in social security support includes the reduction of incentives for early retirement and options for continued employment beyond retirement age.

Health care

The Maltese Government has not stood impassively when faced with the increasing number of potential older persons as clients of public social and health care services (Formosa, 2015c, 2017, 2018b). Presently, the government of Malta employs 14 geriatricians to visit and treat older persons in acute and rehabilitation hospitals respectively, as well as in care homes and long-term care facilities. This means that there is a consultant geriatrician for every 7,948 person aged 60-plus, which compares well with other European Union countries such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250) (2015 figures). The newly incepted Community Geriatrician Service, provides a geriatric medical review with other members of the interdisciplinary team to homebound older persons. An appointment of a liaison psycho-geriatrician also serves to improve the management of an increasing number of older persons with cognitive, mental and behaviour problems, especially persons with dementia. The government's vision is that the institutionalisation of older persons should only occur as a last resort. Hence, it coordinates various community services to aid older persons to age-in-place (Formosa & Scerri, 2015; Scerri & Formosa, 2015). Whilst the handyman service provides various repair jobs that range from electricity repairs to plumbing to carpentry at nominal costs, the incontinence service provides diapers at a heavily subsidized prices. Night-shelters offer older persons who live alone a secure and protective environment to spend the night in, and the respite service targets families who take care of their elder relatives at home by providing six weeks (twice yearly, where each length of stay cannot exceed three weeks) of care service in care home for older persons. Active Ageing Hubs and Dementia Care Centres prevent social isolation and feelings of loneliness through creative learning activities which also function to provide much needed respite to informal carers. Community services also include the Telecare Plus service which enables subscribers to call for assistance when required, and hence, encouraging them to continue living in the community; the home help service which offers non-nursing personal assistance and light domestic work so as to provide respite and support for informal carers; the meals-on-wheels service which supports older persons who are unable to prepare their meals; and the 'Live-in Carer' service which provides financial support to older persons who

employ a full-time carer of their choice to assist them in their daily needs. Domiciliary health services are coordinated through the CommCare Unit which includes an interdisciplinary team made up of administrative staff, nurses, occupational therapist, podiatrists, personal caregivers, physiotherapists and social workers. A Dementia Intervention Team - consisting of a Coordinator, a nurse, an occupational therapist and a social worker - visits persons who have been diagnosed with dementia with the objective of providing them and their cares with professional support and advice.

However, many structural and fiscal challenges remain as far as health ageing policy is concerned. These include improving financing arrangements to foster pre-funding elements, which implies setting aside some funds to pay for future obligations, and encouraging home care to develop alternatives to institutional care by, for example, developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care. There is also an urgent need to improve independent living by providing effective home care, telecare and information to recipients, as well as ensuring availability of formal carers by determining current and future needs for qualified human resources and facilities for community care services. Finally, one locates an urgent need to guaranteeing a seamless continuity of care by establishing better coordination of care pathways through a single point of access to information, and the allocation of care coordination responsibilities via dedicated governance structures for the integration of health and social care services.

Long-term care

Malta operates a universal long-term care coverage, and hence, is concerned about the financial sustainability of its long-term care system as its population continues to age. The long-term care scenario in Malta includes 5,390 beds (4.84% of the total population aged 60-plus) (2015 figures) (Formosa, 2017). Care homes run by either the government, Church authorities or private companies embrace the same ethos - namely, to provide holistic and person-centred care in a physically and emotionally safe and secure environment to older persons who due to physical and cognitive limitations can no longer continue living in their own homes. Other care homes are run in accordance with specific public-private agreements where the government purchases from private companies care services or simply a number of beds for older persons who require long-term nursing care. Some public care homes operate through public-private partnerships, thus having a number of services contracted to a private company, although the government remains responsible for the admission and provision of healthcare services to residents. Another form of agreement stipulates that the government buys a number of long-term care beds in private care homes. The government also operates the St. Vincent de Paul Long-Term Facility which includes some 1,100 residents. It exists as a hybrid between a nursing home and a geriatric hospital where the emphasis is support the activities of daily living of all residents, giving particular attention to nutrition, mobility, and social activities.

Public expenditure on long-term care in Malta is relatively low in European terms, at 1.1% of the Gross Domestic Product, compared to the European Union average of 1.6% in 2013 (European Commission, 2016b). This figure is projected to rise to 2.3% in 2060, though remaining lower than the anticipated 2.7% European Union average (ibid.). The bulk of Malta's public expenditures on long-term care goes toward covering the costs of out-of-home or non-community based facilities, and whilst cash benefits for long-term care do not exist in Malta, public initiatives in home-based care costs amount to less than 0.1% of Gross Domestic Product (Pace, Vella & Dziegielewski, 2016). Older persons who reside at public care homes pay for this service at source, from 60% to 80% of their total income, depending on whether they require residential or nursing services respectively (Formosa, 2016b). However, even when the government draws 80% of pensions at maximum ceilings, this is not of sufficient amount to cover daily costs of long-term care services in public care homes. It is thus imperative that for long-term care to operate within sustainable budgets, the Maltese government should consider the raising of additional taxes or social security contributions to finance the rising demand for long-term care. This may be justified on two main grounds: representing the most efficient way of insuring against risk, and yielding immediate benefits to the public by relieving them of high personal costs or the need to apply for social assistance when their personal savings have been depleted. Private long-term insurance has only played a limited role in Malta. However, as in the near future the public funds earmarked for long-term care will reach a saturation point, private insurance may feature a stronger role in meeting additional costs not covered by public programmes or higher expectations on behalf of potential clients who clamour for more personalised services. This type of private insurance tends to become more affordable when the public system covers the first tranche of costs. This will require an improvement in the governance framework: to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of long-term care services and its financing; to establish good inform (European Commission, 2016b).

Conclusion

There will also be policy issues which, if not immediate, will certainly need to be addressed in the foreseeable future (Formosa, 2015a). First, there will be a need to systematise ageing welfare policies through ethnic lenses. To-date, nothing is known about how ethnic groups might differ in patterns of productive, active, and successful ageing when compared to the average Maltese citizen. Such differences will become of increasing importance though, now that an increasing percentage of the population in Malta belongs to a minority group who will also be ageing as well. The international literature reported that generally, whilst older minorities are disproportionately more likely to be poor, to have poorer health, and to experience more functional limitations, at the same time they are less likely to rely on institutions for long-term care. Undoubtedly, local policies should ensure a common analysis and vision on long-term care that traverses ethnicity, one that supports the

development of fair and sustainable solutions to improve the wellbeing and dignity of all, irrespective of ethnicity.

Secondly, there will also be a need to implement ageing policies that are LGBTIQ-friendly. As elsewhere, current discourse on older people's needs and citizenship in Malta is framed by a heteronormative perspective, which marginalises lesbians and gay men. The 'invisibility' of older lesbians and gay men at all levels of relevant policy means that they face particular risks of exclusion. Although the onset of later life raises the possibility for social exclusion irrespective of one's sexuality, it remains that being old and lesbian or gay compounds this possibility, leading to double and triple jeopardies. The specific concerns of older lesbians and gay men, and the implications of their sexual identities on compromised citizenship in later life, should no longer be neglected by policy makers. This is especially warranted as in the near future policy makers and service providers will encounter the first wave of older lesbians and gay men who want to live their lives openly as sexual citizens.

Third, increasing longevity is leading not only to an increased life expectancy but also an increased burden from chronic disease, which in turn results in considerable morbidity and increased dependence. Hence, public policy can no longer neglect those interfaces between ageing, dying and death, or in other words, palliative and end-of-life care. Whilst general palliative care refers to the care offered by any health care professional to patients not responding to curative treatment, end-of-life care refers to the care given in the last few days or weeks before death. There is indeed an urgent need to enact policy that stresses the right to a respectable death, to be treated as an individual and with respect, and to die in familiar surroundings and in the company of close relatives and friends. Such policy also needs to refer to keeping pain and symptoms under control, whilst also providing access to spiritual care and not to prolonging life futilely. The creation of legislation to introduce advance directives is equally warranted.

Finally, public policy on ageing is required to understand the need to widen and improve capacity building in human resources in ageing welfare. There is no doubt that an examination of workforce literature predicts that we will need substantial numbers of trained ageing specialists in the years ahead. However, given the available demographic projections one must ask if institutions of higher education are doing their utmost to provide the required number of applied gerontological personnel that is needed to serve the interests and need of the growing older adult population. There warrants an accreditation of degrees and diplomas in gerontology rather than concentrations or minors within various disciplines, which tend to fail in integrating gerontology in the disciplines in which they are embedded. Only the latter strategy will result in more reliable and valid studies on older persons, ageing and later life, something that is crucially lacking at present. There will be other key concerns which, of course, space limitation does not allow me to highlight and discuss, such as income security, poverty, assistive technology, dignity, and caregivers, to mention some. One augurs that such topics are dealt with in other research publications by local gerontologists and geriatricians.

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Pathways to residential respite care in Malta: A qualitative study

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Abstract. Although the scope of residential respite is to support and offer caregivers a short break from their responsibilities, caregivers' decision to apply for this service is complex and often involves conflicting perceptions and ambivalent judgements. This article reports on a qualitative study exploring the underlying factors that steer informal caregivers to seek publicly-funded residential respite in Malta. Following in-depth coding and thematic analysis of the emergent data, it resulted that most caregivers who resorted to residential respite were taking care of older persons with relatively high dependence. While some caregivers referred to respite as the only solution to enjoy privacy for a brief period of time in their own home, others perceived respite as filling the gap until their care recipient was admitted permanently to a long-term care site. Most caregivers resorted to residential respite only in times of emergency and when burnt out, but a few made use of the service periodically to take a break from caregiving duties. Lack of co-operation from care recipients, and limited trust in formal care systems, were key factors that hindered the possibility that caregivers use the service more frequently or at all. The crucial policy implication is that the state, as the provider of this residential respite service, should be more sensitive in addressing the consistently changing needs of both caregivers and care recipients. An information campaign about when, how and where, the public service of residential respite care can be accessed is highly warranted if timely access is to be ensured.

Keywords: respite, residential respite, older persons, caregiving, informal caregivers.

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Background

As people age, they are more likely to experience chronic health-related issues which might result in a drastic decrease in their level of functional independence (Mortimer & Green, 2015). Consequently, a greater number of older adults rely on family members for care provision, to the extent that informal caregivers play a central role in this background. Although caring for an older family member at home can be exceptionally gratifying, it can be an overwhelming and challenging experience as well. Apart from being a fundamental source of support to the individuals they care for, informal caregivers are key providers in the welfare system as they play a pivotal role in reducing the national health care expenditure (Bauer & Sousa-Poza, 2015).

Significant challenges are anticipated in the coming years as the number of available caregivers is not progressing at the same rate as the growing number of potential care recipients (Bault, 2012; Lund et al., 2014). The complex needs of caregivers for instance; the need for financial sustenance, consistent support from other family members, enough space to focus and address their own personal, physical and emotional needs and sufficient time for socialisation are very often overlooked (Charles, Bremault-Phillips, Parmar, Johnson & Scarey, 2017). Consequently, this often result in increased levels of stress, burn out, emotional and psychological difficulties which ultimately pose a challenge to the cohesiveness of the family, health services and society (Ziemba, 2002). With the passing of time, the caregiving demands tend to increase and informal caregivers often end up providing care without sufficient care support services that address their needs and those of their care recipients (Garces, Carretero, Rodenas & Aleman, 2010; Redfoot, Feinberg & Houser, 2013). Consequently, various researchers accentuate on the importance of implementing effective supportive strategies to assist caregivers in maintaining their challenging roles as well as enhancing the wellbeing of their care recipients. Such strategies are likely to delay admission to long-term care facilities (Nehen & Hermann, 2015; Vandepitte et al., 2016). Although respite care has been found to be one of the most preferred and most commonly requested family support services for informal caregivers, the use of respite is fairly limited even among those who are overwrought. Moreover, it is not always accessible and affordable (Brandao, Ribeiro & Martin, 2016; Phillipson, Jones & Magee, 2014; Reinhard, Levine & Samis, 2012).

The rationale underpinning respite care is to provide relief to informal caregivers from their caring responsibilities so they can restore and boost their energy levels and find time to address facets of their everyday lives that they had been overlooking due to their caring commitments (Greenwood, Habibi & Mackenzie, 2012; Lund et al., 2014). Evans (2013) delineated that respite should be founded on a coalition between the caregiver, the care recipient and the service provider. Chappell, Reid and Dow (2001:212) defined respite as a “pause, a temporary cessation, or an interval of rest” whereas Jeon and colleagues (2005:298) described respite care as “an arrangement to allow caregivers relief or ‘time-out’ from their care commitments, which may be provided on a regular basis or in emergencies”. This definition was considered to be the most suitable for this study as it entails a comprehensive statement of the main points relating to residential respite care for older persons. Respite

encompasses a variety of care services and respite breaks may be publicly-funded, private, offered by voluntary organizations and non-governmental organizations as well. Informal caregivers' break may vary from a couple of hours a day to a number of sequential weeks annually.

Respite care may be availed of at home, in facility-based units such as day centers and night shelters or in residential care settings (Bamford et al., 2009; Denning, 2013; Vandepitte et al., 2016). Residential respite care is at times referred to in the literature as in-patient or institutional respite encompasses the temporary admission of an individual requiring care to a residential care facility (Neville & Byrne, 2007). The utilisation of beds for respite may vary from an overnight stay up to a few days or weeks and services offered vary from one facility to another. This type of respite care may be utilised in cases of emergency or may be booked in advance (Bruen & Howe, 2009; Neville & Byrne, 2007). However, it is noteworthy to mention that most of the studies on respite care tend to amalgamate community and residential respite together in their analysis.

In a study on caregivers' perceptions regarding the use and non-use of residential respite care, Phillipson and Jones (2011) reported that caregivers of persons with dementia who made use of residential respite care perceived utilising this service when they could not cope any longer. It served them as a break when they needed it most. It was also claimed that, when other family members and friends supported their decisions to apply for residential respite they felt more relieved to make use of the service. Other caregivers opted to apply for residential respite care to facilitate the transition to permanent institutional care for their care recipient. They used this period to evaluate the standards and quality of care of certain long-term care facilities and to build a rapport with the staff in case they decided to admit their care recipient for long-term care to a particular facility. Some of the participants considered using respite as a last resort in case of an emergency or when their care recipient's health deteriorated. On the other hand, non-use of residential respite was associated with previous experiences of inadequate quality of care leading to lack of availability when the service was required, preoccupation that the care recipient would not want to leave the house, deterioration in the general function of the care recipient following respite, not satisfying their obligations as caregivers and losing control over their care recipient (ibid.).

In line with the above study, it has also been reported that caregivers might refuse to apply for respite because of guilt feelings that they are not fulfilling their role, lack of trust in formal care services and fear that their loved one will not be cared for by others in the same way he or she is cared for by themselves. Moreover, family conflicts often arise due to lack of agreement between family members when considering outside assistance (Mockus-Parks & Novielli, 2000). In a review exploring the factors associated with the non-use of respite services by caregivers of individuals with dementia, barriers to respite use included, lack of knowledge on the type of services being provided, fear of disruption of daily routine, difficulty to settle in a new environment, financial issues, problems to access transport services, lack of confidence in formal systems to understand and manage behavioural issues attributed with dementia (Phillipson et al., 2014).

Stockwell-Smith, Kellett and Moyle (2010) also highlighted that uncertainty about the quality of care and lack of awareness on the formal community care support services discouraged caregivers from making use of the service. Moreover, conflicting advice and rumours from former respite users were found to influence caregivers' decision regarding use of community support services. Caregivers also felt obliged to care for their family members as they wanted to reciprocate previous support provided by their care recipient and they expected the same care if they were in the same situation. Caregivers were unable to trust others with care provision and therefore unable to delegate work accordingly. Despite this, in time of crises they had to rely on formal support for their relatives. Stockwell-Smith and colleagues (2010) referred to the importance of comprehending caregivers' needs and expectations and the challenges they encounter when seeking formal support services.

The Context

The Maltese archipelago is made up of three main islands; Malta, Gozo and Comino. According to the National Statistics Office (2018), by the end of 2017, 18.8 per cent of the total population residing in Malta was at least 65 years old. Moreover, by the year 2055, the Maltese cohort of individuals in the age bracket of 65 years or over is projected to increase up to 27.6% (National Statistics Office, 2016).

Community care for older persons in Malta is provided by the state, the private sector, the Catholic Church and the family (Farrugia-Bonello, 2015). In the past, the government's main agenda regarding the wellbeing of older persons was based on the biomedical model. As a result, older persons were often institutionalised to ensure that they were safely taken care of. Throughout the years, there was a paradigm shift in social policy and the focus is now towards older persons ageing actively in the community while institutionalisation is left as a last route (Formosa, 2017, 2018, 2019). Yet, it is also worth mentioning that a Eurobarometer survey conducted by the European Commission (2012) forwarded intriguing data on the views of Maltese citizenries apropos long-term care. When asked what would be the most suitable choice in the case of an older parent residing alone but requiring assistance due to deterioration in his or her functional performance skills, 60 percent of Maltese participants reported that the best choice would be for the older person to transfer to a nursing home or sheltered housing. Such results manifest that over the past years, the Maltese look as if they more willing to consent the arrangement of one's kin into residential and nursing care. This is challenging, when one takes into account that the population forecasts demonstrate a cumulative future demand and expenditures for long-term care (Formosa, 2015).

A number of non-governmental and voluntary organisations provide ongoing support to caregivers and their care recipients. A variety of community respite care services that include respite at home, facility-based respite, and residential respite care services are provided by the state. At the time of the study, the public residential respite care service was provided at three different facilities in Malta and one in Gozo namely; at a public long-term care facility, in a church-run and a private nursing and residential care home. Residential respite beds and packages are paid for by the state through a public-church and public-

private partnership scheme respectively (Diacono, 2014; Mifsud, 2016). The service in all the sites is completely funded by the state and it may be availed of for a maximum period of three weeks up to three times a year.

In view of the above, this study aimed to explore the underlying factors that steer caregivers taking care of older persons to seek residential respite.

Methods

This study adopted an interpretative stance and a qualitative approach was employed. This article is based on the findings derived from twelve caregivers who admitted their care recipients for at least once to one of the aforementioned publicly-funded residential care settings during January to December 2016. Participants were recruited using maximum variation sampling. The study was approved by the University of Malta Research Ethics Committee. Prior to embarking on this study, all the necessary permissions to conduct the study were sought from the respective entities. A participant information sheet was sent to all potential participants through the gate keepers in order to prevent coercing anyone into participating and therefore protecting the principles of voluntary participation and autonomy. Prior each interview written informed consent was obtained. Strict confidentiality was adhered to throughout the whole research process and participants were free to withdraw from the study at any time without any repercussions. Semi-structured interviews were carried out in the participants' home at a place and time convenient for them.

Following the interviews data were transcribed verbatim and was analysed through coding and thematic analysis. During the data analysis, the three types of qualitative data coding- open coding, axial coding and selective coding as suggested by Strauss (1987) - were adhered to. Recruitment of all the participants was carried out through gatekeepers. Pseudonyms were used for participants' names to protect confidentiality. The Lincoln and Guba (1985) model of trustworthiness was utilised.

Results

The following is an overview of the participant's profile, their caregiving experience and level of support. The purpose is to place the reader within the context of the caregivers' situation in order to better understand the findings.

Profile: The age of the caregivers (total of eight females and four males) varied from 35 years to 83 years while the age of their care recipients (a total of six females and six males) varied from 69 years to 91 years. All of their care recipients had several co-morbidities including combinations of hypertension, diabetes mellitus, hyperlipidemia, depression, anxiety, Parkinson's disease, dementia, cerebrovascular accident, arthritis, prostate enlargement and/or cardiovascular disease. The participants' level of education varied from a primary level to a tertiary level of education. Two of the caregivers were working on a full-time basis, one stopped from working on a part-time basis to take full care of her care recipient,

two were pensioners, one opted for early retirement and six were homemakers. Whereas eight of the caregivers were co-residing with their care recipients, three lived nearby in the same locality and only one lived in a different locality. Half of the caregivers stated that they had submitted an application for their care recipients to be admitted to a long-term care facility, two were considering the possibility of filling in an application and four had no intention of applying. Most of the caregivers and care recipients were related by consanguinity (lineal generational or collateral bonds) or by affinity whereas only one relationship was based on a long-time friendship.

The caregiving experience: The participants' caregiving experience ranged from three to twelve years. Most of them reported that it was not their first experience of providing direct care. They mentioned that caring was always an inner part of their personality and mostly they learnt how to care from previous situations. Two of the male caregivers mentioned that earlier on they took care of their father but their role was not as intense as their current one. Another male caregiver reported that prior to his mother, he had cared for an aunt and two of his neighbours.

Level of support: Different levels of informal support from other family members were highlighted by the caregivers. Some felt adequately supported while others felt that they had very limited choice on whom to turn to. Lack of constant and reliable support and limited understanding from other siblings placed considerable pressure on certain caregivers to take full responsibility for their care recipients.

Following data analysis, three themes emerged in relation to the underlying factors which steered caregivers to seek this service. The first theme was 'the push factor to residential respite', the second theme was 'more than just a daily struggle', while the third theme was 'a need for a break before it is too late'.

The push factor to residential respite

Factors leading caregivers to resort to residential respite varied considerably however the main reason was caregiver burnout. A number of caregivers explained that they only sought residential respite when they had no other alternative and they felt that they could not cope any longer with the increasing needs of their care recipients and their own physical and psychological needs. Some opted to take a break locally and still visit their care recipients regularly to ensure they were being cared for adequately while others preferred to go abroad to detach themselves completely and left their care recipients in the hands of formal caregivers.

Other reasons for using residential respite included: to go abroad to visit family and for work related purposes, to prepare for an important family event including a wedding, to make the necessary arrangements in the caregiver's home to accommodate the care recipient's needs following discharge from hospital, as a trial for long-term care and to recuperate after the caregiver underwent a couple of surgical interventions. Eliza explained that for her residential respite meant,

“A family-oriented place which you can use when you feel you can’t cope any longer, it is more or less like a pit stop. They assess the person needing care and also inquire about the needs of the person providing care. Most important I expect they provide some realistic solutions on how to handle difficult situations”. (Eliza)

The ultimate decision to use residential respite did not depend solely on the caregivers but on their care recipients as well. Lack of co-operation from the care recipients resulted in postponing the use of the service. Some caregivers highlighted that once they had approval from their family and friends they felt better about using residential respite for their care recipients. Most of the caregivers stated that to truly benefit from the service and detach themselves completely, the place and service they were going to leave their care recipients at, had to meet their expectations. Most of the caregivers clarified that they expected good quality standard of care in order for their care recipients to return back home without deteriorating and preferably in better shape. Otherwise, the time they used to restore themselves while their care recipient was at respite would be futile.

Caregivers got to know about the service from a variety of sources at different time points during their caregiving journey. Sources identified included; distant family members and friends who had already used the service for their care recipients, educational programs held on local television stations, the local center catering for older persons’ needs, (caregivers phoned to ask what services they could avail themselves of when they were in a crisis), the Dementia Activity Centre, the Dementia Support Group and from the main acute hospital when their care recipients were hospitalised.

More than just a daily struggle

Most of the caregivers stated that as years went by, the intensity of their role increased profoundly. They found themselves resorting and embracing more formal care support as they felt the need to balance their own needs and emotions. The community support services that were availing themselves of mainly encompassed; telecare, the pharmacy of your choice scheme, general assistance for bathing and dressing, domiciliary therapeutic sessions, assistance with changing of nappies, homehelp, the incontinence service (diapers free of charge or at a subsidised price), day centres and the dementia activity centre. The latter two services were being used as a form of day respite few days per week. In addition, the Dementia Support Group, the Dementia Helpline and support from a community social worker were other forms of support that were mentioned.

Although the aforementioned formal community support services served to alleviate the strains of caregiving on a daily basis, most of the caregivers confided that to truly pause from their responsibilities they needed to resort to residential respite for their care recipients. Albeit, this choice brought about a number of dilemmas with it, as most felt that it was a moral obligation to take care of their care recipients and they referred to residential respite as a choice out of necessity. Others delved on their hesitancy to give up caregiving even for a short time despite being overwhelmed with their role. Nonetheless, others reported that they booked residential respite for their care recipient at least once a year to

take a well-deserved holiday. Knowing that they had the necessary arrangements sorted for their care recipient while they were abroad was what kept them going.

When considering the number of years the caregivers had been caring for their care recipients and the number of times they utilized residential respite, overall the participants reported minimal use of the service. Some of the caregivers mentioned that they would have considered using residential respite at an earlier stage during their caregiving role if they had known about it before. Some caregivers highlighted that once they had approval from their family and friends they felt better about using residential respite for their care recipients. In contrast, one of the caregivers perceived resorting to residential respite for his spouse as a sign of weakness from his end. He used this service as a last resort upon persistence from his children. He reported that initially he refrained from using respite as he asserted that,

“It is not my style to delegate...not my style at all...I truly believe in doing what I have to do but at one point I couldn't deal with all the strain and I had to try out respite especially since my children insisted...they kept telling me that I needed a break”.
(Alfred)

Some of those caregivers who were at a cliff's edge in their caregiving journey regarded residential respite as filling the gap until their care recipients were admitted permanently to a residential care home for older persons. Unfortunately, when the caregivers used the service as a last resort they have a lot of unresolved issues and the respite time is often too limited to find a solution for all of these problems.

Moreover, some of the caregivers who were residing in the same dwelling with their care recipients mentioned that for them residential respite meant having some privacy and taking a break in their own home without feeling constantly analysed by the latter. Since some of the care recipients and caregivers were receiving a number of community support services, they reported that different people were coming and going in their own home and they experienced moments where they yearned for some privacy. Residential respite care was the only solution to enjoy privacy in their own home without being constantly interrupted by others.

Need for a break before it is too late!

It was rather difficult for the caregivers to quantify the exact number of hours they dedicated directly in caring for their care recipients. However on average, hours of care dedicated directly to the care recipient's needs varied from an average of 20 hours per week to round the clock care with few hours of rest in between. Differences between spousal and filial caregiving were also highlighted. Caregivers who were co-residing with their care recipients especially spouses were more likely to spend more hours with their care recipients than those who were not residing in the same residence. Half of the caregivers reported that they often encountered difficulties (on a daily basis) to deal with their care recipients especially when assisting them with their personal activities of daily living.

Level of care required as reported by the caregivers varied from providing maximal physical assistance in all Activities of Daily Living ¹ (ADL's) including hoisting the care recipient out of bed as well as carrying out all the Instrumental Activities of Daily Living ² (IADL's) to carrying most of the IADL's. All caregivers mentioned different aspects on how their role was affecting their life. Some caregivers confided that they perceived their care recipients from another lens especially those whose care recipient was experiencing cognitive issues or those whom their care recipients required maximal physical assistance. Some caregivers accentuated that as time went by, their relationships went through a transition and some were still dealing with role reversal. One of the caregivers clarified that at times, she perceived her mother as if she was her daughter and she ended up taking the maternal role. One of the spouses mentioned that the way she perceived her relationship with her husband changed completely when compared to what it was before he started experiencing cognitive decline. Although she acknowledged that he was still her husband and she was ready to do anything for him, now their relationship was more as if he was her son and she became his mother. Whereas financial constraints were highlighted by two female caregivers, spending less quality time with other family members including their children, grandchildren and spouses was mentioned by nine of the caregivers.

Caregivers were feeling that they had multiple roles in their life and due to this, they were missing out on important events and bonds with other close family members. Therefore their role had an impact on the whole family not merely on themselves. This is clearly described by Jane, who said,

“I feel that the relationship I have with my daughter is not as it should be...she comes to ask me something and attempts to talk with me and I have to leave her in the middle of a conversation to go and check on my grandma...I worry since this is a very crucial time to strengthen the bond with my daughter and instead I end up giving full attention to my grandma...even with my husband, really it is not that simple...”. (Jane)

A number of caregivers (six of the seven caregivers who were 60 years or older) stated that they had to deal with their own health issues as well apart from those of their care recipients. They claimed that they were on medication for their own health issues and had to attend to their own hospital appointments on a regular basis. Three caregivers reported that they were suffering from severe arthritis, another two stated that they were suffering from severe sciatic pain, one of whom had cardiovascular problems as well. One caregiver claimed that she underwent two operations to repair a recurrent hernia. Five caregivers (three of whom were young caregivers) reported that there were times when they were feeling overwhelmed, stressed and their care recipients were gradually becoming a burden at times as they were feeling that they had too much to cope with.

¹ Activities of Daily Living (ADL's) may be divided into basic activities, domestic and community activities also known as instrumental activities of daily living. Activities of daily living encompass functional mobility (bed mobility, transfers, ambulation and wheelchair mobility) and personal care (feeding, grooming, oral hygiene, continence and toilet hygiene, bathing and dressing) (Fonti, 2001; Frickle, 2010).

² IADL's entail a sequence of life functions which are fundamental to maintain an individual's immediate environment. These include management of one's medication, clothing care, cleaning, shopping, meal preparation, money management, household maintenance and care to others (Foti, 2001; Frickle, 2010).

Most of the caregivers whose care recipients required a substantial amount of physical assistance were primarily concerned with the repercussions resulting from caregiving on their own physical health while those whose care recipients had cognitive impairment complained of both physical and emotional strain but seemed to dwell more on the psychological strains caregiving was inducing on them. As conveyed by Eliza, who said,

“People were telling me I was running downhill but I felt alone and had nowhere to go until my friend told me about respite”. (Eliza)

Ambivalence about caregiving was clearly highlighted through various scenarios depicted by the caregivers when referring to their daily situations. Most of them made reference to the highs and lows they experienced and they compared their fluctuations in their caregiving journey to a rollercoaster ride. Despite the various implications their caregiving role was having on their well-being, on their relation with others and on their quality of life, all caregivers mentioned feelings of contentment and fulfillment at some point in time. They reported that from their end they felt that they were doing everything in their power to ensure that their loved ones were cared for in the most dignified and respectful way possible. This was clearly outlined by Simone who said,

“I do my role out of the love I have for my mother and my brother...I do get tired at times and I do grumble quite often but I wouldn't have it any other way...at the end of the day I feel exhausted but serene as I feel that I am doing the best I can for my loved ones. I am their family, if it was not for me and my husband they have no one else to take care of them...at least once in a while I take them for respite”. (Simone)

Discussion

The characteristics of caregivers seeking residential respite care services for their care recipients in the study were similar to those documented by other researchers (Bauer & Sousa-Poza, 2015; Mack & Thompson, 2004; Lima, Allen, Goldscheider & Intrator, 2008). When the needs of the care recipient surpass the competence of the caregivers, families tend to seek some form of support (Montgomery & Kosloski, 2013). Different kinds of caregiving relationships differ greatly in terms of the extent and quality of support provided. Such relationships are formed by previous experiences and instigated when the older person needs assistance (Cho, 2007). Indeed, the participants' caregiving experiences depict how the type of caregiver-care recipients' past and present relationships play a key role in determining the caregivers' level of satisfaction with the kind of care provided. Likewise, Briathwaite (2000) and Salin and Astedt-Kurki (2007) outlined how previous life situations have an impact on caring roles. Unequal sharing of care responsibilities amid family members was also accentuated by Singh and colleagues (2015). In line with the findings reported by Rigs and Peel (2016) and Van Bruggen et al. (2016), caregivers in our study reported a shift in responsibilities during their caregiving journey. They felt squashed between different roles and somewhat felt guilty that due to their caregiving responsibilities they were not distributing their attention equally on all their loved ones. Moreover, differences in the type and level of caregiving burden amid spousal caregivers and adult children caregivers have been reported (Chappell & Dujela, & Smith, 2014).

Stolz, Uden and William (2004) highlighted caregivers' own health issues as one of the main driving forces that leads caregivers to seek respite care for their care recipients. Similarly, most of the caregivers in our study were providing a high level of assistance with most of the activities of daily living and they had their own held issues to deal with as well. Moreover, Cheung and Hocking (2004) reported that the majority of caregivers of older persons tend to be spouses, who themselves are ageing and require support and assistance. Caregivers in our study reported that at times they felt so overwhelmed and stressed that they felt that their care recipients were becoming a burden. This is in line with the findings of Ziemba (2002) who reported increased levels of stress, burn out, emotional and psychological difficulties resulting from caregiving. Besides, Yin, Zhou and Bashford (2002) highlighted that implications from caregiving were found to influence the type and quality of care the caregiver provided to the care recipient. Hence, the bio-psycho-social needs of the care recipient and the family's adapting and coping competence need to be periodically and thoroughly addressed (Hannum et al., 2007).

Moreover, Beach and colleagues (2005) reported that care recipients who require high levels of assistance from their caregivers are predisposed to a higher risk of abuse especially if their caregiver is suffering from depression, distress and ill health. Likewise, Dunbrack (2003) argued that inadequate respite services are associated with caregiver burnout, neglect, crises and abuse. This draws attention to address the needs of caregivers in a timely manner since decline in their health and social well-being might initiate a cascade of events leading to hospitalization of both the caregiver and care recipient (O'Connell, Hawkins, Ostaskiewicz & Millan, 2012). Furthermore, Kosloski, Montgomery and Youngbauer (2001) and Dal Santo, Scharlach, Nielsen and Fox (2007) illustrated that complex and demanding caregiving situations compelled caregivers to seek respite care. Notwithstanding the feelings of exhaustion and burden arising from the caregiving load, some of the caregivers in our study implied that they were willing to continue with their role since caregiving kindled feelings of achievement and self-worth as well. They stated that as long as they had the physical and psychological strength and adequate forms of support, they were willing to persist despite the negative effects they were experiencing. Positive effects attributed with caregiving were also highlighted by a number of researchers (Boerner, Schulz & Horowitz, 2004; Haley, LaMonde, Han, Burton & Schonwetter, 2003; Harmell, Chatillon, Roepke & Mausbach, 2011).

Some of the caregivers in our study described how they felt stuck in their role and they sought residential respite for their care recipient once they realised that the situation was becoming untenable and they were facing a crisis implying that they left this option as a last resort. This is highlighted in other studies (Reinhard et al., 2012; Phillipson et al., 2014) which reported that respite among caregivers is fairly limited even among those caregivers who are distraught. Conversely some of the caregivers in our study recounted that although initially it was hard to let go of their care recipient for a few weeks, feelings of guilt abated as the whole family gained from the break.

Similar to the findings of Dimech and colleagues (2009), reasons for seeking residential respite varied considerably. For most of the caregivers residential respite meant a secure place and a support mechanism where they could safely leave their care recipients for a brief period of time in order to attend to their needs, recharge their energy and continue caring for their loved ones once discharged back home. Approval from their family and friends made them feel better about using residential respite for their care recipients. This is also in line with the findings of Phillipson and Jones (2011). For some of the caregivers, residential respite was the only way to have some privacy in their own home. Similar findings are outlined by Svensson, Bergh and Jakobsson (2011).

Some of the caregivers mentioned that they would have considered using residential respite at an earlier stage during their caregiving role if they had known about it before. Phillipson and Jones (2011) reported that a number of caregivers associated residential respite with not satisfying their obligations and only resorted to the service when they were completely burnt out. Unfortunately, when the caregivers use the service as a last resort they have a lot of unresolved issues and the respite time is often too limited to find a solution for all of these problems.

Conclusion

Every effort should be made to support and educate caregivers to identify, understand and address their own self-care needs by utilising formal community support care services including residential respite for their care recipients from time to time. While it is vital to target caregivers at risk, it is equally important to increase awareness and educate caregivers and older persons who are in the initial phases of their journey regarding the role of residential respite and its benefits so they can access the service at the right time and prevent crisis. Social workers and health-care professionals have a window of opportunity to delay admissions to long-term care as they should be on the lookout and detect causes for concern at an early stage and refer to the most appropriate service based on the needs of the individual and his or her significant others before issues escalate and become unmanageable. If there is more public awareness, family and friends are more likely to acknowledge the need for caregivers to take a break and counsel them accordingly. In turn, caregivers will feel less stigmatised and keener to utilise more the service.

Although the findings of this study cannot be generalised due to the small sample size, maximum variation sampling was used to produce a heterogeneous sample. Data was collected retrospectively therefore it was subject to recall bias. Although every attempt was made to avoid researchers' bias while carrying out the interviews, the participants were aware of the researcher's professional background and may have tried to answer in a way to please the researcher. Hence, to combat such limitation the researcher made sure to be objective as possible and avoid making any form of judgement and bias that could have resulted in influencing the data collected.

Implications for research and practise

Since lack of co-operation from the care recipients to use residential respite was one of the factors that hindered caregivers from using the service, further in-depth research on the views of older persons' admitted to residential respite will guide and inform better the development of meaningful programs for older persons using residential respite. In an era of patient and family-centred care, better informing older persons regarding the type of service they are expected to experience is necessary. All professionals working in the primary healthcare sector need to be sensitive to the needs of caregivers and their care recipients and they must ensure that caregivers are informed and provided with timely access to community care support services. Professionals must conduct ongoing evaluations to ensure that the support services provided are addressing the dynamic needs of the caregivers and their care recipients. A stronger bond among all stakeholders is warranted to avoid fragmentation of services and ensure more cohesiveness through teamwork in the best interest of the older person and his or her caregiver. Professional education and support interventions are pivotal in preparing and assisting caregivers to sustain their indispensable role. Hence, caregivers would benefit more if they are trained and offered support on when and how to access services and on managing time more effectively when their care recipient is receiving some form of respite care.

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Communication Training for Informal Caregivers of Persons with Dementia in a Rehabilitation Hospital

Roberta Said¹

Abstract. In 2015, the number of people with dementia in Malta was estimated to be 6,071, equivalent to 1.5 per cent of the population, a number which is predicted to rise to around 10,000 persons in 2030 (2.3% of the Maltese population) and to about 12,955 persons by the year 2050 (3.3% of the Maltese population). Caring for a family member with dementia can be particularly stressful and burdensome, partly due to difficulties encountered during communication. Communication impairment in individuals with early to moderate dementia becomes more prominent as the condition progresses. This exhibits itself as word finding difficulties, decreased verbal fluency, and difficulty in understanding and using complex language forms such as idioms and metaphors. These difficulties lead to communication breakdown, which is one of the key challenges caregivers face when interacting with persons with dementia, resulting in relationship strain between both parties. As this study shows, this affects the caregivers' and persons with dementia's physical and emotional health. Hence, providing caregivers with the necessary information to facilitate communicative interactions is urgently warranted.

Keywords: persons with dementia, communication training, rehabilitation hospital, geriatrics; Malta.

Introduction

Dementia is a neurodegenerative condition, which affects an individual's cognitive abilities (Guendouzi & Muller, 2006). In 2015, the number of people with dementia in Malta was estimated to be 6,071, equivalent to 1.5 per cent of the population, a number which is predicted to rise to around 10,000 persons in 2030 (2.3% of the Maltese population) and to about 12,955 persons by the year 2050 (3.3% of the Maltese population) (Scerri & Scerri, 2012; Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2015). This

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implies that there is a high probability that the number of informal and formal caregivers needed to care for persons with dementia (PWD) will also increase (Formosa, 2018, 2019). Caring for a family member with dementia can be particularly stressful and burdensome, partly due to difficulties encountered during communication (Haberstroh et al., 2011; Small & Perry, 2013). Communication impairment in individuals with early to moderate dementia becomes more prominent as the condition progresses. This exhibits itself as word finding difficulties, decreased verbal fluency, and difficulty in understanding and using complex language forms such as idioms and metaphors (Savundranayagam & Orange, 2014). These difficulties lead to communication breakdown, which is one of the key challenges caregivers face when interacting with PWD, resulting in relationship strain between both parties (Savundranayagam & Orange, 2014). This, consequently affects the caregivers' and PWD's physical and emotional health. Hence, providing caregivers with the necessary information to facilitate communicative interactions is urgently warranted (Sun et al., 2010).

Literature review

Various education and training programmes aim to enhance caregivers' communication patterns with PWD (Passalacqua & Harwood, 2012). These educational programmes are devised on models which attempt to increase person-centred communication, beliefs and attitudes among caregivers caring for PWD, while focusing on the caregiver's and PWD's communication needs through adjustments in the environment. These programmes provide caregivers with information about the various behaviour and physical changes occurring with ageing and dementia; how dementia affects the social, physical and cognitive aspects of an individual; how to optimise the communication environment by using simple and familiar language, how to introduce topics of conversation, correct misunderstandings, using verbal and non-verbal cues to support communication; and how to alter surrounding environments to communicate with PWD (Craig & Killick, 2011; Bayles & Tomoeda, 2013). This information helps caregivers become more aware of the difficulties PWD experiences by enabling them to provide improved care. Additionally, discussions and group role-plays seem to aid caregivers' understanding, as it allows them to apply what they have learnt, thus improving their communication within both home and care home environments. These studies reveal that providing caregivers with the adequate education and training, specific to their needs, will help them to cope better with the physical, emotional and social changes related to dementia. This helps the caregivers to develop skills to communicate better with PWD (Miller, 2014).

Making caregivers aware of the communication strategies they use with PWD is important. This increases their awareness on how they can promote successful communication to maintain and improve the relationship between themselves and PWD as the condition progresses (Bourgeois, 2013). A number of studies set out to identify a number of recommended communication strategies and show how helpful these are perceived to be by caregivers at maintaining communication between them and PWD (Wilson et al., 2013; Savundranayagam & Orange, 2014). Results revealed that caregivers prefer to use short simple sentences or either ask one question and/or give one instruction at a time, rather than paraphrasing repeated messages when communicating with their care recipient. Wilson and

colleagues (2013) identified a number of useful themes which helps the caregiver to provide a more communication-friendly environment for PWD. These include patience, focus on PWD, environmental cues, eye contact, negotiation, explanation of actions, use of PWD's name and demonstration of gestures. Other strategies which caregivers find helpful include the reduction in noise levels, consistent and predictable daily routine, quiet and calm environment, verbal reassurance, re-direction of conversation to familiar topics, negotiation, demonstration gestures and handing objects to PWD (ibid.). These strategies allow caregivers to perceive PWD's needs, consequently reducing behavioural problems that often trigger off communication breakdown and increase caregiver burden (Savundranayagam & Orange, 2011). Making caregivers aware of communication strategies which prevent communication breakdown, help in maintaining interactions that are more coherent. Two studies which aimed at identifying what 'question type' is the most successful at maintaining communication when talking to PWD yielded similar results even though they engaged PWD of different severities - namely, close-ended questions (Tappen et al., 1997; Small & Perry, 2005). However, it is noteworthy that Tappen and colleagues (1997) found that PWD were also able to respond to open-ended questions with equal ability.

The memory-memory processing model by Squire (2004) explains how memory is a series of subsystems which are affected depending on the type of memory difficulties PWD experience. As mentioned above, PWD are still able to respond adequately to open-ended questions, if information asked could be retrieved from the semantic memory. This instance is possible since according to the memory-processing model (Squire 2004), the semantic memory is accessed from the long-term memory, thus making it more resistant to disease progression, as it has been stored for longer periods, helping an individual use it, to retrieve already known information (Bourgeois, 2002). However, when answers required access to the episodic memory, this often created difficulty for PWD. This could have occurred since episodic memory helps one remember details about specific events, as well as, encode new information, which is most vulnerable to disease progression. The episodic memory is affected from early on in the disease, hence influencing which question types are successful at maintaining communication with PWD (Small & Perry, 2005). Besides knowing which question types to use, being able to use repair structures to maintain communication is also important. Gentry and Fisher (2007) tried to establish this by identifying which repairs were most likely to help a PWD communicate. Results revealed that indirect repairs, like paraphrasing, helped PWD maintain coherent conversation, since there were less topic changes in PWD's speech patterns. On the other hand, when PWD were corrected via direct repairs like corrective feedback or filling in the intended message for the PWD, it tended to decrease the production of coherent speech. This could have occurred since these types of repairs might have prevented PWDs from continuing a conversation, as it was completed by the individual initiating the interaction.

In summary, the literature has demonstrated that caregivers of PWD find tailored education, training and intervention programmes effective in assisting adjustments to the cognitive, physical, emotional, and language changes a person experiences due to dementia. However, limited information was provided on how these programmes created change in the caregivers' talk practices to enable them to maintain communication with PWD. The studies

identifying communication strategies gave little attention at how these strategies are helping PWD to communicate better.

Research design

The present study sought to provide more information on how information sessions may enable informal caregivers to adopt the use of 'talk practices' that maintain communication with PWD; identify how these 'talk practices' allow PWD maintain an interaction; and focus on the verbal aspects of caregiver communication by collecting data via audio recording. The research study consisted of a pre- and post-comparison study utilising Conversation Analysis (CA) to compare and identify the caregivers' talk prior to and after they attended a number of information sessions, which aimed at enhancing their knowledge of dementia.

Purposive sampling was used to select participants for the study. Twelve caregivers were referred to attend the information sessions. Caregivers eligible to attend these sessions were selected through a geriatrician who was following PWD at a rehabilitation hospital. Participants were informed about the study after they were told about the information sessions. This allowed the researcher to choose suitable participants for this study. Nine caregivers were selected prior to the commencement of the training programme. These were chosen following strict inclusion criteria for caregivers (which included being a caregiver of a person with early to moderate dementia; attending information sessions; never attended Speech and Language Therapy sessions) and for PWD (which included: being a PWD in the early to moderate stage of the condition, attending memory sessions and never having attended SLT sessions). However, only six dyads consisting of a caregiver and PWD gave consent to take part in the study. No dropouts occurred throughout the study and during the period of data collection. The study targeted caregivers of persons with early to moderate dementia. Caregivers attended information sessions simultaneously with PWD, who attended memory sessions at Karen Grech Rehabilitation Hospital. These classes targeted a number of activities such as reminiscence, crafts, carrying out daily tasks such as cooking, planting flowers, doing exercise and going out as a group. These sessions were facilitated by a number of healthcare professionals namely the Physiotherapist, Nurse, Speech and Language Pathologist and Occupational Therapist. The following 12 sessions, lasting one hour each, were delivered over a span of 12 weeks at this rehabilitation hospital.

- Session 1: Nurse: caregivers introduced themselves. Nurse then talked about the care and needs of PWD; use of signs and pictures was suggested to help PWD maintain familiarity of household rooms and objects.
- Session 2: Pharmacist: discussion of medications taken by PWD and their side effects.
- Session 3: Occupational therapist: how to provide a safe and communication friendly environment for PWD; suggested use of different cueing strategies including signing, semantic, phonemic, repetition and visual - to help PWD remember familiar words; minimise use of questions; prepare PWD about future events to decrease agitation; talk to the PWD about meaningful past events to help them feel secure; not raising one's voice to talk to PWD as this may increase their frustration; to provide a daily routine to provide information about what is going to happen.

- Session 4: Geriatrician: question and answer session dealing with the caregivers' concerns; the importance of checking PWD hearing abilities as this may affect communication.
- Session 5: Malta Dementia Society representative: information was provided on the Malta Dementia Society support services and activities;
- Session 6: Multidisciplinary Care Team: cultural outing for caregivers and PWD;
- Session 7: Speech and Language Therapist: how to deal with communication difficulties exhibited by PWD; using one's name to introduce yourself to PWD; offer choices when talking to PWD; to provide information about what will happen throughout the day; not to continuously ask questions as this requires constant access to the declarative memory; using symbols and visuals to deliver messages and aid in comprehension; use simple commands and familiar words when talking to PWD; to repeat instructions to give PWD time to process information heard; do not contradict PWD and adapt to PWD communication level.
- Session 8: Psychiatrist: a discussion on the importance of taking care of the caregivers' and PWD's mental health;
- Session 9 & 10: Speech and Language Therapist: discussion about memory strategies and behaviour management used when caring for PWD; communicate facing PWD; to speak to PWD in a gentle and encouraging tone to promote communication; minimise use of continuous questioning; use photos from the past within their home environment so as to help PWD recognise they are in their own home; swallowing difficulties associated with dementia;
- Session 11: Physiotherapist: how to carry out exercises to keep a PWD active, as well as, prevent falls and proper handling of the PWD;
- Session 12: Multidisciplinary Care Team: closing remarks and lunch.

In addition, transcribed data, collected from conversations obtained from the caregivers and the PWD, prior to and after the information sessions, enabled the researcher use descriptors to define the function of talk practices caregivers used. These included turn taking, topic management, sequence organisation and repairs. To ensure that the intonation markings within the analysed transcripts were correct, the researcher used a computer programme called 'PRAAT', version 4.3.21 (Boersma & Weenink, 2005). This programme gave the researcher the ability to look at a number of features including loudness and intonation within conversation analysed. These features form part of the CA procedure and occur simultaneously with the 'talk practices' identified. Ethical approval was gained from the research committee at Karen Grech Hospital and the University of Plymouth.

Results and discussion

The caregivers' 'talk practices' presented below involve those practices which were identified as being used by both caregivers of persons with early stage dementia (ESD) and moderate stage dementia (MSD). 'Talk practices' used to maintain communication by both caregivers of ESD and MSD prior to and after the information sessions are summarised in Table 1.

Table 1: Talk practices used by both caregivers of ESD (early stage dementia) and MSD (moderate stage dementia) prior to and after the information sessions

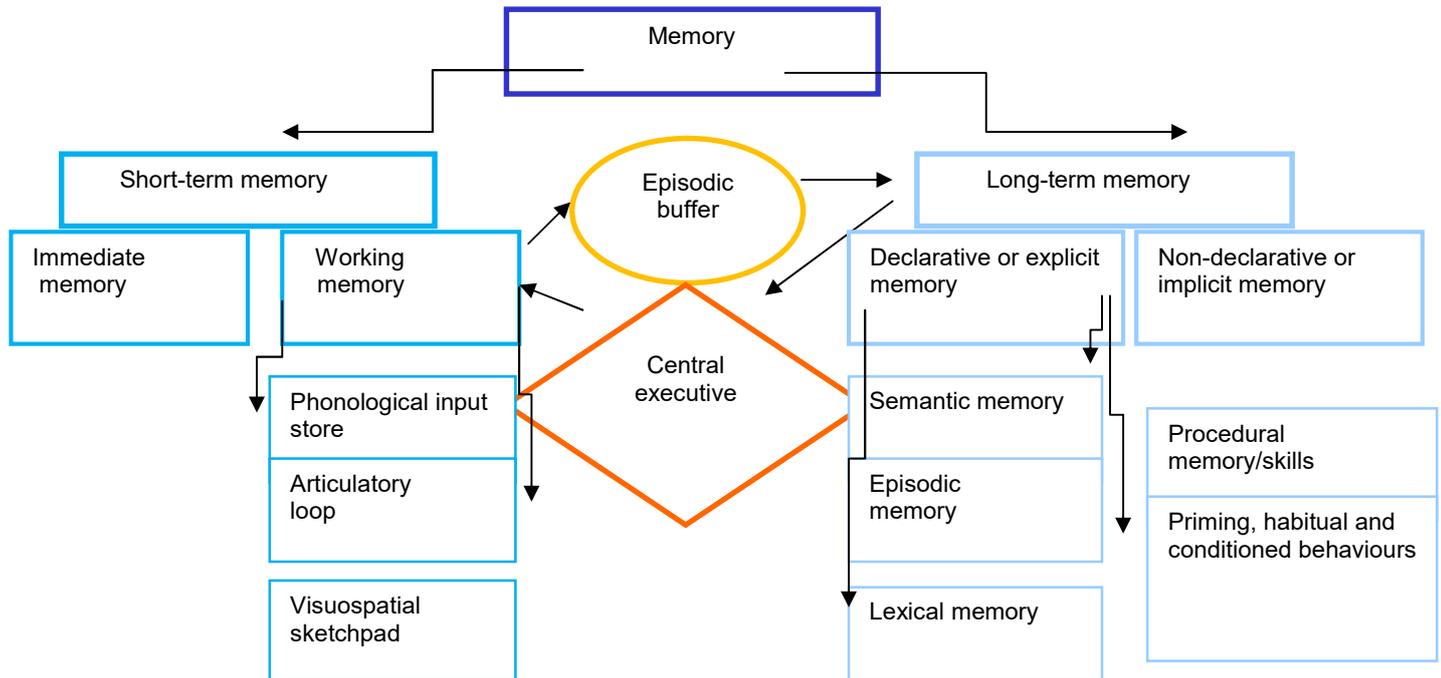
Talk practices identified prior to the information sessions	Talk practices identified after the information sessions
<ul style="list-style-type: none"> ▪ Information-Seeking Questions (I-SQ) as part of an Adjacency Pair (a unit of conversation that contains an exchange of one turn each by two speakers) followed by pauses and overlap to indicate positive feedback. (feedback overlap) ▪ Other-Repair (OR) followed by a decrease in intonation. 	<ul style="list-style-type: none"> ▪ Topic Shift (TS) in conjunction with an Information-Seeking Question (I-SQ) followed by pauses. ▪ Announcements (A) as part of Adjacency Pair. ▪ Invitations as part of an Adjacency Pair. ▪ Complaints as part of an Adjacency Pair.

These results are explained via the ‘memory-processing model’ (Baddeley, 2002; Squire, 2004) referred to earlier. The author chose this memory-processing model as shown in figure 1, on the basis that it illustrates which memory processes are involved in processing language (Schrauf & Müller, 2014). It also helps to identify which memory types, the talk practices were allowing PWD to access, in order to retrieve information, so as to maintain communication with their caregivers.

I-SQ (Information-Seeking Question) as part of an Adjacency pair, followed by a pause and overlap to indicate positive feedback (feedback overlap)

In the excerpts analysed, when a speaker asked an I-SQ, the listener was often required to answer back thus making up an Adjacency Pair. This sequence of talk gave more structure and organisation to the conversations occurring between the caregivers and PWD (Guendouzi & Muller, 2006). Small and Perry (2005) note that questions are components which normally make up a conversational exchange. There are three types of questions, these include: closed questions which require a yes/no answer; open questions, which require lengthier answers related to the who, what, when, where, why and how; and choice questions, which offer an option, for example ‘What would you like, juice or water’? These question types involve the use of short and long-term memory processes (Small & Perry, 2005) whose function are described in Figure 17.1. Within this study, caregivers often used open-ended I-SQ prior to and after the information sessions. This type of questioning demands more processing since it entails providing new lexical, syntactic and semantic information by PWD (Small & Perry, 2005). Accessing this information requires the episodic and/or semantic memory systems, which are both affected from early on in dementia (Savundranayagam & Orange, 2014). As identified within the research the use of open-ended questions can often lead to breakdown in communication since difficulties accessing these memory systems influences PWD ability to respond successfully (Small et al, 2003; Schrauf & Müller, 2014).

Figure 1: Memory processes involved when accessing information to use language



Short-term memory: stores recent events.
 Immediate memory: very limited storage capacity.
 Working memory: information buffering centre where information is held in conscious awareness reviewed and manipulated.
 Phonological input store: auditory information held for a short time.
 Articulatory loop: serves as a sub-vocal (processing sounds into thought) rehearsal faculty.
 Visuospatial sketchpad: where the visual and spatial information is kept active.
 Long-term memory: stores less recent events.
 Declarative (explicit) memory: stores world knowledge that can be consciously reviewed in three types of memory subsystems: semantic, episodic and lexical.
 Non-declarative (implicit) memory: knowledge not available for conscious review.
 Procedural memory/skills: e.g. learning how to ride a bicycle. An automatic process which once acquired is difficult to unlearn unless other abilities such as muscle function, balance or vision, which help execute this function are impaired. Priming, habitual and conditioned behaviour: behaviour which is learned through repetition and practice.
 Episodic buffer: intermediary processor between the working memory and long-term memory.
 Central executive: helps in focusing attention, accessing and retrieving information in the long term storage, helps in encoding information thus aiding in making decisions and plans.

Source: Schrauf & Muller (2014 : 4-5)

Findings within the current study shows that when I-SQ questions were followed by pauses and overlap to provide positive feedback, they enabled the caregiver and PWD to engage in a series of turns that allowed both to maintain communication. The questions posed often required PWD to access information from the semantic memory. The present results seem to be consistent with other research, and thus, potentially validating this result. Studies showed that when open-ended questions require PWD to draw only on the semantic

memory they can still be successful at preventing communication breakdown (Small & Perry, 2005). Tappen and colleagues (1997) suggested that communication is maintained since open-ended questions allow caregivers to choose topics of discussion as well as access information, salient to PWD, thus encouraging interaction. Caregivers' use of family photographs to elicit conversation could have allowed them to speak about topics which were more salient and meaningful for PWD. This, in turn, could have enabled the PWD to maintain conversation with their caregiver. After asking an open-ended I-SQ question to initiate a conversation, the caregivers often used a pause. Bourgeois (2002) reported that PWD may require more time to process auditory information, therefore caregivers' use of pauses possibly gave the PWD more time to understand the question and access the information required to respond. This observation correlates with results of other research (e.g. Small et al., 2003) where caregivers used pauses as they found them useful whilst communicating with persons with early and moderate dementia.

In the excerpts analysed, once the PWD responded appropriately to open-ended I-SQ, caregivers often used feedback overlap, one of the three types of overlap characterised within the Maltese language (Paggio & Vella, 2013) This 'talk practice' provides feedback as to whether responses given in an interaction are acceptable or not by the use of words such as 'orrajt/owkey' (okay), 'sewwa/tajjed' (right/good), 'mhm/m/ehe' (yes). The results of this study shows that caregivers often used it as positive reinforcement, to acknowledge and accept the PWD's response. Additionally, it also promotes speaker change (ibid.), enabling the PWD to feel encouraged and successful at being able to interact successfully, thus allowing them to further engage in conversation. After caregivers used this 'talk practice', PWD often contributed further to the conversation via a complaint, Clarification-Seeking Questions (C-SQ) or I-SQ, depending on the nature of the conversation. These responses could have enabled PWD to store recent information heard in the conversation in their working memory. This might have facilitated retrieval of this information if required.

OR (Other-Repair) followed by a decrease in intonation

Other Repair (OR) occurs when a speaker repairs a listener's response due the occurrence of trouble initiating behaviour (TIB) - thus, allowing a conversation to progress (ten Have, 2007). Data revealed that the use of OR by caregivers occurred prior to and after information sessions when PWD showed difficulties in accessing information from the declarative memory. PWD exhibited this difficulty either by paraphrasing information just heard; by giving incorrect semantic information; by acknowledging that they cannot remember information; or by requesting for repetition of information just heard via O-CRI (Open-Class Repair Initiator). PWD's use of these 'talk practices' enabled the caregiver to adopt the use of OR, which allowed PWD often carry out an SR (self-repair). According to Perkins and colleagues (1998) when a speaker is able to carry out repair on the conversational partner's turn it eases cognitive deficits which limit the PWD ability to respond appropriately. Therefore, the use of OR by the caregivers might have enabled PWD to store the information just heard within their articulatory loop in their working memory, enabling them to SR. One needs to interpret this finding with caution as research identifies this type of direct repair (OR) as both inhibiting and promoting communication between the caregiver and the PWD.

It is probable that this difference in findings could have been due to the various dementia severities exhibited by PWD participating within these studies (Gentry & Fisher, 2007). 'Talk practices' that are successful with persons with early to moderate stage dementia might not be as successful with those in the late stages of the condition. This is because as dementia progresses, the cognitive decline associated with the condition increases. This makes the difficulties the PWD experiences in understanding and responding to language more prominent (Savundranayagam & Orange, 2014), thus influencing which 'talk practices' remain successful at maintaining communication. During this study, one participant caregiver was using OR which was followed by a decrease in intonation. This feature is an aspect of prosody. Prosody is a language characteristic that involves changes in intonation, rhythm and loudness. It is a means of conveying emotional information through spoken words (Juslin & Laukka, 2003). In Maltese, varying intonation helps in conveying this emotional information. Caregivers' use of decreased intonation conveyed an expression of encouragement, which the PWD seemed to have perceived, possibly giving them a greater boost to maintain a conversation.

TS (topic shift) in conjunction with an I-SQ followed by a pause

Topic Shift (TS) occurs when the speaker starts talking about a new subject over a series of turns (Perkins, Whitworth, & Lesser, 1998). From the data within this study, TS usually occurred in conjunction with an I-SQ within the same turn construction unit (TCU). The caregiver used this 'talk practice', when the PWD encountered difficulties in maintaining a conversation related to a previous topic. This could have occurred due to PWD's difficulties in accessing information from the declarative memory or when the caregivers found difficulties in maintaining topic due to the PWD's cognitive difficulties. Garcia and Joannette (1997) reported that due to cognitive difficulties, PWD are unable to discuss a topic for long, thus resulting in the caregiver often shifting topic to maintain a conversation. In the excerpts analysed within this study, when caregivers shifted topic, it allowed PWD to keep engaged in the conversation as well as maintain conversation coherence. Indeed, research reported that TS enhances conversation coherence, increasing the reliability of the researcher's finding that TS is a talk practice which maintains communication with PWD (ibid.). Often, topics talked about were familiar to PWD. These topics were probably selected because the speakers found that they enabled PWD to maintain conversation. This indicates that the topics chosen might have enabled PWD to maintain information previously given within the phonological input store in their working memory. This enabled them to access information more easily when required. Caregivers used I-SQ when introducing and providing information about a topic. Depending on the nature of the conversation, this often gave PWD an opportunity to engage in further conversation, by using C-SQ, responding appropriately, as well as initiating O-CRI or O-IR (Other-Initiated Repair). C-SQs often enabled PWD to repeat back information just heard to the caregiver. This observation might indicate that access to the repeated information was occurring via the articulatory loop within their working memory, thus enabling them to confirm whether responses were adequate. Often, caregivers acknowledged these responses as correct by accepting PWD's responses through use of Announcements (A) or further engaging in conversation through an I-SQ.

A (announcements) as part of an Adjacency Pair

Announcements (A) are a type of offer whereby the speaker provides more information related to events that are about to occur (Guendouzi & Müller, 2006). Announcements are accompanied by a response, thus making up an Adjacency Pair. This allows the listener with an opportunity to contribute to the conversation. In this study, caregivers made use of 'A' in the following instances: when PWD contributed well in previous responses; when they asked questions about information just heard; to introduce a topic which was related to a familiar event; as a way to provide additional information, to enable the PWD to contribute adequately in their next response. In the excerpts analysed, this strategy gave PWD an opportunity to take floor in a conversation, thus encouraging further conversation. It has been shown that when PWD are encouraged to communicate, it decreases their frustration due to difficulties they experience when communicating (Savundranayagam & Orange, 2011).

Invitations and complaints as part of an adjacency pair

Invitations within a conversation are accompanied by a refusal or an acceptance whilst complaints usually accompany an apology or justification. These two combinations make up an Adjacency Pair. Invitations enabled the caregiver speak about an event that was going to occur in the immediate future. This also enabled the caregiver to provide the PWD with choices. In some examples, PWD responded to the use of this 'talk practice' adequately without requiring any form of repair or repetition. It is possible, that by offering choices PWD were able to understand the concepts presented to them and choose among the options presented. This requires less access to information within the declarative memory that is often impaired in PWD (Smith et al., 2011). The use of Complaints allowed caregivers to contribute further to the PWD's response. Caregivers did this either because the response of PWD had some incorrect information or as a way to encourage them to correct an error. It was noted, that the use of a Complaint by the caregiver often enabled PWD to provide a justification to their response, thus encouraging them to continue conversing with their caregiver. The use of a justification could have enabled PWD to access information from the declarative memory. The use of a justification, in response to a Complaint as part of Adjacency Pair was a finding not identified within other research. Therefore, since it is an innovative finding, further research is required for it to be considered valid and reliable. This outcome, possibly resulted due to the opportunity provided to the caregiver to use this 'talk practice'.

How attending the information sessions instilled caregivers to increase their repertoire of talk practices

Results showed that most caregivers increased their repertoire of talk practices post-information sessions. This increase in talk practice repertoire resulted due to the various communication tips which were suggested during the information sessions, resulting in an enhanced quality of interaction between caregivers and the PWD. Table 2 identifies the communication tips proposed in the information sessions.

Table 2: 'Session number and suggested communication tips

Session number	Communication tips to maintain conversation suggested in information sessions
1	Using signs and symbols to help PWD maintain familiarity of the rooms and objects within the house.
9	To use photos from the past within the home, to help PWD recognise that they are in their own home.
7	Using symbols and visuals to deliver messages and aid in comprehension.
3	Use semantic cueing to help PWD remember familiar words.
3,5,7	Minimise use of questions as this requires access to the declarative memory which is impaired in PWD.
3,7	Prepare PWD about future events to decrease agitation.
3,5	Talk to PWD about meaningful past events to help them feel secure.
3	Not raising one's voice to talk to PWD as this may increase frustration in the presence of word finding difficulties.
7	To speak to PWD in a gentle and encouraging tone to encourage communication.
3,7	To provide a daily routine to provide information about what is going to happen.
4	The importance of checking PWD's hearing abilities as this may affect communication.
5	When PWD talks about their past, keep talking on same topic to maintain conversation.
7	Using one's name to introduce yourself to PWD.
7	Offer choices when talking to PWD.
3,7	Use simple commands and familiar words and events when talking to PWD.
7	To repeat instructions to give PWD time to process information heard.
7	Do not contradict PWD and adapt to PWD's communication level.
9	Communicate facing PWD.
7	To give PWD time to respond.

Conclusion: Limitations and strengths of research project

The following are some shortcomings of this study. Sample sizes used within this research were small, therefore it is not possible to generalise the results obtained to a larger population of caregivers within this client group. Another limitation was that if any of the caregivers did not attend a session due to illness or other personal reasons, they missed information since there was no repetition of sessions. This could have limited the caregivers' learning experience. No follow up sessions took place to identify whether the caregivers were able to maintain the talk practices identified. Research demonstrated that ageing causes change in language such as voice tremor, fluency, speaking rate, loudness and pitch, as well as a decline in understanding complex utterances and naming (Yorkston, Bourgeois & Baylor, 2010). Since all participants in this study were elderly persons with dementia, these changes in language could have instilled change in the way their caregivers were communicating with them. This could have enabled them engage in some of the 'talk practices' identified to maintain better communication with PWD. Participant co-morbidities may increase caregiver burden possibly increasing relationship strain between the caregiver and PWD. This can affect the way communication between the two is carried out

(Passalacqua & Harwood, 2012). In this study too few participants were present to identify whether caregivers with multiple co-morbidities engaged in more or less talk practices.

Participants often expressed concern about how to maintain a conversation during recording. This may have reduced spontaneity of data recorded since it was necessary to suggest ideas on conversation topics to trigger off a conversation. Since participants chose topics which were both salient to the caregiver and the PWD it might have helped in researching conversations which approximated to natural ones. Indeed, it is possible that since snippets were taken from the conversations recorded, it did not enable the researcher to pick up all the 'talk practices' which the caregivers were potentially using. This could have been another reason why results showed that one particular caregiver only used two 'talk practices'. Having PWD participate in memory sessions whilst caregivers were attending the information sessions, could have helped the PWD maintain the baseline cognitive and linguistic abilities identified at the start of the sessions. This could have facilitated the caregivers' ability in increasing their repertoire of talk practices after the information sessions. The caregivers' education level and literacy abilities might also have been other factors that could have aided the caregivers' in acquiring knowledge from the information sessions to be able to communicate better with the PWD. This research project has the potential to enable Speech and Language Pathologists provide caregivers of persons with early to moderate stage dementia with more specific 'talk practices' on how to maintain communication whilst interacting with PWD. This can be achieved by carrying out workshop sessions, involving role-play to demonstrate the use of these 'talk practices'. Enabling caregivers to implement these 'talk practices' can help in reducing challenging behaviours PWD exhibit resulting from communication breakdown, possibly reducing caregiver stress and burden.

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Elder Abuse: An Evaluation of Criminal Act XXX1 (2014)

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Abstract. The term 'elder abuse' was first documented in 1975 (World Health Organization, 2014). Studies reveal that older persons are less inclined to report abuse to the police and more likely to report abusive behaviour to less formal institutions for example members of the clergy. In this regard, another development deserving recognition is the creation of an office where older persons residing in care homes and long-term care facilities, and even their relatives, could report any form of elder abuse. In light of the fact that at present, older persons suffering from abusive behaviour in their own home may only report such abuse to the executive police, one may argue that such initiative would be more fruitful if it is extended to cater for all cases of elder abuse and not restricted to abuse suffered at care homes and long-term facilities for older persons. For more effective protection, the Maltese Act XXXI of 2014 could have introduced an 'elder abuse' offenders register which would list all offenders convicted of any form of elder abuse. Whilst acting as a form of deterrence, a public register creates a sense of security for the general public. Employers could use this register, especially those whose service involves frequent interaction with older persons, to search the names of potential employees and determine whether prospective employees were, at some point in time, convicted of any abuse against older persons or otherwise.

Keywords: elder abuse, elder law, active ageing, ageism, age discrimination.

Introduction

The importance of elder abuse legislation is becoming an increasingly urgent concern as the older population continues to increase throughout all continents. This chapter examines the legal provisions enacted by the Maltese Act XXXI of 2014 (Ministry for Justice, Culture and Local Government, 2014) whilst contrasting them to the former provisions of the Criminal Code regulating elder abuse. Act XXXI of 2014 was enacted on 12 August 2014 in order to amend the Criminal Code and develop a new sub-title to the Maltese Criminal Code entitled

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'Of abuse on elderly or dependent persons'. As defined by the newly enacted article 257F of the Criminal Code, for the purposes of this sub-title, an older person is defined as any person who has attained the age of 60 years. As pointed out by various members of the legislature in the parliamentary debates leading to this enactment, prior to 2014 in Malta there was no law dealing specifically with elder abuse. This enactment targets all forms of abuse, irrespective of where such abuse takes place, and by whom it is perpetrated. Since demographic projections anticipate a continuing ageing population, there is no doubt as to the timeliness and necessity of this legal enactment.

The term 'elder abuse' was first documented in 1975 (World Health Organization, 2014). Even though research has shown that abuse of older persons existed prior to such date, such crime was considered as being a family affair, and consequently, discussions on this matter were limited. Various statistics compiled by international organizations including the World Health Organization (2008) revealed that around 3 to 5% of the older population is subject to abuse. However, one must bear in mind that such statistics are based on reported cases and thus one may presume that the percentage is much higher when taking into account the unreported cases of elder abuse. The global focus on elder abuse has sought to harmonise the relationship between human rights and active ageing. Despite the fact that there is no universally accepted definition of elder abuse, an oft-cited definition is that "elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (World Health Organization, 2006 : 1). Several experts in the field agree that there are five prominent forms of elder abuse including physical abuse, psychological abuse, sexual abuse, financial victimisation and neglect. Moreover, Lachs and Pillemer's (2015) study showed that elder abuse is more of a recurrent nature rather than of a remote occurrence, with more than 50% of the perpetrators are adult children, and around 25%, are spouses of the victims. Hence, making the divorced, widowed, unmarried and childless older persons less likely to be abused (Summers & Hoffman, 2006). Pillemer and Finkelhor also found that abuse may be intentional or involuntary due to the perpetrator's incompetence in providing essential care to older persons. Act XXXI of 2014 was precisely introduced in order to safeguard the vulnerability of older persons by incorporating new crimes and imposing harsher punishments for existing crimes. In fact, such enactment attempts to extinguish exploitative behavior, provide older persons with the necessary legal protection, whilst also empowering the judiciary to afford adequate measures of deterrence and protection including the restitution of expenses suffered by victims.

Analysis of the Relevant Provisions of Act XXXI of 2014

Apart from implementing harsher punishments, Act XXXI of 2014, hereinafter referred to as the Act, adopted other procedural safeguards in order to create a more efficient legal framework capable of offering effective remedies to victims of crime. The Act caters for voluntary and involuntary crimes, direct and indirect actions, as well as for crimes of commission and omission in relation to elder abuse. Article 257A of the Criminal Code deals with perpetrators causing or permitting an older person to suffer under circumstances likely to produce bodily harm or death. For an accused to be found guilty under this article, the

prosecution must prove two main elements beyond reasonable doubt - namely, (i) the accused knew or ought to have known that the victim was an elder at the commission of the crime; and (ii), the accused willfully caused or permitted an elder suffered under circumstances which were likely to produce grievous bodily harm or death. With respect to the first element, Article 257A(2) of the Criminal Code stipulates that for the purpose of this article, "the person whose course of conduct is in question ought to know that a person is an elder if a reasonable person in possession of the same information would think that the said person is an elder". Thus, as soon as it is ascertained that a reasonable person ought to have known that the victim was an elder, the first element is proven successfully and subsequently the *onus probandi* shifts from the Prosecution to the Defence. The second element mentioned above, makes reference to "circumstances which were likely to produce grievous bodily harm or death". However, apart from Article 257A introduced by this Act, the crime of causing grievous bodily harm was also regulated by means of Article 216 and 218 of the Criminal Code, but whereas Article 257A is applicable only to older persons and dependent adults, Articles 216 and 218 are generic in nature. Another cardinal difference between these provisions is that whilst for a person accused under Article 216 or 218 of the Criminal Code the prosecution must prove beyond reasonable doubt that the accused's actions have eventually led to grievous bodily harm, in a case wherein a person is accused under article 257A the accused may still be found guilty if grievous bodily harm is not produced as long as it is successfully proven that the older persons suffered under circumstances which were likely to produce grievous bodily harm but that for some reason or another such harm was not produced.

On one hand, if all of the aforementioned elements are successfully proven, the accused shall be liable to the punishment of imprisonment for a term from two to five years. On the other hand, if it is proven that eventually the elder victim of crime suffered grievous bodily harm, the aforesaid punishment shall be increased. In fact, where the victim of crime is an older persons aged under seventy years of age, the punishment shall increase by one to two degrees and thus to a maximum of nine years of imprisonment and where the victim is over seventy years of age, the punishment shall increase to a maximum of twelve years of imprisonment. As an example, in the separate cases of **Il-Pulizija vs Niko Zammit** (decided on the 2 March 2016 by the Court of Magistrates per Magistrate Dr. Micallef Trigona) and **Il-Pulizija vs Christopher Mifsud** (decided on 19 October 2016 by the Court of Magistrates per Magistrate Dr. Micallef Trigona) the Court - after hearing the accused admitting to the charges, including those under article 257A - handed down a judgement of 4 years and 1 month imprisonment and 3 years of imprisonment respectively on the basis of article 257A. Through article 257B of the Criminal Code, the legislator has the power to regulate situations where an elder victim dies due to the grievous injuries suffered. This article may be contrasted with article 220 of the Criminal Code which regulates a similar scenario. However, whereas Article 257B is restricted to elders and dependent adults, article 220 caters for victims of crime of all ages. In terms of article 220, if death occurs within 40 days from the day on which the victim suffered grievous bodily harm, the perpetrator shall be liable to imprisonment for a term between 6 to 20 years, whereas if death ensues after 40 days but within a year, the offender shall be liable to imprisonment for a term from 4 to 12 years. In conjunction to these punishments reference is made to article 222A which provides

that in cases where the victim is an older person, the punishment could be increased by 1 or 2 degrees amounting to a maximum of thirty years of imprisonment. Article 257B, as enacted by this Act XXXIII of 2014, stipulates that in cases of death ensuing from grievous injuries suffered by an older person, the punishment is set between 9 to 20 years of imprisonment if death ensues within 40 days from the infliction of grievous body harm or to 6 to 15 years of imprisonment if death shall ensue within a year from the attack. In addition, article 257B(4) states that where the victim is an older person under 70 years of age the punishment shall increase by 1 or 2 degrees, and in cases where the victim has attained the age of 70 years the prescribed punishment could be increased by 3 degrees amounting to a maximum of life imprisonment. The newly enacted Article 257C of the Criminal Code encapsulates all other offences which are not likely to produce effects described in the preceding articles. In fact, this provision criminalises all actions inflicting unjustifiable pain and mental suffering on elders which are not likely to produce grievous bodily harm, thus incorporating various actions including, but not limited to sexual offences, emotional abuse and neglect.

Sexual abuse

Sexual abuse is the least identified and least reported form of elder abuse. The National Centre on Elder Abuse (2017) defined sexual abuse as “non consensual sexual contact of any kind with an elderly person”. Whilst this definition is limited to undesirable touching, the NCEA argues that sexual abuse is not limited to physical contact but exposure to sexual material may also be classified as sexual abuse. Data from the National Crime Victimization Survey of 2000 reveals that in over 1% of all rapes and sexual assaults the victims were older persons. Moreover, Rennison (2002) argues that due to serious underreporting, only 30% of sexual abuse cases reported. Article 257C, introduced by the Act, holds that the punishment for this offence shall range from 1 to 3 years of imprisonment without prejudice to any other punishment the offender may be liable to under any provision of the Criminal Code. Over the years, the Maltese Courts had to decide on various cases wherein the accused was charged with sexual abuse of older persons. In the case of **Il-Pulizija vs Carl Galea** (decided on the 6 July 2012 by the Court of Magistrates per Magistrate Dr. E. Grima) the accused worked as a carer at St. Vincent De Paul Long-Term Care Facility, and was charged with committing violent indecent assault on an 87-year-old patient. The court, after considering the mental state of the perpetrator as well as that of the victim, sentenced the accused to 7 months of imprisonment suspended to 3 years. This judgement was subsequently confirmed upon appeal.

Psychological abuse

Article 257C is also applicable to cases where an older person alleges any unjustifiable mental suffering. Psychological or emotional abuse refers to the treatment of elderly persons in ways that give rise to emotional pain and suffering. The term ‘psychological abuse’ includes humiliation, threats, as well as other acts causing psychological isolation and neglect. Mental suffering could also be brought about by unlawful confinement and

detention. Since psychological abuse may be verbal or non-verbal, lack of sensitivity and understanding towards elders may also amount to psychological abuse.

Neglect

The notion of neglect can be classified into physical and psychological neglect. Abuse by neglect may be punished both under article 257A catering for actions which are likely to produce bodily harm or death, as well as under article 257C dealing with actions which are not likely to produce same effects, depending on the case at hand. On one hand, physical neglect refers to the failure to supply sufficient and adequate food, accommodation, clothing and support. On the other hand, psychological neglect occurs when an elder is isolated for long periods of time and no significant social contact is provided for the entire duration. Similar to all other forms of elder abuse, perpetrators of such crime may be family members, unrelated offenders as well as employees in a nursing home who have constant contact with the older persons. When referring to neglect, reference is to be made to the so called concept of 'granny-dumping' (Hey & Carlson, 1991). This concept originated in the United States in the 1990s when carers started to abandon their elder relatives in hospital emergency rooms so that the state would subsequently assume the elders' responsibility. Even though such term originated in the 1990s, back in 1978, the Indian Code of Criminal Procedure already criminalised physical neglect by means of article 125 which stipulates that all persons with adequate means are criminally responsible to maintain their parents (ibid.). In the case of **II-Pulizija vs Antonio Borg** decided on the 22 of July 2017 by the Court of Magistrates per Magistrate Dr. J. Mifsud), the Magistrate commented on the suffering experienced by older persons in cases of neglect:

F'ċerti każijiet l-anzjanità t'fisser tbatija u uġieġħ, speċjalment meta l-anzjani jibdeu jiffaċċjaw l-iżolament u jekk ma jhossuhomx ukoll imwarrba. Hemm ukoll min jabbanduna lill-qraba tiegħu f'xi waħda mid-djar tal-anzjani f'pajjiżna u rari jersaq 'l hemm għal diversi raġunijiet¹.

Similar to Article 257C of the Maltese Criminal Code criminalising neglect and isolation, section 215 of the Canadian Criminal Code holds that if a caregiver fails to provide the basic essentials of life to a person under his charge, and the person under his care is unable to withdraw himself from that charge, the carer is guilty of neglect. A judgement referring to the said provision under the Canadian Criminal Code is the case of Mary Nanfo who had pleaded guilty to a charge brought under 215 of the Canadian Criminal Code (The Canadian Legal Information Institute, 2016). After the death of her father, Ms. Nanfo's mother had become fully dependent upon her. It resulted that the accused had failed to provide the basic adequate living conditions. The court pointed out that the accused was often away from home and used to leave her mother with no care whatsoever. In light of the fact that the mother suffered from dementia, incontinence and blindness, due to the lack of care, the mother eventually died and the police found her corpse covered in excrement after 24 hours

¹ *Editor's translation:* In certain cases, senior citizenship implies suffering and pain, especially when senior citizens face isolation and, moreover, feel neglected. There are those who abandon their relatives in one of the retirement homes in our country and rarely visit for various reasons.

of her death. The Court, after considering the absence of the intentional element, sentenced Nanfo to imprisonment for one year to be served as a conditional sentence in the community.

Offences relating to crimes against the property and public safety

Through the recently introduced Article 257D of the Criminal Code, the legislation does not incorporate new crimes, but harshens the punishments corresponding to previously existed crimes when it is successfully proven that such crimes were perpetrated on the property of an elderly person. Article 257D embodies all offences found under Title IX of Part II of Book First of the Maltese Criminal Code incorporating offences such as theft, misappropriation, usury, fraud, crimes dealing with explosive substances, arson and offences related to unlawful entries. Financial or material abuse against elders refers to the financial benefit procured by the offender by misusing the elder's property. Fraud statistics report that around 30% of fraud victims are older persons. Hillier and Barrow (2015) claimed that this deceitful gain could materialise through various means such as through dating and marriage services, fraud through television sales or through investment fraud. Predominantly but not exclusively, material abuse is perpetrated by relatives or caregivers who have more opportunity to swindle the elders in question. Unfortunately, when committed by a relative, only the most radical cases reach the public eye. In the case of **Il-Pulizija vs Joseph Brignoli** (decided on the 3 November 2015 by the Court of Magistrates per Magistrate Dr. J. Mifsud), the Magistrate commented on the brutality of theft on older persons,

Il-Qorti tikkundanna bil-qawwa kollha l-attakki fuq l-anzjani, li ħafna drabi jkunu vulnerabbli li jspiċċaw vittmi ta' nies bla qalb li jagħzlu lil min hu dgħajjed biex jehdulu dak li b'tant saġrifċċji jkun kiseb tul is-snin. Dawn in-nies bla qalb, qabel iwettqu l-attakki tagħhom, żgur li ma jirriflettux biżżejjed u ma jarawx li daww il-persuni li ser jattakaw setgħu kienu l-ġenituri tagħhom stess, li żgur ma jkunux iridu lil xi ħadd jattakahom go darhom u jisriqilhom dak li jkunu ġemmghu tul is-snin biex wara jhalluhom lil uliedhom u lil ulied uliedhom².

As opposed to strangers, relatives hold a position of trust. Financial exploitation may result in circumstances where the offender steals or retains elderly victims' property or money for personal advantage. The misuse of powers of attorney may also constitute financial exploitation and thus falling within the ambit of Act XXXI of 2014. In fact, sub-article (1) of article 257D holds that when such abuse is committed against an elder and the amount of damage exceeds €3000, the perpetrator shall be liable to imprisonment from 2 to 9 years, whereas when the amount of damage lies between €250 and €3000 the punishment shall be

² *Editor's translation:* The Court very strongly condemns attacks on senior citizens, who more often than not are vulnerable to becoming victims of unscrupulous individuals who choose the weak to take what they have earned through so much sacrifice over the years. For sure, before launching their attacks, these unscrupulous individuals do not think things over enough and do not take into consideration that those people they are going to attack could as well as have been their own parents, whom they certainly would not want someone to attack in their own home and steal what they had saved over the years so as to pass it onto their children and grandchildren.

imprisonment from 9 months to 3 years. When this amount does not exceed €250, imprisonment shall not exceed 6 months. Article 257D was put into practice in the case of **II-Pulizija vs Josef Seychell** (Decided on 4 July 2017 as per Magistrate Dr. D. Frendo Dimech), where the Court commented on Act XXXI of 2014 and held that:

Il-Qorti qiset li l-vittmi ta' dan it-tip ta' reati huma persuni li jixriqilhom aktar protezzjoni minn membri oħra tas-soċjetà. Kien għalhekk li l-leġislatur bl-Att XXXI tal-2014 introduċa qafas leġislattiv li l-għan tiegħu kien li kondotta simili, li jisthoqqilha biss stmerrija u għajb, tiġi sanzjonata permezz ta' pieni horox. Il-vulnerabbiltà sabet it-tarka tal-liġi sabiex daww il-membri tas-soċjetà li huma l-aktar vulnerabbli, partikolarment l-anzjani, li haqqhom u jixriqilhom biss rispettt u għajnuna u mhux sfruttament, jgħix mingħajr tħassib jew biża' dwar l-inkoluminità fiżika tal-persuna tagħhom jew tal-proprjetà li jkunul tul hajjithom hadmu, stinkaw għaliha u li għandhom kull dritt li jgawduha³.

Eventually, the Court found the accused guilty of participating in 3 snatch and grabs on elderly persons and sentenced him to 40 months of imprisonment. Moreover, by means of Article 257D(2), after establishing the accused's guilt, the Court may order the perpetrator to return to the victim any stolen property or property obtained fraudulently or order the accused to compensate the victim for his loss. Since such order shall amount to an executive title as defined by the Code of Organisation and Civil Procedure (COCP) the victim may subsequently enforce his title by the issuance of any of the executive warrants stipulated under article 273 of the COCP. This procedure is a completely innovative procedure allowing a victim or *parte civile* in criminal proceedings to avail himself of the remedies under the COCP for the safeguarding of his credit or compensation. In all other cases, the court of criminal judicature would simply accord compensation or reimbursement, and this independently of any civil procedures.

Unlawful arrest, detention or confinement of an older person

The main aim of Article 257E is to regulate the behaviour of caregivers during the late stages of an elder's life. As propounded in the parliamentary debates leading to this enactment, it is not uncommon for relatives that, as soon as they are favoured by the elder's testamentary disposition, they preclude the elder from having any contact with other relatives in order to safeguard their personal interests and avoid any amendments to the previously made will. According to article 257E, this is to be interpreted as unlawful confinement of the elder and punishable by imprisonment. Article 257E promotes the concept of the least restrictive alternative. This notion attempts to strike a balance between the ethical duty of the caregivers to take care of such elders and the right of freedom of the elderly. According to

³ *Editor's translation:* The Court considered victims of this type of crime as being individuals who deserve more protection than other members of society. This was the reason why the legislator through Act XXXI 2014 introduced a legal framework with the view that similar conduct, which merits only disgust and shame, is punishable by harsh sentences. Vulnerability is shielded by law so that, those members of society who are most vulnerable, in particular senior citizens, who deserve and merit only respect and assistance and not exploitation, may live in peace and without fear for their physical safety or that of their property for which they have worked and toiled throughout their lives and have every right to enjoy.

this theory, it is the duty of the caregivers to create a compromise by proposing the least intrusive solution. In terms of Article 257E, when an elder is arrested, detained, forcibly confined without legitimate orders or when the elder's freedom of movement is unjustifiably restricted, the responsible carer shall be liable to imprisonment for a term of 18 months to 4 years. Such punishment shall be increased by 2 or 3 degrees, and thus up to 9 years of imprisonment, when such restraint is committed through the use of violence, deception, improper pressure or threats.

Shortcomings and recommendations

Punishment as a deterrent

As remarked in the parliamentary debates leading to Act XXXI of 2014, the main aim of this enactment was to promote tougher prison sentences which may act as a deterrent to other would-be offenders. However, after analysing various provisions of the Criminal Code, one may conclude that even such penalties may be circumvented. For instance, Article 21 of the Criminal Code empowers the court to award any lesser punishment which it deems adequate as long as there are special and exceptional reasons. By means of this provision, the legislator granted to the judiciary the capacity to impose a punishment less than the minimum imposed by law. In various instances, the Court propounded that Article 21 is only excluded when the legislator explicitly provides for such exclusion. This exclusion is not novel since there are several enactments which exclude the application of article 21, for example Article 60 of the Arms Act⁴ or Article 99A(2) of the Criminal Code. In light of the fact that the legislator failed to provide for such an exclusion, Article 21 is still applicable and if special and extraordinary reasons are proven successfully, the judge may still decide to impose a punishment less than the minimum imposed by this enactment. Another manner by which the perpetrator could circumvent the punishment imposed by the discussed enactment is through the application of article 28A of the Criminal Code dealing with suspended sentences or/and through the application of punishments contemplated in terms of the Probation Act⁵. In fact, in the case of **Il-Pulizija vs Clinton Bugeja** (decided on 24 February 2016 by the Court of Magistrates per Magistrate Dr. A. G. Vella) the accused, after admitting to a breach of article 257C, was sentenced to a 3-year suspended sentence. As explained in the case of **Il-Pulizija vs Noel Grech u Omissis** (decided on the 28 October, 2004 by the Court of Criminal Appeal per Mr Justice Galea Debono) a suspended sentence could be granted whenever the guilty party is not sentenced to more than 2 years of imprisonment. Other enactments, including the Dangerous Drugs Ordinance⁶, expressly prohibit the application of article 21 of the Criminal Code, article 28A of the Criminal Code dealing with the imposition of suspended sentences and the application of the Probation Act. It is the author's opinion that the same could have been proposed for the purposes of the offences enacted in virtue of Act XXXI of 2014.

⁴ Chapter 480 of the Laws of Malta.

⁵ Chapter 446 of the Laws of Malta.

⁶ Chapter 101 of the Laws of Malta.

Underreporting and lack of enforcement units

Elder abuse is highly underreported either due to coercion or else due to other causes attributed to the victim, and that many social and health care professionals do not possess the necessary skills to recognise signs of elder abuse (Lachs & Pillemer, 2015). These causes may be shame, any physical or mental infirmity or timidity. Other barriers to such revelation are conventional perceptions that family privacy is of utmost importance and such privacy should not be tainted. Research indicates that religious ideologies play a pivotal role when determining whether one should report abuse or otherwise (Beaulaurier et al., 2008). The World Health Organisation (2014) suggests that only 2% of all reported cases are reported, and urges all social and health care institutions to set up adequate regulations, guidelines and pathways to be adhered to in cases of suspected elder abuse. As pointed out during the parliamentary debates leading to such enactment, foreign legal systems, including but not restricted to Californian law, enforces a system of mandatory reporting⁷. For instance, section 15630 of the California Welfare and Institutions Code defines a mandated reporter as any person who has the responsibility for the care of an elder. If a mandated reporter fails to disclose abuse, he is punished by up to 6 months of imprisonment or a fine up to US\$1,000. If the unreported abuse results in death or grievous injury, the mandated reporter shall be punished by up to 1 year of imprisonment and a fine of US\$5,000. Moreover, in cases where an employee or an officer of a financial institution fails to report financial abuse, such officer is liable up to US\$1,000 and if such failure is intentional the fine may be that of US\$5,000. One may therefore argue that ACT XXXI of 2014 failed to take the bull by the horns by lacking a system of mandatory reporting. In Malta, mandated reporters may include medical practitioners working in medical institutions as well as other medical practitioners offering home-services. Choice of medical staff should be made meticulously to ensure that the staff has the required commitment and diligence to deal with signs of elder abuse. According to Harbison (2017), care assistants and home care-workers are to be given extensive training since they have most contact with potential victims. A system of mandatory reporting will undoubtedly diminish the problem of underreporting. It is in fact positive noteworthy that those American states which have introduced such system of reporting are already witnessing much positive results and developments (ibid.).

Concluding Remarks

Apart from Act XXXI of 2014, ACT X of 2016 (Ministry for Justice, Culture and Local Government, 2016) which provides for the position of a Commissioner for Older Persons deserves recognition. The main functions of the Commissioner for Older Persons include the scrutiny of alleged violations of human rights in cases of elder abuse as well as the evaluation of contemporary legislation and how such legislation affects the elderly. By means of this enactment, the Commissioner may also issue 'an older person impact statement' that delineates how legislative enactments are affecting elders' wellbeing. Nevertheless, the commissioner's powers in relation to his investigative duties are very

⁷ These included the Parliamentary Debates of the Twelfth Legislature (2013-) Sitting No. 173 of 08/07/2014, Parliamentary Debates of the Twelfth Legislature (2013-) Sitting No. 173 of 22.07.2014, and the Parliamentary Debates of the Twelfth Legislature (2013-) Sitting no. 34 of the Consideration of Bills Committee on 22.07.2014.

limited. According to Article 14 of the Commissioner for Older Persons Act, the commissioner is not permitted to investigate specific and personal reports arising from a private relationship between an older persons and his/her carer. The Commissioner is also restrained from investigating any issue falling within the jurisdiction of any court or tribunal. Hence even though the Commissioner is depicted as 'a focal point for the elderly', in cases of individual abuse the Commissioner has no effective and operative power.

Studies reveal that older persons are less inclined to report abuse to the police and more likely to report abusive behaviour to less formal institutions for example members of the clergy (Gibson, 2013). In this regard, another development deserving recognition is the creation of an office where older persons residing in care homes and long-term care facilities, and even their relatives, could report any form of elder abuse. In light of the fact that at present, older persons suffering from abusive behaviour in their own home may only report such abuse to the executive police, one may argue that such initiative would be more fruitful if it is extended to cater for all cases of elder abuse and not restricted to abuse suffered at care homes and long-term facilities for older persons. For more effective protection, Act XXXI of 2014 could have introduced an 'elder abuse' offenders register which would list all offenders convicted of any form of elder abuse. Whilst acting as a form of deterrence, a public register creates a sense of security for the general public (Letourneau et al., 2010). Employers could use this register, especially those whose service involves frequent interaction with older persons, to search the names of potential employees and determine whether prospective employees were, at some point in time, convicted of any abuse against older persons or otherwise.

Overall one could also argue that even though Act XXXI of 2014 is a step in the right direction; it leaves much to be desired. Elder abuse is a spreading phenomenon that can be controlled and mitigated. However, this requires a harmonised approach between different legal and social/health care sectors in the Maltese society.

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The Adequacy Pension Income Conundrum

David Spiteri Gingell¹

Abstract. In March 2004, the World Bank presented to government a report on the robustness of the pension system. The report was dire. The World Bank projected that the Average Pension Replacement Rate - that is, the average pension in proportion to the average wage - would fall from 54% in 2004 to 14.1% by 2050. As the adequacy of the Maltese pension system collapsed, the cost of the pension system, in terms of the pension deficit as a percentage of GDP, was estimated to increase from (1.8%) in 2004 to (3.3%) in 2050. The World Bank underlined that unless comprehensive reforms were carried out the pension system was neither adequate nor sustainable for future generations. Malta's pension system is a Pay-As-You-Go system - introduced in 1979 following a major reform of the social security landscape. The social security contributory pension, as it is known, was established as the pension an individual is entitled to - resulting in the closure of a private pension market which was, then, vibrant. This article traces the development of the pension system in Malta by charting the 2004 reforms and adequacy followed by the 2010 changes and 2015 restructurings, whilst also asking whether Maltese households are addressing the adequacy pension gap, and whether automatic enrolment is a solution for the adequacy pension income conundrum?

Keywords: pension, income security, retirement, active ageing.

Introduction

In March 2004, the World Bank (WB) presented to government a report on the robustness of the pension system (PS). The report was dire. The WB projected that the Average Pension Replacement Rate (APRR) - that is, the average pension in proportion to the average wage - would fall from 54% in 2004 to 14.1% by 2050. As the adequacy of the Malta PS collapsed, the cost of the PS, in terms of the pension deficit as a percentage of GDP, was estimated to increase from (1.8%) in 2004 to (3.3%) in 2050. The WB underlined that unless comprehensive reforms were carried out the PS was neither adequate nor sustainable for future generations.

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Malta's PS is a Pay-As-You-Go (PAYG) system - introduced in 1979 following a major reform of the social security landscape. The social security contributory pension (SSCP), as it is known, was established as the pension an individual is entitled to - resulting in the closure of a private pension market which was, then, vibrant. Between 1979 and 2003, the year preceding the WB's report, successive administrations failed to give due attention to the long-term performance and robustness of the PS at a time when its fundamentals changed significantly - namely, (i) the fertility rate collapsed, falling from over 2.1 to 1.4, and (ii), longevity increased from 67 years and 74 years of age for males and females in 1979 to 79 years and 84 years in 2003 (respectively). The Maltese PS is, theoretically, a two-thirds salary based pension calculated on the basis of the best consecutive annual three salaries over the last 10 years of employment - subject to a capped ceiling - the Maximum Pension Income (MPI) (The 2004 reforms changed this pension calculation formula for persons born on and after 1962 to the best 10 years over a 40 year contributory period). When the SSCP was introduced in 1979, the MPI was pegged to the salary of the President of Malta (the highest state salary at the time): €13,980. By 2003, the MPI increased only to €15,145 - that is, €1,165 over a 24 years period (€48.5 annually). As salaries increased as Malta enjoyed economic and social growth over the said period, the pension income remained constant - thereby negating the originally 2/3 or 66% relationship with the highest salary paid by the state. Furthermore, the actual value of the pension income was eroded by inflation as the PS did not allow for the MPI to be adjusted to counter inflationary pressures. Pensioners who retired in 2003 were, therefore, 'poorer' than their peers who retired in 1980.

In June 2004, the Maltese government established a technical group to study the WB report, and presented recommendations on the adequacy and sustainability of the PS for future generations. This initiated a process of continuing reform that is still underway today.

The 2004 reforms and adequacy

A strategic goal of the 2004 reform, one retained by subsequent reforms, was to secure an adequacy footprint for future generations, equivalent to that enjoyed by pensioners who were to retire between 2004 and 2010 - an APRR of 54% (Pensions Working Group, 2005). The 54% adequacy rate was seen as a reasonable retirement income benchmark that provides dignity to persons in retirement. It was, however, recognised that a 54% APRR will not secure a quality of life in retirement similar to that enjoyed whilst in employment. Nevertheless, in designing the parametric and institutional aspects of reform to the PS, it was evident that a 54% APRR for future pensioners achieved solely through the SSCP was not achievable. This was not a matter of simply safeguarding the sustainability of the PS. Increases in the contributory rate do not, given Malta's PAYG system, translate to a higher individual pension. Indeed, Malta's PS does not have a ring fenced pension fund where contributory benefits are invested to accrue a higher return to contributors - as contributions paid by beneficiaries are treated as government revenue posted to the Consolidated Fund. Moreover, Malta's PAYG system is not a Notional Defined Contribution (NDC) PAYG where the PS mimics a private pension by allocating individual notional accounts which compound over time by means of an assigned interest rate.

The 2004 reform stipulated that the maximum level of APRR that could be attained by the SSCP in a sustainable manner following parametric and institutional reforms was 45%. Amongst the important parametric changes to the SSCP was the introduction of an automatic indexation mechanism that annually adjusts the MPI by a formula of 70% Wage Inflation +30% Retail Inflation. The objective of this specific measure was to ensure that the pension income of future generations retains a strong link with inflationary impacts on market wages. Be that as it may, the parametric reforms still resulted in a state of play where the APRR of future pensioners (2050) was 9 percentage points (p.p.) lower than that of persons retiring between 2004 - 2010. It was argued at the time that bridging the gap between the maximum sustainable APRR secured through the SSCP and the desired adequacy benchmark of 54% through a voluntary third pension would not achieve the desired result. Research showed that when people are left by themselves, to provide for retirement, most will not save enough for retirement. In Ireland, for example, whilst 41.3% of the individuals working in the private sector aged 20 to 69 were covered by a voluntary private pension plan 31% were covered by occupational private pension plans, while only 12% were covered by personal pension plans. Similar rates of coverage for occupational pension plans were reported in Canada and the United Kingdom (OECD, 2013). The coverage of voluntary pension plans was, at time, also very low (below 5%) in countries such as Greece, Luxembourg, Portugal, and Turkey.

The low take-up of voluntary private pensions (including occupational retirement pensions - where, for example, in the United Kingdom showed a marked decline between 1990 and 2005) is a direct result of the types of heuristics that influence behaviour for generational planning as is the case with regard to saving for retirement. It was, therefore posited, that the 9 p.p. gap between the maximum APRR resulting from a sustainable SSPC and the desired APRR adequacy goal would best be secured through the introduction of mandatory second pension. The selection of a mandatory second pension instrument was strategically chosen to counter the impact of behavioural heuristics which impede persons from thinking long term and preparing for their retirement. The recommendation presented was that an employee and an employer would each pay an additional contribution of 4% annually - incrementally phased over an 18-year period to give both employees and employers time to adjust. The reforms further underlined, that individuals should be provided with opportunity and choice to invest for their retirement in the event that they sought an APRR higher than the 54% benchmark provided by a combined SSPC and a second mandatory pension. Indeed, in 2004 the pension regulatory framework still prohibited an individual to have a second pension. The reforms also proposed the introduction of comprehensive framework for persons to prepare for retirement - from child pension accounts to home equity release; the latter seen to be of specific importance in Maltese society as home ownership is high - with over 76% owning a home, which according to the 2011 Census, over 80% are of a high quality. The reaction by both enterprise and unions to the introduction of a mandatory second pension was negative. Enterprise underlined that the targeted 4% new contribution would undermine competitiveness whilst unions argued that, in the here and now, disposable income will be reduced. The opposition also positioned itself against a mandatory second pension. The government too came out against this

recommendation - responding to the general societal negative response in the run up to a general election which had to take place by early 2008.

In many ways, the 2004 reforms resulted in cherry picking. The recommendations relating to key parametric reforms to the SSCP, which secured the 45% APRR, were introduced effective 1st January 2007. The complementary reforms to (i) ensure that future generations (which reforms defined to be persons born on or after 1962) retire at a pension level similar to persons retiring between 2004 and 2010; and (ii) providing persons with the right to invest for their retirement to secure an income higher than that provided by the SSCP were rejected. Other 2004 reform measures merit mention. First, a safety net was proposed to protect future pensioners from being at-risk-of-poverty (AROP). This was to be secured by means of a Guaranteed Minimum Pension - benchmarked to 60% of the median income. This recommendation was accepted. Second, to avoid a repetition of policy paralysis in the pension policy domain a trigger was proposed to be grafted onto the Social Security Act (SSA) for the carrying out every 5 years of a strategic review on the sustainability, adequacy, and solidarity of the PS. This recommendation, too, was accepted with first strategic review mandated to take place by the end of 2010.

The reforms also included flanking policies. Two such policies, which affected the adequacy of income levels in retirement of both current and future pensioners, were key. The first relates to the removal of a constraint at law that restricted persons from continuing to work whilst in retirement as they would otherwise forfeit their pension. At the time the number of retirees active in the labour market was negligible. The second relates to measures directed to increase female participation in the labour market. Due to local cultural and traditional norms, the majority of households benefited from only one pension income - primarily that of the male spouse who in the Maltese polity is the main bread winner.

The 2010 reforms and adequacy

The 2010 Strategic Review triggered by the newly introduced Article 64B of the SSA confirmed that the attainment of a 45% APRR by SSCP was on track (Pensions Working Group, 2010, 2012). Given that the review was carried out within the midst of the financial and economic crisis a critical question that it grappled with was whether a mandatory second pension remained a viable option. The 2010 review posited that the “question relating to the introduction of a second mandatory pension must be answered with regard to the knowledge and certainty that an APRR of 45% will not be adequate as against the uncertainty on the global economy and behaviour of the financial markets as well as its impact on the national economy”.

The review concluded that a decision to postpone further a mandatory second pension would only exacerbate the issue relating to the adequacy of the APRR; requiring drastic measures in the near future. The review recommended that the government should seek to introduce a mandatory second pension at the earliest possible - and not later than 2018. The review, however, emphasised that the framework for a mandatory second pension should take on board lessons learnt from the economic and financial crisis - embracing mechanisms

such as a default fund based on a lifecycle investment strategy to provide protection to those persons who do not or are unable to decide how to invest and to manage that investment over their working period. Once again the recommendation to introduce a mandatory second pension was rejected by government, the Opposition, enterprise and the unions - the reactions similar to those presented in 2004. The 2010 review, again, underlined the importance of introducing a third pillar framework incorporating occupational and personal pensions, home equity release, etc. at the earliest possible so that individuals are provided with the opportunity and choice to provide for a quality of life in retirement that closer reflects that enjoyed whilst in employment. Once again, whilst accepting the recommendations no action was taken by government.

The 2015 reforms and adequacy

The 2015 strategic review was triggered by the incoming new administration within months from being elected in March 2013 (Pensions Strategy Group, 2015). The incoming government, whilst declaring the technical team to be independent, made it clear that it would reject recommendations that went contrary to pledges made in the electoral manifesto - mainly (i) the 65 years statutory retirement age will not be increased but rather that persons will, mainly, through supporting policies be encouraged to work beyond the statutory pension retirement age; and (ii) no mandatory second pension will be introduced. The main report targeted four aspects - namely, (i) changing needs and issues relating to society and the labour market; (ii) retaining a fair balance between contributions and benefits across generations; (iii) reforms to ensure that the pension income is not the only source of income; and (iv), addressing challenges faced by current pensioners. The 2015 reforms also assessed the possibility, with the assistance of the WB, to migrate the PAYG PS to a NDC PAYG system (recommended in the 2010 review for study). The review concluded that the benefits stemming from such a complex transition were too small to mitigate the risks associated with such an institutional framework overhaul. With regard to adequacy, the 2015 reforms presented five key trusts:

- First, in 2014 recommendations were presented for the introduction of a third pillar pension. The underlying fiscal incentive framework was designed to bridge the 9 p.p. between the 45% APRR SSCP footprint and the 54% APRR benchmark. The review also recommended that the government should work with the financial services industry and employers so that a Voluntary Occupational Retirement Pension scheme (VORPS) is introduced. Both recommendations were accepted. The first private pension products were placed on the market in late 2015; and in 2017 the government issued a tax incentive framework for VORPS.
- Second, with particular regard to future generations, a behaviour inducing scheme directed to incentivise people to work up to 65 years of age rather than opting for early retirement at 61 years of age was introduced - with an individual accruing an additional 23% on their pension income, if they retired at 65 years of age (during which period they do not draw down their pension). This recommendation too was accepted; though it is currently limited to employees in the private sector.

- Third, the primary focus of adequacy and pension income was directed towards current pensioners. Although the recommendations as presented in the review were not accepted by Government in the 2016, 2017, and 2018 budgets the government introduced a spate of measures directed to improve the pension adequacy of current pensioners – primarily with regard to those pensioners who are AROP.
- Fourth, the government took on board a recommendation that secured a female the full pension income of her spouse in the event of his death rather than 5/6ths survivor pension in the event that she qualifies for a pension in her own right.
- Finally, the 2015 review reaffirmed the recommendations presented in the 2010 review that a retirement and financial capability strategy is designed and implemented to inculcate, amongst others, a culture of retirement planning and action.

One other important reform relating to adequacy introduced by government in the 2017 and 2018 budgets was that of rendering pension income for single and married households to a maximum of €14,000 to be tax free.

Are Maltese households addressing the adequacy pension gap?

Research on the extent to which Maltese households are planning for their retirement to ensure that they have a retirement nest egg that provides them a level of adequacy beyond the 45% APRR provided by the SSCP is limited. Nevertheless, converging different empirical data leads one to conclude that, in the main, Maltese persons are not preparing for their retirement.

A study by Caruana and Pace (2013) estimated households' net wealth, which is defined as the sum of real and financial assets net of financial liabilities, at a median value of €215,932. The survey further showed that the main residence accounted for 51% of household wealth in the form of real assets. Furthermore, the share of the main residence in the net wealth of those households in the highest 20% net wealth percentile was lower, contributing about 30% to their total real assets. For the lowest 20% percentile in net wealth terms this was more than half. The survey further showed that a higher level of net wealth was reported when the reference person in the household was a university graduate or self-employed or was aged within the 55 - 64 age bracket. The median net wealth of households represented by reference persons with tertiary, secondary and below-secondary levels of education respectively was found to be €319,994, €226,126 and €129,469 respectively. The survey demonstrated that the median for net wealth, of all households, the median for households represented by a self-employed person was 2.5 times higher. The median net wealth of households whose reference persons were aged between 55 and 64 years was €272,625, and the overall median value of holdings of financial assets was estimated at €26,229. The median value of financial asset holdings was found to vary with the educational attainment and work status of the reference person representing the household. For example, households whose reference person was an employee accounted for 36% of all households and owned financial assets with a median value of €29,769, while households whose reference person was self-employed persons representing 8% of all households, held financial assets with a median value of €68,856. The median financial asset holdings for

retired persons (27% of all households) stood at €28,906. Households with a primary level of education (23% of all households) owned financial assets with a median value of €17,015; those with a secondary level (62% of all households) held financial assets with a median value of €25,407, while those holding a university degree (15% of all households) owned financial assets with a median value of €54,029. The study concluded that 76.3% of households in Malta do not save - with only 23.7% of households being net savers with a median annual savings of €3,000, and an average saving level of €4,400. Other research carried out by Galea (as cited in Ministry for the Family and Social Solidarity, 2017) on attitudes towards retirement found that 64.0% of persons in Malta do not give any thought to the level of savings they should have given their desired retirement age and life expectancy; although 70% of respondents state that the SSCP will only provide sufficient income to pay for bare necessities. Additionally, of those who do think about the level of income they seek in retirement, 52.4% state that they require the same level as pre-retirement income whilst 9.5% state that they do not know (ibid.). Moreover, most of the respondents in a survey on financial literacy state that they do not hold a specific savings plan for retirement - whilst those who do invest for their retirement invest approximately €1,161 annually - or €97 per month (Mangion, as cited in Ministry for the Family and Social Solidarity, 2016).

Is the third pension framework meeting its objective of nudging sufficient persons to bridge the 9 p.p. deficit by investing in it? Whilst it may be early to pronounce judgement the following should be noted. The take up of the personal private pension products is disappointing. In 2015, there were 344 pension members, which increased to 1,446 (increase of 1,106 on 2015) by 2016, and 2,255 (increase of 809 on 2016) by 2017. The response to the VORPS framework by employers has, so far, been cold. One of the big five consultancy firms withdrew from establishing VORPS as a service line for employers and concluded that the framework was not sufficient attractive to introduce a VORPS for its own staff. On the plus side, the following is to be taken into account. The 2004 reform directed to incentivise persons past their retirement age to be active in the labour market was successful. Today there are over 11,152 persons who are of retirement age and who continue to be productively engaged in the labour market. Female participation in the labour market increased from under 30% in 2004 to 53.8% in 2015 - with female participation in the 25-54 age bracket standing at 65.8%. This means that whilst today most retired households depend on one pension - the pension of the single spouse who was the main breadwinner- the majority of future retired households will benefit from a combined retirement income consisting of a pension received individually by both partners in a household. Despite that to date no formal home equity mechanisms are introduced, informal equity takes place - many elder households release their home to private operators of elderly care residences in exchange for placement in such residences. In the 2018 budget the government announced the formulation of a working group to present recommendations on an equity release framework for Malta - which can provide options that allow households to transform home assets into income whilst continuing to live in their homes. Be that as it may there are, however, strong indications that future generation are less likely to be home owners' than their parents' generation. The number of rentals by local persons is on the increase - in part

fuelled by ever increasing costs of residential property which is discouraging young persons from being their own property owners.

Maltese society has a strong culture of handing down wealth from one generation to the next. Many households today are likely, to some extent, to boost their retirement income from inheritance. Although there is no empirical evidence Malta is expected to follow the pattern of other European societies where the passing over of wealth from one generation to the next decreases as future Maltese households are likely to be relatively poorer than previous generations. On balance, it is concluded that future generations are likely to have a lower wealth profile than their parents and the evidence in hand, insubstantial as it is, suggests that young persons are not taking action to have a retirement nest egg that allows them to bridge the quality of life in retirement as close as possible to that enjoyed whilst in employment.

Automatic enrolment: A solution for the adequacy pension income conundrum?

The strategic review inherent in the *Strategy for an Adequate and Sustainable Maltese Pension System* (Pension Strategy Group, 2015) recommended:

The Supporting Retirement Pension Scheme that is to be introduced in 2014 may be subject to heuristics which will influence behaviour with regard to long term planning and savings, particularly given that the scheme is completely voluntary. The Pensions Strategy Group recommends that during 2020 Strategic Review, the proposed pension commission (Recommendation 10) should carry out an in-depth review on the performance of the scheme. In the event that the Review shows that voluntary pensions would not have delivered as planned, it should strategically assess the introduction of Mandatory Opt-In Voluntary Opt Out framework, which would see the employer responsible for managing the administration aspects of the scheme... (Pension Strategy Group, 2015 : 100).

As discussed above, early evidence of the performance of the personal private pensions shows that, given the small number of schemes issued, up-take is impacted by behavioural heuristics. The financial incentive offered to employers to introduce VORPS in their workplaces has, so far, gained no traction. Automatic enrolment (AE) is a possible solution towards addressing the adequacy pension income conundrum - therefore, is a creative innovation. The principle of AE turns behavioural heuristics, in particular inertia, on their head, for under a purely voluntary scheme inertia affects a person in a way that it inhibits them from enrolling. Even if a person believes that becoming a member of a voluntary workplace pension is important to them, they may keep differing taking action as more immediate and pressing matters require their immediate attention. Under a voluntary workplace pension based on AE, inertia works on inhibiting the person from opting out of the PS once they are enrolled. The same inertia that propels a person to procrastinate enrolling in a voluntary pension scheme now restrains the person from opting out once enrolled. AE schemes, such as those introduced in New Zealand (Kiwi Saver) and the United Kingdom (NEST), show that these are successfully meeting their objectives of engaging, and retaining over time, individuals to save for their retirement.

Invariably, the question arises whether - given the controversy that has, since 2004, surrounded mandatory second pensions - a political and social climate exists in Malta for the introduction of AE as a vehicle to address the adequacy issue. The answer is, yes, if only, however, the AE PS is designed to carefully address the concerns raised by stakeholders when rejecting the introduction of a mandatory second pension. It is therefore argued that for an AE PS to work within Malta's social and political milieu it should be based on a number of critical design elements. These are discussed below.

Targeted audience

The AE scheme targets middle income earners. As mentioned earlier, to take account of retail and wage inflationary pressures, the MPI for future pensioners has an automatic indexation mechanism. This indexation came into effect in 2013. Since then, the MPI for those born on and after 1962 increased from €20,964 to €22,803 in 2017 (when compared to the MPI of current pensioners which increases on the basis of a cost of living adjustment which increased from €17,475 to €18,024 over the same period) - an average annual increase of €460. Persons born in 1962 retire at the age of 65 years in 2027. Extrapolating the annual €460 increase to 2027 sees the MPI rise to €27,403. The maximum pension that a person is eligible to on retirement is €18,268. A person earning €30,000 in 2027 will see their income in retirement fall at best by €11,732. An AE should target persons who are (i) 18 years of age or over; (ii) 55 years of age or under; (iii) earn a gross wage or salary that is €18,268; and (iv), joining the labour market as well as persons who are already employed within the age ranges indicated above.

Exempting vulnerable groups

Financial capability is a central social policy concern as lack of financial knowledge, ability, opportunity and assets contribute to poverty and inequality. Research shows that the priority with such persons is less that of making sure that they save for their retirement but rather of providing them with the knowledge and education for them to manage their budgets more efficiently and wisely with financial guidance on money management during unemployment, separation and divorce, debts, priorities and choices, home foreclosure, or when facing long-term financial instability, such as poverty, disability, chronic illness, etc. People in lower income do save - but they do so more to have a small financial cushion for a rainy day or for personal consumption - such as a family holiday. The referenced CBM study shows that people with a level of education below secondary have an annual savings or a surplus of €750 - lower than €3,000 and €4,088 held by persons who hold secondary and tertiary education respectively. Additionally, the median household debt burden for persons with a level of education below secondary education is non-mortgage debt - €6,515. This contrasts with persons holding secondary and university education respectively, who although holding a level of non-mortgage debt, the primary debt is mortgage debt. Persons whose wage is below the MPI enjoy a higher pension than persons whose wage is above the MPI as they obtain the full 2/3 entitlement. Persons who are on a relatively low income should, therefore, be excluded from mandatorily opting into an AE. Whilst they should be

afforded the choice to opt in they should be counselled on the impact that the monthly contribution payment will have on their monthly household budget. An AE scheme should exempt persons (i) whose wage is lower than €18,268; or (ii) are 55 years and over; or (iii) are in temporary or casual employment; or (iv), work less than 40 hours.

The right to opt-out

An employee who is automatically enrolled into an AE has the right to opt-out. The employee should be presented with a reasonable time period to exercise their judgement on whether they exercise the right to opt out - for example, between a period ranging from 60 to 90 days from when they are employed or enrolled.

Contributions paid by eligible employees

The AE scheme is based on the premise that an eligible employee will upon automatic enrolment invest in their pension fund. To render savings in their pension fund meaningful the minimum contribution level is set at 3% of their gross salary or wage. Employees should have the opportunity to increase their contribution rate to 8% of their gross salary or wage should they voluntarily chose to do so.

No obligation placed on the employer to contribute to the employee's pension fund

The AE scheme is designed in a manner that places no obligation on the employer to contribute to an employee pension fund under the scheme. An employer should be nudged to play an active role in an AE scheme through (i) a well-designed fiscal incentive scheme; and (ii), collective bargaining.

Obligation placed on an employer with regard to an automatic enrolment pension scheme

The obligations of an employer under the AE scheme should be only limited to the administrative aspects of the PS. These include mainly:

- Automatically enrolling an eligible employee.
- Enrolling any employee who so requests.
- Affecting an opt-out notice.
- Deducting the contribution from an eligible employee's gross salary or wage and transferring that contribution to the administrator responsible for pension plan chosen by the employee.
- Refunding the employee the contributions deducted from their wages or salaries from the date of their enrolment and when the opt-out notice is affected.
- Providing employees with a choice of AE pension schemes - which can either be tailored designed specifically for the employer or generic ones provided by the financial services market.
- Providing information to employees prior on retirement planning.

Contribution deduction holidays and permissible withdrawal of accumulated funds

The AE pension scheme is based on the principle that once a person opts in they remain locked in. This is an important principle as it ensures that the individual truly accrues a reasonable retirement nest egg for their retirement. There are instances in an individual's or family's lifecycle, however, where circumstances do not permit them to save or leave them with little option but to dip into their savings. An AE PS, therefore, should be designed to take into account such circumstances. Thus, an AE PS should include (i) a contributions deduction holiday, for example of 12 months, due to arising circumstances such as financial hardship, ill health, study, etc.; (ii) withdrawal of 'n' months of contributions made including a percentage of accumulated profit for reasons such as purchasing a residential property; financial hardship; or serious illness; and (iii), opting out in the event of emigration.

Protecting retirement savings in an AE PS

The 2008 economic crisis clearly showed that many members of defined contributions' PS were incapable of choosing the appropriate investment strategies and that most members failed to manage the risk exposure of their pension investment the closer they got to their retirement age. Indeed, analysis of the financial crisis shows that those persons who had shifted their investment strategy from equities to bonds closer to their retirement suffered limited consequential losses whilst persons in similar age groups who failed to adjust their risk by shifting to bonds had their pension investment significantly negatively affected. An AE PS should automatically seek to protect members by mandating that any qualifying scheme should have (i) a default profile option; and (ii), employees on enrolment are automatically placed on the default investment profile of a pension

Conclusion

The reforms carried out since 2004 result in significant innovation and solutions addressing specific issues relating to the PS and its flanking environment - short to medium term sustainability, balancing the inherent gender discrimination of a PAYG PS, reducing early invalidity exit, increasing number of retired persons in the labour market, establishing a balance amongst current and future generations to mention a few. The reforms managed to break the adequacy pension income collapse forecasted by the WB - stabilising the APRR for future generations to 45%. This, however, as shown, is 9 p.p. below that enjoyed by persons retiring between 2004 and 2010. Recommendations to bridge this gap by means of a mandatory second pension resulted in societal and political negative reaction leading to its rejection. Early indications are that bridging this gap through voluntary private and occupational voluntary pensions are not resulting in a large population coverage. This means, that for many, the pension income through the SSCP will not act as a sufficient bridge to secure a quality of life in retirement as close to that enjoyed whilst in employment. This paper posits that the time has come for Malta to consider alternative means of how to address the adequacy pension income conundrum. An AE PS cleverly designed to address

societal and political issues raised with regard to a mandatory second pension is seen as a solution to break the deadlock in this regard.

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Elder Abuse: International and Polish Perspectives

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Abstract. As people age, they find themselves vulnerable to unique social problems, but especially, elder abuse. Elder abuse may be defined as a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Like any other form of abuse, elder abuse is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair. Elder abuse is a critical social problem that often results in devastating outcomes, including serious physical injuries, emotional pain and suffering, shame, depression, shattered trust, financial ruin, and increased risk of mortality. Despite increasing attention, elder abuse is still largely hidden with unresolved questions about the number of victims and relatively little attention devoted to developing and testing interventions. According to World Health Organization (2008), abuse is underreported by as much as 80%, and estimates that around four to six per cent of older people have experienced some form of maltreatment at home. This means that as much as 4 million older people are thought to experience maltreatment in any one year in the Europe. Risk factors include, carer stress, high levels dependency and co-morbidities, family conflict, isolation, and addictive behaviours. Responses to elder abuse range from helplines and counselling, specialised care management, and multi-disciplinary response teams.

Keywords: elder abuse; mistreatment; public policy; Malta; Poland.

Introduction

The second half of the 20th Century witnessed unprecedented demographic changes. Declining fertility rates and mortality levels, and major improvements of life expectancies at birth, had far-reaching effects on global population trends, to the extent that the present epoch has been referred to as the 'age of ageing' (Magnus, 2008). Although policy discourse

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is not immune to approaching later life and population ageing with trepidation, it is positive to note that recent years witnessed the emergence and development of an alternative, optimistic, view of ageing, one that sees ageing trends as an accomplishment. Indeed, many national policies on ageing embrace a positive view of human ageing, as policy makers move away from the traditional view of older persons as poor, frail, and unemployable, and instead, perceiving population ageing as offering a myriad of opportunities (Formosa, 2017a, 2017b). However, later life is not always a bed of roses. As people age, they find themselves vulnerable to unique social problems, but especially, elder abuse. Like any other form of abuse, elder abuse is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair. Elder abuse is a critical social problem that often results in devastating outcomes, including serious physical injuries, emotional pain and suffering, shame, depression, shattered trust, financial ruin, and increased risk of mortality. Despite increasing attention, elder abuse is still largely hidden with unresolved questions about the number of victims and relatively little attention devoted to developing and testing interventions. This is mostly because elder abuse is often time consuming and too complex to address in available delivery systems that are typically fragmented and underfunded.

Defining elder abuse

Elder abuse may be defined as a “single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (Action on Elder Abuse, 1995 : 1). Elder abuse

...may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. (Department of Health, 2000 : 9)

In other words, elder abuse refers to “intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm” (Wallace & Bonnie, 2003 : 40). The kinds of behaviour that can be defined as elder abuse may be of six key types - namely, physical abuse, material and financial abuse, psychological or emotional abuse, sexual abuse, spiritual abuse, and neglect (Fenech, 2018):

- *Physical abuse* consists of an intentional infliction of physical harm on an older person. The abuse can range from slapping an older adult to beatings to excessive forms of physical restraint (e.g. chaining). The inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.
- *Material and financial abuse* consists of the misuse and/or exploitation of an older adult’s material and/or monetary assets. Examples include but are not limited to cashing an older person’s cheques without authorization/permission, forging an older person’s signature’, and coercing or deceiving an older person into signing any document.

- *Psychological or emotional abuse* consists of the infliction of mental harm and/or psychological distress upon the older adult. The abuse can range from insults and verbal assaults to threats of physical harm or isolation. Emotional or psychological abuse is defined as the infliction of anguish, pain or distress through verbal or nonverbal acts.
- *Sexual abuse* consists of any sexual activity for which the older person does not consent or is incapable of giving consent. Sexual contact with any person incapable of giving consent is also sexual abuse. It includes but is not limited to unwanted touching, and all types of sexual assault or battery, as well as showing sexually explicit photographs.
- *Spiritual abuse* refers to banning and / or denying access for an older person to participate in religious services and prayer, as well prohibit ownership of religious symbols; in Indian communities, this also means preventing the access of older persons to traditional healers when they are sick.
- *Neglect* occurs when the caregiver does not meet the physical, social and/or psychological needs of older persons; in other words, it is the failure of the guardian to provide the needed and necessary assistance. As a result, negligence can lead to self-neglect when older persons fail to meet their own needs. With passive and active neglect, the caregiver fails to meet the physical, social, and/or emotional needs of the older person. With passive neglect, the failure is unintentional, often the result of caregiver overload or lack of information.

Abuse can range from what might clearly constitute a criminal offence – for example sexual or physical abuse, theft, etc. - to acts that cause harm to an older person whether by omission or otherwise - for example, neglect through lack of resources or difficulties with interpersonal relationships (Formosa, 2018). Abuse and neglect have been distinguished depending on whether or not there has been an active violation of rights or an absence of action. The abuser can be a stranger, an acquaintance or a trusted other. The perpetrator can be the person him or herself, in which case one would talk about self-neglect. Abuse can take place at home (domestic abuse) or in a health and care setting (institutional abuse). Depending on the motivation of the perpetrator, it can be intentional or unintentional (Anetzberger 2012). Elder abuse occurs in both domestic and institutional settings. Domestic elder abuse generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder (for example, a spouse, a sibling, a child, a friend, etc.). Polish law defines ‘domestic violence’ as

...a single or repeated wilful action or omission that violates the rights or personal rights, in particular that expose these people to the danger of loss of life, health and violate their dignity, physical integrity, freedom, including sexual, causing damage to their physical or mental, as well as causing suffering and moral damage to people affected by violence. (Chancellery of Selm, 2005 : 2)

Hence, the notion incorporates all forms of abuse and violence occurring in the intrafamily relationships in which they are the victims of family members, including older people. On the other hand, *institutional abuse*, generally refers to any form of abuse that occurs in residential facilities for older persons (e.g. nursing homes, foster homes, group homes, board and care facilities, etc.). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection.

Policy measures and elder abuse

One key international policy framework that targets the issue of elder abuse is the United Nations (2002) *Madrid International Plan of Action on Ageing* (MIPAA). The MIPAA is based on the United Nations Principles for Older Persons adopted in 1991 by the United Nations General Assembly under the slogan 'adding years to life, adding life to years', which encapsulates the needed effort towards a just society for all ages. The MIPAA has several implications that address the issue of elder abuse. It calls for changes in attitudes, policies and practices at all levels and in all sectors in order to ensure that people everywhere are able to age with security and dignity, as citizens with full rights. Furthermore, the MIPAA recognizes the universality of the problem of elder abuse. Although the MIPAA points out that the process of ageing brings with it a declining ability to heal and that the impact of trauma may be worsened because shame and fear may result in reluctance to seek help, it also emphasizes that elder abuse is often not solely of a physical form. In this respect, the MIPAA sets out as objectives the elimination of all forms of neglect, abuse and violence directed at older people and the creation of supporting services that address elder abuse.

The World Health Organisation (WHO) also recognised the need to establish a global strategy for the prevention of the mistreatment of older people. In 2002, the WHO collaborated with the International Network for the Prevention of Elder Abuse (INPEA), HelpAge International, and partners from academic institutions in a range of countries, as well as non-governmental organisations, to study the perceptions of older people and care workers on elder abuse through focus groups held in eight countries (Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden). The resulting publication, *Missing voices: Views of older persons on elder abuse* (WHO, 2002a), was considered a milestone in the field and led to the development of further research. In the same year, WHO (2002b) launched *The Toronto Declaration for the Global Prevention of Elder Abuse* which called for a global action plan for the prevention of elder abuse. More recently, the United Nations Economic Commission for Europe's (UNECE) Vienna Ministerial Declaration titled *Ensuring a Society for All Ages: Promoting Quality of Life and Active Ageing* declared that

...many societies are still confronted with man-made barriers and prejudices that constrain the achievement of intergenerational equity and reciprocity. There remains the need for policies on health and welfare of older persons to be complemented with measures to empower older persons, particularly older women, and to prevent elder abuse, neglect and loneliness, as well as by measures to strengthen solidarity among generations...(UNECE, 2012 : 6)

UNECE urged member states to improve the collection and sharing of data, statistics and qualitative information for monitoring better the quality of life and dignity of older persons, including cases of violation and abuses of their rights, in order to design and implement appropriate evidence-based policy measures. The need to safeguard the dignity of older persons, particularly those with disabilities, and fostering their sense of belonging and self-esteem through measures aimed at combating any form of prejudice, neglect, abuse and discrimination was also advocated.

Various countries have attempted to implement UNECE's recommendations (see UNECE, 2013). For instance, the project titled 'The right to live without violence in old age' aimed to alleviate all forms of neglect, abuse and violence against older women and men in the Kyrgyz Republic by protecting older people, with specific attention to older women, against domestic violence, neglect and abuse. Most importantly, it advocated enhanced civil society participation in the promotion and protection of the rights of older victims of domestic violence and abuse. The project achieved many positive changes at civil society level, at community and family level, and at national level. In Ukraine, a project was implemented by Age Concern Ukraine to improve the lives of vulnerable older people in the country by raising awareness of their human rights, reducing the abuse of their rights, and mobilising older volunteers to defend their own human rights. It aimed at achieving a once-for-all change in the national approach to identifying and safeguarding vulnerable adults by gaining national legislative support for local multi-agency vulnerable adults' protection working groups, to have elder abuse recognised as a human rights abuse by all key stakeholders, society and legislation, and by raising awareness among the general public and older persons themselves. In 2012, Poland created the Department of Policy which was tasked to implement improved rates of active ageing amongst Polish older persons. This department launched special programmes aimed at improving the quality of life of older people through a myriad of social activities. An example of this is the Government Programme for Active Ageing for the period 2014-2020, which was a continuation of the 2012-2013 programme, and which highlighted four areas of social activity for seniors - namely, education of older persons, intra- and inter-generational activities, social participation of older people in communal life, and better social services for older persons. The key goal of active ageing policy in Poland is to bring about better levels of social inclusion even for older persons with physical and cognitive challenges when some functional limitations. It is noteworthy that the National Programme for Combating Domestic Violence seeks to protect and assist victims of violence, including older persons, and offenders, through correctional programmes, as well as raising public awareness and dissemination of information about the possibilities and forms of support.

Prevalence of elder abuse

Despite increasing attention, elder abuse is still largely hidden with unresolved questions about the number of victims and relatively little attention devoted to developing and testing interventions. This is mostly because elder abuse is often time consuming and too complex to address in available delivery systems that are typically fragmented and underfunded. The UNECE's (2013) brief on *Elder abuse* underlines that internationally comparable data on abuse of older persons are not readily available, which makes it difficult both to have a good understanding of the dimension of the problem and to monitor trends. Above all, elder abuse remains a taboo for many older persons who tend to keep silent for fear of exposing a family member, losing services or being placed in a nursing home against their will. Detection of abuse among people with limited or reduced capacity, such as those with Alzheimer's disease or other dementias, may be even more difficult since these people may not be able to articulate their need for support. Therefore, even in countries where reporting of abuse is mandatory, underreporting is likely to be substantial. According to WHO (2008),

abuse is underreported by as much as 80%. More recently, the WHO (2016) estimated that around four to six per cent of older people have experienced some form of maltreatment at home. This means that as much as 4 million older people are thought to experience maltreatment in any one year in the WHO European Region.

National studies on the prevalence of elder abuse put down the rates as between 1% and 35% (Formosa, 2015), depending on definitions and survey and sample methods. These figures, however, may represent only the tip of the iceberg, and some experts believe that elder abuse is underreported by as much as 80%. Estimates of the number of elder abuse cases reported range from 1 in 15 cases to 1 in 6 cases. These low rates may be due to the isolation of older people, the lack of uniform reporting laws and the general resistance of people - including professionals - to report suspected cases of elder abuse and neglect. In developing countries, although there is no systematic collection of statistics or prevalence studies, crime and social welfare records, journalistic reports and small-scale studies provide evidence that abuse, neglect and financial exploitation of older people appear to be widely prevalent. In the United States, more than 10% of community-dwelling older adults reported elder abuse or potential neglect according to the 2008 United States National Elder Mistreatment Study with a representative sample of 5,777 older adults (Roberto, 2016).

However, it is positive to note that some countries have tried to gain a better understanding of their national situation by carrying out surveys through different data sources and methodologies (UNECE, 2013). For instance, a survey carried out by the Red Cross of Serbia in 2011 found very different results when comparing data of domestic violence among older persons recorded in police departments with those registered in the social welfare centres in the area of Niš and Novi Sad. The police department in Novi Sad, a city of about 340,000 inhabitants reported 31 cases of family members committing violence against persons aged 65 and above and a total of 34 victims. In Austria, a survey titled *Attacks, violence and aggression against older people* involved 247 experts from Austrian setting up counselling and advisory centres and facilities. As much as 26% of the facilities reported being 'frequently' or 'very frequently' faced with problems of violence in the private environment, followed by 12% in care homes and public institutions. Issues with stress and overburdening of informal carers were found in 85% of the facilities. In Ireland, with a total population of 468,000 people aged 65 years and above, total referrals received by Senior Case Workers for the Protection of Older People increased by 22% from 2008 (1,887 referrals) to 2011 (2,302 referrals). The increased number of referrals is probably also a reflection of the accompanying awareness raising campaign which contributed to people coming forward to ask for assistance of the Senior Case Workers. It is estimated that over 10,000 people experienced abuse in the previous year, highlighting the underreporting of elder-abuse. Moreover, a study on *Abuse and Health among Elderly in Europe* conducted among individuals aged between 60 and 84 years in seven European countries (Germany, Greece, Italy, Lithuania, Portugal, Spain, and Sweden) is a noteworthy example of cross-national research (Soares et al., 2010). The study found that 19.4% of older persons surveyed suffered from psychological abuse, 2.7% from physical abuse, 0.7% from sexual abuse, 3.8% from financial abuse and 0.7% from 'other' forms of abuse. Psychological abuse occurred significantly more often in Sweden and Germany than in the other countries, and financial abuse was seen

more frequently in Portugal and Spain. The study found that 28.1% of older women had experienced some kind of violence or abuse during the previous 12 months.

In Poland, research conducted with a group of 630 people aged 60-plus living in the region of Podlasie indicated that 10% of older persons experienced at least one form of ill-treatment (Halicka, 2010). Elsewhere, Tobiasz-Adamczyk's (2003) study with women aged 65-plus found as much as 14% of respondents admitted that they were victims of violence, ranging from psychological violence (67.3%) to physical abuse (60%) to sexual abuse (14.5%). Similar indicators have been obtained by Maćkowicz's (2012) study on police intervention in domestic violence experienced by older people. The data demonstrated that among all the interventions taken against domestic violence by the police in a calendar year, older persons accounted for 15% of the cases. In most instances, the victim and perpetrator were mothers and sons respectively. Moreover, research conducted among professionals (police officers, social workers, nurses and students) indicated that nearly 40% of respondents had some form of contact with elder abuse, among which the largest professional group (about 75%) consisted of police officers. (Halicka et al., 2009).

Risk factors

Although there is no clear reason for abuse, since its causes are both complex and concealed, research suggests that certain factors are related to abuse. Key risk factors for abuse include carer stress, dependency, family conflict, isolation, psychological problems and addictive behaviours. The existence of more than one of these factors places an older person at high risk of elder abuse.

Carer stress. Caring for a person who is frail or who has special needs is stressful. In many cases, other contributory factors are also present and this additional stress on the carer appears to be the factor that triggers the abuse. More specifically, the following factors may contribute to an abusive relationship: financial difficulties, lack of respite care, inadequate support to give high quality care, heavy physical or emotional costs of being a carer, lack of recognition for the role of carers, personal stress, caring after two generations such as children and dependent parents, and unfamiliarity with the caring role and its responsibilities.

Dependency. Older people are at risk of abuse from people with whom they live and share a relationship of dependency. This dependency may be due to physical impairments such as physical frailty, disability, or cognitive impairments such as dementia. These impairments may hinder the person leaving the abusive situation or reporting the situation. Some perpetrators of abuse, who are dependent on the person they care for, may feel trapped or powerless and perpetrate abuse because of frustration or fear. Whilst older persons who are abused are often dependent on others for all or part of their day-to-day care, the perpetrator of the abuse may also be dependent on the person in order to meet their own needs.

Family conflict. Abuse can be a continuation of domestic violence or family violence that re-emerges as abuse in the caring situation. Similarly, a child who was previously abused may now be a primary carer and repeat the cycle of abuse to a dependent parent or child. In some families, violence is considered the normal reaction to stress, and it may continue from generation to generation. People are also at risk when two or more generations live together and intergenerational conflict exists. In cross-cultural situations where two or more generations hold different cultural values or roles, tension can place dependent older people at risk of abuse.

Isolation. Older persons or their carer may be isolated and lack social contacts or support. The following factors increase the risk of abuse (i) misappropriation of property, money or valuables - a loss of money ranging from removal of cash from a wallet, to the cashing of cheques for large amounts of money, loss of jewellery, silverware, paintings or furniture; (ii) forced changes to a will or other legal document - the making of a new will in favour of a new friend or another family member - while the power of Attorney may be obtained improperly from a person without decision-making capacity; (iii) denial of the right to access personal funds - a family member may take control of an older person's finances or banking, while the older person is still capable of maintaining their affairs; (iv) forging of signatures - on bank accounts or legal documents; and (v), the absence of adequate support for the carer.

Medical/psychological conditions. In many cases of physical and psychological abuse, the mental health of the perpetrator is implicated as the major contributory factor. Abuse may occur when either older persons or carer has a period of mental illness, a history of mental problems, difficulty in controlling anger and/or frustration, and low self-esteem or feelings of low self-worth. An older person may also be considered to be at risk when they suffer from cognitive decline, for example, an older person experiencing a dementia.

Addictive behaviours. Where the carer or family member has a dependency on drugs, both prescription and illicit, alcohol or a gambling problem, an older person can be considered to be at risk of abuse.

Responses to elder abuse

Despite the growing recognition of elder abuse as a public health problem, sparse research focuses on national and community responses to elder abuse. Unfortunately, programmes to address elder abuse implemented at the local or national levels often lack stringent evaluations and are mostly invisible in the academic literature (Roberto, 2016). The following are key and common reactions in attempts to prevent elder abuse:

Helplines and counselling. Free and confidential helplines provide an easily accessible means for them to receive neutral advice and counselling in case of any grievances in relations to elder abuse. Since abuse may be associated with insecurity and shame, a helpline may be a low-threshold way for potential victims to ask for advice. Such centres can be staffed with trained volunteers who can handover difficult cases to professional counsellors, and

generally have access to a network of other professionals who they can refer older persons to for specific issues.

Specialised case management. To address individual cases of abuse, many countries have in place a system of specialized case managers. The latter are the specialists that an older person is referred to in case of abuse. Case managers can respond to a critical situation, advise about next steps, arrange for needed services, develop care plans, and provide a list of attorneys aware of older person issues. Reported cases should be dealt with in confidentiality, and the wishes for privacy should be respected. Case management could take several forms, it can be one person or a team handling the case. Case managers can be social workers, medical or legal specialists; they can work for public or private services or non-governmental organisations. They should be well aware of the complexities of issues related to elder abuse, including legal issues, and maintain a network of experts for referrals. Case management includes psychological assistance and counselling which should focus on breaking through denial and shame, planning how to protect against future abuse and how to build support networks, helping with traumatic or post-traumatic stress. It should help to overcome trauma, resolve conflicts, assess the options and plan for the future. Specialised case management has the potential to address the needs for treatment, education or confinement of the perpetrator.

Multidisciplinary teams. Many local agencies also set up multidisciplinary teams, consisting of professionals from diverse disciplines and agencies, to deal with elder abuse. Multidisciplinary teams may include health and social service providers, law enforcement officers, ombudspersons, mental health care providers, physicians, and advocates for persons with developmental disabilities, lawyers, domestic violence advocates, money managers and case managers. Multidisciplinary teams can discuss difficult abuse cases and learn about available services from other agencies or disciplines. Joint home visits could be carried out to assess particular cases. Good coordination between agencies reduces the burden on older abuse victims for multiple interviews, thereby minimizing the inconvenience of clients. Interagency protocols, memoranda of understanding or contracts may clarify the distribution of work. Moreover, good interagency coordination may also help to identify and respond to service gaps and other systemic problems.

Conclusion

An international perspective on elder abuse, including a focus on the travails Polish public policy on elder abuse, demonstrates clearly that legislation is urgently required to develop, strengthen, and carry out programmes for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. However, it is best if such legislation is preceded by the provision of public educational campaigns to identify and prevent elder abuse, neglect, and exploitation - followed by the promotion of information and data systems, including elder abuse reporting systems, to quantify the extent of elder abuse, neglect, and exploitation in the State. Another step in the right direction constitutes policy measures that encourage training for caregivers, professionals, and paraprofessionals, working in relevant fields on the identification,

prevention, and treatment of elder abuse. It is imperative that the state - perhaps in collaboration with non-governmental organisations - conduct special and on-going training, for individuals involved in serving victims of elder abuse, neglect, and exploitation, on the topics of self-determination, individual rights, and other related topics. It is also important that legislation provides technical assistance to programmes that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation and for family members of the victims. The law should include provisions for immunity for persons reporting instances of elder abuse, neglect, and exploitation, from prosecution arising out of such reporting, under any State or local law.

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Reviewed by Datin Jacqueline Wong¹

The endorsement to create a supportive environment for older people, encouraged discussions on age-friendly cities and communities by influential international organisations such as the World Health Organization (WHO) and the United Nations (UN). In this regards, *Age-friendly Cities and Communities: A Global Perspective* is an important and timely book since it provides a comprehensive view of developing urban environments designed to improve the lives of older persons and ways in which they themselves can be involved in the co-production of age-friendly policies and practices. In this book, the authors made use of a cross-section of approaches namely social policy, sociology, urban planning and architecture.

This edited volume gathers critical assessments from leading international researchers of the problems and potentials of designing environments that benefit citizens of all ages. Part of the Ageing in a Global Context series, the book highlights new approaches in involving older people in the design of cities. It also tackles social inequality and promote community empowerment.

The book is divided into three parts: The first part which consists of four chapters, links the background to the age-friendly cities and communities with theory and development. Inequalities and exclusion of older persons are addressed. This is followed by an overview of the contributing factors that have led to the development of age-friendly cities and communities. Moreover, through a range of theoretical perspective the link between 'community' and 'age-friendliness' is also discussed. The last chapter of this part identifies two key challenges that limit the success and effectiveness of age-friendly cities and communities.

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The second part of the book consisting of five chapters, provides case studies from Europe (Belgium, Germany, Ireland), Asia (Hong Kong), with learning lessons from Japan, Korea, Thailand, Singapore, China and case studies from Australia. The chapter on the case study from Australia provides a review and comparison of age-friendly cities and communities initiatives from Sydney, Melbourne and Canberra.

The last part, also of five chapters, starts by exploring the 'capability' approach in design while responding directly to the lived-experiences of old people. Following this, the authors identifies new and creative ways as an answer to the limitations that presently exists in age-friendly cities and communities. It also describes the evolution of the age-friendly Manchester programme and explores UK government ageing policies whereby we also read about the age-friendliness for the lives of older people with sight loss within English urban and rural communities. Finally, the book concludes by the presentation of a 10-point Manifesto for change. This draws on arguments and perspectives developed by the authors of this edited volume.

The reviewer has identified three 'gaps' in the book. First, most of the perspectives focused on the urban setting and relatively little was said about building sustainable and friendly neighbourhoods for older people living in rural, or remote areas. The focus on cities is understandable as more than half of the world's population are now living in urban areas. However, the perspectives also give rise to suggestions that older people of remote or rural community areas have different ageing pathways and experiences to the general population. To better understand the condition and predicaments of these older people, and the different challenges posed for smaller local authorities, more research and discussion on building and managing an age-friendly environment in such areas are needed too.

Second, although the perspectives concede that older people's ability to participate may be compromised by a lack of social recognition, so far there has been limited exploration of effective ways to deal with individual differences and values in modern communities that have become increasingly diverse and complex, especially in Asia and the Asia Pacific regions. Because communities involve both the creation of solidarity between groups, in some there are 'boundaries', and there are where frail older people remain 'unseen' in cities by the wider community, it is necessary for policymakers and local authorities to understand that social inclusion is integral and to achieve a balance between enhancing social engagement and protecting individual diversity. There is a need for increased discussion of strategies and practices that ensure not only build but also services and products to meet the specific needs and life situations of older people.

Finally, much of the perspectives are descriptive. It provided information about initiatives prompted by recognition of the importance of supportive public policy, environments and services. These covered a range of approaches to fostering age-friendly cities and communities. However, there has been limited documentation of results of the effectiveness of specific approaches, or evaluation of the impact of specific processes, or the outcomes on older people's lives. Infrastructure and services alone are not enough. Just as important is helping the public understand how ageing is not a disease but a biological process. Also, it's

important to note, that there are no easy solutions. Meaningful support is important, especially when a large proportion of older people are taking care of their older parents too.

The need for cities to better cater to older people in planning has to take into the consideration how the built environment affects their quality of life in terms of physical connectivity, cognitive and social health. Concern and issues of loneliness, sickness and employment. Even as cities are redesigning to become more age-friendly, it may cause unintended consequences such as segregation and stigma. No one approach fits all. Future developments of age-friendly cities and communities would benefit from a broader base of evidence and suggest evaluation of process and outcomes for future research attention, and further discussion which will provide further important information and insights on policies, planning, sustainability, and more. Ageing is everyone's concern. We will all get old, one day. The key is to build a community which realises that ageing concerns everyone.

This book is relevant to scholars not only in the field of social gerontology and social policy but also for those involved in public health, urban design and housing. It is also an invaluable resource for policy makers, urban planners, service providers, practitioners and older persons themselves.



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