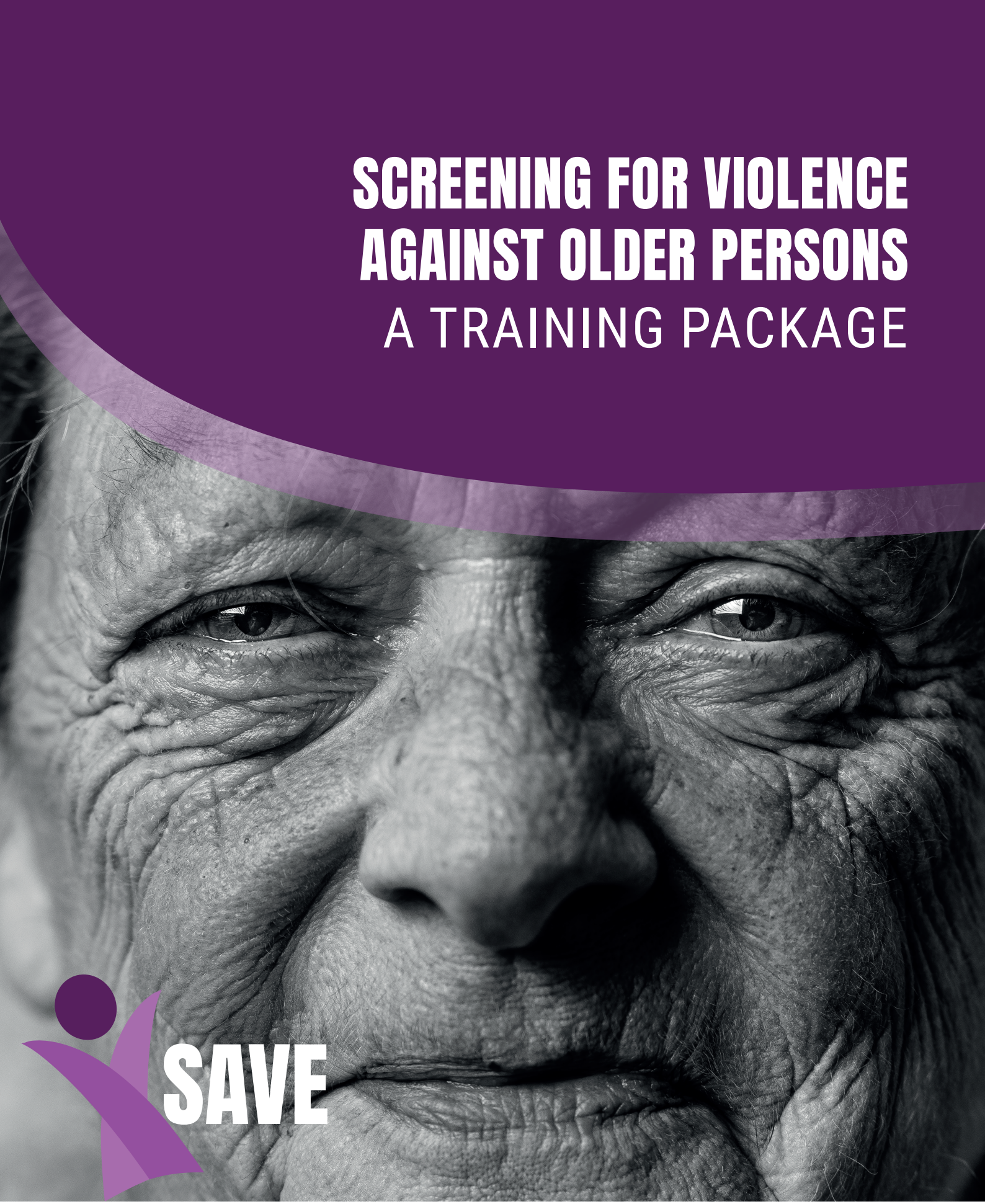
# SCREENING FOR VIOLENCE AGAINST OLDER PERSONS

## A TRAINING PACKAGE



SAVE

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**Authors:**

This document has been developed by the SAVE project partnership

- PCG Polska Sp. z o.o. - Poland (coordinator)
- VoiVa - Finland
- Anziani e non solo - Italy
- Cooperativa assistenza disabili infermi anziani infanzia – Italy
- Universidade do Minho – Portugal
- Cyprus University of Technology – Cyprus

The development of this output was coordinated by Anziani e non solo and Voiva.

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# Introduction

## The SAVE project

SAVE is a European project funded under the Erasmus+ programme.

Specific objectives of the project are:

- increase knowledge of screening tools and their suitability in identification of violence against older persons in social and health care services
- improve capacity of social and health care professionals to identify and intervene and support and refer the cases of violence against older persons to relevant services
- develop educators' competences to teach professionals how to deal with violence against older persons and to support and mentor them
- produce an interactive training program for improving active and innovative learning of social and health care teachers, trainers and professionals in identification and intervention in case of violence against older persons.

The target groups of SAVE are:

- social and health care professionals working in home care, residential care facilities, health centres and hospitals
- social and health care teachers and trainers
- local/regional social and health care decision makers in the community

This document is the intellectual output number 2 of the project: a training curriculum and material on identification and intervention on violence against older persons to be implemented face-to-face.

## The training programme

### Target audience

Target audience of this training programme are social and health care professionals working in home care, residential care facilities, health centres and hospitals. This might include a variety of professionals such as: doctors, nurses, assistant nurses, therapists, psychologists, social workers, social educators etc.

### Learning goals

At the end of the training participants should know:

- what is elder abuse

- how to recognize elder abuse applying screening methods and tools
- how to intervene in case abuse is detected

**Duration and contents**

The training is expected to last at least 12 hours and it is articulated in four modules of three hours each.

Contents of the modules are the following:

| | |
|---|---|
| **Module 1:**<br>Introduction to elder abuse prevalence, signs and symptoms<br>Definition of elder abuse<br>Types of abuse<br>Settings of elder abuse<br>Prevalence of elder abuse<br>How to recognize elder abuse: signs and symptoms<br>Assessment of elder abuse signs and symptoms | **Module 2:**<br>Why to screen: violence screening tools<br>Screening / routine inquiry: definitions<br>Benefits of screening / causes of under reporting of elder abuse<br>Screening older persons / screening caregivers<br>Most used screening tools: characteristics and use<br>Context where screening tools can be applied |
| **Module 3:**<br>How to screen: Ethics and privacy<br>Possible ethical issues related with screening (limits to confidentiality; obligation to report; self-determination; older persons with cognitive limitations)<br>Privacy issues related with screening: to whom can / should the information be shared; how to handle screening results | **Module 4:**<br>Challenges of working with victims of violence<br>Patients barrier to disclosure<br>Managing disclosure<br>Safety planning |

**Training methodology**

The training adopts a combination of theoretical / input sessions and practical exercises / active learning activities to engage professionals to practically apply the theory they have learnt.

- Input session: is a short (10 to 20 min.) session in which the trainer transfers some key messages or information that participants need to contextualise the topic. It is a lecture based on the theoretical contents described in the modules, followed by
- Active learning exercises: active learning is an approach to instruction that involves actively engaging students with the course material through discussions, problem solving, case studies, role plays and other methods. Following the input sessions, participants will therefore be involved in one or more exercises to apply the acquired learning.

**Assessment of the training results**

The training results assessment form is used to assess the competence acquired by the participants at the end of the training programme. Questions relating to the training provided can be selected from the evaluation questions if the training programme was not fully implemented.

## How to use this training programme

The programme can be delivered by professionals from the healthcare, social care and legal sector who have a solid knowledge on elder abuse. Good facilitation skills are also required.

# MODULE 1 - Introduction to elder abuse prevalence, signs and symptoms

## Structure of the module

| | |
|---|---|
| Title | Introduction to elder abuse prevalence, signs and symptoms |
| Goal(s) and objectives | To improve the knowledge of social and health care professionals about the problem of elder abuse<br>Raise awareness of social and health care professionals on the importance of early recognition of signs and symptoms of all types of elder abuse.<br>To improve skills and competencies of social and health care professionals, on how to assess signs and symptoms of elder abuse in order to be able to intervene, support and refer the cases of violence to relevant services. |
| Learning outcomes | At the end of the module learners will be able to:<br>▪ Define elder abuse<br>▪ Distinguish the various types of abuse<br>▪ Realize that elder abuse can occur in a variety of settings<br>▪ Become aware of the prevalence of violence against older people in Europe and worldwide<br>▪ Recognise the signs and symptoms of the various types of elder abuse<br>▪ Assess signs and symptoms of elder abuse and be able to differentiate them, from the normal age-related changes and chronic disease |
| Duration: | 3 hours:<br>▪ 45min-1h input session<br>▪ 20 min (2x10 minutes) breaks<br>▪ 1h and ½ active learning activities<br>▪ 10 minutes of extra time (warm up, waiting for participants, answering questions) |

| | |
|---|---|
| Resources needed: | ▪ Round tables with 4-6 chairs at each according to the size of the group<br>▪ Computer<br>▪ Projector<br>▪ Screen<br>▪ Flipchart per table and one for the instructor<br>▪ Marking pens of different colours at each table<br>▪ Handouts with scenarios |
| Key messages | Elder abuse is a worldwide problem of public health<br>Elder abuse is under-reported<br>There is an increased prevalence of elder abuse because of the aging population<br>Elder Abuse is a violation of Human Rights<br>Elder abuse is a phenomenon with serious medical and social consequences<br>Improving identification and intervention on elder abuse and neglect improves health and safety of older adults |
| Worksheets | Case scenarios |

## Theoretical Background

Population ageing is a phenomenon that affects almost every developed country in the world. Europe is facing an accelerated process of aging, which will increase in the next four decades. The estimated percentage of persons over 65 is expected to reach 28,5% in 2050 and 29,5% in 2060 (EUROSTAT, 2019). With ageing population increasing the number of frail - dependent elderly, vulnerable to abuse is expected to grow. The growing numbers of elderly people imply an increase in the number of people with cognitive impairment and Alzheimer's disease which are considered risk factors for abuse (WHO, 2016). Demographic changes should be considered too, as women constitute the majority of the older population in all nations. Today 58% of older women live in the developing world and by 2025 this will increase to 75% (WHO/INPEA, 2002). In some countries older women face a greater risk of physical and psychological abuse than older men due to discrimination, societal attitudes and a lack of protection of their human rights (Perttu and Laurola, 2020). Moreover, women tend to live longer than men, resulting in the fact that women are the majority in the oldest groups. This can make them more vulnerable for abuse because of the combination of ageism and sexism. (Brownell, 2014). In the context of elder abuse, gender has therefore been considered a potential risk factor (Pillemer et al, 2016).

Important efforts have been made to address violence against women. Many researches have focused on elder abuse generally or abuse of younger women. The problem of abused older women is not fully addressed and there is lack of intervention programs to address aging-specific issues (Yon, Mikton, *et al.*, 2019).

Elder abuse in general is a violation of human, legal and medical rights (World Health Organization., 2008), is considered a stressful life event, with negative impact on older adult's physical and mental health (Dong, Chang and Simon, 2013). It is also associated with high risk mortality rates and increased rates of hospital admissions (Wang *et al.*, 2015). This causes harmful impacts at all levels of society, affecting public health, societal costs, resources and civic participation (Pillemer *et al.*, 2016; Ageless Alliance, 2017; Yon, Mikton, *et al.*, 2019).

## 1. DEFINITION OF ELDER ABUSE

Elder abuse is seen in literature in terms of "elder mistreatment", ''elder maltreatment'' and "inadequate care of the elderly". The past few years there was a lack of consensus on definitions of elder abuse, because the phenomenon of elder abuse has many configurations, it is multidimensional, it includes a diverse set of abusive behaviours, victims, perpetrators and contexts (Dean, 2019; Santos *et al.*, 2019).

Currently the most frequently used definition and widely accepted for elder abuse, is the one developed by the United Kingdom's Action on Elder Abuse in 1995. It has been adopted by international institutes such as the International Network for the Prevention of Elder Abuse and World Health Organization. It defines elder abuse as: **"a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person"** (Action on Elder Abuse, 1995)**.**

Similarly the U.S. National Academy of Sciences defines elder abuse as: "(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm "(Wallace & Bonnie, 2003).

These two definitions share common features such as: actions and omissions on the side of the perpetrator that cause harm or create a serious risk of harm to a vulnerable frail elder. The perpetrator can be a caregiver or other person of trust to the elder (Perel-Levin, 2008; Pillemer *et al.*, 2016).

## 2. TYPES OF ABUSE

The following types of abuse have been recognised (WHO/INPEA, 2002; Wang et al., 2015; Pillemer et al., 2016; Yon et al., 2017; Yon, Ramiro-Gonzalez, et al., 2019):

a) **Physical/verbal** - causing pain or injury as a result of hitting, kicking, pushing, slapping, burning, physical coercion, physical or drug induced restraint, insults and hurtful words, denigration, intimidation, false accusations, verbal attacks, threats, rejection.
b) **Psychological/emotional** - behaviours that harm self-worth or wellbeing, that cause or could cause mental pain, psychological/emotional pain and distress, anxiety, anguish, humiliation or stress to an elderly person.
c) **Sexual** - non-consensual sexual contact of any kind with the older person. Coercion to participate/view any kind of sexual activity or content.
d) **Financial or material abuse** – the illegal or improper exploitation or use of an older person's money/funds, extortion and control of pension money, theft of property, exploitation of older people to force them to care for grandchildren.
e) **Neglect** - the refusal or failure to fulfil a caregiving obligation, such as medications, clothing, nutrition or adequate shelter for the older person

Some scholars also include a sixth form of abuse, i.e. **Institutional abuse**[1] - It includes neglect and poor care practice within a specific care setting. This could be a hospital or a care home. The staff may not be deliberately abusing people. It might just be the way in which the staff are used to doing things. Forms of abuse observed are: psychological abuse, physical abuse, financial abuse, retribution against physically aggressive residents or withhold choices from them. Furthermore, in institutional settings resident-to-resident abuse is also observed

## 3. SETTINGS OF ELDER ABUSE

Elder abuse may occur in a variety of settings:

- Domestic settings, perpetrated by adult caregivers, family members, or other persons
- Residential or other institutional settings such as long-term care facilities, nursing homes, or hospice (resident-to-resident abuse or staff-to-resident abuse)
- Hospitals
- Day care facilities

[1] (Biggs et al., 2019; Kalaga et al. 2007)

- Community

(WHO/INPEA, 2002; Hoover and Polson, 2014; Yon, Ramiro-gonzalez, *et al.*, 2018; World Health Organization., 2021)

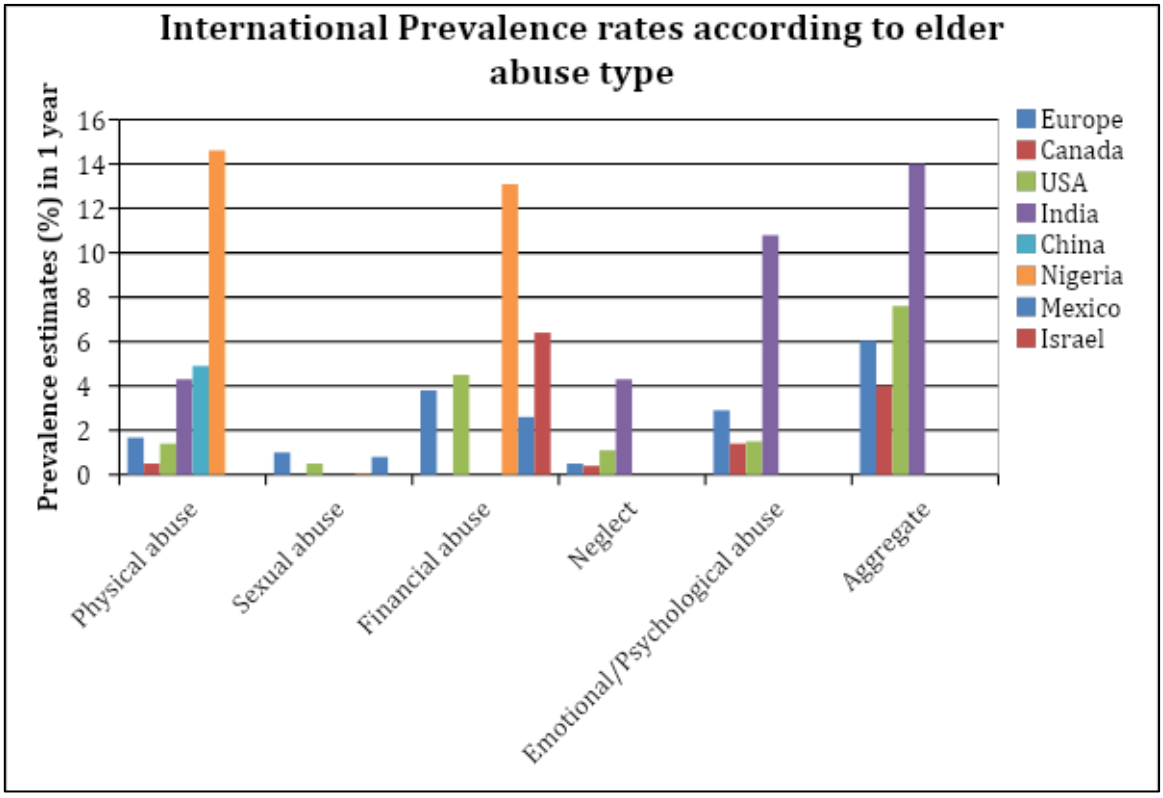
## 4. PREVALENCE OF ELDER ABUSE

In prevalence studies on elder abuse, rates range between 1%-35%. This huge gap can be attributed to the inconsistency of methodological approaches, studies' sample size, variation on definitions used, countries' income classification, and countries' social norms (WHO, 2008; Yon et al., 2017).

Several studies to address the problem and explain the variations, conducted subgroup analyses and meta regression models. The magnitude of pooled prevalence estimates suggest that elder abuse is consider to be a major global problem, however, it may represent only the tip of the iceberg, and some experts believe that elder abuse is underreported by as much as 80% (WHO, 2008).There are many reasons for this, including: isolation of older people, fear of consequences, not recognizing being a victim, the lack of uniform reporting laws and the general resistance of people – including professionals – to report suspected cases of elder abuse and neglect, the lack of training for social and healthcare professionals on how to recognize signs of abuse and how to support older victims, inadequately developed national healthcare guidelines and best practices for dealing with violence of older victims (World Health Organization., 2008), also older adults with cognitive impairment are excluded in many studies, a group that is more vulnerable to abuse (Pillemer *et al.*, 2016). These reasons can lead to the misleading conclusion that violence against older people either does not exist, or exists only slightly.

Pillemer et al. (2016) conducted a scoping review which included population-based elder abuse prevalence studies conducted until 2014. Elder abuse prevalence rates reported for separate and aggregate forms of mistreatment using a 1-year period ranged between 0.04%-14.6% **(table 1).**

Table 1.




(Pillemer *et al.*, 2016)

Elder physical abuse was the most consistently measured mistreatment type. Aggregate abuse incorporated all forms of mistreatment. In Europe elder abuse prevalence rates ranged from 0.5%-6.03% perceived as somewhat or very serious by the older adults in the past year. In detail:

- Physical Abuse 1.67%
- Sexual Abuse 1.0%
- Financial Abuse 3.8%
- Emotional/Psychological Abuse 2.9%
- Neglect 0.5%
- Aggregate Abuse 6.03%

While India and Nigeria had the highest rates in Aggregate, Emotional (14.0%, 10.8%) and Physical, Financial (14.6%, 13.1%) abuse respectively.

The above results suggest that the extent of elder abuse is sufficiently large that social service and health professionals who serve older adults are likely to encounter it on a routine basis. For example, using the prevalence rates just described, a clinician seeing 20 older adults a day may encounter one victim of elder abuse every day (Pillemer *et al.*, 2016).

On the same scope the pooled prevalence estimates of elder abuse in one-year period, in adults aged 60 years or older, reported in 52 publications (28 countries), in Yon et al. 2017 systematic review and meta-analysis, between 2002-2015 were (Yon *et al.*, 2017):

- Overall elder abuse 15.7%, meaning 1 in 6 older adults, which corresponds to 141 million victims annually worldwide. (Overall abuse might consist of any combination of abuse subtypes)
- Psychological abuse 11.6%
- Financial abuse 6.8%
- Neglect 4.2%
- Physical abuse 2.6%
- Sexual abuse 0.9%

Regional variations in overall elder abuse

- Asia 20.2%,
- Europe 15.4%,
- America 11.7%.

The largest multinational study for the prevalence of elder abuse ABUEL (Abuse of the Elderly in the European Region) was conducted in 7 European countries and included 4,467 individuals aged 60-84years. Data presented from January 2009–July 2009 across countries in **table 2** show that: 19.4% of the elderly were exposed to psychological abuse, 2.7% to physical abuse, 0.7% to sexual abuse, 3.8% to financial abuse and 0.7 to injuries. Furthermore, psychological abuse occurred more often in Sweden (29.7%) and Germany (27.1%). Physical abuse occurred more often in Sweden (4%) and Lithuania (3.8%). Sexual abuse occurred more often in Greece (1.5%) and Portugal (1.3%). Financial abuse occurred more often in Portugal (7.8%) and Spain (4.8%). Injuries occurred more often in Lithuania (1.5%) and Greece (1.1%) (Soares *et al.*, 2010).

Table 2. ABUEL study. Prevalence of Abuse and injury in seven European countries.

| Country | Psychological % | Physical % | Sexual % | Financial % | Injury % |
|---|---|---|---|---|---|
| **Germany** (n=648) | 27.1 | 3.3 | 0.9 | 3.6 | 0.4 |
| **Greece** (n=643) | 13.2 | 3.4 | 1.5 | 4.0 | 1.1 |
| **Italy** (n=628) | 10.4 | 1.0 | 0.5 | 2.7 | 0.0 |
| **Lithuania** (n=630) | 24.6 | 3.8 | 0.3 | 2.8 | 1.5 |
| **Portugal** (n=656) | 21.9 | 2.1 | 1.3 | 7.8 | 0.7 |
| **Spain** (n=636) | 11.5 | 1.4 | 0.3 | 4.8 | 0.5 |
| **Sweden** (n=626) | 29.7 | 4.0 | 0.5 | 1.8 | 0.6 |
| **Total (n=4467)** | **19.4** | **2.7** | **0.7** | **3.8** | **0.7** |

(Soares *et al.*, 2010)

## 5. How to recognize elder abuse: signs and symptoms

### Physical abuse

- Complaints of being physically assaulted
- Carer or relative seems to be over-protective, tells conflicting stories, does not leave the older person unattended
- Unexplained falls and injuries, fractures of undetermined causes
- Burns and bruises in unusual places or of an unusual type
- Cuts, finger marks or other evidence of physical restraint, signs that the individual may have been tied, bound
- Person seeks medical attention from a variety of doctors or medical centres

### Neglect

- Malnourishment or dehydration without an illness-related cause
- Evidence of inadequate care or poor standards of hygiene, dirty cloths, poor living conditions
- Wounds which were not taken care of
- Excessive repeat prescriptions or increased stock of drugs at home due to omissions in administration.

Signs of intoxication due to overmedication.

**Psychological/Emotional abuse**

- Change in eating pattern or sleep problems
- Fear, confusion, resignation
- Passivity, withdrawal or depression
- Helplessness, hopelessness or anxiety
- Contradictory statements or other ambiguity not resulting from mental confusion
- Reluctance to talk openly
- Avoidance of physical, eye or verbal contact with caregiver
- Older person is isolated by others

**Sexual abuse**

- Complaints of being sexually assaulted
- Sexual behaviour that is out of keeping with the older person's usual relationships and previous personality
- Unexplained changes in behaviour, such as aggression, withdrawal or self-mutilation
- Frequent complaints of abdominal pain, or unexplained vaginal or anal bleeding
- Recurrent genital infections, or bruises around the breasts or genital area
- Torn, stained or bloody underclothes

**Financial or material abuse**

- Withdrawals that do not match the usual needs of the elderly
- Changes on a will or property title to leave house or assets to "new friends or relatives"
- Property is missing
- Lost of jewellery or personal belongings
- Suspicious activity on credit card or other bank accounts
- Lack of amenities, when the older person could afford them
- Untreated medical or mental health problems
- Level of care is not commensurate with the older person's financial situation or income

(WHO/INPEA, 2002; World Health Organization., 2008, 2021; Hoover and Polson, 2014)

**Institutional abuse**

- Not offering choice or promoting independence
- lack of person centred care planning

- no flexibility in bed times or getting up or deliberately waking someone up
- inappropriate confinement, restraint or restriction
- lack of personal clothing or possessions
- unsafe or unhygienic environment
- development of pressure sores and ulcers without an illness-related cause
- lack of choice in food or menus or menu planning
- unnecessary involvement in personal finances by staff or management
- inappropriate use of nursing or medical procedures
- inappropriate use of power or control by staff.
- Discouraging visits or the involvement of relatives or friends
- Overcrowded establishment
- Authoritarian management or rigid regimes
- Lack of leadership and staff supervision
- Insufficient staff resulting in poor quality care
- Abusive and disrespectful attitudes towards older adults
- Lack of respect for dignity and privacy
- Failure to manage residents with abusive behaviour
- Not providing adequate food and drink, or assistance with eating
- Misuse of medication
- Failure to provide care with dentures, spectacles or hearing aids
- Not taking account of individuals' cultural, religious or ethnic needs
- Interference with personal correspondence or communication
- Failure to respond to complaints

(WHO/INPEA, 2002; World Health Organization., 2008, 2021)

## 6. RISK FACTORS FOR ELDER ABUSE

Across countries main risk factors are identified at levels of individual (victim and perpetrator), relationship, community, and society. Understanding these factors can help identify various opportunities for prevention (Pillemer *et al.*, 2016; CDC, 2020).

### Individual level (Victim)

- Dependency, disability
- Poor physical health
- Cognitive impairment, dementia
- Behavioural problems
- Poor mental health
- Lower income or poverty
- Being female, women are more commonly victims than men
- Age, abuse increases as people get older
- Financial dependence
- Race/ethnicity, discrimination

**Individual level (perpetrator)**

- Psychological problems, mental illness
- Substance or alcohol abuse
- Financial dependency
- Stress, burnout, heavy care burden
- Emotionally exhausted

**Relationship**

- History of abuse
- Family conflict and poor relationships
- Abuser's financial/ emotional dependency on the older person or vice versa
- Other family members not supportive

**Community**

- Loss of friends
- Social isolation of elderly and caregivers, limited access to social support
- Lack of supporting/training services for caregivers
- Lack of access to resources
- Geographic location

**Society**

- Cultural norms that encourage discriminatory and marginalizing behaviors against older people
- Inadequate health and social services for older people
- Health and social care staff inadequately trained, staff burnout

(Gorbien and Eisenstein, 2005; Wang *et al.*, 2015; Pillemer *et al.*, 2016; Dean, 2019)

Frail older persons living in residential or other institutional settings usually have multiple forms of impairment (mental, cognitive, physical) and disabilities. Their disabilities and dependence on others for care, makes them more vulnerable to abuse and neglect (Yon, Ramiro-Gonzalez, *et al.*, 2018).

## 7. ASSESSMENT OF ELDER ABUSE SIGNS AND SYMPTOMS

It has been observed in several studies that social and health care professionals are not sufficiently trained in recognizing signs of abuse in the elderly. This results in incidents of abuse going unnoticed and under-reported (WHO/INPEA, 2002; Perel-Levin, 2008; Schmeidel *et al.*, 2012; Hoover and Polson, 2014; World Health Organization., 2021).

The training of social and health care professionals is considered vital as they should be able to differentiate in their assessment the signs of abuse, from the normal age-related changes and chronic disease. Clinicians need to be knowledgeable of how to initiate investigation and proper intervention (Perttu, 2018).

### Age related changes and processes

- The bones of older persons are thinner and less dense, making them more susceptible to fractures as the result of bone disease or injury.
- Normal aging skin has relatively well-preserved blood flow. In aging skin thins and elastic strength declines. The elderly are more susceptible to decubitus because of disease states and not on the basis of age alone.
- Photoaging means photodamage that occurs over long periods of time due to exposure to harmful UV rays. The UV radiation affects the collagen fibers in the skin. Damage to collagen results in a loss of skin elasticity, which results in the early appearance of wrinkles and other age markers. Signs can include: wrinkles, inelasticity of skin, dark spots ("age spots"), broken blood vessels, a yellowish tint to the skin, leathery texture to the skin, mottled pigmentation and easy bruising.
- Bruises often occur more frequently and resolve much more slowly in older persons than in younger persons and can last for months instead of the usual one to two weeks.
- Old age results in a decline of both smell and taste. This can lead to decreased appetite, weight loss and malnutrition.
- The opening of the sphincter may be difficult (Swallowing difficulties/Dysphagia). Solid food or tablets can be difficult to swallow and can get stuck in the esophagus. Food or drink may enter the respiratory tract or lungs (aspiration). This can lead to aspiration-related pneumonia.

- The elderly are much more prone to dehydration with minimal provocation than are younger people. Older persons have decreased body water reserves and thirst sensation; they may not feel thirsty after up to 12-24 hours of lack of water. This can lead to dehydration and confusion.
- Older persons have decreased gastrointestinal absorption, and their bodies, due to age-related changes in body water, fat, and lean muscle, distribute drugs differently. In general, there is more fat and less water, leading to longer time of action of fat-soluble drugs and higher abrupt drug concentrations for water-soluble medications.
- Occasionally, impaired eyesight may make it more difficult to keep one's home or clothes clean; however, if cognitive ability remains normal, elders are able to perform the activities of daily living and maintain appropriate hygiene.
- Women experience several physiologic changes in the genital tract as they age. Both progesterone and oestrogen levels decline with ageing. Decreased oestrogen levels result in changes in the shape of the vagina, increased vaginal dryness, and thinning of the vaginal walls. These changes may cause pain and bleeding during sexual intercourse. Such age-related changes as altered acidity of the vaginal secretions and decreased oestrogen levels make older women more prone to spontaneous vaginal and bladder infections. (Dyer et al., 2003)
- Ageing skin thins and its ability to function deteriorates. The amount of natural fats in the skin decreases, and the skin dries more sensitively. When dry, the skin may shrink and become inflamed. Rash is usually accompanied by itching. The surface of the skin is reddened, it flakes and cracks. Most of the elderly suffer from dry skin. (Sherman V. and Creamer D, 2009).
- Changes in old age affect the functioning of specific organs, mood, attitude towards the environment, physical condition and social activity, determining the position of the elderly in the family and society. This can lead to loss of social roles and reduction of interpersonal relations. These can be accompanied by depression, reduced satisfaction with life, isolation, reduced interest and increased feelings of loneliness and danger. (Dziechciaż M, and Filip R., 2014).
- High age and calcification of blood vessels can predispose the break of blood vessels under the nasal mucus (Epistaxis). (Pope L. E. R and Hobbs C. G. L, 2005).
- Multimorbidity is more common in the elderly population. The term “multimorbidity” refers to at least two concurrent long-term illnesses, injuries or disabilities affecting health status, according to international definition. Multimorbidity can lead to polypharmacy, which may change the manifestation of individual diseases in as side effects of medicines. The term “polypharmacy” means that a person has at least five long-term medicinal products at their disposal. In this case, the combined effects of medicines should be taken into account in the assessment of symptoms. Polypharmacy does not in itself increase multimorbidity, but it increases the risk of being hospitalized due to harms of combined effects of medicines, for example. (Masnoon et al., 2017).

Healthcare professionals can often find it difficult to distinguish signs of violence from normal ageing related changes and physical injuries. Health problems and illnesses at an older age can mimic and overlap with the symptoms of violence. (Collins, 2006; Palmer et al., 2013). **Table 3** shows examples of physical marks and injuries in older people that make it difficult to interpret signs of violence.

**Table 3**. Interpretation of physical marks and injuries

| Mark/Injury | Assessment |
|---|---|
| Senile purpura<br><br>*(Ceilley R.I, 2017)* | Purpuras are benign in-skin bleedings (lat.purpura). The primary symptom of senile purpura is large, purple bruises, which are most common on the back or forearm of the hands. They turn brown when they fade. These bruises usually last from one to three weeks before fading. In most cases, senile purple develops from a small trauma. The most common factor directly affecting the development of senile purple is thin, easily damaged skin. |
| Bruises (Wiglesworth A. et al. 2009) | Bruises are most commonly seen in physical abuse but can be a result of caregiver neglect. To be taken into account in the assessment:<br>· Age-related changes<br>· Effect of medications (e.g. blood thinners, Non-steroidal anti-inflammatory drugs, NSAIDs)<br>· The extent of the bruise: suspect violence if the diameter of the bruises exceeds 5 cm.<br>· Determining age by color: The color of the bruise is uncertain when determining the age of the bruise in the elderly. |
| Fractures (Gibbs LM 2014) | There is little data on forensics of fractures in older people. Bones of older persons are thinner and less dense, making them more prone to fractures. falls which are the most common cause of injury in older persons.<br>To be taken into account in the assessment:<br>• Poor nutrition, vitamin D deficiency, alcoholism, age-related sex hormone deficiencies, osteoporosis, chronic corticosteroid use, cancer. |

| | |
|---|---|
| Burns<br>(Dyer et al. 2003) | Burns in older people also may result from abuse or neglect.<br>Size, location, shape, pattern and story of burn has to be to be assessed.<br>The cause can be use of too hot water when showering the older person.<br>Take into account any area of soft tissue that should not come into contact accidentally with any hot object, etc. such as the back of the hand, the soles of the feet, the buttocks or the back.<br>Shaped like an object: iron, tobacco. |
| Pressure sores (decubiti/bed sores)<br>(Dyer et al. 2003) | There are divergent views regarding which decubiti are due to illness and which are due to neglect or even violence<br>In general large infected /necrotic decubiti, multiple decubiti, especially multiple deep decubiti and smelling dead tissue can be indicative of neglect.<br>Bedsores are most commonly found over the sacrum, hip or heels<br>Can be caused by factors: acute illness, circulatory disorders, poor nutrition, poor mobility status (tied down in one position) or poor standard of care.<br>Diabetes predisposes to pressure sores. |

## Active Learning Activities

A series of exercises that can be used to practically apply the theoretical contents taught in the module.

### LEARNING ACTIVITY 1 - THE GALLERY EXERCISE

**Method:** Group discussion. Group discussions are used to promote exchanging of ideas and active learning. One way to facilitate a group discussion is known as the Gallery Exercise.

In the gallery group discussion exercise, participants work in smaller groups and discuss issues related to a certain topic or subject. The room is organized into separate areas with a different topic or subject to be discussed at each area. Each area has 4-6 chairs, a table and a flipchart. Each group is allocated an area to begin, they then discuss the topic and write down their conclusions on the flipchart paper before moving on to the other tables. Trainers are encouraged to visit each table during the exercise to help maintain topic relevance and to assist with any questions.

To learn more about the method you can visit: Gallery Group Discussion Exercise | Training Workshops (ventureteambuilding.co.uk)

At the end of the exercise, groups present the information back and participants are given some time to tour the galleries to see what the other groups have contributed.

**Equipment and materials:**

- round tables with 4-6 chairs at each according to the size of the group
- computer
- projector
- screen
- one flipchart per table and one for the instructor
- marking pens of different colours at each table, (one colour for each group)
- Handouts with scenarios

**Time allocated:** 65-70 minutes

- 5 minutes to brief and set up
- 3 x 10 minutes working at each gallery (depending on the number of participants)
- 20 minutes for presentations (prepare and deliver)
- 5 minutes to tour the galleries
- 5-10 minutes to review and debrief

**Gallery Group Discussion Instructions:** Divide participants into 3 groups (no more than 6 per group) and sit around the table. Each table is asked to work with one case scenario. If there are more than three small group tables at the training, duplicate case examples may be used for the additional tables. Each table should be asked to identify a note taker and a person to report back to the entire group. Encourage the groups to choose a new note taker and reporter for each exercise, so everyone has an opportunity to participate in these roles. Give each group a different colour pen to help separate their contribution to each flipchart.

Begin the exercise and give each group ten minutes per gallery to discuss the topic. Towards the end of the ten minutes, the nominated scribe should begin writing down the main points discussed.

Write your answers in the table:

| Indicators | Type of abuse | Victim | Perpetrator |
|---|---|---|---|
| | | | |

Next, move each group on to the next gallery and have them discuss the new topic and add their contribution. Continue this for each subsequent gallery. Once all groups have

contributed to each flipchart, get them to return to where they started and allow time to review and discuss the contributions added by the other groups. Each group will now present their gallery piece and their findings to the other groups. At the end of the presentations, allow participants five minutes to walk around and look at the galleries on show.

Finally, you can ask some questions to review and debrief:

- What surprised you the most?
- Do you feel each topic was adequately explored?
- Did you find anything frustrating?
- What did you enjoy the most?
- What can you take away from the exercise? How can you use it?

Case scenarios are adapted from: National Adult Protective Services Association (2010) ELDER ABUSE DYNAMICS FOR ADULT PROTECTIVE SERVICES (sdsu.edu)

**HANDOUT No 1 - CASE SCENARIO:1 - TONY AND JOSEPHINA**

Tony and Josephina have been married for almost 60 years. He is 80 and she is 77. Two years ago, Josephina was diagnosed with Alzheimer's disease. The disease progressed very quickly. Their son, Henry, told the residential care home director that Tony and Josephina's marriage had been tumultuous. During all of their married life, Tony had been verbally and physically abusive to Josephine. For years he told her that she was stupid and ugly, that no other man would want her, and that she was lucky he put up with her, though he might leave her at any time. He threw things at her, slapped her in the face, threatened to kill her, and once, pushed her down the stairs. On several occasions, Josephina left Tony. When Henry offered to help her move in with his family, she refused and went back to her husband. Since then, Henry has tried to talk to his mother about her relationship with Tony, but she always shut him off, saying that a wife had her duties, and it was none of his business. Three months ago, Tony was diagnosed with liver cancer. His prognosis is not good. Recently, the aide who assists Josephina with her toileting and bathing noticed bruises on her breasts and inner thighs. When asked about the bruises, Josephina shook her head and cried, but did not answer. The aide suspected that Tony was having intercourse with his wife, and that she was unable to resist. When Tony was confronted, he became angry, saying "It's nobody's business but ours! She's my wife and I can make love to her whenever I want. I've done it for 60 years. Besides, I don't have long to live, and I deserve to have some pleasure before I die."

***

Please identify:

- The types of abuse

- The indicator for each type
- The victim
- The abuser

Having in mind Tony's answer "She's my wife and I can make love to her whenever I want…", do you think that sexual abuse is love? A discussion about consent for sexual intercourses between spouses might be introduced.

## HANDOUT No 2 - CASE SCENARIO: 2 - ROSIE AND HER PARENTS

Rosie is a 47-year-old woman with Down Syndrome. When she was born, her parents vowed never to place her in an institution, as was often done in those days. As a result, she has lived with her father and mother her whole life, and has had little exposure to the outside world.

As her parents have aged, Rosie has taken on more and more of the household work and personal care for her parents. Although Rosie is relatively high functioning, she struggles to help her father, Frank, age 79, who has severe Parkinson's disease, and her mother, Betsy, age 72, who is legally blind and increasingly frail. The family has a limited income and barely makes ends meet. They do have a home health aide paid through Medicaid twice a week, as well as Meals on Wheels and senior transportation. Due to his Parkinson's disease, Frank is unable to feed himself. Rosie tries to help him, but often gets frustrated and roughly jams the spoon into his mouth. On one occasion, she broke his front tooth. She blamed Frank, because "He jiggles around too much." Returning after a long weekend, the aide found Betsy unresponsive and lying on the floor between the bed and the doorway of the adjoining bathroom. She had several pressure ulcers on her left hip and left leg, apparently the result of her lying on that side for an extended period of time. She called an ambulance, and the paramedics reported the carpeting beneath Betsy's body was badly soiled.

Rosie and Frank said that they found Betsy lying on the floor in her present location several days earlier. Rosie said she tried to help her up, but her mother cried out in pain and told her to leave her alone. After that, they left her lying on the floor, bringing her food and water and giving her medications. Frank said that Rosie put a pillow under her head and tried to care for her. When asked why he did not call for medical assistance, Frank told the paramedics that his wife said not to call anyone. The paramedics reported the case to police.

***

Please identify:

- The types of abuse
- The indicator for each type
- The victim
- The abuser

Why do you think the paramedics reported the case to the police? Why didn't just take Betsy to the hospital?

HANDOUT No 3 - CASE SCENARIO: 3 - JAKE AND REGINA

For years, Jake, who is 56, has been struggling to make a living as an artist, with little success. Sometimes he does house painting. But because he is an alcoholic, he doesn't hold onto a job for long. So, he turns to his mother, Regina, for financial help. In the beginning, Jake claimed that the money Regina gave him were loans, and that he would pay her back as soon as he "got on his feet." But the loans were never repaid. Now Jake is saying that if only he could take another art course, his paintings would finally begin to sell. He wants Regina to take out a reverse mortgage on her house, so he can have €10,000 for his art studies. Regina, who is 75 years old, has advanced macular degeneration and relies on a private pay aide to help her with housework and to drive her to appointments. She is reluctant to mortgage her home. As an immigrant woman, she is very proud that she owns her own home free and clear. Also, her mother lived to be 101, and Regina is worried that if she cashes in on her home now, she will outlive the income provided by the reverse mortgage. She is also concerned that she will be unable to continue to pay for the increasingly levels of assistance she will need to cope with her vision loss. But she also wants to support Jake's dream of being a painter. He has sold an occasional picture, and she believes that he has real talent. Jake is getting impatient with his mother. He claims that if she really loved him, she would help him out. Yesterday he barged into her house and kicked Bootsy, Regina's small dog. Regina started to cry, and begged Jake not to hurt the dog. She promised him that she would find the money "somehow." Jake replied, "You better find it." Before he left, Jake took the ATM card from Regina's wallet without her knowledge. He had helped her use it previously as her sight was failing, so he knew the PIN. That day and the next he made two withdrawals totalling €1,000.

***

Please identify:

- The types of abuse
- The indicator for each type
- The victim
- The abuser

What do you think Regina was thinking and feeling when she promised to Jack that she would find the money?

Did Jack commit a crime?

## LEARNING ACTIVITY 2 - GROUP WORK BASED ON VIDEOS

**Material:** videos, pens, papers

**Timing:** 45min

**Description of the exercise/instructions**

- Organize the participants in 4 groups of 4-5 members (depending on the number of participants)
- Ask them to agree who will be taking notes and who will present the results to the whole audience in the group
- Each group watches one of the following videos:
  - Government of Alberta, in partnership with the Alberta Elder Abuse Awareness Network – "Elder Abuse - learn the signs and break the silence" https://www.youtube.com/watch?v=OEGhbbpel30
  - Center of excellence on elder abuse and neglect – University of California, Irvine "I have a prescription to pick up" - Mr. Stepania https://www.youtube.com/watch?v=ua0VhxRE3Nk&t=47s
  - Center of excellence on elder abuse and neglect – University of California, Irvine "I have a prescription to pick up" – Mrs Appelby https://www.youtube.com/watch?v=nmb9vKsvNys&t=2s
- Within each group, have the students make a list of possible responses on the paper for the questions below – at first without discussion. Each student folds over the paper when they've finished writing on it and passes it to the next person in their group. When all students in the group have written a response, unfold the paper and the smaller groups can discuss the responses. If there is time, each group can share their best response along with some thoughts to the whole class and answer the following questions**:**

  1. Was elder abuse present?
  2. Identify and describe the forms of elder abuse experienced in the video.
  3. What signs and symptoms alerted you to potential elder abuse?
  4. What risks factors for elder abuse and or neglect were evident in the video for the individuals presented?
  6. Reflect and discuss a situation where you suspected abuse in an older adult but you weren't sure how to address it.

Suggestions for the trainer: it might be useful to underline that based on the information we get from the videos, abuse might be suspected but it is not certain, therefore it is important to be cautious with allegations and do not come immediately to conclusions.

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# MODULE 2 – Screening of elder abuse

## Structure of the module

| | |
|---|---|
| Title | Screening of elder abuse |
| Goal(s) and objectives | Goals of this module are to increase:<br>▪ knowledge on screening of elder abuse<br>▪ understanding the complexity of screening of elder abuse<br>▪ the understanding of the reasons for screening<br>▪ knowledge on screening tools used in different health care settings |
| Learning outcomes | Participants will be able to<br>▪ define the concepts, terms and objectives of screening<br>▪ understand the wide set of scientific criteria established for screening<br>▪ understand the minimum requirements for asking about violence<br>▪ use screening questions naturally with the older persons<br>▪ understand the screening as a process |
| Duration: | 3 hours<br>▪ 45min-1h input session<br>▪ 20 min (2x10 minutes) breaks<br>▪ 1h and ½ active learning activities<br>▪ 10 minutes of extra time (participants taking their seats, getting to know briefly the participants and trainers, answering the questions) |
| Resources needed: | ▪ Round tables with 3 - 4 chairs at each according to the size of the group<br>▪ Computer<br>▪ Projector<br>▪ Screen |

| | |
|---|---|
| | ▪ Flip chart papers on the tables and a flip chart for the trainers<br>▪ Handouts for the participants |
| Key message | ▪ Screening is a complicated issue as elder abuse is multifaceted and multidimensional<br>▪ Screening for elder abuse is based on professional ethical principles<br>▪ Screening questions should be as a part of normal conversation process<br>▪ Screening/asking about elder abuse is just the first step of the screening process |
| Learning Activities | Instructions for the trainer<br>Handouts for the participants |

## 1. WHAT IS SCREENING?

Screening, as defined by the UK National Screening Committee (UK NSC), is "**a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications**". (Feder G. et al, 2009)

Screening has become a central focus in public health care systems. Wilson and Jungner laid the foundation for modern screening in 1968 and started scientific debate about the benefits, harm, costs and ethics of screening. They stated screening as: "the presumptive identification of unrecognised disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly. Screening tests sort out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic. Persons with positive or suspicious findings must be referred to their physicians for diagnosis and necessary treatment." Wilson and Jungner also set in 1968 ten screening principles. (J.M.G. Wilson & G. Jungner, 1968).

Screening is for people who do not have symptoms. The purpose of screening is to identify people in an apparently healthy population who are at higher risk of a health problem or a condition, so that an early treatment or intervention can be offered. This, in turn, may lead to better health outcomes for some of the screened individuals. Screening is not diagnostic. It is not the same as early diagnosis but points to the necessity of further review. Early diagnosis is intended to detect conditions as early as possible among people with symptoms. (WHO Regional Office for Europe; 2020).

In addition to the screening concept there are terms such as universal screening and selective screening. Universal screening means a large scale assessment of whole population groups - assessing everyone, whereby no selection of population groups is made. Selective screening means screening targeted to one or more subgroups of a population determined to be at risk for some disease or condition. (WHO, 2013).

Screening in public health is a well-defined evidence-based issue. In the field of violence, screening is generally referred to as the action by which professionals detect abused individuals while excluding (screening out) the non-abused individuals. Screening for violence can be defined as: "Assessment of current harm or risk of harm from family and intimate partner violence in asymptomatic persons in a health care setting". (Perel-Levin, 2008)

National Sexual Assault, Domestic Family Violence Counselling Service in Autralia (1800RESPECT) defines screening by following way: “Screening is an informal process that aims to open up a conversation about domestic violence and family violence. It is a systematic way of providing the space for a person to talk about domestic and family violence. It usually involves asking clients about their experiences. This might include asking whether there is domestic or family violence in their life or if they have felt unsafe in their relationship”. Asking about violence should happen in the normal process of conversation and take place as part of the developing relationship between client and worker. (1800RESPECT). The challenge to do that in normal conversation is that the questions should be asked using the same words as they are on the instrument as well as in the same order. The questions on the screening instruments are designed in a very specific way. The words used in each question are carefully selected. The results of each validation is tied to that specific wording; changing words can change the efficiency of an instrument. (Yaffe M. J. 2015). Screening is most effective when it is done with all clients of a service, rather than with select people or groups, such as based on clients’ demographic background, occupation, faith, culture, disability status or age. This is known as “routine screening”. (1800RESPECT).

## 2. SCREENING CRITERIA AND PROGRAMMES

Wilson and Jungner’s screening principles set in 1968 (Wilson & Jungner,1968) are still the base for screening criteria used in national screening programmes for diseases and conditions which often have a high mortality rate. They can preliminarily filter whether a screening programme might end up being effective within a given country and health system. The United Kingdom provides examples of accurate sets of screening criteria with a list of 20 criteria to be considered for screening (UK NSC, 2014) and Finland 14. (STM, 2014)

The criteria used by most countries to assess a screening programme are the following (Perel-Levin S., 2008):

- The condition should be an important health problem, well understood and with a known risk factor, or indicator;
- The test should be simple, safe and validated;
- The screening test should be acceptable to the population;
- There should be available effective interventions to follow up;
- There must be evidence from reliable randomised controlled trials that the screening programme reduces mortality or morbidity and is cost effective;
- There are adequate staff available;
- There should be evidence that the complete screening programme (from test to intervention) is “clinically, socially and ethically acceptable to health professionals and the public”.

Many countries have increased screening of individual diseases to ensure equality. Including a new screening test in the national screening programme demands a great deal of preparatory work as well as a wide discussion in society about the objectives and effects of screenings. Public debate and an efficient support for the implementation of a screening increase its acceptability and can also increase the participation of the target population. A screening should produce enough health benefits to be justified from the perspective of public health. Therefore, there must be a good understanding of the benefits, costs and societal impacts of a screening until a decision is made to stop or start a new screening programme. Screening is a valuable part of improving the well-being and health of the population. (STM – Finnish Ministry of Social Affairs, 2014)

Many Member States are running or establishing population-based screening programmes for breast, cervical and colorectal cancer according to the Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC) (European Commission, 2008).

An effective screening programme can deliver significant public health benefits. Although good-quality evidence may show that screening can deliver benefits, these will only be delivered if the programme is run effectively. Screening can also lead to harm. Because screening tests are not 100% sensitive or specific, there will always be false positives and negatives. The challenge for policy-makers is to consider all the potential benefits and harm and decide in the context of their health system and their values or ethics whether the screening programme is expected to produce benefits at a reasonable cost. (WHO, 2020)

## 3. SCREENING OR ROUTINE ENQUIRY?

The term “screening” is professional language used in public health and may sometimes confuse the discussion with other fields such as social services. In order to advance cooperation and communication between professions, language is a key element that needs to be clarified so that all the professionals involved understand what they are talking about and can work together towards solutions. The significance of words should not be taken lightly. While the term “screening” may have a specific meaning in public health, it also refers to a stronger attitude involving follow-up. The term “enquiring” may be interpreted as a “softer” attitude of just asking and not necessarily following up. The critical point in screening is that it is a first step, not an end in itself. (Perel-Levin S., 2008). It is important to emphasise the same point when talking about “enquiring” and that should be understood by all professionals involved.

The term “routine enquiry” in the context of domestic violence refers to investigating intimate partner violence without using the public health criteria of a complete screening programme. According to WHO it can also mean a low threshold to routinely ask women about abuse in a healthcare setting, but not necessarily all women (WHO, 2013).

Screening, as defined by the UK National Screening Committee, refers to the application of a standardised question or test according to a procedure that does not vary from place to place. In routine inquiry procedures are not necessarily standardized but questions are asked routinely in certain settings or if indicators of abuse arise. According to some scholars, routine inquiry is a more suitable approach for domestic violence (Taket A. et al., 2003), however we do not have studies in relation to elder abuse.

A handbook by the United Kingdom Department of Health recommends moving towards routine enquiry; "all (National Health Service) Trusts should be working towards routine enquiry and providing all women with information on domestic abuse support services". "Routine" refers to taking the initiative, being proactive and asking all women. That helps avoid stigma and inappropriate judgements. (Department of Health, 2005).

## 4. SCREENING TOOLS AND THEIR USE

The fundamental function of any assessment tool is to guide professionals through a standardised screening process and to ensure that signs of abuse are not missed.

Screening tools should be able to correctly detect the case of abuse or neglect and those without. The idea is to raise the level of suspicion of the professional undertaking the screening about the possibility of abuse and then to follow this up. An effective screening test/tool is based on its ability to distinguish the people who do experience abuse (true positives) from those that are not abused (true negatives). A false positive occurs when a person is identified as being abused when they are not. A false negative means the persons are identified not being abused but they actually are. (WHO, 2020; McCarthy L. and al., 2017)

Screening instruments have been categorised in different ways. Cohen (2013) categorised screening instruments into three groups based on both method and intention of the screening instrument. The first group comprised direct questioning tools that ask about the elders' experience or self-reports of the older person; tools that assess signs of actual abuse; and tools evaluating risks of abuse. Most screening instruments incorporate the direct questioning method, and assessment of risk of abuse.

Self-report has the advantage of being more economical and better allowing for mass screening. It may also facilitate more honest answers when completed in private. Disadvantages include that it may be unsuitable for those who are cognitively impaired, do not have adequate language or reading ability, or who lack the time or motivation to complete. (Schofield M. J., 2017).

Direct questioning by professionals allows for a physical observation of the person. Evidence also suggests that most victims will not initiate disclosure but will, when asked directly, admit experiencing abuse (Cohen M., 2011). Disadvantages include the lack of time for many

busy professionals, potential lack of training and comfort in asking highly sensitive questions, potential inaccuracy in scoring and interpretation, and there may be a lack of known referral and intervention options in some cases. (Schofield M. J., 2017)

Screening based on risk indicators of abuse has been justified because it can be difficult to get reliable answers to questions by direct questioning. Risk factors tools have been shown to reliably distinguish abuse and non-abuse cases. (Cohen M et al., 2006)

Each of these have both strengths and limitations as screening measures. Cohen has pointed out that all 3 forms of screening - direct questioning, screening based on signs and risk of abuse indicators would be needed to optimise identification of cases of abuse. That would be a comprehensive screening model. Most screening instruments incorporate the direct questioning method, and assessment of risk of abuse. (Cohen M., 2013.)

Another way of categorising screening instruments is to consider the setting and purpose of the screening tool. One set of screening instruments has been designed for mass screening of elders and/or their caregivers at the community or population level. Another set of instruments has been designed for more targeted screening among elderly in health, social and institutional service settings. (Schofield M. J., 2017)

Identification of elder abuse is complex. Therefore, an effective screening instrument should try to assess both signs of abuse (e.g. suspicious bruises, transfer of property) as well as risk factors of abuse (e.g. history of violence, relationship problems between older person and possible perpetrator). The questionnaire cannot be too long. Social and health care often need short, user-friendly, and multidisciplinary instruments that can be completed in busy practice settings. Moreover, several screening instruments should be completed by highly skilled professionals. Useful instrument should be one that can be applied by a wide variety of professionals and in multiple settings. There are tools that often focus only one theory of elder abuse, such as on the caregiver model. This kind of tools ignore non-dependent older persons. Different types of perpetrators are also possible. (De Donder et al., 2015).

An ideal tool should include (1) risk factors of abuse and early signs of abuse; (2) provide both shortness and thoroughness, enabling accurate assessments to be completed in time demanding work environments; (3) be used by informal carers, by formal carers (medical and non-medical), or health and social services; (4) pay attention to different types of perpetrators; (5) refer to the physical, psychological and the social environment of older people and (6) be tested for reliability and validity. Such an instrument developed will provide the possibility of an early detection of elder abuse which is needed to provide support and care, and to prevent worsening of elder abuse. (De Donder et al., 2015).

Finally, Nelson et al. (2012) points out in the broad literature review that the prevalence of abuse and the sensitivity and specificity of screening instruments depend on definitions of abuse (physical, sexual, emotional, and combinations) and acuity (current, past, and any). These definitions are not standardized across instruments.

Screening tools are not diagnostic and are used to highlight the need for onward referral or further assessment. Though they require further testing, they can help health and social care professionals to provide a systematic and objective approach to the decision-making process. Training, staff supervision and support are required in order to have a system that will handle issues sensitively and effectively. (McCarthy et al., 2017).

## 5. SCREENING IS A PROCESS

A screening programme is a pathway that starts by identifying the people who are eligible for screening and stops when the outcomes are reported. A screening programme will only be effective if all parts of the screening pathway are provided. (WHO, 2020) Essential steps in a simplified screening pathway:

- Identify the population to be screened based on best evidence
- Invitation to participate supplying information tailored appropriately for different groups to enable informed choice to participate
- Conduct screening test(s) using agreed methods
- Refer all screen-positive results to appropriate services and make sure screen-negatives are reported to individuals
- Intervention, treatment and follow-up: Intervene or treat cases appropriately. In some conditions surveillance or follow-up will also be required.
- Reporting of outcomes: Collect, analyse and report on outcomes to identify false negatives and to improve the effectiveness and cost–effectiveness of the screening programme.

(Modified from: WHO, 2020)

As a general conclusion Perel-Levin (2008) states: “Screening is a first step. When elder abuse is suspected, further assessment and appropriate referrals must follow. Referrals and ongoing contact with the voluntary sector need to be part of the process. Formal and clear procedures and mechanisms, regular case reviews, peer staff development and regular reflective practice need to be in place to sustain the implementation of a successful screening programme”.

## 6. WHY TO SCREEN ELDER ABUSE?

Studies show that professionals’ identification using structured tools increased the rates of abuse higher than those found in prevalence studies (Cohen M., 2011). There are convincing reasons to screen for elder abuse. Evidence by the scientific literature shows that abuse in later life is linked to adverse health impacts.

Abused older persons have been reported:

- to be at higher risks of mortality (Lachs M. S. et al, 2018; Mouton C.P, 2003; Dong XinQi et al. 2009; Dong X.Q. et al 2011; Schofield M.J. et al, 2013)
- more likely to experience disability (Cooper C. et al 2006; Schofield M.J. et al. 2013)
- to be at a higher risk of hospitalisation (Dong & Simon, 2013)
- higher risk of nursing home placement (Lachs et al. 2002)
- to have suicidal thoughts and attempts (Barron, 2007; Lazenbatt A. et al. 2010; Olofsson et al. 2012)
- to have chronic pain, lung, bone or joint problems, metabolic syndrome, gastrointestinal symptoms and stress, depression or anxiety (Bitondo-Dyer C. et al. 2000; Fisher & Regan, 2006; Lazenbatt et al., 2010; Fisher et al., 2011; Dong et al. 2013)
- obvious traumatic injuries and pain. A review by Murphy et al (2013) screened different injuries, for example dental, neck and skull and brain injuries.

Health and social care services may be the only contexts where older people are seen and have contact with others. This can be a valuable opportunity to detect abuse and a chance for victims to disclose and be offered support and assistance. If detected early enough, elder abuse victims can be offered the opportunity for an intervention and help to reduce the risks they may be exposed to. This can prevent serious harm from occurring or even save lives. Incidents that may appear relatively minor can have a debilitating and long-lasting effect on older people. It may not be possible for an older person to recover and "move-on" from the situation in the way that a younger person might. (McCarthy et al. 2017).

Cases of elder abuse often go unidentified and unreported by health professionals (Cooper et al. 2009). Common reasons for underreporting include varying levels of understanding about elder abuse by health professionals; inadequate training on the signs of elder abuse, particularly financial abuse; limited access to standard screening and assessment tools; and inadequate organizational support to aid the reporting of identified cases of elder abuse (Brijnath et al. 2020)

## 7. BARRIERS FOR SCREENING

Concerns of elder abuse may create significant additional work and propel the clinician into a world that he or she is likely to be unfamiliar with (mandatory reporting statutes, adult protective service workers, and a criminal justice system).

Providers may be sceptical about the possibility of making a change once elder abuse is identified and reported. Lack of time, lack of knowledge, lack of confidence that there are adequate resources and systems to address potential elder abuse, gaining sufficient privacy to ask the sensitive questions about abuse, and lack of skills in eliciting reports of abusive acts or situations. (Rosen et al. 2016). Screening tools that take more than an hour to administer meet with increased resistance which decreases screening quality (Yaffe et al. 2008).

Schmeidel et al. (2012) studied barriers to elder abuse detection and reporting. They analysed participants' statements and found five major categories under which most statements could be grouped:

**Professional orientation:**

Nurses, physicians, and social workers each approach elder abuse with different values that they have developed over their years of practice. Nurses expressed passion about caring for their patients and preventing and detecting elder abuse. Nurses reported wanting to look for other explanations than elder abuse to explain why their patients are not doing well. They thought the physician should look into it and report it.

Physicians' greatest barriers in disposition was the set of priorities with which they are otherwise concerned. Because of their limited time schedules, they prioritize what they feel most concerned and comfortable dealing with. If they did see abuse, they wanted to let social workers investigate and deal with it since they were the "experts." They looked for "high suspicion" and "enough information" in order to report.

**Assessment:**

Assessment for elder abuse was a major practical barrier that many found difficult to overcome with the resources available to them. A lack of time was one of the most commonly mentioned problems. Physicians and nurses cited that they had to prioritise what could best fit into the limited time they had, and most often elder abuse didn't fall at the top of that priority list. If they suspect abuse, they didn't have enough time to gather sufficient evidence to support reporting. Privacy was a problem: Social workers seemed most comfortable asking caretakers and family to leave the room, but nurses and physicians noted that it was difficult to find privacy in every visit. Several nurses thought that it was almost impossible to detect abuse in a one-time setting.

**Interpretation:**

Interpreting and implementing the law in clinical practice proved to be more difficult for most nurses, physicians, and social workers. Difficult issues for physicians and social workers was interpreting whether the patient who was being abused or neglected was a dependent adult. If a person chooses to live that way the question is whether a person is competent or is his/her decision-making impaired. Dependence was an important issue for reporting.

**Systems:**

There was the internal system of responsibility within a clinic or hospital, and the external system for reporting. Exact protocols for reporting elder abuse in the internal system were crucial. Nurses seemed to be generally unaware that the protocols exist in the hospital. Nurses preferred to refer suspected abuse to the physician and/or to the social worker and physicians to the social worker. There were also frustrating experiences and results from reporting because the external system seemed to be underfunded and overworked.

**Knowledge and education:**

Nurses and physicians were not as comfortable with their knowledge of abuse as social workers. Social workers thought that education and awareness of elder abuse could be improved for clinicians. Professionals experienced that the given education was inadequate and impractical for approaching an elder with suspicion of abuse. Many would like to have more case-based training. Some physicians and nurses presented inaccuracies in their knowledge about elder abuse. Most physicians thought that elder abuse was rare. Most nurses were unaware of many of the laws surrounding confidentiality, anonymity, and personal responsibility for reporting, as well as who should specifically be the one to report. There was uncertainty what mandatory reporting includes.

Abuse is rarely self-reported by older persons themselves. Identifying elder abuse can be made based on indicators raising the suspicion of abuse. Indicators can be observed symptoms or signs of an older person's or caregiver's behaviour and/or based on physical injuries (medical markers). Identifying risk factors associated with potential elder abuse may allow the professionals to intervene at an early stage and stop abuse from continuing. Although there are established risk factors for elder abuse, assessment should not be guided by risk factors alone. Violence can happen and affect people in any circumstances. Therefore, routine assessment for elder abuse is recommended for all patients. (Pickering et al., 2016)

## 8. MINIMUM REQUIREMENTS FOR ASKING ABOUT ABUSE

Professionals are trained to ask questions in the right way, i.e.:

- safe, respectful, sensitive, initiative taking, using non-threatening language
- development of rapport between professional and a person interviewed
- non-judgemental, empathetic attitude
- Introduction: "*I would like to ask you a few questions about events that may happen in the lives of older people.*"

Professionals are trained to

- use the instrument
- abuse of older women/elder abuse, dynamics, supporting, risk assessment, safety planning

Professionals know the practical procedures

- there are written guidelines how to use the screening tool
- there are written guidelines on what to do after possible disclosure (screening process)

- agreed practice in own workplace
- multi-professional and multi-agency working model
- There are support and consultation possibilities for the professionals
- Effective staff guidance and supervision

## 9. COMPLEXITIES OF SCREENING FOR ELDER ABUSE

Screening for elder abuse is defined as a process of eliciting information about abusive experiences in a caring or family relationship from older or vulnerable adults who do not have obvious sign of abuse such as physical injuries. The rationale for screening among asymptomatic individuals for IPV and elder and vulnerable adult abuse and neglect could identify abuse not otherwise known, prevent future abuse from occurring, and reduce morbidity and mortality.

A cornerstone of effective screening is the development of valid and reliable screening measures with low measurement error. This has proved to be a challenging task, not only because for methodological issues (such as for example the absence of a gold standard for the creation/validation of these measurements), but because elder abuse, like other forms of family and interpersonal violence, is a largely hidden phenomenon, occurring in the home or institutions, usually without witnesses. Because of fear, intimidation, and lack of support, many individuals do not disclose abuse unless directly questioned, and many who are directly questioned will not disclose. Victims are often reluctant to disclose the abuse because of shame or fear of being judged, failure to identify the behaviour as abusive, dependence on the abuser, or feeling that the abuse is their fault. (Schofield Margot J. 2017). Cultural and language barriers may also hinder the disclosure of abuse. (Lachs and Pillemer, 2015).

Prevention, identification, and stopping abuse is important to avert both short- and long-term serious health outcomes. (Nelson et al. 2012). Screening is considered particularly important for problems with serious health implications, and where overall rates of identification are considered to be low. This is certainly the case for elder abuse and neglect (Schofield, 2017).

There are many complexities in the issue of screening for elder abuse. Elder abuse itself is a complex issue and screening in elder abuse is multifaceted. It is not realistic to simply categorize people as abused or as not abused. In clinical practice, human beings do not fit neatly into a sensitivity and specificity effectiveness concept. (Cohen, 2011).

The many faces of elder abuse add further complexity. While physical, sexual and, to some extent, financial forms of abuse are more readily measured and verified, other forms such as psychological, emotional, verbal, and coercive abuse, and neglect and abandonment are much more difficult to verify, or even for the elder to understand. Yet, these are the most prevalent forms of elder abuse. There is a clear need for better measures of these more

hidden forms of abuse since research has demonstrated considerable health impact of abuse and neglect. (Schofield, 2017)

Elder abuse and neglect are very heterogeneous; medical indicators should be viewed in the context of home, family, care providers, decision making capacity, and institutional environments. (National Institute of Justice, 2000)

Identification of abuse is not clear-cut. Its diagnosis is mostly uncertain, which increases practitioners' fear that they may do more harm by taking any action. (Wiglesworth A. et al 2009). Screening and the use of screening tools to assist in case finding may help in detection of abuse and neglect, but this needs to be handled sensitively by the professional using the tool. Without an approach that is sensitive and acceptable, older people are less likely to disclose abuse (or reply accurately). Professionals must not only identify abuse but should also be able to provide further screening, follow-up or referrals to other agencies as well as intervention and support. (McCarthy et al. 2017)

There does not appear to be supportive evidence that screening and early detection of elder abuse and neglect reduce exposure to abuse, or physical or mental harm from abuse. It is not clear if using specific screening protocols decreases the incidence or impact of elder abuse any more than simply having a generally increased threshold of suspicion. (Hoover & Polson M, 2014). The United States Preventive Services Task Force (2018) states that "the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect".

The statement of United States Preventive Services Task Force is based on the review for the evidence on screening and interventions for intimate partner violence (IPV), elder abuse and abuse of vulnerable adults by Feltner et al. 2018. Scholars set five key questions for the assessment: 1) Benefits of Screening for IPV; 2) Accuracy of Screening for IPV; 3) Harms of Screening for IPV; 4) Effectiveness of Interventions; 5) Harms of Interventions. They concluded that screening and interventions for the older population are likely to be different than those for IPV due to the nature of the abuse, for example the different relationship with the perpetrator. Also, some older and vulnerable adults may not have sufficient physical, mental or financial abilities to engage in screening. Other challenges may include legal requirements related to disclosure, underlying medical conditions of patients (e.g., cognitive impairment), and dependence on the perpetrator for caregiving and access to medical care. For these situations they thought the screening instruments could be targeted toward caregivers.

The US Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (US Preventive Services Task Force 2018).

Individual professional organizations can give different views and recommend screening or routine enquiry. For example, in US the Joint Commission, National Center on Elder Abuse, National Academy of Sciences and American Academy of Neurology recommend routine screening. The American Medical Association recommends also routine inquiry. Identification of and intervention in abuse are considered by many to be a professional

responsibility for physicians and can be an accreditation requirement for hospitals. The University of Maine Center on Aging, Maine Partners for Elder Protection, recommends screening once or twice yearly. (Hoover & Polson, 2014).

As mentioned in Chapter 1, several numbers of health problems and their complexities in older age may mimic and overlap symptoms of abuse resulting in a reluctance among professionals to become involved as they may fear potential errors of judgement in determining whether abuse may have occurred or not, or that an intervention might do more harm than good (Cohen, 2011). The high burden of chronic illness in older people creates both false negative findings (e.g., fractures misattributed to osteoporosis) and false positive findings (e.g., spontaneous bruising misattributed to physical abuse) in the evaluation. (Lachs and Pillemer, 2015).

There are also difficulties in distinguishing between abuse and neglect versus other conditions. Older people often suffer from multiple chronic illnesses. Due to the complexity of health problems in the old age, signs of abuse may overlap with symptoms and outcomes of side effects of medications. For example, bruises may be due to high doses of anticoagulants. (Wiglesworth et al. 2009). Malnutrition, which may be due to neglect, may just as well be caused by a variety of physical and psychological and age-related changes, many of them unidentifiable. (Pickering, 2014). Distinguishing conditions caused by abuse or neglect from conditions caused by other factors can be complex. Often the signs of abuse and neglect resemble—or are masked by—those of chronic illness. (National Institute of Justice, 2000). Differentiating between unintentional and intentional injuries and between illnesses that occurred despite appropriate care or as a result of neglect is also time consuming. (Gibbs, 2014).

Screening practices are considered useful only if they lead to effective referral and treatment. Very little research has addressed this question. Most studies of screening for elder abuse do not report on follow-up of those identified as at risk, except among studies of suspected cases reported to authorities such as Adult Protective Services (APS). The actions taken to reduce exposure to abuse or neglect are reported, but actual health outcomes are not adequately measured. (Schofield, 2017). There is insufficient evidence to support any particular intervention for elder abuse. Also, interventions had no effect on abuse in most studies and may have even increased future abuse. This suggests that the pathway from identification of risk to successful improvement of outcomes is fraught with many difficulties and will require more innovative approaches. There is a clear need for intervention programs, as a legal framework is insufficient on its own to address this complex social problem, and has potential to create harm as well as benefits. (Ibid).

## 10. BENEFITS OF SCREENING

Studies show that professionals' identification using structured tools elicited rates of abuse higher than those found in prevalence studies. (Yaffe 2008; Cohen et al. 2007) although it is important to be aware that this might also include a share of false positives.

It has been suggested that rather than being a neutral question, screening has an effect regardless of whether treatment or any other intervention is provided. Receiving validation and support from a social and health care provider in relation to abuse can alter the way a person views their situation There is evidence from experimental studies that screening itself has a therapeutic effect (as other interventions as well). However, it must not be assumed that if screening has an effect, it will invariably be positive. (Spangaro et al. 2009).

Clear communication may help an older person's understanding regarding the reporting process and the events that may follow. It is important to note there has been no research on safety risks for victims being reported, therefore it is not advisable to inform the family and/or suspected perpetrator that a report will be done. (Pickering et al. 2014) There are increasing numbers of older persons receiving services by home care practitioners. Thus, these providers are in key roles regarding the identification of victims. Routine assessment for elder abuse using an evidence-based, valid, and reliable tool can increase identification and mandatory reporting rates. (Ibid.)

## 11. LIMITATIONS OF SCREENING

Currently there is no gold standard for elder abuse screening. A positive screen for elder abuse does not mean that elder abuse is occurring but does indicate that further information should be gathered. (National Center on Elder Abuse 2016). Screening is not either 100% accurate; it does not provide certainty but only a probability that a person is at risk (or risk-free) from the condition of interest. (WHO, 2020)

Elder abuse is complex and has multiple dimensions. These include the type of abuse, risk factors and the level of risk, the nature of the relationship between the victim and the perpetrator, and the presence or absence of risk factors. As a result, the needs of abused older persons experiencing abuse vary, as each set of circumstances invokes a different set of responses. It is particularly unlikely that one intervention will be appropriate for all older persons screened positive for abuse. (Spangaro et al. 2009).

Family violence research has raised concerns about possible adverse effects of screening, including revenge for disclosing abuse, psychological distress, family disruption and in older family's risk of a person being removed from home to care facilities. (MacMillan et al. 2009).

Given the added dependency between carers and elders, it may be that screening for elder abuse and neglect could put the older person at greater risk. For instance, postal surveys may be opened by abusive carers. The presence of carers may also make it difficult for screening to take place in the home or in the health care setting. Although no studies have

specifically sought to examine this question, there is very little evidence available of actual harm caused by screening for elder abuse or neglect. (Schofield M. J., 2017)

The systematic reviews by Nelson et al (2004, 2012) suggested that the potential for harm is small, but may include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and distress caused by false-positive results. Further research is required to address this important question.

Van Royen et al (2020) noted in their comprehensive review of elder abuse assessment tools and interventions that most of the surveys did not address potential side-effects of addressing and preventing abuse (quaternary prevention). The level of quaternary prevention is often not included in the usual levels of prevention (primary, secondary and tertiary prevention). Quaternary prevention is the fourth level of prevention, which means "mitigating or avoiding unnecessary, harmful or excessive interventions when interfering in the life of an elderly person." This may mean, for example, transferring an elderly person to a nursing home or other institutional care. (De Donder, L. 2014). These side-effects may include, for example, inappropriate risk assessment, a breach of confidentiality, invasion of privacy, damaging the relationship between victim and abuser, and failure in safety plan. Taking into account perspectives of (abused) older persons and caregivers in the development of assessment tools and intervention protocols is lacking. Cimino-Fiallos and Rosen (2021) point out that the development of assessment tools and interventions does not take into account the perspective that a person receiving care is behaving abusive towards his/his carer. Then one of the side-effects of screening is that if a caregiver is wrongly accused of abuse, they could become more reluctant to seek indicated medical care in the future.

## 12. COGNITIVE IMPAIRMENT AND SCREENING

Detecting abuse of older people with dementia is even more challenging due to the presence of cognitive impairment as those affected may be unable to articulate what is happening to them. General elder abuse screening tools are not appropriate for use with persons with dementia as they are based on the older person's ability to answer comprehensively the questions. This is partly due to the limited reliability of self-report data with this group, and potential bias arising from asking carers to report on their abusive behaviour towards the care-recipient. This is an area where alternative assessment methods need to be explored. There are a number of approaches and techniques that health and social care professionals can use with older people with dementia and their caregivers. (Downes et al. 2013).

It is difficult for health care professionals to question carers about abuse as they risk making the situation worse or cause the caregiver to isolate the victim. Interview techniques, such as asking the carer about the demands and difficulties of caring for the older person with

dementia and about any feelings and frustrations they may have about their caring role would be good before proceeding to direct questioning about abuse. Caregivers who show signs of anxiety or depression or who mention difficult behaviours of the care recipient should be alerting signs of abuse for professionals. Secondary symptoms of dementia such as aggression are particularly challenging for caregivers and professionals should be especially concerned about that. There is the likelihood that they suffer physical or psychological abuse. (Wiglesworth et al. 2019).

It is believed that screening instruments, which rely on healthcare professionals' assessment of abuse, may be more useful than other methods where direct questioning of the older person with dementia is not possible. With this approach, a many-sided multidisciplinary assessment may be conducted in cases of suspected abuse in order to assess warning signs to determine if they are indicative of abuse or due to the natural course of a disease. In the course of an assessment, a health or social care practitioner can observe the interactions between the older person and the caregiver, talk to other family members and establish caregiving patterns. Health professionals need to be equipped with both the knowledge and the tools to recognize the warning signs of abuse in this group. (Downes et al. 2013)

Healthcare professionals who routinely come into contact with older people and their carers have a significant role to play in detecting abuse. However, no abuse screening instruments have been either developed or validated for use with older people with dementia, routine and sensitive screening for elder abuse in people with dementia is recommended. By combining unstructured questioning about abuse with routine assessments with older people with dementia and their caregivers may provide opportunities to both perpetrators and victims to report abuse. There are a number of approaches and techniques that health and social care professionals can use with older people with dementia and their caregivers. (Downes et al. 2013)

Van Royen et al (2020) noted in their review the screening tool specifically to elder abuse in persons with dementia is required. This tool should capture the specific characteristics of abuse involving older persons with different stages of dementia. Social and health care professionals should be educated on the nature and prognosis of dementia and when providing care at home be alert of the potential risk related to symptoms associated with different stages of dementia. Also, assessment tools should include clear referral pathways on what to do when potential abuse is found—when to report, who to contact, and how to involve the older person in the referral process. A clear referral pathway has been identified as an important requirement for future developed assessment tools.

## 13. FURTHER DEVELOPMENTS IN SCREENING OF ELDER ABUSE

Given that much elder abuse involves important familial relationships, and most of the abuse involves psychological abuse and neglect, there is a need for greater development of

psychological and therapeutic approaches to change potentially harmful relational dynamics. The burdens of caring can exacerbate long-standing relationship dynamics, as well as foster new problems, and there is a need to distinguish between these situations. While there has been considerable development of therapeutic approaches for intimate partner violence, there is little development of approaches to elder abuse that may help to preserve positive aspects of the carer relationship with victims. Approaches to date have largely focused on structural interventions such as placing the abused person in institutional care, or provision of nursing and home care services. (Schofield, 2017)

It has been identified three types of interventions for intimate partner violence that may help reduce risk and improve outcomes, and it is worth considering how these approaches could be applied to elder abuse. The most common intervention is referral to community services such as counselling, legal services, alternative accommodation, and social welfare services, and empowerment strategies such as support groups, education, and volunteer advocates may be useful. The equivalent of dedicated domestic violence services is not readily available for those experiencing elder abuse, and their greater dependency makes it difficult to seek out support services. (Ibid).

Home visits by professional staff could be expanded to provide more preventive and supportive interventions to assist those in the home. Social support is a critical element of any supportive care and needs to be provided in an ongoing way to be effective. One approach to intervention is to offer programs to address risk factors of the abusive care-giver. These may include counselling, groups programs, provision of respite care, substance abuse therapeutic programs, and helpline support services. Individual supportive counselling may be useful to reduce anxiety, stress, and depression in the carer, and cognitive-behavioral methods can be used to educate the carer about the reasons for a dependent person's behavior, their needs, and developmental limitations. (Ibid).

## 14. CONTEXT WHERE SCREENING TOOLS WERE APPLIED IN SAVE PROJECT

Various elder abuse screening tools have been conducted in various health care settings. Basic justifications for screening in certain settings and findings of these studies are presented below. This list is not exhaustive. Other healthcare specialists such as orthopaedic surgeons, optometrists, plastic surgeons, and dermatologists may also be effective in screening for elder abuse. (National Center on Elder abuse 2016).

Elders are seen in primary care settings for common conditions associated with aging. Therefore, primary care settings may provide a valuable opportunity for elder abuse screening. Pickering et al. (2016) suggest that professionals working in home healthcare have an advantageous position to identify and report elder abuse and neglect because they directly observe most assessment criteria. Furthermore, this is an important setting for elder abuse assessment as older adults are receiving more services from home healthcare providers.

Older adults suffering from elder mistreatment are more likely to present to the Emergency Department (ED), be hospitalized, and be placed in a nursing home. Available research suggests that elder mistreatment victims are less likely to have outpatient care from a primary provider than other older adults but receive emergency care more frequently. (Rosen T et al. 2020). Emergency departments serve an important role when older adults interface with healthcare services, and ED nurses may be able to recognize and identify abuse (Phelan, 2012; Rosen et al. 2016; Rosen et al. 2020).

The ED setting is a particularly important environment in terms of elder abuse, as the consequence of abuse may be a reason for attendance and the first point of contact with formal services. In addition, staff in ED appears to recognise child protection concerns more frequently than elder abuse. This may be due to a societal reluctance to interfere in the private lives of families when there is no legislative imperative, such as the Childcare Act for children. Therefore, careful consideration is demanded when older people attend ED, with particular attention paid to assessment of objective and subjective data in terms of manifestations and potential indicators of abuse. Some screening tools are not realistic in the ED due to the length of time needed to complete or their lack of psychometric support. The fact that ED facilities are busy through-put environments where staff are under time pressure to assess, treat and dispatch clients. (Phelan 2012)

Long-term care settings including nursing homes and skilled nursing facilities present opportunities for screening and detection of elder abuse. Cohen (2011) indicates studies have found that data on the prevalence of abuse or neglect in long-term care institutions is lacking, in part, due to inadequate procedures for its assessment and identification. While many tools have been suggested and tested for use in the long-term care setting, they need to be further validated to encompass possible abusive behaviors that may be characteristic of institutions.

Many of the documents used in this module are for screening of domestic violence experienced by women. The same instructions can be used for both men and women. In SAVE -project we used the selected instruments for both. The reason is that in the older population there are also older men who are victims of domestic violence although most of the victims might be older women. It is unclear whether women are more likely to experience elder abuse and neglect because of gender-based dynamics often underlying violence, because of population demographics in which older women outlive older men, or a combination of both. (Pickering C.E.Z. et al 2016.) Pillemer K, et al (2016) concluded in their review that gender is a potential risk factor for abuse.

Cohen (2011) has proposed a typology of screening tools where instruments are classified into three categories: direct questioning tools, signs of abuse, and indicators of risk for abuse. **Direct questioning tools** consist of sets of questions either asked directly by professionals or self-administered aimed at eliciting disclosure of abusive situations. **Signs of abuse tools** consist of lists of signs of different types of abuse (e.g., bruises), often constructed based on professional experience and **Indicators of risk tools** consist of looking for factors associated with abuse (risk factors), even in the absence of signs of abuse

or disclosure. The presence of risk indicators is by no means equivalent to the identification of abuse, and risk assessment often leads to further assessment.

Save – project's literature review found eight direct questioning tools. Three of them presented broader psychometric data and sensitivity and specificity analyses. These were H-S/EAST, EASI and VASS. Of these, H-S/EAST and EASI tools were piloted in the project.

The Elder Abuse Suspicion Index (EASI) **(**Yaffe et al. 2008) was developed over 2002–2003 from literature searches, existing scales, and taxonomies for elder abuse, and drew on the World Health Organisation (WHO) definition of elder abuse and family violence. It comprises five interview questions for clinicians to ask of patients, and one item for completion by the clinician in relation to observed indicators of abuse. The validation was undertaken with a sample of 663 patients recruited by physicians at two Montreal family medicine centers and a government community-based health and social services center. A key advantage of the instrument is that it is very short and quick to administer, taking about two min. It has been rated as having content validity in at least seven diverse countries by WHO (World Health Organization 2008). There is also a self-administrable version for patients, the EASI-sa (Yaffe MJ et al. 2012) and EASI-ltc for long-term care (Ballard SA et al. 2019).

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) (Neale et al. 1991) is a 15-item questionnaire that measures three forms of elder abuse: violations of personal rights or direct abuse, characteristics of vulnerability, and potentially abusive situations. It was developed from a pool of over 100 items sourced from various elder abuse screening instruments and refined to best 15 items. It is designed to be administered by interview of the elder person by health care providers in clinical settings, and by review of case notes. It has been used in a number of studies and with different populations.

The Vulnerability to Elder Abuse Scale (VASS) (Schofield and Mishra 2003) is a brief 12 item questionnaire designed to assess risk of elder abuse over the past 12 months. It has 4 subscales of three items each with yes/no response options and is supported by psychometric evaluation. The subscales are Vulnerability, Dependence, Dejection, and Coercion. Ten items were adapted from the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), with two additional questions: “Has anyone close to you called you names or put you down or made you feel bad recently?” and ‘Are you afraid of anyone in your family?’. The VASS is designed for self-completion by older adults.

## Active Learning Activities

A series of exercises that can be used to practically apply the theoretical contents taught in the module.

## EXERCISE 1 - SCREENING QUESTIONS AS A PART OF CONVERSATION PROCESS

### Instructions for the trainer

**Method of the exercise:** Role play in small groups based on the case study using EASI screening tool

### Resources needed

- 2 volunteers: one is playing an older person's role, the other one the role of the professional. Other participants in the group will play as observers
- The handouts of Sofie's case study
- EASI screening tool handouts
- chairs, paper and pens for all the participants.

**Time frame**: 40 minutes

### Steps of the exercise

Before the exercise, have the theoretical background session on what is screening and the complexities and challenges of screening for elder abuse. Is it just asking questions? How to establish a confidential relationship with an elderly person? What do professionals have to learn when asking for consent to the interview, for introducing the questionnaire and asking screening questions in a safe and normal discussion process with an older person? How to assess the signs of possible abuse?

The course of the exercise:

- Prepare the stage for the role play with a table and three - four chairs around it. Take care that the audience can see and hear the actors.
- The other option is to prepare the training area with tables and 3-4 chairs around them.
- Distribute the handouts (case study of SOFIE) to the participants playing the role of Sofie and EASI form for the participants playing the role of professionals.
- Explain the steps of the exercise.
- Give each small group time to read the handouts and at least 20 minutes for screening discussion.
- Ask an observer to write down his/her comments and questions: what was useful and not so useful in the conversation?
- After each small group discussion, show the general discussion questions using the powerpoint.
- Ask participants to share their reflections with the whole audience according to the general discussion questions.

### Notes to the trainer

Tell all the participants safety rules: no accusation or criticism is allowed towards the work of the actors.

**General discussion questions**

- What do you think about the task of introducing screening questions in a normal discussion process?

-What are the principles of conversation to win the trust of an older person?

-What signs can mimic abuse?

-In Sofie's case, what difficulties there are in distinguishing between abuse and neglect versus other conditions?

-What kind of consequences can screening have for Sofie and her family?

**HANDOUT for the participants – SOFIE**

**Background information for Sofie's case study**: Sofie is an 85 years old woman living in a residential care home. She has been living there over 20 years because she has many chronic diseases and some mental health problems. She has many kinds of medication. She has osteoporosis, and must avoid falling to prevent fractures of the bones. Sofie is skinny, and she doesn't have much appetite. She should also be advised to drink more water. She

got an early retirement for chronic diseases and mental health problems. Her husband had an alcohol problem and died from that half a year ago. Sofie has mixed feelings – somehow her husband's death was a relief, but she feels herself also lonely. Sofie receives home care services twice a week for the medication. She has physical difficulties walking and therefore needs help with daily activities. The home care workers also follow her mental health situation. Lately she has had some memory difficulties as well. She has two adult children. They visit their mother from time to time. Of them, Sofie's son visits more often, and he helps his mother with her shopping.

One day, when the home care worker comes to check on Sofie's condition and medication, she finds Sofie resting on the couch. Sofie looks tired and absent. Her son is doing the dishes in the kitchen. The worker starts asking how Sofie is doing. Sofie's trying to sit up, but it's hard. While helping Sofie, the employee notices bruises on Sofie's elbow and abrasions in the legs. The boy explains that the mother fainted as she got out of bed, and he helped her rest on the couch. The worker helps Sofie shower and notices ulcers in her lower back.

The worker reports her observations to a social worker who will soon be talking to Sofie.

**The exercise in small groups**: The social worker comes to visit Sofie and explains the cause of the visit. Sofie is a little surprised that a social worker came so soon to see her. The social worker and Sofie sit on the couch and the worker starts a conversation with Sofie explaining that the social workers are responsible for the safety and wellbeing of their clients. Therefore they have to ask some questions due to Sofie's situation, such as Sofie's relationship with her son and whether she feels safe in her home. The social worker also says that they ask certain questions from all of their clients while using questions from the screening form. Sofie responds after thinking about every question for a long time.

Sofie answers every question in mind for a long time. He answers the first question, "yes." She needs her children's help with shopping and banking and sometimes eating. For other questions, after a long thought, she answers "no." From time to time, the social worker makes specific questions, such as giving examples of forms of violence. In addition, the social worker must bear in mind the last question in the EASI form (question 6), in which the employee evaluates his or her own findings during the discussion.

The social worker leaves and decides that Sofie's situation needs to be monitored more frequently.

| ELDER ABUSE SUSPICION INDEX © (EASI) |
| --- |
| **EASI Questions**<br>**Q.1-Q.5 asked of patient; Q.6 answered by doctor**<br><br>**Within the last 12 months:** |

| | | | |
|---|---|---|---|
| 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO | Did not answer |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with? | YES | NO | Did not answer |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO | Did not answer |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO | Did not answer |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO | Did not answer |
| 6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? | YES | NO | Not sure |



Mark J. Yaffe, MD McGill University, Montreal, Canada mark.yaffe@mcgill.ca
Maxine Lithwick, MSW CSSS Cavendish, Montreal, Canadamaxine.lithwick.cvd@ssss.gouv.qc.ca
Christina Wolfson, PhD McGill University, Montreal, Canada christina.wolfson@mcgill.ca

## EXERCISE 2 - SCREENING AS A PROCESS

### Instructions for the trainer

**Method of the exercise:** Role play in small groups

**Resources needed**

Small groups playing the case studies of Martta, Lauri and Leila (handout for the participants 1, 2 and 3)

- 2 volunteers for each small group; one plays the role of an elderly person and the other plays the role of a professional
- 2 chairs/each small group

Evaluation team meeting as a small group (handout for the participant 4)

- the same participants who presented professionals in role play exercises 1, 2 and 3 may be selected for the team, or they may be participants following role-playing exercises
- the purpose of the team is to discuss the cases and conclusions of the cases of Marta, Lauri and Leila based on screening questions: the challenges in each case and the justification for decisions and further follow-up

Paper and pens for all the participants.

**Time frame**: 40 minutes

**Steps for the exercise:**

- Before the exercise, have the theoretical background session on screening as a process, complexities of screening for elder abuse, benefits and limitations of screening, and cognitive impairment and screening.
- Prepare the stage for role exercises with the table and two chairs. In this case, the role exercise of each case report is presented individually to the entire audience. Make sure the audience sees and hears actors. In this case, the entire audience acts as an observer, making observations, comments and questions, writing them down on paper.
- You can also divide the training space into several parts and small groups can do exercises 1, 2 and 3 at the same time. In this case, 1-2 participants in each small group act as observers. This may save time, but the space should be large so that small groups don't disturb each other.
- Small groups can present all three cases/role exercises, or you can also choose one or two of them according to the needs and/or occupations of the training group.
- Explain the course of the exercise: the exercise goes through the screening process from start to finish (from the discussion and screening situation to the team meeting and case evaluation).
- Distribute a case report to small groups and give them 5 minutes to read it and discuss the exercise.
- Each small group's role exercise lasts about 15-20 minutes.
- Ask participants in the role exercise to share their thoughts after each exercise.
- Case studies 1, 2 and 3 are different and all have their own challenges.
- Case study (team meeting) 4 gathers all the cases together for evaluation and discussion of the working team. At the team meeting, the performers can be the participants who played the role of professionals in the role exercise.

- Tell participants the safety rules: there will be no criticism of their performance for role performers.
- Lastly, have a joint final debate in accordance with the questions given.

**General discussion:**

•

• What did we learn through these exercises?

**Notes to the trainer**

- Tell all the participants safety rules: no judgement, accusation or criticism is allowed towards the work of the actors.
- Emphasise how multidisciplinary and multi-agency work could help to solve the cases and overcome the challenges.
- Screening is not intended to directly categorise people as abused or not-abused, i.e. screening is not diagnostic. In clinical practice, human beings do not fit neatly into a sensitivity and specificity effectiveness concept. The purpose of screening is to raise possible concerns about the safety situation. Therefore, every case needs follow-up.
- While physical, sexual and, to some extent, financial forms of abuse are more readily measured and verified, other forms such as psychological, emotional, verbal, and coercive abuse, and neglect and abandonment are much more difficult to verify, or even for the elder to understand. These are more hidden forms of abuse. Therefore, ask participants to think of especially those when discussing cases.
- Note that this exercise could also be done at the conclusion of the training, to practice and summarise all issues discussed in the four modules.
- Note, that this exercise is about the EASI tool and the answers “yes”, “no” or “Did not answer” are due to this tool. Other instruments can have other options for answers and conclusions might be different.

**HANDOUT 1 for the participants - MARTA**

**Background information for Marta's case study:**

An 85-year-old woman, Marta, with a sore hip came to the emergency room accompanied by her 55- year - old son. However, her hip was not broken, according to the X-ray so she can go home with some pain medication. The nurse responsible for discharging patients from the hospital will talk to her. She starts the discussion by asking if she receives any home care services. Marta's son replies she doesn't need any because he is her informal carer. However, the nurse wants to talk to Marta alone and ask her to go to a separate examination room. Marta's son resists and says his mother is unable to talk because of his memory disorder. The nurse thinks the boy smells like alcohol and his appearance is untidy. Marta doesn't seem to be paying attention to the nurse's and son's conversation but looks around a little scared.

**The exercise in a small group:**

The nurse guides Marta to the room and starts asking about her home conditions, how Marta feels to be home and if she is worried about something. Marta thinks it's good to be home and the boy takes good care of her. However, Marta understands that it's hard for the boy because he can't get out with his friends if he wants to. Fortunately, however, other schoolmates come to them, and they can play games together. Of course, boys are noisy, as boys that age can be.

The nurse wonders about Marta's answers and asks what age the boys are. Oh, they're school-age! The nurse is confused by Marta's words and is unsure what Martha is talking about and whether this is a sign of memory disorder. That's why the nurse starts asking more questions about Marta's home conditions using some screening questions. For most of the questions Marta answers "I do not know" or is screened negative for abuse. Eventually, the nurse decides to end the conversation and escort Marta back to the boy.

**HANDOUT 2 for the participants - LAURI**

A 72-year-old man, Lauri, has come to the hospital for a medication check as he has several medications. Lauri moves independently and seems competent in the conversation. The hospital is working on a project to screen the experiences of violence among older people. The idea is to find people who need help. The social worker of the hospital comes to meet Lauri and asks if she could ask him some questions due to Lauri's home conditions, how he spends his days, does he feel lonely or something. Lauri agrees and the social worker starts during the discussion to ask him screening questions.

Lauri says he is living alone because his wife passed away two years ago. However, he does not feel lonely because adult children often come to greet him. All children have a good life, although the spouse of one child has been unemployed for several years. This has caused the family financial worries and Lauri sometimes assists the family financially. Lauri is screened negative for abuse however he seems hesitant sometimes.

The social worker interprets the hesitation so that Lauri thinks carefully about the answers. So, the social worker thanks Lauri for the conversation and says goodbye.

**HANDOUT 4 for the participants - LEILA**

**Background information for Leila's case study:**

A home care worker brought an elderly woman, Leila, to the hospital because Leila was feeling dizzy. She had fallen and hurt her forehead in the corner of the table. There is a big bump on the forehead. The home care worker wants Leila's head to be examined. The home care worker tells Leila is living with her husband who has severe dementia symptoms.

The employee does not know whether Leila's man is involved in the fall, however, he thinks the man is always in a good mood and does not seem aggressive. However, the worker says he/she is worried about Leila's home situation and how she is managing their family life. Taking care of a man with severe dementia is heavy duty and limits Leila's life. Once Leila's injury has been examined, the worker contacts the hospital's social worker and asks her to chat with Leila. Leila is referred to the hospital's social worker.

**The exercise in a small group:**

The social worker starts a conversation with her asking permission to ask questions of the screening tool. He/she explains that the conversation is confidential. Leila's personal data is not recorded in the questionnaire. The purpose of the discussion is to ensure Leila's safety and well-being at home and to assess whether she needs help at home. Leila agrees. All the questions Leila replies "no". She emphasises that her husband has always been good to her and dementia symptoms have not changed his character. However, the social worker shares her concerns with Leila. Leila looks annoyed. The social worker asks if a social worker of elderly care could still visit her home just to ensure her safety. Leila says yes.

Based on her answers, Leila's screening result is negative. The last question in the EASI form is: "Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?"

Because the social worker is concerned about Leila's home situation, she ticks the box "Not sure".

**HANDOUT 5 for the participants - ASSESSMENT TEAM MEETING**

The hospital has an assessment working group focusing on domestic violence, which meets to discuss the cases of Marta, Lauri and Leila.

The nurse who talked to **Marta** explains Marta's situation and says that Marta was not able to reliably answer the questions on the screening form. So, Marta was not eligible for screening, meaning that she was not part of the screening target group. Team members ask the nurse how Marta reacted to each question. How had the adult son behaved? The team is trying to find out:

• Were there any signs of possible abuse in the screening discussion?
• Were there any hints or concerns about her safety in Marta's home situation?
• Was the assessment on Marta's decision-making capacity/competence the right one, i.e. she was not the target group for screening?
• Was Marta given the opportunity to make an informed decision to participate in the interview?
• How can the interpretation of her situation be ensured?

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The team continues by discussing **Lauri**'s situation. A social worker who spoke to Lauri talks about the conversation and says that according to his/her assessment Lauri did not experience any violence (Lauri's screening result was negative). The team reviews Lauri's answers to the questions and consider whether it made sense to decide that he did not experience violence/abuse in his home situation. They're thinking about:

• Was Lauri's case false negative (however, he experienced abuse)? Is that decision possible to make based on the screening result?
• If he experienced violence, what was it like?
• What if, however, he experiences abuse, but because of the negative result and conclusions, he does not receive help?
• In Lauri's case, how can we be sure that the interpretation of his situation is correct?
• In his case, did the whole screening process take place?

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Finally, the team discusses **Leila**'s case. However, the social worker had concluded that she was experiencing violence from her husband (screened positive). Leila's case is the only one that was followed by information about how the questions had affected her. The social worker of the home care had informed the team that Leila was very upset after the discussion. Leila had experienced that her husband was unjustifiably accused of abuse.

• Was Leila's case false negative (she actually experienced violence)? Can this be inferred immediately from the answers to the screening questions?
• What consequences can a discussion have in a situation like Leila's?
• What if Leila doesn't really experience violence but is offered services that she doesn't think she needs?
• In Leila's case, how can you be sure that the interpretation of her situation is correct?

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# MODULE 3 - How to screen: Ethics and privacy

## Structure of the module

| | |
|---|---|
| Title | How to screen: ethics and privacy |
| Goal(s) and objectives | This module will explore:<br>Possible ethical issues related with screening (limits to confidentiality; obligation to report; self-determination; older persons with cognitive limitations)<br>Privacy issues related with screening: to whom can / should the information be shared; how to handle screening results |
| Learning outcomes | At the end of the module learners will:<br>Know how to collect the consent to screening, from competent as well as from legally incompetent older persons<br>Know how to protect the privacy of the older person, during and after the screening<br>Know how to ensure accuracy and authenticity of collected information<br>Know how to deal with collected information in relation to his/her duty to report |
| Duration: | 3 hours<br>▪ 45min-1h input session<br>▪ 20 min (2x10 minutes) breaks<br>▪ 1h and ½ active learning activities<br>▪ 10 minutes of extra time (warm up, waiting for participants, answering questions) |
| Resources needed: | Flip chart |
| Worksheets | Worksheet 1 and 2 |

## 1. GETTING THE CONSENT TO SCREEN

In this module we will discuss ethical issues related to screening as well as abuses that might happen during it.

### Lack of consent

The first kind of abuse that might be committed during a routine inquiry / screening process is the lack of consent from the person interviewed. Indeed, the issue is not as simple as it seems, considering that:

- consent can be also provided non-verbally and
- there can be a lack of consent even upon a signed consent form

In fact, on one hand we should consider *how* the consent is provided and on the other *for what* the consent is provided, what are its boundaries in terms of time and domain.

#### *How consent can be provided*

When it comes to *how* the consent can be provided, there are different ways:

- Implicitly (for example if the interviewed person responds to the enquiry without opposing to it)
- Explicitly (agreeing to participate in the inquiry / screening). In this case, consent can be provided:
- Verbally
- In a written form, including in front of testimonies or a public officer

Generally speaking, and unless this is differently disciplined by single States, the consent to a routine inquiry / screening should not have a specific form to be considered valid. Therefore, we could say that the way to acquire consent to be sought should be based on utility: *written consent can be helpful to prove in an unequivocal way that the person actually agrees and it is easier to be archived and kept.*

#### *Boundaries of consent*

When it comes to the boundaries of consent, this can be referred for example to agree to reply to questions, but not to the fact that answers are written down or kept; or to the way they should be kept or managed.

However, it should be kept in mind that information collected, or even only heard, during a routine-inquiry or screening procedure might refer to situations or crimes triggering in the interviewer who, because of professional role, has this obligation, mandatory reporting. Therefore, if by collecting the consent from the interviewed person, we don't clearly explain

the potential consequences of his/her replies, we might end up limiting his/her autonomy, self-determination and ultimately his/her dignity, as the person might be considered as not having the dignity to decide how to act according to possible consequences. Moreover, it could be considered a risk to his/her physical and emotional integrity, since a revelation of abuse can lead to more abuses, often in escalation, as a punishment, retaliation or revenge.

## When and how then consent is correctly given

### *Who has the legitimacy to give consent?*

**The interviewed person:** Usually, the person who participates in the screening /routine inquiry is the same providing consent to it.

However, this might not be the case when the person is legally incompetent. Indeed, providing a consent implies being able to act a right and only who is legally competent – and therefore has the capacity to understand and will - can do this.

On the other hand, we might as well have the case of a person lacking legal capacity but able to respond to a routine inquiry / screening, without being able to understand the legal consequences of his/her words. It means that we might in fact have all the responses to the inquiry / screening, but that – from an ethical and legal point of view – these replies were collected abusing the (lack of) capacity of the older person.

**The guardian:** In most cases, national legislation foresees that another subject can replace or support the incapable person to allow him or her to commit a legally valid act. This person is usually called "guardian". What the guardian is authorized to do depends on the law or on the judiciary provision that nominated him/her. Therefore, the interviewer should check which kind of power the guardian has and make sure that he/she has the power to provide the consent to participate in the screening / routine inquiry or if the older person can do it by him-herself.

**The guardian and the interviewed person:** Indeed, another option is that the guardian is appointed to take some decisions together with the care recipient.

**The guardian, the interviewed person and the judge:** In addition, there might also be the case that some acts need to be performed by the guardian but only upon specific authorization of a judge. This is usually the case for all those acts which might have important consequences for the older person from the economic or legal point of view (i.e. health, civil rights…).

### *What is legal competence and how to assess it?*

Legal competence is the formal ability to exercise rights and duties. If someone has limited or no legal competence, then he/she might for example not be able to perform acts such as sign contracts or provide consent to a medical practice. The law presumes that adults have

capacity however this might be limited by specific conditions or diseases. The loss of legal capacity is usually assessed by a judge with the support of medical consultants.[2]

## 2. PRIVACY

### Privacy as data protection

Because of the characteristics and the sensitivity of information that can be collected through a routine inquiry / screening procedure and because of the consequences that can come out of it, it is easy to understand that it is necessary that this information is kept confidential and accessible only to a limited number of persons.

Confidentiality of information collected through a routine inquiry / screening can be challenged during two phases: during the inquiry / screening and after the inquiry / screening.

#### *During the inquiry / screening*

The inquiry / screening should take place in a room which can allow confidentiality: therefore, it should be possible to prevent other people from entering the room while the inquiry/ screening is in progress and to conceal from view the person involved. Ideally, the room should be sound-proof so that what is said can't be heard from outside.

#### *After the inquiry / screening*

After the inquiry / screening, data collected should be managed carefully and, in any cases, at least in compliance with the GDPR (where applicable) and with any other eventual existing national laws and regulations on data protection.

### Privacy as violation of other rights

Issues dealing with privacy for routine inquiry / screening procedures do not relate only to collected data and do not only refer to the stage preliminary to the inquiry/ screening itself. Let's see what other rights can be infringed.

#### *Privacy as interviewed right to a private life*

According to article 8 of the ECHR[3] individuals have a right to private life. This doesn't coincide with the right to confidentiality mentioned earlier in relation to data management.

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[2] note that these concepts vary according to national legal systems

[3] Right to respect for private and family life: 1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others

The concept of right to private life has been widely discussed by the European Court of Human Rights[4] and from its judgements and holdings, it has started to be understood that the right to a private life is not only a matter of data protection but it means also a life as much as possible deprived from external interferences (right to be left alone), then and therefore as a right protect own moral integrity; again, then and therefore as a right to individual identity (right to be, became and remain myself) and finally also as a right to self-determination[5] even in relation to situation dealing with own physical integrity[6].

In this context, self-determination translates as a consent to participate in the inquiry /screening process. It might however be abusive to think that, once consent is provided, it is provided once and for all, once and forever. Since routine inquiries deal with the more intimate aspects of an individual and might involve their closer emotional bonds, the consent provided can only be circumstantial, precarious.

***Right to withhold and right to withdraw the inquiry: self- determination. When the alleged loss of self-esteem hurts more than physical wounds***

Consequently, the person who consented to the routine inquiry / screening should always be allowed to suspend the consent, or revoke it or limit it to certain information or treatments (for example: "I agree to participate in the interview but I do not consent to the communication of the outcomes to certain persons or organizations"). So, the fact of having received a consent to the procedure, should not imply for the interviewer the expectation that it won't be modified, as it happens for example with contracts. This is because of the intrinsic quality of the rights which are impacted by this kind of inquiry / screening.

The only boundary to this absolute disposability of the consent provision is the obligation to mandatory reporting to which some professionals are subjected to.

Indeed, to allow the individual to exercise his/her self-determination in relation to the outcomes of the replies he/she will give to the inquiry / screening (for example, those referring to a crime subjected to mandatory reporting), the interviewer must inform the interviewed that if his or her duty to report should be triggered, the respondent's choices about his or her consent to the interview and how to process its content will be limited.

For instance, should the interviewed person refuse to share information about a crime he/she was subjected to, this might be impeded by the obligation to report by the professional doing the interview. Therefore, it is easily understandable that, not to limit the self-determination of the interviewed person beyond what is foreseen by the laws and by the law-and-order needs, it will be necessary to clearly inform him/her about this.

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[4] International court of the Council of Europe which interprets the European Convention on Human Rights The court hears applications alleging that a contracting state has breached one or more of the human rights enumerated in the Convention or its optional protocols to which a member state is a party.

[5] Gladysheva v. Russia, no. 7097/10

[6] Glass v. the United Kingdom, no. 61827/00

## 3. How to conduct the inquiry / screening

In this chapter we will talk about the legal and ethical implications which might be related to how the routine inquiry / screening is performed.

### Oral, written, taped inquiries: which protects the interviewed better and which protects better the data?

Unless there are specific legislations regulating routine inquiries, the way in which it should be done is not binding. The choice of how to perform it should only be dictated by weighing the purpose of the inquiry / screening and, above all, considering which is the better method to document it. In practice, the routine inquiry / screening can be conducted:

- orally, without documenting it;
- orally, but documented in writing, paraphrased by the interviewer
- written, by the interviewed
- audio or audio-video recorded

You can refer to what was earlier explained in relation to privacy-issues connected with collecting and archiving the outcomes of the interview.

### Accuracy and authenticity: paraphrasing or quoting; opened/ closed-ended question; free storytelling, loaded questions

When it comes to assessing options to ensure accuracy and authenticity of information collected, we should consider that screening-tools based on closed-ended questions might have some limitations.

While close-ended questions, especially in written form, have the obvious advantage of being more practical, it is well-established in literature[7] that this kind of approach to questions does not enjoy the favour of scholars. Indeed, a closed answer is intuitively less attributable to the interviewed person compared to something expressed in own-words and therefore possibly less authentic.

Moreover, in a closed question it is easier to fall into the fallacy (although probably done in good faith) of asking a complex question, which implies some assumptions of the interviewer rather than of the interviewed person. So, if a routine-inquiry / screening performed with closed-questions is probably more efficient, its elaboration should be more accurate, weighted and verified compared to those based on open-questions.

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[7] Lipton J.P. On the psychology of eyewitness testimony, in "journal of applied psychology", 1977, 62, pp.556-564; De Cataldo Neuburger L., Psicologia della testimonianza e prova testimoniale, Milano, Giuffrè, 1988;

Inbau F.E., Reid J.E., Buckle J.P., Jayne B.C., Criminal interrogation and confessions. Aspen, Md, Gaithersburg, 2001;

De Leo G., Scalzi M. e Caso L., La testimonianza. Problemi, metodi e strumenti di valutazione dei testimoni, Bologna, Il Mulino, 2005

## Legal and ethical implications around questions

The choice between a free storytelling and a closed or open question has ethical and legal implications which goes beyond the way the interview is done and the issue of the protection of data collected. To understand this, it is necessary to make explicit some premises and logical steps.

Abuses which might be revealed in relation to routine-inquiry / screening procedures, often, fall into the category of domestic violence and abuses (including here also those happening in residential care, since while these places are not properly their homes, they are their domestic setting). It is well known that abuse and domestic violence, since they happen in a private context, often occur far from the eye of the society and therefore the sole witnesses (and therefore quite often the only available body of evidence) are the victims themselves.

This forced judges and lawmakers to find criteria to validate the narration of the victim when it is the only available evidence. These criteria are subjective and objective credibility of the tale:[8]

The first criterion, the *subjective credibility*, translates as the reliability of the person who is narrating the event. In relation to older persons, their credibility is often limited by their frail condition (no matter, in this context, if it is valid and true or assumed as an – even if implicit – stereotype due to the fact that in a specific circumstance the older person had frailty).

The second criterion is *objective credibility*, which is in practice the intrinsic credibility of the tale, disregarding its congruence with the other body of evidence available during a trial, since – as mentioned – when it comes to domestic abuse there are usually no other proofs. Basically, the narration of circumstances must be self-consistent as it could not be sustained by other means.

The set of answers to closed questions is hardly capable of "telling a story", even more to tell a credible story. Therefore, using closed-answers might have a scarce (or in any case lower) capacity to support the legal prosecution of an abuse. Indeed, the older person will be less able to tell a credible story, this would make the condemnation and repression of abusive behaviours more difficult and consequently less capable to prevent further abuse, since the victim won't be protected and the abuser can continue committing violence.

That can be different if we think about general prevention. Indeed, routine inquiries based on closed answers could work well in disclosing abusive situations as data collected could

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[8] For an example see: Italian Supreme Court of Cassation, 3rd, Criminal Section, 06.11.2014. n. 45920. Which held, in a case of sexual violence against a minor with an intellectual disability, that the declarations of the injured party "can legitimately be used alone as the basis for affirming the criminal responsibility of the accused, after the verification, accompanied by suitable justification, of the subjective credibility of the declarant and the intrinsic reliability of his account, which, however, must in this case be more penetrating and rigorous than that to which the declarations of any witness are subjected" because "although it is true that even if the state of mental disability of the injured party, as already stated by this Court, does not exclude that the testimony of the same is given full probative value, it is equally true, however, that this is possible if the judge has ascertained, and has given adequate reasons, that the testimony was not influenced by the mental deficit

well show their incidence on the older population and allow authorities to activate with policy, legal and administrative measures to face the phenomenon of elder abuse. Of course, it could also be the start of a further open-questions interview, with all the benefits we mentioned above.

Therefore, when deciding to adopt a closed-ended screening tool as opposite to ask open questions we have to be aware that it has ethical, legal and practical implications : it has an impact on general or special prevention[9], regardless of how the outcomes should be protected in terms of confidentiality or if it is better to document them in one way or another.

## How to document an inquiry / screening [10]

Also, the way we document the screening or an inquiry based on open questions (which might be a follow up of a screening), has consequences and raises issues that, although not properly abusive, could definitely cancel the good reasons to support their use and sometimes even have legal consequences on the interviewer.

In case of answers to open questions, it is important to report them verbatim, using quotation marks to keep them as much as possible loyal to what the interviewed persons wanted to say.

Indeed, resuming or paraphrasing his/her words could result, even if unintentionally, in a distortion of them, with double negative effects:

The *first one* is to make the narration not credible and therefore weaker (as we saw earlier) in the context of a trial.

The *second* is that an unfaithful narration, in case of an official reporting, can lead - according to the national regulations and the professional role of the interviewer, to commit a crime, even if not directly towards the interviewed person, such as an abuse against public trust. Similarly, to unfaithful narration, modifying the document in which the interview is reported can also have an abusive or criminal effect as considered as an alteration of the document and therefore a falsification. In this we can include very trivial situations like deleting something with a corrector or an eraser (thus that it is impossible to see what was previously written and therefore to understand if the aim was to simply remedy a typo or to manipulate the contents of the document).

A further element to be considered is accuracy, that is referring to every given information precisely. For instance, referring that an act (which according to the interviewer was abusive) was committed on the interviewed by “an acquaintance” (instead of reporting “by the spouse” or “by the child” … together with the name) might imply difficulties or delays in implementing protective interventions and therefore not to avoid reiteration of the abuse.

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[9] In the legal context we refer to general prevention as impeding someone to commit a crime and to special prevention as impeding someone who has committed a crime to commit more.

[10] Note that this section might require adaptations according to local legislation and/or practices

## How to keep and preserve the routine inquiring / screening results

Having explained how a routine inquiry / screening should be conducted, we can now explain where, how and how we should keep the outcome data of a routine inquiry / screening. While this can be regulated by the data-protection discipline in place, we should also consider the aim for which these inquiries are performed.

Provided that the aims could be: the general prevention, the special prevention and the reporting to repress abuse and violence. The outcomes of the inquiry / screening should be incorporated in a durable document, which should be archived so as:

They can be promptly usable to be attached to a legal charge, to elaborate statistics or to feedback to the interviewed persons.

It can be possible to separate this information from others concerning the interviewed person, to classify and protect them from the access of third parties who could directly or indirectly impede its use. So, for example, it should be avoided to leave these data accessible by the alleged abuser, so that he / she can't modify or destroy them or impose on the victim to withdraw the narration by threatening him/her or abusing him/her further.

## Conclusions: Privacy right vs duty to report vs interviewed will

As mentioned earlier, in case of a routine inquiry / / screening there are three important needs that should be considered:

Data protection and confidentiality – and therefore not sharing and communication the information collected the obligation of some professionals, in given circumstances, to report the right to self-determination of the interviewed person on if to participate to the inquiry / screening and on if and how he/she could dispose of the information coming out of the interview.

There might be regulation at national level on how these needs should be balanced to respond to all these equally valid ethical and legal issues. In any case, it is important to act in a way which balances all these needs so that, as much as possible, one is not sacrificed over another.

A way to balance all these needs is to timely provide all this information to the older person so that he/she can self-determine him/herself.

If the interviewer has the obligation to report in specific cases, this information should be provided before the interviewed person provides his/her consent to the inquiry / screening and before any questions from whose answers the interviewer knows that information about abuse or violence might be disclosed. That -of course- in a way which can be understandable by the interviewer, considering his/her cognitive and cultural capacities.

This will allow the interviewed person to understand the consequences to the replies that he/she will give and decide whether to reply or not. On the other hand, this will also allow

the interviewer not to violate his/her professional duties to second the will of the interviewed person, or to protect his/her safety in case of risk of retaliation or escalation.

Should this not happen, the consequences of the information provided by the interviewed person will exit his/her control sphere and therefore the perimeter of his/her self-determination would be irreversibly reduced as he/she won't be able to assess the risks before deciding if and what to narrate.

The information duty of the interviewer will also have to include the organizations and agencies to which the interviewed person can turn to in case he/she is a victim of abuse. Therefore, the duty to information is not only limited to the duty to inform others, but also to be informed about places and services to support victims of abuse.

## 4. ETHICAL PRINCIPLES OF SCREENING FOR ELDER ABUSE

There are some clear ethical risks to screening such as the consequences of false positives (incorrect accusations of abuse) or false negatives (missing cases of abuse where an intervention may save lives). Accusing someone of abuse when it is not happening or missing a case of abuse when it is occurring can have devastating consequences. Is the overall harm of not detecting/leaving someone in a dangerous situation, outweighed by the risk of falsely accusing an individual? Such incidents could have devastated and far-reaching effects for the individuals involved. Unlike screening in physical health, such as cervical screening to detect potential cervical cancer, there are more nuanced situations specific to elder abuse that require careful and ethical consideration. For example, elder abuse victims may not have requested or wanted investigation. Assessment of decisional capacity also needs careful thought and consideration. Screening tools used within an overall system may help to provide a professional with a more objective approach, but this approach must be carefully balanced. (McCarthy et al. 2017).

Abuse by a family member or intimate partner is complex because the elderly may be struggling against social, cultural, and religious aspects of life to live with abusive person(s). Also, intervention in case of abuse can be accompanied by personal, legal, and ethical concerns, because of lack of professional principles. Saghafi et al (2019) discussed in their review on comprehensive ethical principles such as autonomy, competency, beneficence, and respect for human rights and dignity. Autonomy includes independent decision making without any limitation, and respect for independence. It also means how decision-making should be done; patients have the right to participate in making decisions related to themselves. Decision making, however, is due to person's capability for decision making and his/her mental capacity is approved. (Ibid).

Principle of competency means professionals' own competence for working with older persons. The professionals should self-assess their competence in attitudes about aging and older victims, knowledge and skills. Principles of ethics can differ. et al ethical risks related to informed consent, confidentiality/limits of confidentiality, self-determination, privacy, cooperation with other professionals and reporting. Professionals cannot blindly follow the

mandated reporting law. That could potentially do more harm to the older person than good, such as revenge by a perpetrator who is also the primary caregiver. If the response is inactivity that could allow harm to continue. These are complex ethical issues, not clear-cut in practice or on paper. (Scheiderer, 2012)

In cases where the older person lacks competency, ethical issues should be considered. It is notable that capacity and competency are not the same: capacity has dimensions such as decision-making, self-care and self-protection. For example, in dementia, there is memory impairment, but personality, values and long-term memory can stay intact. Cultural and gender differences should be noted when trying to determine decision-making capacity by means of valid and reliable measurements. Respect for confidentiality and trust is one of the most important ethical principles that must be taken into consideration. However, the exception can be where serious harm is caused. In addition to the legal aspects of abuse, mandatory reporting depends on the laws of different countries and different laws can regulate mandatory reporting and reporting of suspected elder abuse. However, it is important to try to engage the older person in the reporting process and only report relevant data to respect his/her privacy as far as possible. Mandatory reporting is valued when there are protective systems and laws to help the elderly and prevent further harm. (Saghafi et al. 2019).

Health care approach to screening is articulated by the principles of beneficence and non-maleficence. Beneficence is balancing of potential benefits and potential risk of individual harm. Benefit is often described by the concept of substantial benefit which refers to an outcome that now or in the future might be regarded as worthwhile. Beneficence and non-maleficence mean that the professionals try to straggle benefits for those they work with and do no harm by the professional activities. In management of elder abuse cases this ethical principle has weaknesses: our current scientific knowledge on screening and its results is contradictory and incomplete. It is required from professionals to make complicated ethical decisions whether and how to take an action on any detected or suspected case of elder abuse. This usually requires difficult balancing acts between protecting older people and preventing further harm by reducing the older person's control of his/her own life. (Scheiderer, 2012)

## 5. WINNING TRUST OF THE RESPONDENT

### What is trust

Trust is a central part of all human relationships, including romantic partnerships, family life, business operations, politics, and medical practices. If you don't trust your doctor or social worker, for example, it is much harder to benefit from their professional advice.

There are many definitions of trust, but for our objectives we will define it as one's willingness to be vulnerable to others on the basis of one's positive expectations of the other's

intention and competence. It means that one has confidence that the other party in a transaction cares for him/her and will behave in a way that is beneficial or at least not detrimental to him/her. Therefore, in trusting others, one expects that one's vulnerability will not be exploited for reasons such as power, profit or pleasure.[11]

### How to win trust of the client

Gaining trust in a client-professional relationship requires time and might be influenced by a variety of factors. These are some elements that the professional can take into account in order to build a positive relationship with the client: to convey the message of care and interest, it has been recommended that the professional sits down next to the client, spends more time with them, speaks with a soft voice in a respectful manner, remembers their life events and files, expresses interest in their life conditions and does helpful things for them (Jacobsen and Vesti, 1992; Northhouse and Northhouse, 1985; Fine and Glasser, 1996; Thom and Campbell, 1997; Behnia, 2002).

To respond to the client's desire to know the professional's competence, motivations and opinion about the client, professionals need to make explicit their motivations for working with him/her and to disclose their personal experiences (Fong and Cox, 1989; Hassan, 1997). However, note that professionals should be judicious in their use of self-disclosure.[12]

## Active Learning Activities

A series of exercises that can be used to practically apply the theoretical contents thought in the module.

### EXERCISE 1 - SELF-ASSESSMENT OF THE PROFESSIONAL ETHICAL COMPETENCIES FOR WORKING WITH OLDER VICTIMS OF ABUSE

**Method of the exercise:** Group work based on an individual self-assessment task

**Learning objectives:**

- Participants understand how screening for elder abuse is based on ethical principles
- Participants are able to contemplate complex ethical issues when working with an older victim of abuse

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[11] Behnam Behnia, Trust Development: A Discussion of Three Approaches and a Proposed Alternative, *The British Journal of Social Work*, Volume 38, Issue 7, October 2008, Pages 1425–1441, https://doi.org/10.1093/bjsw/bcm053

[12] Benham, *ibidem*

- Participants become aware of their own professional competences

**Time frame:** 40 minutes

**Material required:**

- Questions for self-reflection on paper
- Pens
- PowerPoint slide of general discussion questions for the end of exercise.

**Instruction for the trainer:**

- Before the exercise, have the theoretical background session on Ethical principles of screening for elder abuse. During the session discuss with the professionals what kind of ethical principles there in their profession. Also, ask them to think of their professional ethical principles from the point of view of elder abuse.
- Explain the course of the exercise. Point out that each professional is free to choose what he/she want to share with the group. That is important for creating a safe environment for the exercise.
- Distribute the questions on paper to the participants or share the questions on a PowerPoint slide.
- Give the participants 15 minutes for self-assessment.
- After the self-assessment, divide the participants into groups of 4-5 persons. The groups can be formed according to the same profession or mixed professions.
- Give the participants for 10 minutes for sharing their self-assessment with the group.
- After the group discussion, participants share their reflections with the whole audience according to the general discussion questions.

**Questions for the self-assessment**

- Each profession has its own ethical principles. Write down, in your opinion, 2-3 most important ethical principles of your profession.
- In your opinion, what is professional ethical competence in your profession when working with older victims of abuse?
- Do the ethical principles of your profession give attention to aging and/or elder abuse?
- What principles are complex and possibly difficult to follow in the elder abuse area?

**Questions for the general discussion**

- What is professional ethical competence, especially when working with older victims of abuse?
- Did you find in the group discussion similar challenges following ethical principles when working with older victims of abuse? What kind of challenges?

**Notes to the trainer**

Encourage discussion and collaboration among the participants. Try to find the same/similar challenges in each profession when working with older victims of abuse.

Emphasize how multidisciplinary and multi-agency work could help to overcome these challenges.

## EXERCISE 2 – SCREENING COMPETENT AND INCOMPETENT OLDER PERSONS

**Method:** Sociodrama is a powerful teaching strategy that combines a case study approach with traditional role-play methodology to illustrate critical issues in screening. Consistent with principles of adult learning, this technique allows the audience to identify issues and possible solutions for patients and staff. Some participants are selected from the group to enact a described scenario. Note that it would be better if actors do not previously agree on how they would behave, to make reactions more spontaneous and similar to a real-life situation. The rest of the audience first observes the scene and then the facilitator guides the audience discussion using open-ended questions. During this period of structured discussion key instructional issues are identified and the shared clinical expertise of the audience participants forms the basis of learning. After some time dedicated to discussion, those who suggested different ways of dealing with the situation are invited to replace the original "actors" and to re-do the scene. As the time allotted comes to an end, the facilitator may choose to summarize the content or focus on issues not identified by that particular audience so that further thought and discussion may occur.

### Instructions for the facilitator

Note: this procedure can be applied with one or both scenarios, according to available time. You can also choose the scenario which is more similar to the context where the training is implemented or you can adapt it accordingly.

At first instance, allow students to perform the scene as they wish to – only remember them to try to apply the principles of an ethical screening that were previously explained and to try to include all the issues described in the scenario as they are relevant to assess the decisions they will take.

At the same time, instruct the rest of the audience to take notes of what they see, what they notice and if there is anything they would do differently.

Allow 10 / 15 minutes to perform the scene. Once the scene is over, open the discussion with the audience by asking for example:

- What important issues did you identify in this scene?
- How would you have acted with the older person in this case?
- How could this have been managed better?
- What feelings did it evoke in you and why?

Allow 20 minutes for discussion and eventually help the audience to identify the main critical issues and to come up with alternative solutions in line with the principles taught in the module.

After that, invite those members of the audience which were more active in suggesting alternative behaviours to re-enact the scene. Repeat the process.

**Suggestions for facilitators**

The main issues that should be explored within the scenario are:

- If the consent was correctly collected (for example if permission was obtained from the right person)
- If privacy is respected
- If the outcomes of the screening are correctly reported
- If the professional behaves according to its duty to report

As an alternative to socio-drama, the scenarios can also be presented as cases for discussion

**HANDOUT 1 - SCENARIO 1 – COMPETENT OLDER PERSON**

M. is a social worker employed in a day care facility for older people. M. is responsible for new admissions and today he/she welcomes A., a 78 years older person who is accompanied by his/her adult child. A. has some physical frailties, but no cognitive issues compromising his/her capacity to understand and will.

According to the procedures in place in the centre, M. has to submit a screening questionnaire to A. While doing so, it turns out that A. might have been psychologically abused by his/her adult child.

**HANDOUT 2 - SCENARIO 2 – INCOMPETENT OLDER PERSON**

M. is a nurse employed in a residential care facility for older people. M. is responsible for new admissions and today he/she welcomes A., a 78 years older person who enters the centre upon the initiative of his/her guardian. A. used to live alone. He/she has a grand-daughter who seldom visits him/her. A. doesn't have significant physical health issues, but he/she has been suffering from MCI and a guardian was appointed to help him/her make legal decisions.

According to the procedures in place in the centre, M. has to submit a screening questionnaire to A. While doing so, it turns out that A. might have been financially abused by his/her grand-daughter.

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# MODULE 4 - Challenges of working with elder victims of violence

## Structure of the module

| | |
|---|---|
| Title | Challenges of working with elder victims of violence |
| Goal(s) and objectives | ▪ Improve knowledge about possible challenges of working with elder victims of violence and strategies to overcome these challenges<br>▪ Raise awareness of the importance of people rights and safety planning in case of suspicion of abuse<br>▪ To improve skills and competencies, build capacity to manage disclosure, properly intervene, support and refer the cases of violence to relevant services<br>▪ To support development of intervention measures in cases of violence against older people<br>▪ Raise awareness of the importance of self-care and where to turn for support for staff engaged in screening for abuse victims |
| Learning outcomes | ▪ At the end of the module the participants should be able to:<br>▪ List possible challenges of working with elder victims of violence<br>▪ Understand the rights of the elderly in the screening process<br>▪ Manage disclosure<br>▪ Arrange a safe screening environment and be aware of the ways to increase the safety of the interviewed person<br>▪ Recognise the signs of professional burnout in the context of working with violence victims<br>▪ Implement self-care strategies<br>▪ Know where to look for support in to prevent and/or deal with Post-traumatic stress disorder (PTSD) |
| Duration: | 3 hours<br>▪ 45min-1h input session<br>▪ 20 min (2x10 minutes) breaks |

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| | ▪ 1h and ½ active learning activities<br>▪ 10 minutes of extra time (warm up, waiting for participants, answering questions) |
| Resources needed: | ▪ Post its<br>▪ A flipchart or a board<br>▪ A time meter (e.g. a stopwatch on a smartphone).<br>▪ Two colour cards showing "yes" or "no". |
| Key message | ▪ There are different types of challenges in working with victims of abuse. Being aware of them is the key success factor to working with violence experiencing individuals<br>▪ Elderly abuse, although a complex phenomenon, can and should be prevented with the use of government and institutional strategies and programs |
| Worksheets | - |

## Theoretical background

### 1. EXTERNAL CHALLENGES

#### COVID-19

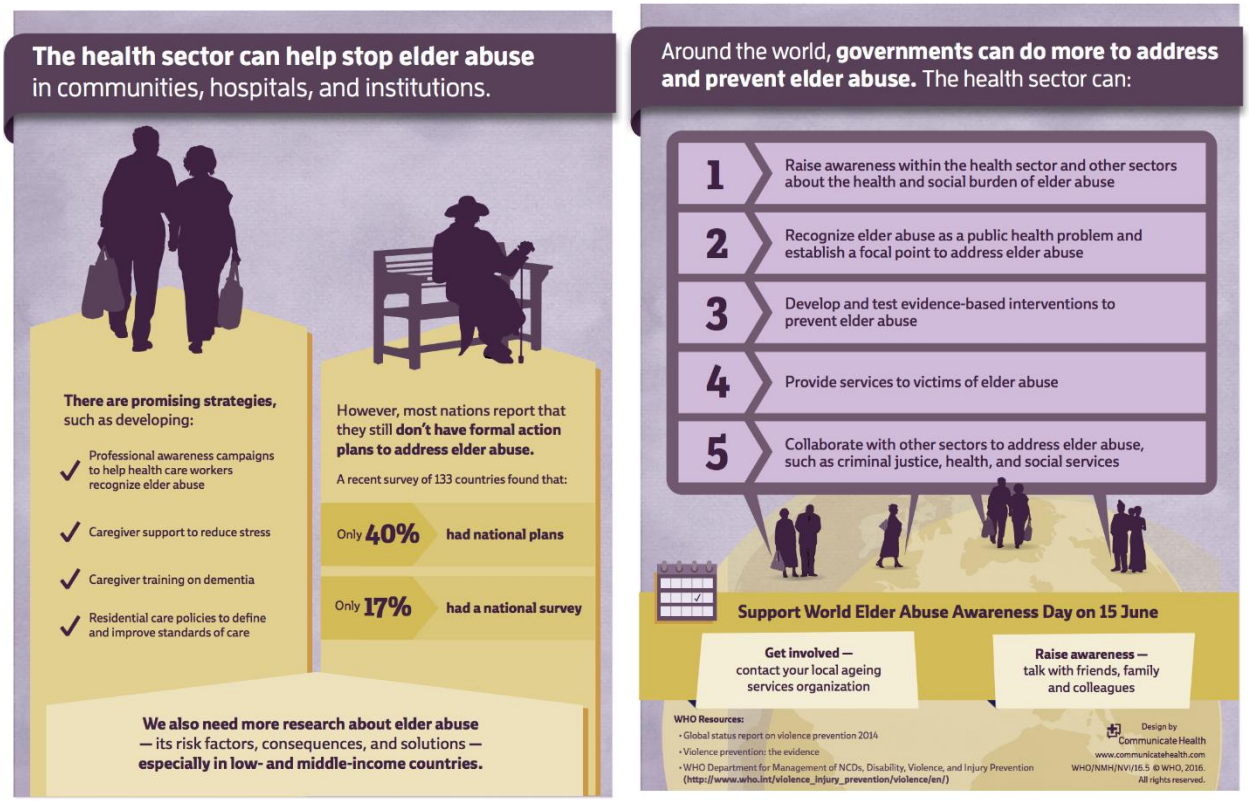
Coronavirus and resource limitations connected with the pandemic caused the decrease in social care service provision. At the same time, the prevalence rates of elderly violence increased by as much as 84% as far as community settings are concerned (Chang & Levy 2021, Results).

The human rights issues at stake may have fallen a bit to the background of today's world priorities to just survive the pandemic at all costs.

#### Government / political strategies

Once the dust of the pandemic has settled, government initiatives such as increased funding for prevention and intervention are essential to continue building awareness of violence against the elderly and strategies to prevent it from happening. The legal framework and policies are essential to support the organizational processes and actions on the ground. It is the government of a given country who is responsible for and decides on factors such as:

- defining in the national legal environment, what types of violence are codified as crimes, creating laws in alignment with international legal frameworks, signing and reinforcing international treaties against violence
- implementation of procedures in case of abuse suspicion, report or detection to follow by emergency rooms and healthcare, social care, police and crisis intervention institutions. These may include outlining the processes, institutions involved and their responsibilities, preparing standard documents, but also issuing requirements for physical aspects like ensuring dedicated space, providing confidentiality during investigation, securing the abused person from the influence of the abuser by police officers, etc.
- funding and promoting studies and research programs in the area of elderly abuse, publish reports in this topic to build awareness and drive strategic decisions
- issuing requirements for thematic training of healthcare, social care staff and police officers
- implementing national action plan to address violence against older persons
- services in place for older victims of abuse or neglect from their carers
- promote preventive programs, including services training and supporting caregivers
- support for NGOs that serve needs of elderly abuse victims and/or protect their rights.




Source: WHO, https://www.who.int/health-topics/elder-abuse#tab=tab_1 (Accessed June 1st, 2021)

## Demographic changes and care expenses

The global population of people aged 65 years and older will more than double, from about 727 million in 2020 to over 1,5 billion in 2050 (UN DESA, 2020). Progressive demographic changes in population put pressure on health and social welfare systems. The growing participation of older people in societies means growing expenses on community and institutional care on the part of local governments and public institutions. Additionally, some countries (i.e. Poland) struggle with skilled nursing personnel shortages - they also age and retire and not enough new professionals enter the labor market to satisfy the growing need for care services. It causes the quality of care to deteriorate. These are the main factors behind more frequent abuse against the institutionalized elderly persons: lower standards of care and not properly trained or overworked personnel.

The current model of care for the elderly most prevalent in local governments (residential homes, home care, long term healthcare wards) requires cutting down expenditures and, simultaneously, increasing access and upholding quality of (health) care, which is unsustainable in the long run. Without strategic focus on prevention (stay independent and age at your own home as the best solution) and effectiveness of care services, budgets will not cope with the demographic pressure with increasing costs of long-term care and decreasing tax revenues from the working part of society.

The demographic change is also reflected in the required greater involvement of informal carers and family members and their growing dedication to caring for the elderly. The prolonged period of providing care for the elderly is tiring for families and calls for various forms of support for carers involved. The latter's physical and psychological well-being depends more and more on wider access to respite care, implementing innovative forms of support, building support networks and providing telecare as a public service. Without such support, overtired and stressed caregivers provide an outlet for their emotions in violence.

## Lack of awareness

The number of elderly people experiencing violence and abuse is predicted to increase with the aging of the population. However, not everyone understands that some of the negative relationships in the family or between the charge and the guardian may be a form of violence. For the elderly, violence can have for instance the following faces: isolating, taking money (e.g. retirement or disability pensions), insults, threatening with putting into a nursing home, persuading mental illness, forcing changes to a will, neglect, leaving an elderly person unattended. It is important to sensitize society to the bad treatment of old people, with particular emphasis on working with children, youth, the employees of public institutions, but also with the elderly themselves. Seniors, when experiencing violence, are often not aware of the phenomenon taking place. As long as those instances of violence or/and neglect are by some people considered as normal, simply unrespectful behaviour, one will benefit from nation-wide awareness campaigns.

### Discrimination: ageism, sexism

Sex, race and age discrimination is considered by some as the greatest threat to modern democracy and social cohesion (Szukalski 2009, p. 59). Among these, ageism is one of the most significant risk factors for violence against people over 60. Ageism is "the systemic stereotyping of and discrimination against people because they are considered old." (WHO 2015). In a socio-cultural context, elderly people are often perceived as weak, helpless, dependent and in need of care.

Such an approach to old age is often reinforced by sexism defined as "beliefs around the fundamental nature of women and men and the roles they should play in society". (EIGE 2021) Considering one gender as superior to other leads to many unfair gender stereotypes that can affect both sexes in different situations, but women in particular. Additionally, on average and worldwide women live longer than men. In 2020, women accounted for 55% of the global population aged 65 years or more and 62% of the global population aged 80 years or more (UN DESA, 2020). Taking under consideration the above, women and older women are a particularly vulnerable group affected by both ageism and gender inequality and therefore more often experience violence (UN DESA 2020).

It is however worth mentioning that the latest meta-analysis shows no gender differences in elder abuse (Yon et al., 2017). Some studies show that women are more vulnerable to some forms of abuse while men are more vulnerable to other forms. While women are the majority of most societies in the older age groups, one should not underestimate abuse in case of older men.

## 2. ORGANIZATIONAL CHALLENGES

There is still a lot that can be done within health sectors and social assistance systems in all countries, starting from basic research on the elderly abuse topic and aiming at developing long-lasting goal oriented sectoral strategies to fight elderly abuse. Organizations' structures and institutions' priorities are the driving factors behind properly implemented prevention programs.

Screening for older adult mistreatment often competes with other organizational priorities. Although screening for abuse victims has been accepted in paediatrics context and wards, it is not as prevalent and obvious during the adult and elderly treatment. It requires effort and time to settle in the Emergency Room (ER), home care and residential care context. Professionals should have time and resources to get used to the screening methodologies (Couture et al. 2016, p. 13-14). Other factors inhibiting screening for elderly victims of abuse have been time constraints reported both by social workers and healthcare workers (Schmeidel et al. 2012) and not having other colleagues to discuss cases with (Killick &Taylor, 2009; Stolee et al. 2012).

Research in this area has found that social workers might prefer more time to screen their caseload and have access to pre-planned clinical supervision sessions, rather than having a

specific screening tool. Also, older adult mistreatment must be a priority set by upper management of health care or social care institutions so that enough time can be allocated for screening and the efforts undertaken are valued and acknowledged.

One of the many sectoral and organizational challenges is also shifting responsibility – instead of having a requirement in place for all sectors to screen for abuse victims, both social care and health care claim it is the job of the other party to monitor/ screen and start intervention procedures (Couture et al. 2016, p. 4). The social workers rely on nurses, nurses claim they have other priorities and rely on social assistance systemic approach and relationship to detect such cases.

## 3. PATIENTS' BARRIER TO DISCLOSURE

Violence against the elderly takes place in a variety of settings. It is difficult, as in the case of other types of violence, to define its type and extent, because many older victims do not disclose it. The reasons for this are typical of the crisis of violence, including lack of faith in the effectiveness of the actions of law enforcement agencies. The situation of an abused elderly person is very difficult, multi-layered. It is a mixture of extremely different ambivalent feelings and physical state.

### Care with Shame

A huge problem is the reluctance of abused elderly people to reveal the violence they experience from their children, grandchildren and spouses – a violence that happens in a supposedly trusting relationship. These are not only the material but also emotional entanglements in which s/he is. The feeling of having to protect and support them causes them to endure suffering in silence. Old parents often feel responsible for the behavior of their adult children, in line with the belief that they raised them that way. It comes with shame and, at the same time, will to care for the perpetrators – children or close relatives. It is important to encourage them to change their thinking.

### Depression

Older people who do not accept their situation, lost in the sense of their social role, sometimes lonely after retirement, more often suffer from symptoms of depression. In Europe, the share of people reporting such conditions generally increases with age. On average almost 8% of people aged 65-74 (from 2,4% in Romania to 20,7% in Portugal), and over 10% in the group aged 75+ (from 3,1% to 17,1% respectively) reported to have had chronic depression (Eurostat 2017). Those rates are much higher for elderly living in institutionalized care. A study conducted in Germany revealed that almost 30% of nursing home residents had minor or acute depression, and an additional 18% were depressive. Almost 30% of residents were prescribed antidepressants, although some of them were never formally diagnosed (Kramer 2009, Results).

It's a condition that should be treated, not taken for granted at this age. Also, it is worth noting that there is a strong link between elder abuse and arising negative emotional and physical health issues such as depression as the outcome of mistreatment itself (Acierno et al., 2017). Depression, anxiety and posttraumatic disorder were indeed reported as the most prevalent psychological consequences of elder abuse. (Dong et al., 2013).

The state of depression makes it difficult for people to introduce changes in their life, limits their activity and often causes them to remain passive in a difficult situation. Sometimes it is connected with learned helplessness.

### Hope

In case of domestic violence, very often a so-called cyclical course takes place – the perpetrator, apart from the periods when s/he hurts, has better days, when s/he treats the victim well, is devoted, warm and understanding. This ties the abused person dependent on the perpetrator very much and gives a false hope for a lasting improvement in the relationship, the hope that the abuse against him/her is incidental and will soon end. This dynamic is not necessarily present in residential care settings.

### Guilt

The typical behavior of the perpetrator involves putting the blame on the victim. S/He hit, pushed, challenged, because "you want something again", "you do not give me peace", "you get dirty", etc. The constant repetition of this makes abused persons believe that if they were different, more efficient, independent, helpful, the situation would improve – so they feel they are the guilty ones.

### Fear

Abused persons, dependent on the perpetrator, are afraid of the consequences of disclosing the violence. They feel the fear of:

- total rejection,
- escalating aggression,
- retaliation by the aggressor,
- fear of placing them in nursing homes, which is associated with losing access to their own place of residence, to grandchildren, etc.
- lack of funds, not being independent, not being able to cope financially. (Perttu & Laurola, 2020)

### Need of care

Biological vulnerability and higher fatality of older people is one of the reasons for the majority of abuse cases against this group not being identified or reported. It is estimated that every 1 in 6 elderly people are victims of violence and at the same time only 4% of violence cases are being reported by this group (WHO). What is more, abuse is more prevalent in case of cognitive deficits – 47% of abuse victims identified come from the group of the elderly with dementia (Couture et al. 2016, p. 2). For an elderly abuse victim, being in need of care, with dementia, dependent, are the factors conditioning often the only one way out of the violent environment – institutionalization.

### Duty to report

Professionals and citizens, according to specific national laws, might have the obligation to report a crime if they become aware of it. Since regulations varies across countries, it is necessary to explore this issue at national level.

## 4. RESPECT THE RIGHT OF OLDER PEOPLE TO NOT TALK

### Understanding

If one suspects that an elderly person is a victim of violence – a healthcare or social care professional should talk to them, provide support, offer personal help. Most victims remain silent out of shame, fear, or helplessness, or ignorance of their rights. They are also often under pressure from perpetrators or a family member. The moment when the abused person starts talking about their experiences can be very difficult for them, so it is important to treat them with attention and understanding (Perttu & Laurola, 2020, p. 68).

The abused person should first of all find out from the health or social care staff member that s/he is not to blame for what is happening, that the perpetrator is always responsible for the violence. The health or social care worker's compassion, their support may be decisive for the victim's further decisions. Information about violence cannot be left, disposed of or forgotten. A perpetrator who feels unpunished acts more and more cruelly, and this may endanger the health and even life of the victim.

A professional should encourage the person experiencing violence to call the police in an emergency. Professional staff should not have doubts whether they should "interfere" in the life of another person by offering so called "first-line support" (WHO, 2013) - expressing empathy, conducting gentle conversation, providing necessary information, as for an elderly person their actions and care may be the only chance to change the situation. A professional involved in the screening process should inform her/him that both mental and physical violence are crimes and that reporting the case to the police should be considered as the only way to bring the perpetrator to justice, provided the elderly victim wants to follow this path. The worker should then indicate the institutions or organizations that provide free psychological and legal advice, and offer medical help. It would be also helpful if the worker finds someone else (supported member of family, neighbours, friend of victim) to encourage

the abused person to not change her/his mind and to report a crime. This non-institutional support should not be forgotten and may be more important than professionals' efforts.

The basic rights of people using health care are described i.e. in the European Charter of Patients' Rights (Active Citizenship Network 2002). It indicates, among others, that the patient has:

- the Right to Information,
- the Right to Consent,
- the Right to Privacy and Confidentiality,
- Right to Safety.

## 5. Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is a psychiatric disorder featuring symptoms of intrusion, avoidance, negative alterations in cognition and mood and hyper-arousal. Exposure to a traumatic event such as elder abuse may be connected with the development of PTSD. However, research in this area is scarce and though there seems to be a link between elder abuse and PTSD, the relationship is not yet completely clear (Acierno et al., 2017). It is important to increase understanding and improve strategies for dealing with PTSD in the elderly who are victims of abuse. (Choi et al., 2018)

### PTSD symptoms

Per Royal College of Psychiatrists, PTSD is an anxiety disorder caused by very stressful, frightening or distressing events. It is a mental health condition characterized by an experience of a traumatic event, such as becoming a victim of violence, and a following psychological impact so severe that it impairs normal function for a long period of time. The initial emotional shock, fear, anxiety, sadness, and anger may subside over months, but PTSD can persist for decades. As PTSD sufferers age, it is not uncommon for symptoms to increase, emerge, or re-emerge.

PTSD may manifest differently in older adulthood, as indicated by more frequent reports of poor health, chronic pain, and cognitive impairment among older people compared to younger adults with trauma histories. The relation between cumulative trauma exposure and post-traumatic outcomes may become more complex with age. (Ogle et al., 2014)

Many people feel grief-stricken, depressed, anxious, guilty and angry after a traumatic experience. As well as these understandable emotional reactions, there are three main types of PTSD symptoms (Giving care, 2017):

***Flashbacks and nightmares***

The flashbacks in PTSD can be so realistic that it feels as though one is living through the traumatic experience all over again. Besides seeing it in their minds, a victim may also feel the emotions and physical sensations of what happened – fear, sweating, smells, sounds, pain. Flashbacks can be triggered off by ordinary things. For instance, if one had a violent argument and had to run away in the rain, a rainy day might start a flashback.

***Avoidance and numbing***

Reliving a traumatic experience over and over again can be too upsetting to handle. So, a victim's strategy to distract themselves is keeping their mind busy by losing oneself in a hobby, working very hard, or spending one's time absorbed in crosswords or jigsaw puzzles. Victims try to avoid places and people that remind them of the trauma, and try not to talk about it. They may also deal with the pain of these feelings by trying to feel nothing at all – by becoming emotionally numb. A victim chooses to communicate less with other people who then find it hard to live or work with such a person. Self-destructive behavior such as alcoholism, substance abuse, self-harm, and suicidal tendencies may also follow the experience of a traumatic event.

***Being 'on guard'***

The victims of abuse or other traumatic events may find that they stay alert all the time, as if they were constantly looking out for danger. They can't relax. This is called 'hypervigilance'. They feel anxious and find it hard to sleep. Other people will notice that they are jumpy and irritable.

***Other PTSD symptoms***

- muscle aches and pains
- diarrhoea
- irregular heartbeats
- headaches
- depression
- insomnia, frequent awakenings
- psychotic symptoms PTSD driven
- personality changes
- feelings of panic and fear
- drinking too much alcohol
- using drugs (including painkillers)

Research shows that older women may be at a higher risk for developing PTSD than older men because of domestic sexual and physical abuse (Dietlevsen, N. & Elklit, A. 2010 para. 3). However, older women are usually under-diagnosed and are more often perceived as suffering from depression, anxiety, or poor physical health rather than PTSD. Higher rates of PTSD were reported among victims of emotional mistreatment (84.6% versus 52.4%) and physical mistreatment (46.2% versus 23.8%). (Sirey et al., 2018)

Role changes and functional losses (retirement, increased health problems, reduced income, loss of loved ones, decreased social support, cognitive impairment, functional decline) may make coping with memories of earlier trauma more challenging in old age. To manage PTSD symptoms in early and mid-life, individuals may engage in avoidance-based coping

strategies, e.g. alcohol abuse. Adaptation and resilience may, however, develop over a lifetime and provide a rich source of coping resources.

All of the above, in particular visible symptoms such as poor eye contact, withdrawn nature, signs of self-destructive behavior or self-neglect, should additionally raise suspicion and alert the personnel using an elderly abuse screening instrument. The EASI tool has an additional question to professional staff themselves inquiring about such instances.

**Assessment and Treatment of PTSD**

A full mental examination, including a cognitive screening, is recommended to assess elderly patients for PTSD (Kaiser et al., 2017). It is also helpful to watch for trauma and related symptoms, as older adults tend to minimize their importance since traumatic events are likely to have been experienced long ago.

Treatment of PTSD typically involves both medication and psychotherapy (Lancaster et al. 2016, Evidence-Based Treatments).

- **Psychotherapy.** In the process of recalling the event that caused the trauma, discussing it, and trying to understand it, the mind archives these memories as normal, so that the victim's life can go on.
- **Cognitive behavior therapy (CBT).** This type of therapy helps change the way a victim thinks about his/her memories, making them less stressful and easier to deal with. Relaxation techniques are usually used here to help bear the pain of memories related to the event that caused the trauma more easily.
- **Eye movement desensitization and reprocessing** (EMDR) **method**. In this therapy, eye movement helps the brain to process recurring memories and understand the event that caused the injury.
- **Group therapy.** Conversations in a group of people who have experienced similar events helps to dispel feelings of isolation and loneliness.
- **Medication** may include anti-psychotics, anti-anxiety, and antidepressant drugs. Antidepressants will reduce the severity of the symptoms of post-traumatic stress and relieve depression. If these measures prove to be effective, they should be continued for about a year and then slowly discontinued. If symptoms are disturbing sleep and clarity of thinking, sedatives can help, but these should not be taken for longer than 10 days.
- **Body-focussed therapies** Physiotherapy, craniosacral therapy, massage, acupuncture, reflexology, yoga, meditation and tai chi therapy allow you to control stress and reduce the feeling of constant 'readiness' and tension.

A physician should create a treatment plan that is customized to the patient's unique symptoms, including factors such as the elderly person's living arrangements, financial possibilities and independence rate. Guidelines from the National Institute for Health and Care Excellence (NICE) suggest that trauma-focused psychological therapies (CBT or EMDR) should be offered before medication, wherever possible.

## Self-Care in PTSD

Self-care activities in case of elderly patients with PTSD could be like the general self-care guidelines for victims of violence recommended for instance for safety planning support, enhancing psychological and emotional strengths, and dealing with the trauma of being abused. It must be noted however, that there is no research on evidence supporting their use in PTSD. The below activities are also advised for professionals working with victims of violence as a means of preventing professional burnout (Perttu & Laurola, 2020, p. 85-86).

| HELPFUL STRATEGIES | WRONG STRATEGIES |
|---|---|
| **recognize when it is necessary to ask for professional help**<br>keep life as normal as possible<br>get back to your usual routine<br>go back to work (or - if retired - get an occupation or find a hobby)<br>eat and exercise regularly per your possibilities<br>talk about what happened to someone you trust<br>take time to be with family and friends<br>try relaxation exercises<br>go back to where the traumatic event happened<br>spend time in nature – doing outdoor activities such as hiking, walking, biking. If you need support in going out, don't hesitate to ask for it (neighbours , social worker, carer, an NGO, etc.)<br>eliminate the feeling of helplessness, remind yourself that you have strengths<br>help others, your relatives and people in need (e.g. donate blood), become a volunteer, take positive action<br>be careful when driving – your concentration may be poor<br>be more careful generally – accidents are more likely at this time<br>speak to a doctor, a friend, a close person | blame yourself for it and worry – PTSD symptoms are not a sign of weakness. They are a normal reaction<br>hide your feelings, don't keep it to yourself. Treatment is usually very successful<br>avoid talking about it<br>expect to forget everything quickly. The memories may stay for some time<br>expect too much of yourself. Let yourself adjust to what has happened<br>stay away from other people<br>drink lots of alcohol or coffee or smoke more<br>get overtired<br>miss meals<br>take holidays on your own. |

| | |
|---|---|
| expect to get better. | |

**How to help a person with PTSD**

Below are recommendations for friends, relatives, and colleagues of victims of abuse or other traumatic events on how they can help the victimized person in their community or family.

| **DO** | **DON'T** |
|---|---|
| watch out for any changes in behaviour – poor performance at work, lateness, taking sick leave, minor accidents<br>watch for anger, irritability, depression, lack of interest, lack of concentration<br>take time to allow a trauma survivor to tell their story<br>ask general questions<br>let them talk, don't interrupt the flow or come back with your own experiences<br>be with them, assure them they can trust you | tell a victim you know how they feel – you most probably don't<br>tell a victim they're lucky to be alive – it may not feel like that to them and it's not<br>a form of empathic communication<br>belittle their experience or feelings – "it cannot be that bad, really …"<br>recommend that they just need to "pull themselves together"<br>judge the person or the circumstances |

## 6. MANAGING DISCLOSURE

Persons providing assistance to the elderly should have basic information on state institutions responsible for providing assistance to this social group. In the EU, care for the elderly is provided through two complementary systems: the health care and the social assistance system supported by the 3rd sector – non-governmental organizations as well as private for-profit organizations.

If the safety of the injured person is threatened, the healthcare and social care professionals should act as soon as possible to prevent contact with the perpetrator. According to the different national systems and regulations this might include for example moving the victim to a shelter, the issuing of a restraining order for the perpetrator, the implementation of a safety plan.

There are several organizations which can be contacted in case of detecting/suspecting violence and other entities offering support for victims of violence. While these should be checked specifically in relation to the area where the victim lives, they might include:

**The police**

In situations that directly threaten life or health – call the police. For victims who cannot make a phone call, there have been user-friendly accessible apps developed recently. You might check the availability of these apps in your country.

**Healthcare system**

Within the health care system, there are basically three types of services that can be involved:

- ***Emergency services:*** in situations that directly threaten life or health
- ***Community based services:*** such as the family doctor or community nurses
- ***Specialised services:*** such as residential care facilities, day-care center, specialised physical and mental health services

**Social Assistance/Welfare System**

The social assistance system can offer support to elder abuse victims through a variety of means, such as:

- Cash benefits / allowances
- Home care assistance
- Crisis intervention and protection
- Specialised services such as those for victims of violence

If employees of an institution or organization dedicated to providing help, health care and social care professionals, through observations, intuition, reports from third parties, screening results believe that someone is being harmed and needs help, they should not be indifferent. When it comes to the life or health of another person, professionals should act reasonably, rationally, decisively to protect the victim. As mentioned, professional intervention might be guided by laws and/or reporting practices of own institution.

## 7. SAFETY PLANNING

Developing a security plan is a method of dealing with the threat or another form of violence. Thanks to the preparation and development of a personalized plan, an elderly victim of abuse will know how to behave in a situation of violence directed against her/him and her/his close ones. In other words, a set of actions to create a safety plan can help lower a victim's risk of being hurt by a perpetrator.

Some of the preparations for a safety plan might seem obvious, but during moments of crisis and high-stress situations such a list of steps to take helps to act clearly and logically. In a frame below an example of steps to create a safety plan are presented.

It should be stressed that when the safety plan is prepared no item can be a trigger for further violence; for example, the bag described in point 3 (frame below) is only beneficial if there is absolutely no chance of the perpetrator finding it, as finding the bag can be a trigger for an abusive event.

### Emotional Safety Planning and Self-Care

Physical safety is important, but it's also important to take care of the emotional wellbeing of abused persons. Planning emotional safety is about developing a plan that helps accept different emotions and decisions, a plan that will build resilience to deal with the impact of abuse. Steps to advise to the elderly victim of abuse include:

- Seek out supportive caring people
- Work towards achievable defined goals
- Create a peaceful physical place where your mind can relax and feel safe
- Remind yourself that You are special and important
- Be kind to yourself
- Practice self-care activities, i.e.: keeping a personal journal, reading a book, taking a walk, having a cup of coffee, knitting, painting, watching a favourite program, listening to the radio/ or favourite music, baking, praying, cuddling a pet, singing, etc.

**Steps to create a Safety Plan in case of domestic violence (Centre for Family Support, 2021)**

1. Prepare a list of emergency numbers to keep with you at all times (Police, friends, ambulance, etc.).

2. Identify places to go if you have to leave, even if you think it will never happen.

3. Prepare a bag with the necessary things and store it in a place accessible to you, unknown to the perpetrator, where you can quickly retrieve them. Make sure that there is no chance of the perpetrator finding it, as finding the bag can be a trigger for an abusive event. Items recommended to pack:

- ID card, passport, driving license
- money, payment cards
- mobile phone
- keys to the apartment, car, work
- medications, prescriptions
- insurance card
- school and work certificates, (grand)children's health books
- notebook with addresses and telephone numbers
- birth certificates of (grand)children and marriage certificate
- clothes, underwear.

4. Tell your close relatives, family, neighbours, etc. about your situation. Their help is very important to you. Ask them to call the police when your safety is in danger.

5. Agree with your neighbours and friends a specific signal, a sound that will inform them that you and your (grand)children are in danger and their help or the Police are called.

6. Talk to the (grand) children if they may be involved - they should be prepared for possible violent events. Teach them to call the police and give signs to their neighbours. Work out a sign to call for help with them.

7. Consider how the perpetrator behaves and reacts when his/her anger is approaching: identify the signals of the impending violence from the perpetrator (what s/he says, how s/he behaves under the influence of alcohol, what his/her facial expression is, what gestures s/he makes, whether any obsessive thoughts appear, etc.), what can cause to defuse the threatening situation.

8. Make a copy of the documents that are important to you, keep them in a place inaccessible to the perpetrator, e.g. with trusted friends; the perpetrator, having your documents, may try to destroy them or use them against you.

9. Open your own bank account, you will be able to manage your money.

10. Create several plausible reasons for leaving the house at different times of the day or night. Ex. trip to the grocery store, spending time with friends, staying at work longer, finding unnecessary errands to complete.

11. If possible, practice how to get out safely, including (grand)children, if they live with you. Will you use doors, windows, or stairs? Check this escape route so that you know if it will be usable for you in the moment of an attack and will ensure you leave home as quickly as possible.

12. Plan for what to do if the perpetrator finds out about your plan.

13. If possible, keep weapons like guns and knives locked away and stored as inaccessibly as possible.

15. Be mindful of how clothing or jewellery could be used to physically harm you. Avoid wearing scarves or jewellery that can be used to harm you.

16. Back your car into your driveway when you park at home and keep it fuelled. If possible, keep the driver's door unlocked with the rest of the doors locked to allow for quick access to the vehicle.

17. If violence is unavoidable, make yourself as physically small as possible. Move to a corner and curl into a ball with your face protected and arms around each side of your head, fingers entwined.

## 8. Risk of professional burnout – a few words for Professionals

Working with the elderly who may be or are victims of violence can bear various and ambivalent feelings:

- not having adequate skills or support to deal with a certain case/situation
- lack of self-confidence in social and healthcare personnel in regard to effective reaction to suspicion of mistreatment
- almightiness, being assured of knowing everything on how to react and what to do
- confusion – anger resulting in helplessness and frustration at:
- no results from the efforts undertaken,

- inadequate or non-existent (quality) services for older abused persons, no simple and quick solutions
- the time it takes to listen and support,
- lack of cooperation from the other party – the abused person
- the recurrence of the violence due to the victim coming back to the perpetrator
- overprotective attitude and behavior from the professional
- withdrawal
- fear (of a perpetrator)
- empathy, sympathy, internalization of the victim's feelings and suffering.

**Strategies to support professionals in screening for abuse victims**

Clinical supervisors and social workers must have a significant level of **training** regarding not only screening for older adult mistreatment but also managing this type of a situation. In the same sense, tools and procedures developed for healthcare institutions and home care must not only cover screening but also interventions related to older adult mistreatment.

The Screening process requires a combination of psychosocial, medical, and legal knowledge, that may be different in case of different personnel. It can also impact the interpretation of results. What could help is definitely **providing specific guidelines**, colleagues' and organizational support/resources. The screening procedure must go beyond screening itself and help them develop person-centered interventions within the context of clinical supervision. The procedure must address questions: how to screen, which questions to ask the client/patient or family, and how to intervene. The newly implemented screening procedure then has potential not only to support victims of abuse (once revealed), but also to increase professionals' sensitivity to subtle signs of mistreatment.

In practical research and test implementations of the screening process some participants reported "not documenting the information because of confidentiality issues and unclear procedures" (Couture et al. 2016, p. 17). In focus groups that followed the tests they mentioned that maintaining a relationship of trust is more important for some social and health care professionals than discussing older adult mistreatment with potential victims. In such situations having a specific procedure in place and a training addressing the confidentiality questions would ensure that implementation of the screening procedure happens with a full span, and is not dependent on the biased approach and uneven competences among the professionals.

Another concern resulting from research is that the screening tool may not be used systematically, especially by the more experienced professionals, who claim they can sense the violence clues without needing to ask a series of questions. At the same time such a screening tool provides structure and support for screening for less experienced workers.

Besides the above-mentioned organizational and work environment factors, health care and social care institutions willing to effectively screen for abuse victims should also consider

**regular supervision** as a tool for prevention and dealing with potential trauma (Powell et al., 2015, Discussion).

Supervision can have the following forms:

- training regarding the screening procedure applied
- ongoing supervision – shadowing
- caseload evaluation by each social worker/healthcare professional
- weekly 30-min individual supervision meetings with their supervisors and discussion about the cases screened.

Well conducted supervision should result in increased knowledge about older adult mistreatment and risk factors and higher level of perceived competency to deal with cases. There should be new intervention plans created for clients/patients to specifically address the mistreatment situation and implementation of support from other institutions and service providers should follow naturally.

## Active Learning Activities

A series of exercises that can be used to practically apply the theoretical contents thought in the module.

### EXERCISE 1 - POST-IT PARADE

**Aim of the exercise:** helping participants empathizing with their selves.

**Material needed:** post-its

**Instructions:** provide to participants several post its. Ask them to write on post-it notes all the feelings or situations that they expect may be experienced by a professional working with potential victims of violence in their country, organization, culture, or support system. Ask them to use one post-it note for each feeling or situation they can think of.

The facilitator then collects the post-its as they are being produced by all training participants and places them on a wall/flipchart, grouping them for categories.

The suggested answers from the group are then being discussed on a forum and the trainer complements the knowledge, if needed.

### EXERCISE 2 - GAME "REPLAY"

**Aim of the exercise:** reviewing the contents of the module

**Material needed:**

- A list of 8-12 open-ended questions to repeat with the group.
- A flipchart or a board[13] with the pattern as shown to the right.
- A time meter (e.g. a stopwatch on a smartphone).
- Two colour cards that allow the other group to be clearly shown "yes" or "no".
- A small prize for the winning team (recommended, not necessary).


**Instructions:** The trainer informs participants about the rules:

- Teams take turns choosing a question number.
- The answer to each of the questions is 1 point. There are 3 hidden bonus questions for 2 points.
- After the question is read by the leader, the team has 20-30 seconds to prepare an answer.
- The second team listens to the answer and relates to it while picking up a yes/no card. A yes card means they agree with the answer. The no card means that the answer is not completely correct.
- If the opponents have added important information, the teams divide the point for the question.
- If the opponents corrected a significant error in the team's response – they take over all points.
- Regardless of the result, the next question is chosen by the second team.
- The winning team receives applause and a small prize from the leader.

Remember that the most important goal of the game is not to win or have fun, but to repeat the material effectively. Therefore, the trainer watches over the merits of the answer, does not hesitate to fill in the missing information briefly and quickly, so as not to disturb the dynamics of the game.

**Note for trainer:** Questions for the repetition of the material should take the form of an open question or a request to provide a certain number of features or name all elements of the closed catalogue. From the questions, choose 3 to be the bonus questions.

**Examples of questions:**

1. What can governments do (more of) to prevent elderly abuse? Give at least 3 ideas. For listing more strategies, there are extra points – a **bonus** question.

[13] The numbers in the board represent the question number. During the game, cross out those questions that have already been asked. This not only helps participants to shoot new questions but also builds up tension. The optimal number of questions is between 8 and 12. There should always be an even number. Make a note of the team name and underneath keep track of their score

2. What are the symptoms of PTSD? Name the main 3 groups.
3. Give 5 examples of the emotional self-care technique.
4. List 5 different feelings that may stop an elderly victim of abuse from disclosure.
5. Name at least 7 steps in creating a safety plan (**bonus** question).
6. During screening you found out your elderly patient is a victim of abuse. What could be your first 3 steps to take to manage this disclosure?
7. What charges can a perpetrator face once reported to the prosecutor? Name 3 to win a point, name at least 6 to get a **bonus** point.
8. What are the basic healthcare rights per EU Charter of Patients' Rights?
9. Name at least 3 types of therapy of PTSD.
10. Give examples of at least 3 things a person should NOT say to an elderly victim of violence with PTSD.

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## Learning assessment

You can use the following questions to assess the learning of your students. Correct answers are underlined.

**1.** The key elements in most definitions of elder abuse are: actions and omissions on the side of the perpetrator that cause harm or create a serious risk of harm to a vulnerable frail elder. The perpetrator can be a caregiver or other person of trust to the elder. True or False?

**2.** Unexplained falls and injuries, fractures of undetermined causes, burns and bruises in unusual places or of an unusual type, cuts, finger marks or other evidence of physical restraint, marks on the skin suggesting that the individual may have been tied, bound are consider signs of physical abuse. True or False?

**3.** Which of the following are risk factors for elder abuse?

a) Dependency, disability of the older adult
b) Poor mental health of the older adult
c) Being female
d) Lack of supporting/training services for caregivers
e) All of the above

**4.** The term "routine enquiry" refers to investigating intimate partner violence without using the public health criteria of a complete screening programme True or False?

**5.** A positive screen for elder abuse means:

a) that elder abuse is surely occurring

b) that further information should be gathered

c) that the person is not victim of abuse

**6.** Detecting abuse in older people with dementia compared to older people without dementia is:

a) more challenging

b) less challenging

c) there is no difference

**7.** In what ways can consent be provided in a routine investigation/screening?

a) only explicitly
b) only implicitly

c) both explicitly and implicitly

**8.** During a routine investigation/screening procedure, the interviewer (the professional) has a "duty to report" in all cases. True or False?

**9.** When documenting answers to open questions, the interviewer should report them *verbatim*. True or False?

**10.** What are the main symptoms of Post-Traumatic Stress Disorder (PTSD)?

a) Flashbacks and nightmares
b) Avoidance and numbing
c) Being 'on guard'
d) All the above

**11.** Which of the grouped activities below together are good examples of the emotional self-care technique.

a) help others, your relatives and people in need (e.g. donate blood), become a volunteer, take positive action; spend time in nature – doing outdoor activities
b) stay away from other people; try relaxation exercises; take holidays on your own
c) take time to be with family and friends; eat and exercise regularly per your possibilities; drink lots of alcohol or coffee or smoke more
d) hide your feelings, don't keep it to yourself; avoid talking about it

**12.** Which of the below different feelings may stop an elderly victim of abuse from disclosure.

a) Care or Shame for the perpetrator
b) Guilt
c) Hope
d) Fear
e) All the above