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SAFE

A SAFER LIFE FOR OLDER WOMEN

A TRAINING MANUAL FOR PROFESSIONALS

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Introduction

This manual is designed for teachers and trainers to deliver education and training on the prevention of and response to violence and abuse against older women. The main target group for training is professionals of health and social care. Trainers should have field experience working with older victims and survivors for understanding the educational needs of the professionals. This manual provides information and offers a strong educational tool. The manual provides ideas for the basic education of social and health care students and in-training and further training of professionals.

Violence against older persons is a shared field between domestic violence services and elderly care. This manual aims to combine these two separate fields. The manual is divided into 5 modules:

1) Module 1 - Perspectives to violence against older women
2) Module 2 - Working with an older survivor
3) Module 3 - Practical procedures
4) Module 4 - Working as a professional
5) Module 5 - Conducting Training with Social and Health Care Professionals

Each module includes the topics and their theoretical background, learning outcomes and key messages. Learning outcomes help the trainer to build the content of the training and key messages to focus on the key issues of the training. It is important that the trainer knows what s/he wants the training participants to achieve through each session and exercises. The trainer offers the basic foundation of knowledge on the topic and helps professionals to connect their existing knowledge and skills as well as their past experiences with the new knowledge. The manual is based on both latest studies and knowledge in the field as well as experiences gained through SAFE project activities. The suggested teaching methods (exercises) are published as a separate booklet.

Objectives of the manual

- to improve professional development of teachers and trainers to work as educators in violence against older persons and in gender-specific issues
- to improve quality of teaching and training for developing working life-oriented training curriculum
- to build capacity of social and health care professionals to identify and intervene in abuse of older women
- to support social and health care authorities and professionals as well as other stakeholders to develop intervention measures in cases of violence against older women

Using case studies in training

- By using case studies the participants become actively engaged in problem solving, analytical and critical thinking, decision-making in complex situations and coping with ambiguities of the cases.
- Case studies are particularly useful in short training courses. They also provide realistic simulations of real life.
- In longer training courses it may be even more effective to get participants to develop their own case studies based on their own experiences in work life.
- The trainer can ask questions designed to make participants focus on particular aspects of the problem. Case studies can also be supported by visual aids, e.g. videos.
- Case studies may also be used in role playing: the trainer can provide the participants with only part of the case study and get the participants to act out the scene.
- The trainer can provide tools for a systematic approach to the analysis of the case studies, e.g. SWOT analysis (Strengths, Weaknesses, Opportunities and Threats), or questions:
    - What is the problem in this case?
    - What is the context of the problem?
    - What is the goal of the problem-solving of the situation?
    - What key facts should be considered?
    - What alternatives are available in the case?
    - What would you recommend for a solution — and why?

Module 1: Perspectives to violence against older women

Topics

- Definitions
    - Elder abuse
    - Violence against older women
    - Domestic violence
- Theories of abuse
- Diversity of violence against older women
    - Prevalence, forms and special features of violence against older women
    - Perpetrators of older women
- Human rights and women's rights approach

Learning outcomes

The participants

- understand the gendered nature of violence against older women
- understand the diversity of violence against older persons
- understand why violence occurs – can describe theories on violence against older persons
- become aware of ageism and gender discrimination from the perspective of Human Rights and Women's Rights

- can challenge their own attitudes and beliefs toward older women

Key messages

- it is essential to help participants to become aware of thoughts, attitudes and beliefs on older women and violence against them
- violence against older persons is a different phenomenon compared with violence against other age groups
    - changes in physical and cognitive health and their connection to violence are seen as risk factors;
    - how ageing is experienced/seen by individuals and society
- violence against older women has its own characteristics due to the situation of older women

Suggested teaching methods

Exercise 1: Awareness raising on thoughts, attitudes and beliefs on older women
Exercise 2: Quiz on ageing and older people
Exercise 3: Expectations for women and men in society
Exercise 4: Myths and facts about violence against older women
Exercise 5: Where do you stand on human rights?
Exercise 6: Theories of violence against older persons
Exercise 7: Violence against younger and older women

Definitions

Elder abuse

When talking about violence and abuse toward older people, the term 'elder abuse' is commonly used. As per the most commonly used definition by Action on Elder Abuse in 1995[1], elder abuse is:

> *"A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."*

An Irish Working Group on Elder Abuse (2002) further highlighted the importance of thinking elder abuse as an umbrella concept for the wide range of harm inflicted to older people or violations to their human and civil rights[2]. Overall, it has been debated whether the expression "relationship where there is an expectation of trust" shared in these definitions should be a defining factor in the phenomenon. Abuse sometimes occurs without any expectation of trust and in complete absence of a relationship between the offender and the victim, for example in cases of fraud and bag-

[1] Action on Elder Abuse (n.d.) What is Elder Abuse? Available at: https://www.elderabuse.org.uk/Pages/Category/what-is-it
[2] Working Group on Elder Abuse (2002). Protecting Our Future. Report of the Working Group on Elder Abuse. September 2002. Available at: http://www.ncaop.ie/publications/research/reports/73_ProtectingourFuture.pdf

snatching.[3] The following, broader definition by the US Department of Justice and Department of Health and Human Services (2014)[4] takes such incidents into consideration:

> Elder abuse *"includes physical, sexual or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community, or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability."*

Violence against older women

Age alone does not define abusive behaviour as elder abuse. An older woman may experience abuse by the same partner throughout her life. Younger and older victims of violence share the same characteristics and consequences, such as fear of retaliation and stigmatization, desire not to leave home and to protect the abuser, emotional distress and, in cases involving persons with decreased capacity, difficulties in reporting the abuse. However, despite the similarities across the life-course, there are profound differences in terms of what kinds of interventions are appropriate and what types of services are available.

This curriculum uses the term 'violence against older persons' when generally describing the phenomenon. The curriculum, however, highlights the gendered nature of violence against older persons. The phenomenon of 'violence against older women' is rooted in the same gender inequalities and norms as 'violence against women'. Violence against older women has been defined by WHO in 2014[5] and 2015[6] as follows:

> *"Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering" to older women, "including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." "This can also include financial abuse, exploitation or deprivation of resources, neglect, and abandonment".*

Domestic violence

While violence against older women can be perpetrated by persons who do not have a relationship of trust with the victim, as it can happen in a community care and institutional care context. This

[3] M. O'Brien et al. (2016). Elder Abuse, Context and Theory: Finland, Ireland, Italy and Romania. A publication by Erasmus+ S.T.Age project. Available at: http://www.combatingelderabuse.eu/wp-content/uploads/2016/04/Booklet_stage.pdf

[4] M-T Connolly, B. Brandl and R. Breckman (2014). The Elder Justice Roadmap. A Stakeholder Initiative to Respond to an Emerging Health, Justice, Financial and Social Crisis. US Department of Justice & Department of Health and Human Services. Available at: https://www.justice.gov/file/852856/download

[5] World Health Organization (2014). Worldwide action needed to address hidden crisis of violence against women and girls. News release 21.11.2014. Available at: http://www.who.int/mediacentre/news/releases/2014/violence-women-girls/en/

[6] World Health Organization (2015). World report on ageing and health. Available at: https://www.who.int/ageing/events/world-report-2015-launch/en/

curriculum uses the term 'domestic violence' to draw attention particularly to violence and abuse including a family/close relationship dynamic. This is to better accommodate the target groups of this manual. According to the World Health Organization (WHO) domestic violence can be defined as:

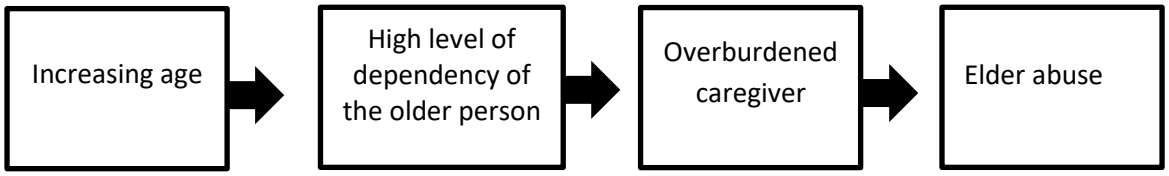
> *"... any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors ".*

Sometimes domestic violence is also referred to as domestic abuse or family violence. Domestic violence against women often gets the form of Intimate Partner Violence (IPV) with coercive elements. Women are far more likely than men to be IPV victims and to be injured or murdered by an intimate partner.[7] IPV among older persons can manifest itself in two ways, as IPV developed into the relationship early on or as a new experience of violence occurring when persons age. New experiences of violence at old age can also occur when an older person becomes involved in an abusive relationship, e.g. through a new marriage. IPV developed into the relationship as part of a life-cycle is abuse with early start that continues into the victim's old age.[8]

Theories of abuse

Theories represent a systematic way of understanding behaviours, situations and events. Theoretical orientation not only steers the study of a social issue but the integration of theoretical approaches into practical interventions. In order to fully intervene, professionals must understand the issue under study in all its complexity. Most common theories aiming to explain violence against older people include:

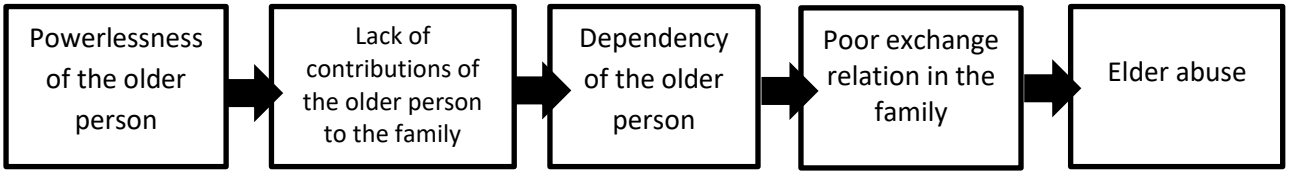
Caregiver stress theory focuses on the family members caring for an older adult with significant care needs. Without support, the carer may be unable to adequately manage his/her responsibilities and become overwhelmed and frustrated, leading to abuse. In many instances, the person caring may not have the knowledge and skills to manage a particular situation, or may be unaware that their behaviour is considered abusive. Caregiver stress model has been criticized for giving an idea that violence can occur because caring is too difficult[9]. This message indirectly blames victims for being too needy and may release perpetrators of the responsibility of abusive behaviour.



[7] G. Zara & S. Gino (2018). Intimate Partner Violence and its Escalation Into Femicide. Frailty thy Name Is "Violence Against Women". Frontiers in psychology, 9, 1777.
[8] C. Policastro & M. Finn. (2015). Coercive Control and Physical Violence in Older Adults: Analysis Using Data From the National Elder Mistreatment Study. Journal of Interpersonal Violence May 14, 2015, 1–20.
[9] B. Brandl & J. A. Raymond (2012). Policy Implications of Recognizing that Caregiver Stress Is Not the Primary Cause of Elder Abuse. Generations – Journal of the American Society on Aging. Fall 2012, Vol. 36. No. 3.

Graph source: Mathew and Nair (2017) [10]

Social exchange theory focuses on the social exchange within a relationship. It is based on the idea that social interaction involves the exchange of reward and punishment between at least two people and that all individuals seek to maximise reward and perform instrumental services. Where this balance is upset or perceived to be upset, and one party feels they are not getting a fair return for their expenditure, the disadvantage party may resort to abuse. For example, an adult child assisting a parent may feel entitled to keep some of their pension.[11] In the social exchange theory of ageing, a perceived loss of status and power is associated with ageing. Because resources decline with age (e.g. health, income, community roles, ability to work to provide for others), old people are more likely to be in unequal or imbalanced social exchanges. These imbalanced relationships can result in a power disadvantage, were in the older person is required to depend or relay on others to meet their basic needs.[12]



Graph source: Mathew and Nair (2017) [13]

Social learning theory proposes that violent acts are learned behaviour transferred through the process of modelling where the person has learned to use violence in an earlier context to either resolve conflicts or obtain a desired outcome. For instance, a child has learned by watching his/her parents relationship that abusive behaviour is a way to get what one wants. In violence against older persons, an abused child may abuse her or his parents as the caring roles turn upside down. In addition, when an abusive spouse becomes ill or disabled, the previously abused partner may start abusing his/her spouse.[14]

Power and control theory, feminist theory highlights men's power and control over women. According to the approach, men's violence against women should not be seen as arbitrary but within its social and cultural context: among those practices that men use to keep women in their subordinate position, violence and abuse are the most effective forms of control. This theory

[10] A. Mathew and S. B. Nair (2017). Theoretical Perspectives on Elder Abuse: A Framework Analysis for Abused Elderly in Kerala. IOSR Journal of Humanities and Social Science (IOSR-JHSS) Volume 22, Issue 9, Ver. 4 (September. 2017).
[11] Y. Momtaz, T. Aizan Hamid & R. Ibrahim (2013). Theories and measures of elder abuse. Review Article. Psychogeriatrics 2013; 13: 182–188.
[12] J. Dowd (1975). Aging as Exchange: A Preface to Theory. Journal of Gerontology 1975, Vol. 30, No. 5, pp. 584-594.
[13] A. Mathew & S. B. Nair (2017). Theoretical Perspectives on Elder Abuse: A Framework Analysis for Abused Elderly in Kerala. IOSR Journal of Humanities and Social Science (IOSR-JHSS) Volume 22, Issue 9, Ver. 4 (September. 2017).
[14] Y. Momtaz, T. Hamid and R. Ibrahim (2013). Theories and measures of elder abuse. Review Article. Psychogeriatrics 2013; 13: 182–188.

focuses on spousal abuse as a significant dimension of violence against older persons, wherein older women are more vulnerable because they tend to have less power than men.[15]

Generational Intelligence Framework offers an insight into violence against older persons that incorporates both interpersonal relationships and the wider social environment. Biggs and Lowenstein (2011)[16] define generational intelligence as "the ability to reflect and act, which draws on an understanding of one's own and others' life-course, family and social history, placed within its social and cultural context". According to this theory, attitudes and ideas about other generations and age groups are shaped by society and culture. Negative social attitudes towards older adults are acknowledged as a permissive element for violence, creating a context or social space that makes the behaviour possible, even likely. In the context of generational intelligence, violence against older persons is seen as a form of damaged intergenerational relations, due to ageism or dysfunctional organisational environments.[17]

The Ecological Model Theory (Social Ecology Theory) explores the relationship between individual and contextual factors and explains violence as the result of multiple influential factors on behaviour. Ecological theory is useful for understanding violence against older persons because it offers a broad understanding of risk factors, prevention and interventions as it applies to the older victim, the perpetrator, the context of caregiving and the broader societal context.

Social ecology theory has been applied as The Ecological Model by WHO[18] to examine the roots and risk factors of violence against older persons. The following systems may overlap, since risk factors found in one system may also appear in another:

- Microsystem (individual level) refers to the relationship between the older person and their caregiver and close family
- Mesosystem (relationship level) refers to the relationships between the older person and his/her wider community
- Exosystem (community level) focuses on the interactions e.g. between an older person and elderly care services in the community and society, and their impact on his/her well-being
- Macrosystem (societal level) refers to the beliefs in and attitudes towards older persons, e.g. how valuable older people are seen in the society

Diversity of violence against older women

Prevalence of violence against older persons

[15] Ibid.
[16] S. Biggs & A. Lowenstein (2011). Generational Intelligence: A Critical Approach to Age Relations. London: Routledge. 1st edition.
[17] Ibid.
[18] Krug EG, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano 2002 (ed.). World Report on Violence and Health. World Health Organization. Geneva.

It is hard to estimate the prevalence of violence against older persons in our society. Some countries have better developed reporting systems while in others data is not yet systematically collected. Overall at the European level, the DAPHNE III AVOW Project, provided the following abuse prevalence rates for older women aged 60 years and above in the participating countries (Austria, Belgium, Finland, Lithuania, and Portugal): neglect: 5.4 per cent; emotional abuse: 23.6 per cent; financial abuse: 8.8 per cent; physical abuse: 2.5 per cent; sexual abuse: 3.1 percent; violation of rights: 6.4 per cent; overall abuse: 28.1 per cent[19].

The following paragraphs will address the prevalence in the SAFE project countries (Finland, Romania, Italy, Greece, Portugal) separately using additional resources.

In Finland, figures vary depending on the studies reviewed. Kivelä et al. (1992)[20] reported that between the age of 60 and 75, 9 per cent of women and 3 per cent of men experienced abuse, rising to 8.3 per cent for women and 7.7 per cent for men in those over 75 years of age in two municipalities in Finland. The AVOW research project found that 25 per cent of Finnish women over the age of 60 living at home had experienced violence or abuse during the past 12 months[21]. Population based surveys in Finland and in the Nordic countries show that between 4 per cent and 6 per cent of older people experience some form of abuse in home settings and that abuse and neglect in institutions may be more extensive than generally believed.[22]

In Italy, prevalence of violence against older persons, in general, can only be estimated from comparative research carried out at an EU level. For example, the ABUEL Project, Abuse and Health among elderly in Europe (2012), using a sample of people between 60-84 years old in Italy, found that 13.4 per cent of those surveyed reported abuse - excluding abandonment and negligence[23]. This sample did not include more vulnerable older people or those living in residential and other care setting. Men reported higher figures than women (60.7 per cent, male; 39.3 per cent, female). People in the 70-74 age group reported the highest incidences of abuse.[24]

In Portugal, the first national prevalence study, "Aging and Violence," estimated the prevalence of abuse and neglect of older people in family settings over a 12-month period. The study was conducted through a telephone survey of a representative probability sample (N = 1,123). Overall, 12.3% of older adults had experienced violence against older persons in family settings in this

[19] Luoma et al. (2011). Prevalence Study of Abuse and Violence against Older Women. Results of a Multi-cultural Survey Conducted in Austria, Belgium, Finland, Lithuania, and Portugal. (European Report of the AVOW Project). Finland: National Institute for Health and Welfare (THL).
[20] S-L Kivelä et al. (1992). Abuse in old Age – Epidemiological Data from Finland. Journal of Elder Abuse and Neglect. 4(3). 1-18.
[21] M-L. Luoma et al. (2011). Prevalence Study of Abuse and Violence against Older Women. Results of a Multi-cultural Survey Conducted in Austria, Belgium, Finland, Lithuania, and Portugal. (European Report of the AVOW Project). Finland: National Institute for Health and Welfare (THL).
[22] M-L Luoma & M. Koivusilta, (2010) Literature review, Finland and the Nordic countries. National Institute for Health and Welfare, Finland.
[23] Di Rosa et al. (2015). Mistreatment of older persons in Europe and in Italy Results from the ABUEL study. CAREGIVER DAY 2015 Prevenire l'Abuso verso gli Anziani Carpi (MO). Carpi.
[24] Ibid.

study.[25] In the AVOW study[26] the prevalence for overall abuse among the Portuguese respondents was as high as 39,4 per cent.

In **Greece**, there is no official data regarding older victims of DV and violence against older persons. According to the ABUEL study findings[27] prevalence of abuse in Greece in the last 12 months, was reported as such: psychological abuse at 13,2%, physical abuse at 3,4%, sexual abuse at 1,5%, financial abuse at 4% and injuries at 1,1%. The same study states that in Greece, women reported higher figures in all types of abuse and injuries than men.

In **Romania**, there is a lack of data regarding the prevalence of violence against older persons. However, the Special Eurobarometer Survey[28] found that Romania is the only country in the EU where the majority of population (86 per cent) considers that poor treatment, neglect and abuse of older people is widespread at national level. Romania also ranked the highest in terms of the perceived risk of older people being maltreated generally; 84 per cent of the Romanian population believe that older people are living in poor conditions, 86 per cent consider that older people lack attention to their physical needs, 84 per cent consider that older persons receive inadequate care, 76 per cent think that older persons are psychologically abused and 71 per cent think that they are physically abused.

Forms of violence against older persons

Form of violence against older people, as defined by WHO (2002)[29], include:

- **Physical abuse** – the infliction of pain or injury, physical coercion, or physical or drug induced restraint. Physical abuse may include hitting, slapping, pushing, kicking, spitting, misuse of medication, restraint or inappropriate sanctions.
- **Psychological or emotional abuse** – the infliction of emotional abuse, verbal abuse, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, isolation or withdrawal from services or supportive networks.
- **Financial or material abuse** – the illegal or improper exploitation and/or use of funds or resources. This can include theft, coercion, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, misuse of power of attorney or the misuse or misappropriation or property, possessions or benefits.

[25] A.P. Gil et al. (2015). Elder abuse in Portugal: findings from the first national prevalence study. Journal of Elder Abuse and Neglect 2015;27(3):174-95.
[26] M-L. Luoma et al. (2011). Prevalence Study of Abuse and Violence against Older Women. Results of a Multi-cultural Survey Conducted in Austria, Belgium, Finland, Lithuania, and Portugal. (European Report of the AVOW Project). Finland: National Institute for Health and Welfare (THL).
[27] J. Soares et al. (2010). Abuse and Health among elderly in Europe. Kaunas: Lithuanian University of Health Sciences Press.
[28] European Commission, Special Eurobarometer 283 (2007) Health and long-term care in the European Union. Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf
[29] World Health Organization (2002). World report on violence and health. Geneva:WHO. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/chapters/en/

- Sexual abuse – non-consensual touching or non-touching sexual contact of any kind with the older person. Sexual violence can be the continuation of domestic violence into old age. It can also be incestuous acts towards an older person. These acts also qualify as sexual abuse if they are committed against a person who is not competent to give informed approval.
- Neglect/abandonment – intentional or unintentional refusal or failure to fulfil a caretaking obligation by e.g. ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating, and failure to provide appropriate equipment.

Special features of violence against older women

Most literature on violence against older persons does not pay attention to the significance of gender. However, many researchers criticize the use of gender-neutral terms such as 'elder abuse' due to the special circumstances and challenges older women face as victims of violence. There is a lack of visibility of older women also in the feminist discourse on violence against women.[30] There has traditionally been a gap between elderly care, domestic violence and feminist women's services also in practice: elderly care services do not pay attention to the gender of the victims and feminist services do not pay attention to older women as victims.

In terms of characteristics of the phenomenon, the same main trends apply with older populations than with those younger. Power and control play central roles in violence against older women: older women are generally more likely than men to be victims of violence and most perpetrators are men. The inequality and discrimination experienced by women intensify with old age.[31] Specifically speaking, older women face cumulative discrimination: they experience discrimination due to their gender over the lifespan and when they grow older they additionally face ageism. Older female victims of violence face triple jeopardy being part of three different marginalized groups: they are old, abused and female.[32] Module 2 will further describe the challenges and consequences older women face as victims of violence.

In addition to the forms defined above, older persons may also face forms of violence usually seen as concerning mainly younger age groups, such as coercive control as a form of intimate partner violence and sexual harassment and stalking. This concerns particularly older women.

- Coercive control is a pattern of behaviour that involves the abusive partner's use of physical violence and related tactics, such as isolation, emotional abuse, and/or economic abuse, as

[30] UN DESA Division for Social Policy and Development (2013). Neglect, abuse and violence against older women. United Nations. Available at: https://www.un.org/esa/socdev/documents/ageing/neglect-abuse-violence-older-women.pdf
[31] P. Brownell (2014). Neglect, abuse and violence against older women: Definitions and research frameworks. Review article. SEEJPH 2014, posted: 13 January 2014.
[32] B. Penhale (2003). Older Women, Domestic Violence, and Elder Abuse: A Review of Commonalities, Differences, and Shared Approaches. Journal of Elder Abuse & Neglect, 15: 3-4, 163-183.

a means of maintaining control over all aspects of their partner's life. The victim becomes captive in an unreal world created by the abuser, entrapped in a world of confusion, contradiction and fear. This type of violence follows regular patterns of behaviour.[33]

- Sexual harassment is means unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature.
- Stalking is unwanted or obsessive attention. Stalking behaviours are related to harassment and intimidation and may include following the victim in person or monitoring them.

Perpetrators of older women

Research has shown that over 50 % of all perpetrators of older women are spouses/partners. Social and health care professionals often see adult children as the main perpetrator group. This misconception is likely because the adult children identified as perpetrators often have mental and/or substance abuse problems and hence are or become users of social and health services.

The prevalence rate by type of perpetrator in the AVOW study[34] differed by type of abuse. The most prevalent category of abuser in the category of physical and sexual abuse, as in IPV studies on adult women of all ages, was the spouse/partner (50.7 per cent and 55.4 per cent, respectively). Spouses/partners was also the most prevalent category of abuser for emotional abuse (43.9 per cent) and violation of rights (59.0 per cent). While spouses/partners remained the most prevalent category of abuser for financial abuse (33.7 per cent), this was closely followed by the categories of daughter, son, son/daughter in-law (28.7 per cent). The most prevalent category of abuser for neglect, however, was son and daughter or son/daughter in law (40.6 per cent), followed by spouse/partner (17.3 per cent), paid home help or caregiver (15.8 per cent) and other family members (15.5 per cent).

Human rights and women's rights approach

Violence against older persons is a form of violation of human rights. In particular, different forms of abuse can violate individual human rights such as the right to autonomy, freedom and privacy. At the same time, violation of personal rights of older people can be seen as a form of abuse in itself. Professionals, researchers and governments are becoming more and more aware that to protect older people from poor treatment and cruel practices and to empower them to speak up social policy must move from a needs-based approach to a rights-based one. As a result, human rights are increasingly becoming the foundation of elder abuse prevention practices.

[33] S. Walby & J. Towers (2018). Untangling the concept of coercive control: Theorizing domestic violent crime. Criminology & Criminal Justice 2018, Vol. 18(1) 7–28.
[34] Luoma et al. (2011). Prevalence Study of Abuse and Violence against Older Women. Results of a Multi-cultural Survey Conducted in Austria, Belgium, Finland, Lithuania, and Portugal. (European Report of the AVOW Project). Finland: National Institute for Health and Welfare (THL).

Human rights are the minimum standards required for all individuals to live with dignity and be treated with respect. They are legal guarantees that protect individuals and groups against infringement upon their fundamental freedoms, dignity and entitlements. They entail both rights and obligations. States assume obligations and duties under international law to respect, to protect and to fulfil human rights. The Universal Declaration of Human Rights, adopted by the General Assembly of the United Nations (UN) in 1948, is the most important international human rights instrument. The core idea of the declaration is set out in Article 1, which states that all human beings are born free and equal in dignity and rights. The rights included in the declaration are, e.g. the right to life, liberty, due process, ownership of property, education, political participation, work and leisure. The declaration also promotes non-discrimination and equality by stating that *"everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind".* While the Universal Declaration of Human Rights applies to all persons regardless of age, age is not listed explicitly as a reason why someone should not be discriminated against. No systemic and comprehensive regional conventions to protect older people's rights yet exist, complicating efficient prevention of violence against older persons.

Many human rights conventions and instruments exist, however, to protect the rights of other specific, vulnerable groups. Such groups include, e.g., children, disabled persons and women. The Convention on the Elimination of All Forms of Discrimination against Women was adopted by the UN in 1979 and entered into force in 1981. The 2011 Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) is the first instrument in Europe to set legally binding standards to prevent gender-based violence. Since 2014 when the convention came into force, it has been the obligation of the state to take measures to prevent violence against women, protect its victims and prosecute the perpetrators.[35]

Non-discrimination is a cross-cutting principle in international human rights law. Ageism and sexism, stereotyping and discrimination against individuals or groups on the basis of their age and sex, create contexts where violence against older persons is permissible. Hence in a society that respects the rights of all people, ageism as a root cause is to be addressed at a systems level and as a principle to guide the development and implementation of best practices against violence against older persons. In addition to international instruments, such as the planned Convention on the Rights of Older Persons, and action taken at a national level, practical applications against ageism and sexism are needed at individual, family and community levels. Health and social care professionals are in key position in protecting older women from treatment violating their rights and empowering them to acknowledge and use their rights to improve their well-being.

For more information about human rights as they relate to older people, see: M. O'Brian et al. (2019). My Human Rights, My Well-Being. A booklet by the Two Moons project: https://twomoons.eu/outputs/

[35] Council of Europe (2019). Treaty No.210. Council of Europe Convention on preventing and combating violence against women and domestic violence. Available at: https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/210

Module 2: Working with an older survivor

Topics

- Long-term suffering and its consequences
    - Trauma caused by violence for older women
- Help seeking process and challenges of older women victims of domestic violence
    - Why older women do not leave?
- Working with older women
    - Risk factors, signs, red flags of violence on older women
    - Psychological First Aid (PFA)

Learning outcomes

The participants

- understand the long-term trauma (PTSD) caused by violence and its effects on behaviour of abused older woman
- able to recognize signs of violence in older women's life
- the capacity of the professionals is improved for working with older women victims and survivors of violence or who are at risk of violence
- are able to promote quality development of the services from the point of view of the needs of older women

Key messages

- Understanding Post Traumatic Disorder in older persons as a consequence of long-term violence is a key element in working methods of the professionals
    - how it influences older person's behaviour
        - in help-seeking
        - how they receive help
        - ability to make changes in their lives
    - challenges for the professionals
- recognition of risk factors for prevention of violence is crucial (primary prevention)

Suggested teaching methods

Exercise 8: Post Traumatic Stress Disorder (PTSD) and interaction between victim and professional

Exercise 9: Analysis of family caregiving situation

Exercise 10: Risk assessment

Exercise 11: Psychological First Aid (PFA)

Exercise 12: Safe discussion when abuse is suspected

Long-term suffering and its consequences

Individual trauma can be defined as resulting "*from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being*".[36]

The individual's experience of these events or circumstances varies greatly. How the event is experienced may be linked to a range of factors, for example the individual's cultural beliefs, availability of social support and the individual's age. Both aspects of the traumatic event, the context in which the event takes place and individual characteristics influence the person's risk for developing psychological problems subsequent to trauma. Interpersonal violence tends to be more traumatic than natural disasters because it is more disruptive to our fundamental sense of trust and attachment and is typically experienced as intentional.[37] Harmful effects may occur immediately or be delayed and the duration of the effects can be short to long term. The possible physical and psycho-social consequences of experiencing violence and abuse are numerous and varied but often include:

Cognitive and emotional consequences

- Cognitive impairment/ increased risk to develop dementing illnesses
- Depression, anxiety
- Posttraumatic disorder (PTSD)
- Suicidal thoughts/attempts
- Increased risks for developing fear and anxiety reactions
- Learned helplessness

Physical health consequences

- Increased risk for developing chronic diseases
- Exacerbation of pre-existing health conditions
- Increased susceptibility to new illnesses
- Nutrition and hydration issues
- Sleep disturbances
- Substance use
- Injuries, cuts, bruises, and broken bones
- Bone or joint problems
- Digestive problems
- Chronic pain and soreness

[36] Substance Abuse and Mental Health Services Administration 2014. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[37] International Society for the Study of Trauma and Dissociation. Trauma Faq's. Copyright © 2004-2018 by ISSTD. http://www.isst-d.org/default.asp?contentID=75.

- High blood pressure or heart problems
- Increased risks for premature death

Post-traumatic Stress Disorder, PTSD

Post-traumatic stress disorder (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 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. The three groups of symptoms common to PTSD are repeatedly experiencing the traumatic event as nightmares or flashbacks, avoidance of trauma-related circumstances and increased anxiety. Self-destructive behaviour may also follow the experience of a traumatic event, such as alcoholism, substance abuse, self-harm, and suicidal tendencies.

Help seeking process and challenges of older women victims of domestic violence

A European study[38] examined the help-seeking behaviour of older women subjected to abuse across five European countries. While overall 30.1% of the older women reported at least one experience of abuse in the past year, less than half of the victims talked about it in the informal setting or reported it to any formal agency. Victims abused by current partners or a spouse were most passive to seek help. Older women may face the following barriers to help-seeking:[39]

- Attitudes and beliefs: older victims/survivors may not be believed if they speak out about domestic violence. The preconception also is that as a mature person they should be more able to cope living with abuse.
- Barriers related to emotions: fear of being alone after several years (or decades) of marriage or a long-term relationship; fear of the unknown (some older victims/survivors have never lived alone); fear of 'starting again'; feelings of shame in relation to disclosing abuse experiences to others; and feelings of loyalty, guilt and care for the abuser.
- Coping with violence: Many of the older victims/survivors develop coping mechanisms over the years of violence and accepted violence as the norm and as part of everyday life
- Caring responsibilities: The status and role of the victim and perpetrator in terms of caring, illness and dependency is a barrier for some; preconceptions that the other person would be unable to manage without the carer.
- Having too much to lose: The form of loss in terms of the fractured relationships with adult children and grandchildren, but also pets and the role that they had in an older person's life, may prevent an older person to leave.

[38] I. Tamutiene et al. (2013). Help seeking behaviour of abused older women (Cases of Austria, Belgium, Finland, Lithuania and Portugal). Filosofija. Sociologija. 24. 217-225.
[39] M. Rogers (2016). Barriers to help-seeking: older women's experiences of domestic violence and abuse. Briefing note. Available at: http://usir.salford.ac.uk/id/eprint/41328/

- **Stigma and embarrassment** prevent older victims from contacting services or disclosing abuse to practitioners. Some older victims/survivors do not want to access services or share experiences with younger victims/survivors.
- **Unsuitable or lacking services:** Many older women feel that the services are not appropriate or not meant for them; that the services are for those who have experienced physical violence only; or that they would be not accepted in that environment.

Why older women do not leave?

While there can be various individual reasons for why an older woman would choose to stay in an abusive relationship, research has managed to find common traits. In addition to the above-mentioned barriers, the following effects may contribute to the situation:[40] [41]

Cohort effects

The generation of women who are older than 55 years and who raised their children during the 1960s and 1970s share the following traits:

- upbringing that often-reinforced traditional gender roles, including the submissiveness of women, marriage as a permanent bond and divorce as a taboo, the importance of privacy in family matters, a strong commitment to family loyalty and solidarity, and not seeking help from professionals

Period effects

Period effects mean the influence of history, events, and circumstances external to the individual:

- individual and institutional ignorance about abuse; child, domestic, and violence against older persons were not discussed or even recognized
- born before 1950, most came of age during a time when education and independence were not yet encouraged for women

Financial barriers

- many did not hold paid employment when they were younger, even women in their preretirement years may be unemployable because of both ageism and lack of work experience

Stigma and shame

- older women may be particularly likely to feel ashamed or embarrassed at experiencing abuse from their partners and they may also feel shame that they have put up with it for so long. Those starting a new relationship in later life may be embarrassed and ashamed to admit they have made a mistake.

In line with the above considerations, professionals should re-consider what successful outcomes mean in the context of violence against older women. The goal of extricating older women from their households is often not what is best or most desirable by the victim. Preventing re-

[40] T. Zink et al. (2003). Cohort, Period, and Aging Effects. A Qualitative Study of Older Women's Reasons for Remaining in Abusive Relationships. Violence Against Women, Vol. 9 No. 12, December 2003 1429-1441.
[41] S. Straka & L. Montminy (2006). Responding to the Needs of Older Women Experiencing Domestic Violence. Violence Against Women, Volume 12 Number 3, March 2006, p. 251-267.

victimization and reducing risk may be more desirable outcomes for the older women experiencing violence, rather than removing them from abusive contexts.[42]

Risk factors, signs and red flags of violence on older women

Understanding of risk factors is the basis for effective prevention of violence against older women. A risk factor is a condition or characteristic that increases a person's risk or vulnerability to harm. Gender is a significant risk factor in itself since women's family, social and cultural roles contribute to power imbalances and shifts in control that can increase risk of abuse. Risk factors exist at different levels: individual level (victim or perpetrator), relationship level and broader environment in which older people live. The main risk factors at each level include[43]:

Individual level – older person/victim	Individual level – perpetrator of violence	Relationship level	Environment – community and society
Cognitive impairment, psychiatric illness and psychological and behavioural problems; Poor physical health, functional dependence; Low income/pension; Past experiences of abuse and related trauma	Psychiatric illness or psychological problems, inadequate coping skills; Exposure to abuse as a child; Poor quality of a relationship between a carer and an older person; Caregiving burden and/or stress; Assumption of caregiving responsibilities at an early age and inadequate preparation for fulfilling these duties;	Family disharmony, poor or conflictual relationships between family members; High levels of financial and/or emotional dependence of a vulnerable older person on their carer or vice versa; History of disruptive behaviour by an older person; Lack of appropriate assistance to family members;	Lack of social/formal support for older people or carers or lack of information about support services; High levels of tolerance and acceptance of aggressive behaviour; High levels of decision-making freedom within healthcare and social services and a lack of service provision standards; Ageism and negative attitudes towards older people

Red flags health and social care professionals should look out for when meeting older persons, particularly those with disabilities, include[44]:

[42] National Institutes of Health (2015). NIH Workshop: Multiple Approaches to Understanding and Preventing Elder Abuse and Mistreatment. Available at: https://www.nia.nih.gov/sites/default/files/d7/nih_workshop_on_multiple_approaches_to_understanding_and_preventing_elder_abuse_-final.pdf

[43] S. Perttu (2018): WHOSEFVA Training Materials. Daphne project 2016-2018. http://whosefva-gbv.eu/

[44] Center of Excellence on Elder Abuse and Neglect (2019). Red flags of abuse. University of California, Irvine. Available at: http://www.centeronelderabuse.org/red-flags-of-elder-abuse.asp

Signs of neglect

- Lack of basic hygiene
- Lack of adequate food
- Lack of medical aids (glasses, walker, teeth, hearing aid, medications)
- Lack of clean appropriate clothing
- Person with dementia left unsupervised
- Bed bound person left without care
- Home cluttered, filthy, in disrepair, or having fire & safety hazards
- Home without adequate facilities (stove, refrigerator, heat, cooling, working plumbing, and electricity)
- Untreated pressure "bed" sores

Sign of financial abuse

- Lack of amenities victim could afford
- An older person voluntarily giving inappropriate financial reimbursement for needed care and companionship
- Caregiver has control of elder's money but is failing to provide for elder's needs
- Caretaker living off elder
- Older person has signed property transfers (Power of Attorney, new will, etc.) when unable to comprehend the transaction

Signs of psychological/emotional abuse

- Caregiver isolates elder (doesn't let anyone into the home or speak to the elder)
- Caregiver is verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring

Signs of physical abuse

- Inadequately explained fractures, bruises, welts, cuts, sores or burns

General red flags[45]:

- Implausible/vague explanations
- Unusual delay in seeking care
- Unexplained injuries - past or present
- Inconsistent stories
- Sudden change in behaviour

[45] L. Mosqueda (2015). Medical aspects of elder abuse. University of California, Irvine School of Medicine. Webinar dated January 12, 2015.

Principles of safe discussion, when abuse is suspected[46]:

- Create a safe environment for discussion
- Speak to the client and the caregiver/relative separately
- Establish a trusting relationship
    - mutual respect
- Use soft and non-judgmental words to help the person ease up
    - Recommended is to use "I" statements:" According to my experience many women are suffering..."

Talking directly about violence may not always be productive due to the stigma and shame related to the phenomenon. Questions professionals may ask older women to assess the situation include:

- How are things going at home/in residential care?
- How are you spending your days?
- How are you feeling about the amount of help you are getting at home/in residential care?
- How do you feel your (husband/daughter/other caregiver) is managing?
- Do you have everything you need to take care of yourself?

Important things for professionals to remember when working with older women:[47]

- Do not mistake trauma reactions together with disabilities (e.g. hearing/vision impairment, aphasia) for senility
- Be aware that older women may process information more slowly than younger adults and take longer to put their thoughts into words
    - provide sufficient time to respond
    - this is a normal age-related change and should not be viewed as evidence of lack of mental capacity
- Avoid expressions of disgust, horror, or anger in response to the abuse
- Identify the victim's strengths and skills and build upon them.
- Offer hope. Focus on offering strategies that promote victim safety and break isolation, support the victim's decisions, and provide additional information
- Support any decision the victim makes: staying, leaving, or leaving and returning to an abusive relationship.
- Older women may need support on a long-term basis as well as practical help and emotional support from workers in a wide range of agencies

Questions professionals can use to support the victim's self-determination:[48]

[46] K. Glasgow & J. Fanslow (2006). Family Violence Intervention Guidelines: Elder abuse and neglect. Wellington: Ministry of Health. Available at: https://www.health.govt.nz/system/files/documents/publications/family-violence-guideliens-elder-abuse-neglect.pdf.
[47] M. Scott (2008). Older Women and Domestic Violence in Scotland. University of Edinburgh. Available at: https://www.era.lib.ed.ac.uk/bitstream/handle/1842/2776/owdvupdate.pdf;sequence=1.
[48] Registered Nurses' Association of Ontario (n.d.). Preventing and Addressing Abuse and Neglect of Older Adults: Tips from the RNAO Best Practice Guideline and eLearning course. Available at:

- What is most important to you?
- What would you like to know about?
- Who in your family or friends could help you?
- What do you hope to happen?
- What are your concerns?
- What do you need/expect from the professionals?

Psychological First Aid (PFA)

Many older victims who have experienced an acute traumatic event such as violence, show symptoms of longer-term period of suffering from a Post-Traumatic Stress Disorder (PTSD), as described earlier. Psychological First Aid (PFA) means ways/methods to assist people in the immediate aftermath of a traumatic event to reduce initial distress, and to foster short- and long-term adaptive functioning.[49]

PFA can be used after an immediate or a recent crisis event as the first contact with distressed person. However, sometimes PFA is used days or weeks after an event, depending on how long the event lasted and how severe it was. In many cases violence against older persons has lasted years before the victims contact support services. In these cases PFA is also helpful as a start of recovering process. Psychological first aid covers both social and psychological support but is not and does not replace professional counselling. It is a form of support that may be delivered by professionals and non-professionals alike after a brief orientation.

Guiding principles of PFA[50]

- Providing immediate physical care and safety: as soon as possible effectively organized help improves prognosis the best
- Assessing/Addressing basic practical needs (for example, food and water, blankets) and concerns
- Show understanding for shock reactions which may cause e.g. shame, quilt; provide basic information common distress reactions
- Practical assistance (e.g. housing, financial); can increase sense of empowerment, hope, and restored dignity
- Active listening; opportunity to talk without pressuring them to talk
- NO talking about deep feelings emerged by the traumatic event or details of traumatic experiences and losses
- Comforting people and helping them to feel safety and calm
- Promoting hope
- Conveying sincere compassion
- Discussing coping strategies; letting people cope their own way

http://rnao.ca/sites/rnao-ca/files/Booklet-RNAO-web.pdf

[49] J. Bisson & C. Lewis (2009). Systematic Review of Psychological First Aid. World Health Organization.

[50] Ibid.

- Evaluating risk (including suicide risk, harming others)
- Protecting from further harm

Module 3: Practical procedures

Topics

Promising practices in identification, examination and treatment of older victims of domestic violence

- screening/routine enquiry
- examination and documentation for health care professionals

Multi-agency cooperation

- how to build multi-agency cooperation and trust

Safeguarding and protection of older abused women

- Safety planning for older women victims of violence

Learning outcomes

The participants

- understand the health care aspects of identification of violence against older women
- understand the comprehensive medical examination procedure in order to determine whether an older person may be a victim of violence
- know the importance of and are able to build multi-agency cooperation and trust
- have an understanding what safeguarding means and are able to do safety planning

Key messages

- It is important to take into notice changes of normal ageing process, medications and illnesses in assessing signs and marks of possible violence in older persons
- Multi-agency and multi-professional cooperation is an essential aspect of prevention of violence against older persons
- The safety aspect is a vital and comprehensive one; as such it should be taken into account on every step of the way by professionals who work with older victims of abuse
    - The victim's safety should also be considered in sharing data and making referrals

Suggested teaching methods

Exercise 13: Stakeholders mapping

Exercise 14: Getting to know other organizations and building a directory of useful contacts

Exercise 15: Safety planning – Saara's story

Promising practices in identification, examination and treatment of older victims of domestic violence

Improving identification of older persons who experience abuse should be a high priority of health and social care services. Rates of abuse identification by health and social professionals are usually low compared to the prevalence of violence against older persons reported in surveys in different Western countries. This module will give guidelines for best practices in identification, examination and treatment of older victims.

Screening

Module 2 presented the risk factors and red flags of violence against older person. However, identification of violence against older women should not rely merely on professionals' knowledge and skills to spot signs of abuse. Screening for violence against older persons is defined as a process of obtaining information about violent experiences in a caring or family relationship from older or vulnerable persons who do not have obvious sign of violence such as physical injuries. The rationale for screening among non-symptomatic persons is that identification may prevent future violence and reduce risk of future health impacts as a result of the violence.[51] Screening is just the first step in prevention of violence against older persons. It is for early identification and appropriate interdisciplinary response should follow. Screening should be systematic and done by a standardised tool. Such tools exist for universal screening, assessing everyone, and for selective screening, assessing only those who meet specific criteria.

There are certain preconditions for using any screening instrument:

- Professionals are trained to use the instrument in a way that is safe, respectful, sensitive, initiative taking
- Professionals are trained:
  - on violence against older persons and special situation of older women, dynamics, supporting, risk assessment, safety planning
  - on multi-agency work
- Professionals know the practical procedure/existing response protocols
  - agreed practice in own work place
  - local/regional response protocols
  - professionals know each other's roles, responsibilities and limits of the roles
- There are possibilities for support and consultations of the professionals.

Examples of well-researched screening tools for violence against older persons include, e.g.:

- Elder Abuse Suspicion Index (EASI)[52]

[51] M. Schofield (2017). Screening for Elder Abuse: Tools and Effectiveness. In: X. Dong (ed.). Elder Abuse. Research, Practice and Policy. Springer.
[52]M. Yaffe et al. (2008). Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3).

- Risk on Elder Abuse and Mistreatment Instrument (REAMI)[53]

Examination and documentation for health care professionals

A European document on assessing signs and examination of violence against older persons[54] was recently published by European council of legal medicine (ECLM). The main purpose of the guidelines by ECLM is to provide a common framework for healthcare professionals and forensic practitioners to properly document and evaluate potential victims of violence against older persons. In order to determine whether an older person may be a victim of violence, the document gives the following general principles:

- Obtain informed consent prior to examination;
- If the older person does not have capacity to consent, the appropriate steps must be taken to ensure a lawful examination is undertaken;
- Perform a detailed review of the event under investigation and make inquiries for previous history of abuse (or possible abuse) and relevant socio-familiar information;
- Undertake a full medical history (including medical, surgical, gynaecological, psychiatric, and medication history);
- Screen for all of the aforementioned types of abuse as more than one modality can be simultaneously present;
- Perform a full clinical examination of the older person;
- Appropriately sample and collect and preserve all physical evidence;
- Request further ancillary investigations as required by the specifics of each case;
- Determine the appropriate following course of action in order to protect the older person, secure their rights, and avoid further abuse;
- Keep in mind that for a complete investigation, it may be necessary to perform more than one evaluation.

Please see the document for the full medicolegal evaluation process with full procedure for each stage (E. Keller et al. 2018[55]).

Medical documentation has legal or forensic implications in addition to the clinical applications. Proper documentation can lead to the protection of older patients' autonomy, finances, and even their life and health. A general approach to documentation can be presented as follows:[56]

See EASI tool: https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/EASI.pdf

[53] L. De Donder et al. (2018) Risk on Elder Abuse and Mistreatment - Instrument: Development, psychometric properties and qualitative user-evaluation, Educational Gerontology, 44:2-3, 108-118.

[54] E. Keller et al. (2018). European council of legal medicine (ECLM) guidelines for the examination of suspected elder abuse. International Journal of Legal Medicine. Published online 27 June 2018. Springer.

[55] ibid.

[56] E. Pham & S. Liao (2009). Clinician's Role in the Documentation of Elder Mistreatment. Available at: http://www.centeronelderabuse.org/docs/clinroledocumentem_liao2009.pdf

Interview and history-taking	Physical examination	Assessment
Document response to open-ended questions	Document the patient's physical and cognitive abilities	Provide the reasons that lead to your conclusion, "connect the dots"
Use direct quotations	Highlight findings that deviate from or contradict claims made in the history	Specify the degree of the mistreatment
Interview patient separate from caregiver or suspected perpetrator	Record the interaction of the patient with the caregiver	Specify the severity of harm or potential harm to the patient
Document discrepancies between different sources	Document observed inappropriate concern by caregiver: - overconcern, e.g. a perpetrator refuses to leave the examination room when asked - underconcern	Document your level of confidence that mistreatment occurred, e.g. "definite", "probable", "possible", "unlikely"
Ensure documentation by multiple professionals from different disciplines	Record any change in patient behaviour when caregiver leaves: - e.g. shrinking down with head bowed and eyes to the floor - increased anxiety and agitation	Document the patient's capability to make decisions
Document reliability of the source	Record skin lesions on a body diagram	Record report to the appropriate authorities
Record the patient's cognitive and functional statuses	Take pictures of any lesions	

Multi-agency cooperation

The sociological concept of social capital, "social networks, the reciprocities that arise from them and the value of these for achieving mutual goals"[57], has been identified as having significant potential for reducing disadvantage, and enhancing health and wellbeing. Social capital emphasises the factors of effectively functioning social groups that include matters such as interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity. Effective professional multi-agency cooperation against violence is an example of social capital that is based on both tangible (spaces, systems) and intangible (actors, professionals) resources, the relationships among these resources as well as the

[57] T. Schuller (2000). Social capital: A review and critique. In Baron et al. (Eds.) Social capital: Critical perspectives. Oxford: Oxford University Press.

impact that these relationships have on the resources involved in each relationship, and on larger groups, here: victims of violence.

The first output of the SAFE project was to develop a Multi-Agency Procedure of the social and health care professionals and public authorities. This publication provides recommendations for modalities of identification and intervention in different settings in the five partner countries of the project. The information was gathered through collaborative learning groups of professionals working in the area of violence/ abuse prevention and intervention. The recommendation 4.4 of the publication concerns inter-institutional collaboration and collaboration between professionals in the field of prevention, specifically the need to create or reinforce a community network and to establish an integrated system of intervention enabling all the relevant actors to collaborate and use the existent resources, facilities and specialists in an effective manner.

The professionals participating in SAFE collaborative learning groups saw intervention chains consisting of various agencies and professionals as a helpful measure for supporting older victims of abuse.
The participants of the collaborative working groups identified the following professionals and organisations who have vital roles in intervening in instances of violence against older women, depending on the severity and the complexity of the case: municipality social service or regional protection office (through the social workers, psychologists, specialized inspectors, social mediators, home care workers), police, health system (family doctors, specialists providing homecare services, nurses, medical doctor/forensic specialist), public prosecutor/ lawyers/ judges.

Obviously, this chain is not fixed, since the order of intervention can sometimes start with a phone call at the emergency services (112), or at the specialized services like 24/7 free to call lines, or at the initiative of some dedicated services like centres for abused women. Also, depending on religious beliefs on the individual, priests or clerical staff can also play a role in the intervention chain, advising the victim, the family or the oppressor to do the right thing, or providing counselling and support on their way to the recovery. Perpetrators should also be considered: probation services and centres for offenders can play a significant role in preventing further recurrence of violence.

There intervention network in the community may also include organisations that are more general - like pension authorities, senior citizens' clubs, older people's helplines, other public or private organisms representing the elderly and NGOs supporting older people.

The participants to the local collaborative groups agreed that, disregarding the professional or institutional responsibilities in the matter, all who recognize violence against older persons are responsible to intervene and refer to appropriate services. Also, there was an agreement on the necessity to have a social worker as case manager or responsible, and on the issue of the case monitoring, which needs to be done by the social welfare services and, correspondently, by the (proximity or local) police/ law enforcement/ probation officer.

Another important aspect pointed out is related to the follow-up of the case. The support for those affected and the preventive measures against violence should not end with the report of the case

and with the intervention of other professionals. Professionals involved in the case management of older women victims could be involved in continuing to maintain contact and follow-up the cases. This follow-up measure has proven to be valuable and effective from the perspective of the professionals because it builds trust between the victims and the professionals and, on the other hand, it is also important for the perpetrators, because they notice that there is still public attention to their family, so they cannot simply go back to their prior violent or abusive behaviour.

Building multi-agency cooperation and trust

Tackling violence against older women requires a multi-agency response, if the services and expertise that the agencies can bring are to be properly utilised and built into the development and delivery of effective local strategies. However, strategies alone are meaningless without commitment and action from each individual network agency both collectively and independently. The main benefits of multi-agency collaboration include:

- leads to enhanced and improved outcomes for older victims
- helps to build consensus, break down professional boundaries and attitudes
- promotes mutual support, encouragement and exchange of knowledge between professionals leading to more manageable workloads
- increased fit by services offered and those required by older people
- improved co-ordination of services resulting in better relationships and referrals
- increases level of trust between professionals and agencies; every partner agency knows what each can and will deliver

In developing an effective multi-agency strategy and network, the following aspects should be considered[58]:

- Organisations in the network should agree on a core, common definition of violence against older persons and women, as a prerequisite to successful information sharing.
- Organisations should take a lead on developing information sharing protocols related to client cases in their area, in accordance with local policies and legislation.
- Coordinating the agencies involved and managing their often complex relationships is resource intensive: partnerships should consider appointing a violence co-ordinator in their area

Safeguarding and protection of older abused women

Some older victims of violence and abuse may lack capacity to take certain decisions for themselves and will need additional help to support and empower them to take decisions within the local legal framework. A lack of mental capacity could be due e.g. to a neuro-cognitive disorder, a mental

[58] Home Office UK (2004). Developing Domestic Violence Strategies – A Guide for Partnerships. Home Office, Violent Crime Unit.

health problem or substance misuse. Also in such situations, professionals should start from the assumption that the older person is able to make their own decisions. A person's capacity can be temporarily affected by stress, anxiety, medication, illness, infection or injury. Professionals should always be able to prove that they have made every effort to encourage and support the person to make the decision themselves.[59] Anything done for or on behalf of a person who lacks capacity must be done in their best interests and in a way that interferes as little as possible with the person's rights and freedoms.

Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by, or lives with a family member or intimate partner and is seen to be making decisions which place them in danger. Skilled assessment and intervention is required to judge whether such decisions should be described as 'unwise decisions' which the person has capacity and right to make, or decisions not made freely, due to coercion and control, and therefore part of the abuse. Judgements about capacity should always be decision-specific; an older person may have capacity to make one decision, but not another.[60]

Safety planning for older women victims of violence

Older women may decide to remain living with someone who physically abuses them. While these decisions may be perceived as unwise or unsafe, as described above, the older adult has the right to make such decisions, as long as they are competent. A plan of care for such a situation should include helping them to develop a safety plan. Perpetrators often isolate their victims and do not allow them to make their own decisions. Safety planning restores power and control to older persons as they make decisions about how to enhance their own safety. The first issue to assess is the urgency for safety – is the situation life threatening and needs immediately actions. There is also the need to think about the victim's physical and health status and the competence for own decisions however it is important to understand that psychological trauma caused by violence is not the same as cognitive impairment.

The status of the situation between the older person and the perpetrator can the start for the safety planning. The older person may:

- Want to stay with the perpetrator
- Be in the process of leaving or going back to the perpetrator
- Have already ended the relationship with the perpetrator

A good safety plan is victim-drawn and victim-centred. It is based on the older person's goals, and not the professional's opinions. Safety planning involves problem-solving in advance. The professional help is to support the empowerment of an older person by:

- Building rapport and helping the older person to feel safe by active listening

[59]Local Government Association (LGA) (n.d.) Adult safeguarding and domestic abuse. A guide to support practitioners and managers. Available at: https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf

[60] ibid.

- Learning about what the older person fears about the perpetrator and what might happen if harmful actions or threats are performed
- Asking what the older person wants to do and why. Learning about the motivation behind the older person's decisions can help to understand her or his goals. You may be able to suggest other options for reaching the same goal
- Brainstorming creative options and ideas together

Checklist for creating a safety plan[61] [62]

- What experience has the older person had with safety planning and protection strategies?
    - Which strategies worked?
    - Which were ineffective?
- How has the perpetrator behaved in the past? Is the perpetrator likely to re-offend?
- Does the perpetrator have access to weapons? Have weapons been used in the past?
- Is there a restriction order in effect? If so, what is the status? Ask the victim to tell about it to friends, neighbours and service providers.
- Can the victim recognize the signals of a violent act?
- Is the living situation reviewed with the victim so that s/he can try to leave before the situation escalates to violence:
    - how to leave: the safest way from the home; the safest room in the home with door locks and a window to call for help;
    - where to go: in advance agreed place
    - temporary living arrangements: agreed in advance
- Where does the older person keep important phone numbers, personal documents?
- If the older person is living with a disability, are there physical barriers in the person's environment that may prevent a safe exit or access to safety?
- Are advance arrangements done for the care of pets?
- Has the older person practiced giving precise information on where s/he is if there is danger?
- Is the older person willing to move to a safe place (e.g. shelter)?
- Is s/he advised to write down violent situations: date and what happened; to save text messages, emails and phone calls?
- What are the older person's community supports networks?
- Does the older person have information on different support services?
- If the perpetrator does not live with the victim, does s/he have a peep hole in the door and safety chain and locks on the door?

[61] Registered Nurses' Association of Ontario (n.d.). Preventing and Addressing Abuse and Neglect of Older Adults: Tips from the RNAO Best Practice. Guideline and eLearning course. Available at: http://rnao.ca/sites/rnao-ca/files/Booklet-RNAO-web.pdf

[62] Women In Transition, Inc (n.d.) Keeping Safe: A Workbook for Developing Safety Plans. Available at: https://vawnet.org/material/keeping-safe-workbook-developing-safety-plans

- What challenges might affect the older person's safety or ability to follow through with a safety plan? This could include things such as substance abuse, mental health issues, or memory illnesses.
- Is the older person comfortable with the safety plan and willing to live within its possible restrictions, at least in the short-term?

For examples on personal safety plans, see: https://cnpea.ca/images/safety-panning-toolkit-full-document-eao_mar-29-2017.pdf [63] and https://www.seniorscouncil.net/uploads/files/Documents/Safety_Plan_for_Older_Adults.pdf [64]

Module 4: Working as a professional

Topics

- Professional challenges in working with older trauma survivors
- Secondary traumatization, compassion fatigue and professional burnout
- Protective factors
- General ethical guidelines and considerations
- Working with family members and perpetrator
- Safety issues of professionals
- health and social care settings as public places with open access
- safety issues of workers

Learning outcomes

The participants

- are able to assess own attitudes and values in professional work
- are willing to organize organization's measures in order to identify, prevent, and/or minimize the effects emotional and psychological burden associated with direct work to older trauma survivors
- know how to maintain own safety and wellbeing

Key messages

- It is important to identify as early as possible signs of professionals burn-out
- There are ways to protect workers from professional burn-out through organizational and individual strategies
- Confidentiality is an important part in developing trust in a care relationship; The older person's permission should be always obtained before discussing any concerns with family members or caregivers

[63] Elder Abuse Ontario (2017). Safety Planning for Older Adults. Keeping Safe in Unhealthy Relationships. Toolkit for Service Providers. Available at: https://cnpea.ca/images/safety-panning-toolkit-full-document-eao_mar-29-2017.pdf
[64] Edmonton Seniors Coordinating Council (2007). https://www.seniorscouncil.net/uploadsSafety Plan for Older Adults. Available at: /files/Documents/Safety_Plan_for_Older_Adults.pdf

- Safety is not a concept professionals should actively explore just from the victim's perspective; working with victims of violence may set professionals into personal danger

Suggested teaching methods

Exercise 16: Protection from professional burnout
Exercise 17: Duties and obligations of professionals
Exercise 18: Professional duties when violence is disclosed
Exercise 19: Trust-building for multi-agency cooperation

Professional challenges in working with trauma survivors

Health and social care services are at the frontline for identifying violence against older persons and offering support for the families. Working with victims of violence may cause uncomfortable feelings in a professional, provoking difficult experiences, memories and emotions in oneself. Working with an older victim may cause ambivalent feelings in the professional, such as empathy, confusion, frustration and anger. The work the professionals do with victims of violence is influenced by their own possible experiences of violence and survival as well as receiving help and support

The emotional and psychological risks associated with direct work to vulnerable people have been largely overlooked in educational curriculums and training. It is important that practitioners and educators understand the risk factors and symptoms associated with these to identify, prevent, and/or minimize their effects and maintain self-care. To clearly understand any secondary or vicarious effects of client work on the professional, one must first have a firm working knowledge of the primary effects of trauma and stress reactions on the clients.

Secondary traumatization, compassion fatigue and professional burnout[65]:

Compassion fatigue and professional burnout are common among individuals that work directly with trauma victims such as health care workers, psychologists, first aid responders and most common in the health care field: when health care professionals struggle with their responses to the trauma suffered by their patients their mental health, relationships, effectiveness at work, and their physical health can suffer. Compassion fatigue can outbreak suddenly. Effects can spread out to all areas of life, including impact on family life and changing view of life and world. Contributing factors in health care are, e.g. "culture of silence", lack of awareness of symptoms and poor training in the risks associated with high-stress jobs.[66]

[65] J. Newell & G. MacNeil (2010). Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers. In the book: 2010 Lyceum Books, Inc., Best Practices in Mental Health, Vol. 6, No. 2, July 2010.
[66] S. Michie & S. Williams 2003. Reducing work related psychological ill health and sickness absence: a systematic literature review. Occupational and Environmental Medicine 2003; 60:3–9.

Secondary traumatic stress describes responses of professionals who work with trauma survivors with traumatic experiences. Secondary traumatization results from engaging in an empathic relationship with an individual suffering from a traumatic experience and or bearing witness to the intense or horrific experiences of that particular person's trauma. It involves helping or wanting to help a traumatized or suffering person. Secondary traumatization shows itself as behavioral stress symptoms that may also include a full range of post-traumatic stress disorder (PTSD) traits.

Compassion fatigue is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout. It is used to describe the overall experience of emotional and physical exhaustion that professionals experience due to the long-term use of empathy when treating patients who are suffering in some way. Compassion fatigue is not limited to workers who do direct trauma work. It is due to ongoing need to be empathetic.

Professional burnout is a gradual and progressive process that occurs when work-related stress results in emotional exhaustion that is due to repeated use of empathy combined with the day-to-day work place difficulties and hurry. Professional burnout is similar to compassion fatigue because it doesn't require direct contact with trauma clients. Professional burnout develops over time with contributing factors related to both the individual, the populations served and the organization.

Protective factors

The protective factors related to the aforementioned conditions may be divided into organizational strategies and professionals' individual self-care strategies as follows[67]:

Organizational strategies

- Organizational culture
    - the values and culture of an organization
    - supportive environment
    - gives permission for workers to take care of themselves
    - allows taking time off for illness
- Workload
    - having a more diverse caseload is associated with decreased vicarious trauma
- Safe Work environment
- Education on Trauma
- Group support/Team work
    - opportunities to debrief informally and process with supervisors and peers
    - working with feelings which occur during and after the interactions with traumatized patients
- Effective supervision

[67]J. Newell & G. MacNeil (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. Best Practices in Mental Health: An International Journal, 6(2), 57-68.

    - responsible supervision creates a relationship in which the worker feels safe in expressing fears, concerns and insufficiencies, e.g. a weekly group supervision and/or peer support
- Possibility to have formal consultations from expert workers/organizations
- Creating professionals' networks
- Self-care
    - Balance between work and private life
- Management strategies: Regularly using instruments to evaluate the extent to which these conditions exist within their workforce.
    - Evaluating organizational risk factors

Professionals' individual self-care strategies

- The utilization of skills and strategies by workers to maintain their own personal, family related, emotional, and mental/spiritual needs while responding to the needs and demands of their clients
    - for burnout include setting realistic goals with regard to workload and client care, utilizing coffee and lunch breaks, getting adequate rest and relaxation
- Social support from professional colleagues, taking on a particularly difficult client, or emotional support, such as comfort, insight, comparative feedback, and humor.
- Development of individual coping strategies and coping skills
    - Staying in touch with family, friends and colleagues.
    - Appreciating the little things in life
    - Taking time to reflect or express gratitude by reading, writing, prayer or meditation.
    - Expressing oneself through creative activities

General ethical guidelines and considerations[68]

The meaning of ethical principles and considerations is to ensure the rights of older persons. Sometimes professionals have to do difficult decisions. In such situations, the following guidelines come in handy:

- Older people should be involved in making decisions about their life as much as possible
- The preferred approach is to empower older people, which is based on values such as self-determination, informed choice and the right of adults to make their own decisions.
- The older persons have the right to get support and help for doing conscious decisions.
- It is important to work in ways that respect the older person's privacy and dignity.
- In identified or suspected cases of abuse all interventions should be kept at the least restrictive level possible to maintain the individual's autonomy.
- The right to self-determination and freedom to choose have to be respected. For example, an older adult may choose to live in harm or even self-destruction, provided he/she is

[68] Adapted from: S. Perttu & V. Kaselitz (2006). Addressing Intimate Partner Violence. Guidelines for Health Professionals in Maternity and Child Health care. University of Helsinki.

competent to choose. A mentally competent person has the right to refuse any unwanted intrusion into his/ her life. In these cases the professionals have to assess the safety of an older person and give her/him safety information.

- If the situation is instantly dangerous for physical safety of an older person the professional has to consult for example police or a social worker and take appropriate actions, even if this goes against the older person's wishes.
- If a crime according the criminal act has happened or the circumstances indicate the crime has happened the professional has to follow the laws and rules of the country in question.
- Confidentiality has to be respected but should not be a barrier for action.
- The cultural and religious issues, gender and abilities and recourses should be taken into account in all communication with an older person.

Working with family members and perpetrators

While health and social care professional's priority remains the safety and well-being of an older person, it is also important to respect the person's right to confidentiality. Confidentiality is an important part in developing trust in a care relationship. The issue of confidentiality should be discussed with the older person to ensure full awareness of its meaning. The older person should be reassured that any conversation had will not be discussed with their spouse/partner, nor will it be discussed with any other member of the family, without his/her consent.

The older person's permission should be always obtained before discussing any concerns with any family members or caregivers who might be able to help. For a patient who is deemed incapable, professionals should identify and contact the substitute decision-maker, communicate their concerns to that individual, and provide the same information about local resources. No contact to family members should be made in domestic abuse situations in which the perpetrator is still unknown to professionals. Even a phone call coming from a certain agency may sacrifice the safety of the older person and lead her in danger.

Furthermore, it is important to consider violence against older persons from two perspectives: abuse that is perpetrated deliberately, and abuse that is not. This is particularly true in cases of neglect because one form of neglect can be intentional and one unintentional i.e. the perpetrator is doing his or her best but cannot provide the level of care and support that is needed, sometimes because they don't know what care support is available and sometimes because the local authority does not provide the support that is needed. From the perspective of the older victim the experience of abuse is the same but the appropriate and ethical intervention methods are very much dependant on the active or passive nature of neglect.

Safety issues of professionals

Health and social care workers experience the highest incidence of violence, threats of violence, and bullying/harassment of any sector. Workplace violence is any act or threat of physical violence,

harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. Those affected by violence or harassment at work tend to report higher levels of work-related ill-health. Consequences of workplace violence may include[69]:

- Physical injuries
- Short- and long-term psychological trauma
- Fear of returning to work
- Changes in relationships with co-workers and family
- Feelings of incompetence, guilt and powerlessness
- Fear of criticism by supervisors or managers

Measurements and action a health and social care provider can take to protect its employees include[70]:

- create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions
    - the policy should cover all workers, patients, clients, visitors and anyone else who may come in contact with the personnel
    - ensure that managers, supervisors, co-workers, clients, patients and visitors know about this policy
- Encourage employees to promptly report incidents
- Investigate all reports of violence
- Ensure that no employee who reports or experiences workplace violence faces reprisals
- Train workers on recognizing and preventing workplace violence
- Written policy for work safety and security
- Provide comfortable client or patient waiting rooms designed to minimize stress
- Ensure that counseling or patient care rooms have two exits
- Counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents
- Visitors should check in
- Alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, mobile phones and private channel radios where risk is apparent or may be anticipated
- Arrange for a reliable response system when an alarm is triggered
- Cooperation with the police

What should employees do?[71]

- Report all violent incidents promptly and accurately, no matter how minor in your opinion

[69] S. Perttu (2014). Safety of the health care workers. PowerPoint presentation 12 September 2014.
[70] Occupational Health and Safety Administration (2016). Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers. OSHA Publication 3148-01R, (2004).
[71] Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (PDF). OSHA Publication 3148-01R, (2004).

- Understand and follow the workplace violence prevention program and other safety and security measures
- Participate in employee complaint or proposal procedures covering safety and security concerns
- Participate in safety and health committees or teams that receive reports of violent incidents or security problems
- Take part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior or criminal intent and discusses appropriate responses
- Held their employers accountable of any breaches and take care of their own well-being

Module 5: Conducting Training with Social and Health Care Professionals

Topics

- How to develop a training agenda
- Mentoring

Learning outcomes

The teachers/trainers

- are able to communicate with the audience by listening to them
- are aware of multifaceted competencies needed from the trainers to work effectively
- are empowered to enhance their skills to work as trainers in the field

Key messages:

- The most important for the trainer is to understand the training as a sharing event
- Mentoring and tutoring skills are essential for a trainer/teacher

Suggested teaching methods

Exercise 20: Mentoring

Training as a sharing event

The most important principle for the trainer is to understand the training as a sharing event: employees of the violence prevention services share their experiences and knowledge as domestic violence experts and the social and health care professionals share their experiences and knowledge founded in their experience and practices.

How to develop a training agenda

Select the modules and topics you wish to use and prepare your own agenda, based on what would be most useful in the participants' context. You can also choose an order for the topics. Depending on the participants' level of knowledge and professional experience, the time for training can be adapted. The work of health care professionals working in special areas, for example in emergency, is very hectic and they are not perhaps used to having many hours training. You can offer them short training periods, however, it would be good to provide them an opportunity to slow down and reflect their work.

Given the length of this training package, it is unlikely that all of the modules will be included in a single training programme. Instead, the modules form a curriculum which can be delivered flexibly over a series of workshops (organised e.g. once per week, twice per month) with the aim of combining learning with practice.

Mentoring

Mentoring is a system of semi-structured guidance where one person shares their knowledge, skills and experience to assist others to progress in their own lives and careers. It means that an experienced person (mentor) assists another (mentee) in developing specific skills and knowledge. A mentor - mentee relationship focuses on developing the mentee professionally and personally.[72]

A mentor - mentee relationship creates a safe learning environment, where the mentee feels free to discuss issues openly and honestly, without worrying about negative consequences on the job. In a good mentoring relationship the mentor is interested in helping others to succeed - even if the mentee may surpass them in achievement. The mentor is reliable, honest, and trustworthy keeping things confidential; capable of active listening - not interrupting, picking up important cues from what someone says, able to reflect back the relevant issues and check understanding, minimizing assumptions and prejudices. The mentor can pass on own knowledge and expertise clearly, encouragingly and helpfully.[73]

Appendix 1: Exercises booklet

[72] University of Cambridge (2019). What is mentoring? Available at: http://www.admin.cam.ac.uk/offices/hr/ppd/pdp/mentoring/what/
[73] ibid.

http://www.safeeuproject.eu/