A Global Response to Elder Abuse and Neglect:
Building Primary Health Care Capacity to Deal with the Problem World-Wide

Table of contents

Acknowledgments

This publication results from the joint research programme *A Global Response to Elder Abuse and Neglect. Building Primary Health Care Capacity to Deal with the Problem World-Wide* undertaken by the World Health Organization Ageing and Life Course unit (WHO/ALC) and the Center for Interdisciplinary Gerontology at the University of Geneva (CIG-UNIGE). The project was initiated and supervised by Dr Alexandre Kalache, Coordinator of the WHO Ageing and Life Course unit and by Professor Charles-Henri Rapin from the University of Geneva. Ms Karina Kaindl coordinated the project and wrote this report under the direction of the project supervisors.

This project received technical and financial support from the Department of Noncommunicable and Chronic Diseases and the Family and Community Health Cluster of the WHO, and the Center for Interdisciplinary Gerontology at the University of Geneva. Gratefully acknowledged is the cooperation and support of the Ministry of Social Welfare and Labour / the Spanish Society of Geriatrics and Gerontology (IMSERSO/SEGG) which provided funding for the research in Spain and for the costs that emerged for the translation into Spanish, and of the Department for Victorian Communities, which organized, carried out and funded the research in Australia.

The study coordinators wish to warmly thank their research partners from Montreal who provided the set of questions and the Social Work Evaluation Form originally devised and piloted by them, both tested within this project.[1] The Montreal team has also generously provided the focus group research protocol used locally and their expert advice. Special thanks are due to the older persons, PHC professionals and social workers who took part in the national studies of the participating countries. Gratefully acknowledged are also the technical contributions of our research experts, evaluators, country coordinators, and focus groups facilitators.[2]

The generous financial support for the completion of this study and publication of this report was provided by the Geneva International Academic Network (GIAN)[3]. The GIAN is an international research network founded by the University of Geneva, the Graduate Institute of International Studies (GIIS) and the Graduate Institute of Development Studies (GIDS). Its main objective is to create synergies among various entities, principally academic institutions and international organizations, through support for policy-relevant research in the service of peace and justice.

[1] The team consists of the researchers Mark Yaffe (McGill University and St. Mary's Hospital Centre), Maxine Lithwick (CSSS René-Cassin), and Christina Wolfson (McGill University and Sir Mortimer B. Davis Jewish General Hospital).

[2] A list of the research experts, evaluators and country coordinators can be found on pp. 29-30.

[3] http://www.ruig-gian.org

Preface

UN estimates indicate that by 2025 the number of older persons (60+ years old) will double from the current 600 million to 1.2 billion. Out of one million people that turn 60 every month 80% are in the developing world. Although the proportion of older people out of the total population is higher in developed countries, the percentage increase of the elderly population is much greater in the developing world.[4] Furthermore, rapid ageing in developing countries is taking place in a context of fast social change - such as urbanization; increased participation of women in the workplace; industrialization - and prevailing poverty. While elder abuse is not a new phenomenon, the speed of population ageing world-wide - in this context of profound societal changes - will inevitably lead to an increase of its incidence and prevalence.

Until very recently elder abuse, the mistreatment of older people, had been a social problem hidden from the public view - mostly regarded as a private matter, although it is a manifestation of the timeless phenomenon of inter-personal violence. Child and partner (mainly female) abuse were the first to emerge and were both seen as mostly family (domestic) violence issues. Public awareness towards child abuse and violence against women only gained prominence once studies in the last quarter of the 20th century provided the evidence of their magnitude. As a consequence, inter-personal violence was only then framed within age-specific compartments. Apart from other parameters which try to explain victimization in different population groups, ageing may trigger an additional risk of abuse – due to increased dependence on others, social isolation and frailty. Moreover, older men and women come from generations used to avoid discussion of private issues. That helps to explain why elder abuse continues to be a taboo, mostly underestimated and ignored by societies across the world.

The evidence is however accumulating to indicate that elder abuse – which includes the pervasive issue of neglect - is an important public health and societal problem that manifests itself in both developing and developed countries. As such, it demands a global orchestrated response to it. From a health and social perspective, unless the Primary Health Care (PHC) and Social Services sectors are well equipped to identify and deal with the problem, elder abuse will continue to be under-diagnosed and overlooked.

The Ageing and Life Course unit of the World Health Organization and the Center for Interdisciplinary Gerontology/University of Geneva with partners from all continents conducted this study chiefly aimed at the development of a strategy for the prevention of elder abuse within the PHC context. It consisted of a qualitative research project in eight participating countries focused on testing questions originally devised by researchers in Montreal which were aimed at raising awareness on the issue of elder abuse among PHC professionals.

[4] *UN Population Division* 2004.

Abbreviations

ALC	Ageing and Life Course unit/World Health Organization
Aus	Australia
Bra	Brazil
Chi	Chile
CIG	Center for Interdisciplinary Gerontology
C.R.	Costa Rica
CSSS	Centre de Santé et de Services Sociaux
EASI	Elder Abuse Suspicion Index
GIAN	Geneva International Academic Network
GP	General Practitioner
HUG	Hôpitaux Universitaires de Genève (University Hospital of Geneva)
INPEA	International Network for the Prevention of Elder Abuse
Ken	Kenya
MIPAA	Madrid International Plan of Action on Ageing
NGO	Nongovernmental Organization
PAHO	Pan-American Health Organization
PHC	Primary Health Care
Poliger	Policlinique de Gériatrie des Hôpitaux Universitaires de Genève (Geriatric Policlinic of the University Hospital of Geneva)
Sin	Singapore
Sp	Spain
SWEF	Social Work Evaluation Form
Swi	Switzerland
WHO	World Health Organization

Suggested Citation: WHO/CIG, A Global Response to Elder Abuse and Neglect. Building Primary Health Care Capacity to Deal with the Problem World-Wide. Geneva, World Health Organization, 2006.

Executive summary

The World Health Organization and the Center for Interdisciplinary Gerontology/University of Geneva, in association with institutions in eight countries (Australia, Brazil, Chile, Costa Rica, Kenya, Singapore, Spain and Switzerland), formed a joint research programme aimed at tackling a substantial, yet hidden social problem: elder abuse and neglect. The foundations of the study were provided by the ground breaking work conducted by a multidisciplinary and inter-institutional team from Montreal.[5]

The project objectives are:

i) To develop and validate a reliable instrument applicable in different geographical and cultural contexts to increase awareness amongst PHC professionals to the problem of elder abuse and neglect.
ii) To build the capacity of PHC workers to deal with elder abuse and neglect through evidence-based education for the development of prevention strategies.

The original project outline comprised the development and validation of a universal routine screening tool to facilitate the detection of elder abuse and neglect amongst PHC professionals. However, consultations with experts and advisers during the initiation phase of the project have indicated that it is critical to apply the concept of an elder abuse screening tool in the field of Public Health Care, since it involves psychosocial moments of stress not only for the patients but also for the PHC professionals, who are currently not well enough equipped with follow-up strategies. It was considered more appropriate to aim at the development of a tool that helps in raising awareness to the issue of elder mistreatment among the PHC professionals and sensitizing them in dealing with potential abuse cases. Therefore, the WHO-CIG study's goal is to provide an instrument to detect suspicions of elder abuse modelled on the *Elder Abuse Suspicion Index* (EASI) - the questionnaire previously developed and tested in Montreal.

Elder abuse and its detection are challenging and highly sensitive issues which need a linguistically and culturally specified approach and vocabulary. As a consequence, the creation of a "universal" tool implies global testing. It was considered that a first step should be the qualitative testing of a set of questions - those led to the Montreal EASI - in the eight participating countries mentioned above. Further action such as the piloting of the tool in clinical settings and the expansion of the range of participating countries will form future studies.

The results of the study confirm that in the opinion of the older people involved and, in particular the PHC professionals, the provision of a short instrument covering key dimensions of elder abuse might be a critical step in preventing and detecting it. However, according to such results the development of a universal instrument that is applicable to all cultural and geographical contexts is not yet reached; the appropriateness of its content and wording vary greatly depending on the setting. Nevertheless, the study participants indicated that they believe that it is essential to equip PHC professionals with a set of questions which can serve as a starting point to raise awareness to elder abuse.

[5] See footnote on p. 2.

1. Research background

1.1. What is elder abuse and neglect?

The WHO-CIG adopted the definition developed by *Action on Elder Abuse* (UK)[6] in 1995:

"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."

Elder abuse has serious consequences for the health and well-being of older people and can be of various forms: **physical**, **verbal**, **psychological/emotional**, **sexual,** and **financial abuse**. It can also simply reflect **intentional or unintentional neglect**. Abuse and neglect are culturally defined phenomena that reflect distinctions between values, standards and unacceptable interpersonal behaviours.

Like any other form of abuse, elder abuse is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair. The study "Missing Voices - Views of Older Persons on Elder Abuse"[7] indicated that older persons themselves perceive abuse under three broad areas: **neglect** (isolation, abandonment and social exclusion); **violation** (of human, legal and medical rights) and **deprivation** (of choices, decisions, status, finances and respect).

Modernization, industrialization, aging population, urbanization, and increase in numbers of women in the work force may explain increased reports of elder abuse. Yet, prevalence rates/estimates exist only in selected countries and have so far generally been restricted to a few developed nations. Where there are prevalence studies on elder abuse, rates range between 1% and 35%[8] depending for instance on definitions, and survey and sample methods. However, these figures may represent only the "tip of the iceberg", with some experts believing that elder abuse is under-reported by as much as 80%. Reporting estimates range from only one in six to one in fifteen cases being reported. These low rates may be due to the isolation of older people, the lack of uniform reporting laws and the general resistance of people - including professionals - to report suspected cases of elder abuse and neglect. In developing countries, although there is no systematic collection of statistics or prevalence studies, crime and social welfare records, journalistic reports and small scale studies provide evidence that abuse, neglect and financial exploitation of older persons appear to be widely prevalent.

1.2. Preliminary work

The WHO-CIG joint programme responds to the recommendations of the **Madrid International Plan of Action on Ageing** (MIPAA)[9] the principal outcome of the World Assembly on Ageing which took place in Madrid, April 2002. The MIPAA is based on the UN Principles for Older Persons adopted in 1991 by the UN General Assembly under the slogan **"To add life to the years that have been added to life"** which encapsulates the needed effort towards a just society for all ages. The Plan has several implications that address the issue of elder abuse. It calls for changes in attitudes, policies and practices at all levels and in all sectors in order to ensure that persons everywhere are able to age with security and dignity, as citizens with full rights. Furthermore, MIPAA recognizes the universality of the problem of elder abuse. While it is pointed out that the process of ageing brings with it a declining ability to heal and that the impact of trauma may be worsened because shame and fear may result in reluctance to seek help, it also emphasizes that **elder abuse is often not solely of the physical form**. In this

[6] See also http://www.elderabuse.org.uk/Mainpages/Questions.htm
[7] *WHO/INPEA* 2002a.
[8] See e.g. *Pillemer* et *Finkelhor* 1988, *Yan* et *Tang* 2001, and *Ruiz Sanmartín* et al. 2001.
[9] *UN* (2002).

respect, the Plan sets out as objectives the elimination of all forms of neglect, abuse and violence directed at older persons and the creation of supporting services that address elder abuse.

The MIPAA delineates three priority directions: **older persons and development**; **advancing health and well-being into old age**; and **ensuring enabling and supportive environments**. Every single one of these directions has major implications in the needed global effort to fight elder abuse. More specifically, MIPAA strongly recommended more emphasis on elder abuse prevention and management through the adoption of multi-sectorial, interdisciplinary community based approaches to eliminate all forms of neglect, abuse and violence. Furthermore, MIPAA states that there is an urgent worldwide need to expand educational opportunities in the field of geriatrics and gerontology for all health professionals who work with older persons and to expand educational programmes on older persons' health for professionals in the social service sector. Informal caregivers also need access to information and basic training on the care of older persons. This goes together with the encouragement of health and social services professionals to report suspected elder abuse as well as with the demand on health and social services professionals to inform older people suspected of suffering abuse about the protection and support that can be offered.

The World Health Organization has recognized the need to establish a global strategy for the prevention of the mistreatment of older people. The WHO Ageing and Life Course unit (ALC) has been working in the field of elder abuse since early 2000. In 2002 the results of a multicentric study conducted by ALC in collaboration with the International Network for the Prevention of Elder Abuse (INPEA), HelpAge International (HAI) and partners from academic institutions in a range of countries as well as NGOs representing grass roots organizations over the previous two years were published. That study focused on views and perceptions of older persons and PHC workers on elder abuse through focus groups held in eight countries (Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden). The resulting publication *Missing Voices – Views of Older Persons on Elder Abuse* was considered as a milestone in the field, and has led to the development of further research. In November 2002 WHO launched, together with INPEA and academic partners, *The Toronto Declaration for the Global Prevention of Elder Abuse* at the Ontario Elder Abuse Conference. This declaration is a call for action aimed at preventing elder abuse world-wide.
Over the years, the Center for Interdisciplinary Gerontology at the University of Geneva (CIG-UNIGE) and the Policlinique de Gériatrie des Hopitaux Universitaires de Genève (POLIGER-HUG) have undertaken some very important multi-sectorial research work on elder abuse, such as the development of screening tools and training courses for social and health workers. This seminal work has been conducted in partnership with the internet network "Vieillir en Liberté" (RIFVEL) for the exchange of information among French speaking communities and in close relationship with local grass roots organizations. Moreover, in 2004 the POLIGER organized in collaboration with the CIG and a variety of other institutions at the international colloquium HEATWAVE 2004. Specialists from various domains discussed and presented their perspectives, interpretations and advice on the issue with the purpose of coming up with a simple plan for future heatwaves in order to draw a lesson from summer 2003 where approximately 40'000 older persons died in Europe due to neglect and inappropriate care.

The cooperation between existing public health, social, medical, and legal activities and systems needs to be improved, as they depend on each other for the prevention, detection and reduction of elder abuse. As a response, in January 2004, the WHO-CIG project collaboration "A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem World-Wide" was initiated.

1.3. Elder abuse and neglect and the role of PHC professionals

Since the appearance of the term "granny battering"[10] in 1975, physicians have been generally slow to react towards the issue of elder abuse and neglect. The paucity of research in this area has been matched by limited awareness amongst PHC professionals. Research on assessing interpersonal violence in adolescence, young adults and women is far more advanced than that on elder abuse and neglect and has been recognised as problems in need of attention over a longer period of time.
Perceptions are changing - reflecting results from studies in many countries.[11] Elder abuse is starting to be recognized as a serious social and [public] health issue. The occurrence and severity of elder mistreatment are likely to increase markedly over the coming decades, as the population ages, caregiving responsibilities and relationships change, and increasing numbers of older persons require long-term care.

The US National Research Council[12] recognized that substantial research is needed to improve and develop new methods of screening for possible elder mistreatment in a range of clinical settings. Moreover, they strongly recommend systematic studies of reporting practices and the effects of reporting.

Although a comprehensive health care response is the key to a coordinated community-wide approach to family violence, physicians report only 2% of all reported cases of elder abuse, compared to reports from family members (20%), hospitals (17.3%), and home health aids (9.6%).[13] Even though the detection of elder abuse is an issue in some hospitals, only a few hospitals have appropriate protocols and follow-up guidelines for dealing with the problem.[14]

It is central to understand the nature and value of increased and more refined medical and social surveillance and screening practices and their effect on geographically based elder mistreatment rates. There is no doubt that health care settings are particularly important. For instance, in the USA each year approximately 85 percent of persons aged 65 and older use formal ambulatory care services and 16 to 20 percent are hospitalized.[15] Therefore, physicians need to be able to recognize risk factors and to apply the diagnostic techniques specifically involved in elder abuse detection. However, many physicians and other PHC professionals are not yet familiarized with the definitions, epidemiology diagnosis and intervention strategies associated with elder abuse, since it is usually not a problem that can be assessed quickly. Nevertheless, the emergency room and walk-in clinics together with family doctors' practices are commonly used by elder abuse victims. Similarly, the busy primary care office, though hardly the ideal setting for a time-consuming examination, may be the victims' only hope of detection and protection. In either setting, an understanding of good assessment practices is necessary for the physician who is in touch with the potential victim.

The medical profession is just beginning to turn its attention to research, detection, and prevention of elder abuse. Since physicians are in a unique position to detect elder abuse and neglect first-hand, they have a special responsibility to promote greater awareness and effective interventions for this problem. However, physicians cannot tackle elder abuse alone. The cooperation between existing public health, social, medical, and legal activities and systems needs to be improved, as they depend on each other for detection, for assessment techniques and for the reduction of the occurrence of mistreatment. This is particularly true since a substantial proportion of elder mistreatment episodes appear to occur in frail elders, who are often least likely to participate in household surveys and who may be difficult to reach due to social isolation.

---

[10] See *Baker* 1975.
[11] PubMed for example delivered 1111 hits for "elder abuse" in February 2006.
[12] *National Research Council* 2003.
[13] See *Rosenblatt* 1996.
[14] See e.g. *Ahmad et Lachs* 2002; and *Lachs* 2004.
[15] *National Research Council* 2003.

Consultation at the medical practice is sometimes the only regular interaction that older people have outside their home.

1.4. How to detect elder abuse in a PHC setting

Many aspects of elder abuse would appear to make it a condition ideally amenable to traditional public health screening, such as the facts that it is prevalent, it causes morbidity and mortality, and traditionally it would appear that it is often hidden during consultation. But compared to other diseases and conditions, screening for elder abuse is problematic, since some patients are probably not eager to be detected as a potential victim of abuse. Also "true positives" are not well defined by blood tests, or consensus criteria as for other conditions/diseases which are screened for.

Several screening and detection tools for elder abuse have been developed and tested. However, they have rarely been properly validated for wider use. The very multiplicity of tools reveals the need to develop, through collaborative research, a reliable and simple tool that can be adapted and used in different geographical and cultural settings. This will help to maximize the full understanding and multiple dimensions of the problem.

Screening tools may have several limitations. For instance, some of them are only developed for research purposes, with low efficiency in clinical settings, their sensitivity and specificity rates are not fully addressed, or physicians do not use them because they are too long, their vocabulary is inappropriate, or they are designed for home use. The requirements for a detection tool are thus high: It should be practical, easy and quick to administer, with appropriate and clear wording suitable for different contexts, and it should show a high sensitivity rate.

However, screening tools by themselves are not enough. For professionals to be able to use the tools effectively, they need to be aware of the problem and its consequences and to have access to strategies to intervene and achieve positive outcomes for individuals. Among the obstacles for physicians to overcome in order to detect elder abuse are a lack of awareness of the problem, insufficient knowledge about how to identify or follow up a potential case of abuse, ethical issues, time constraints and the victim's possible reluctance to report to physicians. It is therefore crucial not only to raise PHC professionals' awareness but also to equip them with sufficient training and intervention strategies to enable them to react appropriately when a person is at risk of being abused or neglected. Above all, they need the confidence to overcome the very real barriers that prevent detection and intervention.

2. The project

2.1. Aims and objectives

Based on the recommended strategies outlined in the "Missing Voices" study the WHO-CIG programme objectives were:

i) To develop and validate a reliable instrument applicable in different geographical and cultural contexts to increase awareness amongst the PHC professionals to the problem of elder abuse and neglect.

ii) To build the capacity of PHC workers to deal with elder abuse and neglect through evidence based education for the development of prevention strategies.

Following the initiation of the project in January 2004, a meeting was held between the project coordinators, the scientific steering committee and members from affiliated organizations. The following recommendations for the study were made:

Although elder abuse is a universal phenomenon that appears in similar forms regardless of its geographical and socioeconomic context, the **appropriate responses may vary**, depending for instance on local beliefs and values, availability of resources and legal frameworks. However, while the roots of abuse may be very different between societies, cultural norms should not be used as an excuse for mistreatment to occur or to be ignored.

When testing an instrument to detect potential abuse cases it is crucial to have **basic response mechanisms** in place; otherwise many PHC professionals will remain reluctant to deal with the issue. Also standardized training modules that focus on the detection, prevention and management of elder abuse, taking already existing models into consideration, need to be developed.

The "perfect tool" does not exist. Depending on a person's professional background either an anecdotal or an evidence-based approach is preferred. A balance needs to be found between a scientifically validated and simple tool, which is at the same time suitable for use by a wide range of PHC professionals, but which is also comprehensible by older people. Simplicity is the key to success in ensuring that a tool would be used by PHC professionals. A useful comparison was made to screening for alcoholism (e.g. the CAGE tool with four questions[16]). The ultimate goal should be to **sensitize medical professionals and raise their awareness about elder abuse and the possibility that it can occur.**

GP practices/PHC centres seem to be the best locations for the detection of elder abuse within this research proposal. Amongst PHC professionals the **physician is in the best position to detect abuse** since he/she is often the first port of call for older persons. The difficulty arises from placing another burden on the physician's already full agenda. Nurses may be a valuable alternative since they often have, depending on the setting, regular contact with patients.

As a consequence, it was decided that the best option would be to adopt the *Elder Abuse Suspicion Index* that had been developed and tested in Canada and through focus group discussions to adjust it for cultural and linguistic factors in the eight participating countries.

[16] See *Ewing* 1984.

2.2. The *Elder Abuse Suspicion Index*

The *Elder Abuse Suspicion Index* (EASI) is an instrument that was developed and tested in Montreal by a research team from McGill University, St. Mary's Hospital Centre, CSSS René Cassin, and Sir Mortimer B. Davis Jewish General Hospital, with funding from the Canadian Institutes of Health Research. EASI consists of a few copyrighted, brief and direct questions (five questions for the patient and one for the physician) asked in the course of any office physician-patient encounter, and formulated in doctor-friendly language. It is readily applicable to cognitively intact seniors (65+ years old). EASI was designed not to necessarily "detect cases" but to raise suspicion of the occurrence of elder abuse in order to justify referral to community experts in elder abuse such as social workers. A secondary aim was to help familiarize family doctors with elder abuse through the repeated use of a simple set of questions about elder abuse. Although EASI cannot guarantee detection of elder abuse or mistreatment, its application already indicates that the doctor is aware of elder abuse and may therefore refer potential cases to social and community services.

The style of the EASI questions and application is along the lines of recommendations found in the relevant literature. The use of explicit, behaviourally specific closed questions, contextually orienting preface statements, and simultaneous assessment of both assault by strangers and abuse by family members/caregivers, is appropriate for older adults. Moreover, there are several advantages of in-person interviewing: this permits visual assessment of both the respondents' physical presentation and his/her reactions to the questions. Interviews also offer opportunities for non-verbal indications of support. Finally the validity of clinical diagnosis made on the basis of in-person interviews is higher than that of other methods, such as telephone surveys, simply because more convergent (or divergent) lines of data are available to in-person interviewers.[17]

Compared to other elder abuse screening tools, for example the H-S/EAST (*Hwalek-Sengstock Elder Abuse Screening Test*[18]) with originally 15 items, EASI has fewer questions and requires less time to administer (on average two minutes). Furthermore, out of the 104 doctors, who participated in the Montreal study, 95.8% rated the questions as "very easy" to "somewhat easy"; and 70.5% considered the questions to have either some or a big impact on approaching elder abuse.[19]

In the Montreal study, results of the EASI were compared with a Social Work Evaluation Form (SWEF)[20] to validate the tool. This form is a standardized social work assessment to evaluate in greater depth older people at risk of being abused. The form comprises 67 questions, and it takes on average 66 minutes to administer. Question 59 was the "gold standard" question to compare and validate the results of the EASI.[21] Within three weeks after the application of EASI by physicians, social workers who participated in the study administered the evaluation form to seniors. The interview took place either at the older person's home or in a safe place to talk that was mutually acceptable to the participant and the social worker. The correlation between the EASI and the SWEF reached a sensitivity rate of 0.44 and a specificity rate of 0.77.[22][23]

The findings of this study conducted in Montreal offer an excellent groundwork on which further research can build. However, the original EASI project was obviously focused on the reactions from family doctors and older persons in the context of a

---

[17] See also *Acierno* 2003.
[18] See for example http://www.elderabusecenter.org/print_page.cfm?p=riskassessment.cfm
[19] See Yaffe et al.
[20] This form was developed likewise by the Institute René Cassin.
[21] The SWEF can be found in Annex 2.
[22] See Yaffe et al.
[23] The sensitivity rate indicates the proportion of people with the target disorder who have a positive test result. It is used to assist in assessing and selecting a diagnostic test/sign/symptom. The specificity rate is its equivalent for negative tests and indicates the proportion of people without the target disorder who have a negative test.

Western urban society. The aim of the WHO-CIG project proposal was to explore the reactions of similar groups in other cultural contexts and to test a set of questions in geographically different settings across the world. Therefore, focus group participants in eight countries commented on the questions used by the Montreal researchers that ultimately led to the development of EASI[24]. This was one step in the process of looking at the validity of the EASI in different cultural and geographical contexts, and to assess its acceptance and usefulness among medical doctors and older patients in places other than Canada.

2.3. Research design and methodology

In order to obtain information on specific issues which may vary from one geographical setting to another, focus groups were selected as a method because of their ability to explore beliefs, attitudes and behaviours in a target group. Furthermore, people usually feel comfortable in a focus group discussion, because it is a form of communication found naturally in most communities.[25]

Participants were asked to express their opinions about whether the proposed questions are appropriate, relevant and understandable. Based on these findings training modules, identification methods, and intervention strategies can then be developed or adapted according to local conditions.

The eight participating countries (Australia, Brazil, Chile, Costa Rica, Kenya, Singapore, Spain and Switzerland) were engaged through professional links from WHO and identified according to the following parameters:

- Possibility of collaboration with a local coordinator and a focus group/workshop facilitator.
- Participating countries should cover a wide range of regions. In this case, Africa (1), South America (2), Central America (1), Europe (2), South-East Asia (1) and the Western Pacific Region (1) were included.
- Follow-up mechanisms should be in place to provide information on local support and service networks in case a piloting phase in clinical settings would follow the qualitative research.

The research design included the conduct of seven focus groups in each country to test the bank of twelve questions that led to the EASI. The groups were split up into:

i) Three groups of older persons - further broken down into one group of older women only, one group of older men only, and one group of both older men and women.
ii) Four groups of PHC professionals.

Each group ideally consisted of six to nine people. The two-hour focus group sessions were tape recorded, transcribed and analysed and the findings from each country were summed up in a report.

Furthermore, workshops were organized to test the general reaction of social workers towards the concept of the *Social Work Evaluation Form* (SWEF) but also to gather general information on elder abuse issues such as local assessment and intervention strategies, and cultural specific elder abuse categories.
In a second workshop reactions from PHC professionals and social workers were sought to see how useful the PAHO (Pan American Health Organization) guidelines on abuse

[24] In the WHO-CIG focus group study materials from the Montreal EASI project were used according to a memorandum of collaboration between the researchers and WHO-CIG. Questions that were used in the WHO-CIG focus groups are based on the original EASI focus group protocol (Annex 1) except that the order of the questions was changed and some of the questions were split up.
[25] See e.g. *Hudelson* 1994.

and neglect were considered to be.[26] This manual could be used as follow-up and intervention strategies for PHC professionals to use concerning the issue of elder abuse and neglect. The comments and reactions gathered in these two workshops were likewise summarized in the country reports.

The WHO-CIG project coordinators provided all the necessary information/documents for the conduct of the focus groups and workshops, including session outlines and administrative forms. Refreshments, or a meal, reimbursement for the travel and information material was offered to the participants. Other forms of remuneration were not included.

In summary, the activities in every participating country included:

1. **Four focus groups with GPs/PHC doctors:**
   - Expose GPs to the bank of twelve questions (brief introduction)
   - GPs "pilot" the set of questions with a small sample (15-20 patients) to acquire familiarity with the instrument (where possible)[27]
   - Focus group discussions with GPs on experiences, perceptions and suggestions after the application of the questions[28]
   - Report

2. **Three focus groups with older people:**
   - Expose older people to the bank of twelve questions (brief introduction)
   - Focus group discussions with older people on suggestions and perceptions of the twelve questions[28 above]
   - Report

3. **Workshop with social workers:**
   - Introduce social workers to the SWEF
   - Workshop with social workers to seek their views and perceptions on how applicable the evaluation form is within the reality of the country
   - Report

4. **Mixed workshop on the PAHO manual:**
   - Introduction of PAHO training model to GPs and social workers
   - Focus group discussion following a workshop format on the manual's content
   - Report

Since elder abuse is a universal phenomenon the project's target was not to apply any social, gender or ethnic discriminations to the study. However, certain exclusion criteria are justified with the purpose of protecting participants and for the overall benefit of the study. Therefore, cognitively impaired older persons were excluded.
In some countries it was difficult to find GPs or front line doctors willing to participate in the focus group discussions. In this case, they were replaced by nurses, dentists and geriatricians. Also the age limit for participants in the focus groups for older people (65 years+) was lowered in some settings (Singapore) according to the national definition of 'older person'. 'Being literate' was added as additional inclusion criteria in Brazil for the focus group discussion held with older people.

[26] These guidelines are taken from the PAHO document "Guía clínica para atención primaria a las personas adultas mayores" (2002) and can be found in Annex 3.
[27] Due to a very tight project schedule the pre-sampling was only possible in Chile and Spain.
[28] Along the lines of the work conducted in Montreal.

The aim of the focus group discussions was to seek the participants' opinions on each of the twelve items by asking:

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

Furthermore, participants had to choose at the end of the session the five most relevant questions to be included in the final tool.

The project coordinators identified a local coordinator in each participating country who was in direct/regular contact with Geneva. This coordinator appointed a local facilitator with a background in qualitative research methodology to organize and conduct the focus groups and workshops, to provide relevant background information, to analyse the data and to prepare the final country report based on the focus group and workshop sessions. These country reports were translated into English, if written in a language other than English. Afterwards, they were reviewed and a content analysis was performed to obtain feedback on the questions and also to discover emerging themes/answers relevant for the identification of elder abuse. Derived from these discussions the following findings for the tested questions were formulated in order to adapt the instrument and to make it compatible for piloting in the eight participating countries. [29]

[29] A summary of each country report can be found in Annex 4.

3. Findings and discussion

3.1. Focus groups with older people

In some countries, the older participants did not clearly understand the purpose of the focus group discussions and the concept of commenting on or discussing the questions (Chi, Ken). These groups talked about their experiences in relation to each question instead of discussing their content and choosing the five most relevant questions.[30] The groups in Spain discussed a different set of questions and are therefore not taken into account in the table below.[31]

A number of general issues emerged from the discussions with older people:

- Frail older persons' dependence on caregivers could influence their answers. It is therefore crucial to **ask these questions in private**.
- The pressure on GPs' time and the cost to the patient would make a **shorter questionnaire** more useful. Lack of training was also a concern.
- An essential issue that was brought up in several discussions was the need for GPs to have **follow-up strategies for a GP** when they identify a person at risk of being abused.

The five preferred questions chosen by the older people in the different settings were Questions 4, 5, 6, 8, 11 (in order of number of responses):

Table 1 Five preferred questions of older people[32]

Q # / country	1	2	3	4	5	6	7	8	9	10	11	12
Aus				x	x	x		x			x	
Bra			x	x	x	x	x					
Chi (n. a.)												
C.R.	x		x	x	x				x			
Ken (n. a.)												
Sin	x			x	x	x		x			x	
Sp (n. a.)												
Swi				x	x	x		x			x	

The **wording of the questions came across as somewhat stilted and sometimes too 'clinical'**. The term 'prevented' appears to be an improper word to use. It was suggested that 'deprived' (Sin)[33] or 'denied' (Sp) would be better alternatives. Other expressions such as *basic daily needs* (Aus, Bra, Sin), *adequate living space* (C.R.) or *impeded your free movement* (Aus) appeared to be incomprehensible. *Health aids* or *hearing aids* can be omitted (C.R., Sin). Some of the questions include too many different ideas and are too wordy (e.g. Question 4). Other questions were too general (Question 10) and could be better elaborated with specific examples. In order to make the questions simple and straightforward, only one idea should be addressed within each item. For example, Question 6 asks about three different things: i) being taken advantage of; ii) prevented from doing things and iii) interference with being with the people you wanted to be with.

The **questions were in general considered as being comprehensive covering all key areas of elder abuse**. However, some forms of abuse, such as emotional abuse,

[30] The focus group protocol including the set of twelve questions can be found in Annex 1.
[31] See also *Summary of report from Spain* in Annex 4. Comments that are also applicable to the set of twelve questions are integrated in this chapter (*3. Findings and discussion*).
[32] In some countries there were six questions chosen, either because two or three questions were considered equally important or because participants felt that it was necessary to retain six questions instead of five.
[33] The brackets indicate which country groups are meant or made a specific comment. See also list of abbreviations on p. 3.

neglect (Sin), deprivation of food and the burden of child care, were considered as relevant issues that were not specifically addressed. Also societal abuse - in the form of 'Ageism' - was a recurring theme. The subtle and sometimes not so subtle changes in the way older people are regarded by society as being 'less of a person' as they age was an often expressed concern which was considered by participants to constitute abuse.

Question 2 and 3, tackling the issue of asking for help and dependence, are good questions but most older people would find it hard to admit that they need help or depend on somebody.

It was pointed out that it is becoming **less likely that older persons have a consistent and close relationship with a doctor** they know. However, some questions (e.g. Question 12) require a trusting relationship between the patient and the doctor, and depend on the **doctor's skills to ask the questions in a sensitive way** that would encourage people to trust them.

Other questions cannot be asked in all cultural contexts. It was a general comment that the **question about sexual abuse** (Question 12) **would be very confrontational** and should not be asked of all people. In Kenya, the issue of sex is considered to be a topic that is too delicate to be discussed with a stranger or even a doctor known to the person. It was suggested that this question should only be asked if there is already some suspicion of sexual abuse.

Depending on the geographical setting some questions were given more weight and emphasis. The question on **alcoholism** was considered much more relevant in Costa Rica and Kenya than in other countries. It was also suggested that drug abuse be included in this question. Question 7, relating to the risk of financial abuse, was considered as one of the most important questions by the Brazilian focus group participants. Also in Kenya **financial dependence** was identified as a high risk factor since virtually all households depend on older parent(s) for financial support for food, clothing, fees, and medical care. However, the issue was regarded as less important in the other countries. The **burden of child care** on the older people appears to be an overwhelming concern in Kenya that was not directly addressed in the questions. The Brazilian group of older men and women felt that physicians should not be concerned with the concept of 'being taken advantage of' as this was considered a daily issue that people in Brazil are used to.

3.2. Focus groups with PHC professionals

The organization of focus groups with physicians caused difficulties as only a limited number (Aus, Ken, Sin) or none (Chi) were willing to participate in the groups. In some countries they were [partly] replaced by nurses (Aus, Chi) or dentists (Ken).

Some general comments were made throughout the discussions:

- The term **'elder abuse' has a negative connotation** and elicits such fear and anxiety even amongst healthcare professionals that there may be a need to look for other terms that can be used to replace it.
- It is essential to **determine whether or not there is a cognitive deterioration in the older patient** before asking such questions (as this questionnaire cannot be used when a patient is cognitively impaired).
- These **questions should not be asked in front of the potential perpetrator** (e.g. a caregiver).
- All these **questions should be asked in a more conversational** way rather than like a questionnaire or checklist. Physicians may not have enough time to ask these questions. Alternatively, in some situations, **nurses could administer this questionnaire**.
- Asking these questions would also require **physical examination** as part of the screening.

- **PHC professionals need to be familiar with the various elder abuse categories, and follow-up and intervention strategies** when administering this questionnaire.
- How should a PHC professional react if there is substantiated suspicion of abuse but the potential victim is not willing to denounce the perpetrator or to be referred for **further action**?

The five preferred questions chosen by the PHC professionals in the different settings were Questions 4, 8, 5, 11 and 12:

Table 2 Five preferred questions of PHC professionals

Q # / country	1	2	3	4	5	6	7	8	9	10	11	12
Aus				x		x		x	x		x	x
Bra				x	x	x		x			x	x
Chi				x	x			x	x		x	
C.R.				x	x			x			x	x
Ken	x			x	x			x				x
Sin			x	x	x			x			x	
Sp[34]			x	x	x			x			x	
Swi				x	x	x		x			x	

Overall, the **questions are considered useful** as the instrument is shorter than other tools and helps in raising awareness. Also all the key areas of elder abuse are covered. Issues of loneliness, dependence on others for their basics, being mistreated, being vulnerable at the hands of the powerful, being taken advantage of, overwhelming financial responsibility and being caregivers in their state of fragility are critical issues today which the questions capture. However, in order to be used effectively **it was recommended to shorten the questionnaire** and **simplify its wording**.

The **questions appeared to be overly formal and convoluted**. There are a number of terms that are too difficult to apply such as *adequate living space* (Aus, Bra, Chi, Sin), *free movement* (Bra), *unwanted approaches* (Bra), *health aids* (Chi), *basic daily needs* (Aus, Bra, Sin, Sp), and *taking advantage* (Sin). Other expressions are not specific enough such as *needed things* (Aus).

Some of the **questions should be separated** as they contain different concepts that are not related to one another. For instance, Question 4 inquires about basic *and* secondary needs in one question. Question 5 is asking about different emotions ("sad, shamed, fearful, anxious, or unhappy") in one sentence. In Question 8, there are two different issues being addressed: i) misuse of money and ii) being forced to sign documents. Other items could be combined such as Question 2 and 3, or Question 11 and 12.

Some words are **difficult to translate** into other languages, e.g. an equivalent for 'dependent' (Question 3) does not exist in Mandarin. Generally, it was challenging to translate some of the expressions into Brazilian Portuguese or the whole questions into Bahasa Melayu or Chinese and its dialects.[35]

General remarks looking at the questions as a whole recommended that the **second part of the question could be omitted** (that is *"Was this an isolated event or has it occurred more than once?"*) (Aus, Bra, Sin, Sp). However, it is important to get some idea as to whether this is an isolated incident or part of an existing and/or long-standing pattern, even in detecting suspicions of abuse. Furthermore, the **time frame of the questions is not clear**: should the main focus be on recent situations or on events that happened several/many years ago or even within a lifetime? Another suggestion was to add a part asking about the relationship with the perpetrator (C.R., Sp).

[34] Only two groups in Spain discussed the bank of twelve questions. The others tested the original EASI (see also the *Summary of the report from Spain* in Annex 4).

[35] For the groups in Singapore the questions were translated into Mandarin, as the majority of Singaporeans are Chinese, and are not English speaking but Mandarin and its dialects.

Similar to the discussions with older people, it was mentioned that many older people feel uncomfortable when requesting help, either because they want to stay independent or they are afraid of being rejected. This factor renders it more difficult to identify abuse as **some people may not answer the questions fully** because they fear repercussions by the perpetrator. A **trusting relationship between the physician and the patient** where the medical practitioner has prior knowledge of the social or home situation and family relationships of the older patient has before asking these questions is crucial. Moreover, some of the questions (e.g. Question 12) would require **several visits** before they can be asked (Aus, Sin).

Although **sexual abuse** of older people is a category that needs to be included, **it may be detrimental to the wellbeing of an older person if an untrained person asks them about the issue**. Furthermore, there were doubts about whether a person would be willing to answer such a direct and delicate question (C.R., Ken, Sp). Also the gender dimension was emphasized: it was pointed out that it would be difficult in some countries if a male GP asked an older woman about this issue (Sin).

The concept of preventing somebody from something needs further clarification (Question 4) as at times the necessities of older parents cannot be met because of a lack of financial means and resources (C.R., Sin) or sometimes it is life events or health problems that curtail the freedoms and choices of older people such as advice from family or doctors to cease driving a car (Aus). The deprivation of something that is needed by an older person is therefore not necessarily an abuse, although this depends on the definition of need that is being used. Additionally, it should be further specified whether the question refers to a person or an abstract body - for example the community (Sp).

Question 11 was considered ambiguous as it is not clear whether this item refers to **accidental harm** (such as a fall or bruise when transferring someone into a wheelchair or bath) or **intentional harm** (being intentionally rough or violent).

As in the groups with older people, some questions are considered important according to the geographical context they are asked in. Question 9 on **alcoholism** polarized participants. More significance was attached to the question in Australia, Chile and Costa Rica than in other countries. Also **illicit drug-taking and gambling addictions** by caregivers or family members could be added to this item (Aus). However, it was pointed out that drinking too much alcohol should not be automatically considered as a risk factor for elder abuse; but it may be implicated in the development and perpetuation of abusive situations and therefore should act to raise suspicions that abuse exists or has taken place.

Issues that were neglected in the questions were **chemical restraint** (Aus), **threatened physical violence** (Aus), **involvement in decision making** (Aus), **abandonment** (C.R.) and **neglect** (Sin).

There were only a few comments on the **order** of the questions. In most cases it was suggested to leave the order the way it is, or to reverse the order of the first few questions.

3.3. Implications of the results for the EASI tool

The country coordinators presented the focus group findings at a meeting where recommendations and conclusions were discussed. Two researchers from the Montreal team also participated in the meeting.

At this meeting the set of twelve questions was compared to the original EASI[36] (five questions for the patient + one for the physician). Based on their study results for the twelve questions, the group agreed that EASI was a good and simple tool that

[36] See pp. 20-21.

covers all the important abuse categories. Also its wording is appropriate for cultural and geographical contexts other than Canada. Question 1 of the EASI is a way of asking older people if **they need help** and to introduce potential **situations of risk**. Question 2 inquires whether any kind of **deprivation** is taking place. Question 3 covers **psychological and verbal abuse**. Question 4 is about **financial abuse**. Question 5 tackles **physical and sexual abuse**. Question 6a is an **observer question** and Question 6b is a question about privacy and honesty and is only for research purposes. The country findings of the WHO-CIG study indicate that in most focus group discussions the same questions were chosen as most relevant. The following questions correspond to each other between the two sets of questions:

Question 2 (EASI):

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?

and Question 4 (WHO-CIG focus group questions[37]):

4. Has anyone prevented you from having needed things such as food, medication, clothing, adequate living space, or health aids such as eyeglasses, hearing aids, etc.?

Question 3 (EASI):

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

and Question 5 (WHO-CIG focus group questions):

5. Has anyone close to you unfairly yelled at you, or talked to you in ways that you did not like, or made you feel especially sad, shamed, fearful, anxious, or unhappy – in a way that left you upset for a long time?

Question 4 (EASI):

4. Has anyone tried to force you to sign papers or to use your money against your will?

and Question 6 and Question 8 (WHO-CIG focus group questions):

6. Has anyone close to you made you feel that you were being taken advantage of, or prevented you from doing things that were important for your well being, or interfered with you being with the people you wanted to be with?

8. Has anyone that you would trust used or tried to use your money, possessions or property in ways that you did not want, or forced you to sign documents that you did not understand or did not want to sign?

Question 5 (EASI):

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

and Question 11 and Question 12 (WHO-CIG focus group questions):

[37] See also Annex 1.

11. Has anyone physically hurt you, for example has hit you, pushed you or has impeded your free movement?

12. To a degree that it upsets you, has anyone touched you in ways you did not like, or made unwanted sexual approaches?

By looking at the EASI questions a few comments were made. For Question 2 it was mentioned that types of deprivation depend on the cultural context and may need modifications. Furthermore it was discussed whether 'sad' should be included in Question 3 but the project group decided that 'sad' is not an emotion which is necessarily associated with situations of abuse. The issue of 'neglect' was not adequately addressed in the whole questionnaire. It was also suggested to take all 'Has this happened more than once' out. Furthermore, a few minor modifications were recommended for the EASI (highlighted in yellow):

Subject No. ☐☐☐☐☐☐ Doctor No. ☐☐☐

Instructions to patients:

I am now going to move to the research study in which you have agreed to take part. (*If there is an accompanying person say to her/him:* Since the researchers ask that this be done in private, would you please leave us for a few moments?) *If accompanying person does not leave, ask questions anyway, but record below his/her presence*…I will now ask about life situations or relationships that may have occurred over the last 12 months. While it may be difficult to do, please try to answer each question with only the words Yes or No.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?

☐ Yes ☐ No ☐ Did not answer

If Yes: Have problems been common between those people and you?

☐ Yes ☐ No ☐ Did not answer

2. Has anyone prevented you or tried to prevent you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?

☐ Yes ☐ No ☐ Did not answer

If Yes: Has this happened more than once?

☐ Yes ☐ No ☐ Did not answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

☐ Yes ☐ No ☐ Did not answer

If Yes: Has this happened more than once?

☐ Yes ☐ No ☐ Did not answer

4. Has anyone tried to force you to sign papers or to use your money or your belongings against your will?

☐ Yes ☐ No ☐ Did not answer

If Yes: Has this happened more than once?

☐ Yes ☐ No ☐ Did not answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

☐ Yes ☐ No ☐ Did not answer

If Yes: Has this happened more than once?

☐ Yes ☐ No ☐ Did not answer

Doctor: Do not ask this next question to the patient. It is for you only to respond to.

6a. Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or within the last 12 months?

☐ Yes ☐ No ☐ Not sure

6b. Doctor: Aside from you and the patient, is anyone else in this room during this questioning?

☐ Yes ☐ No

M.J. Yaffe, MD mark.yaffe@mcgill.ca

M. Lithwick, MSW mlithwick@ssss.gouv.qc.ca

C. Wolfson, PhD tinaw@epid.jgh.mcgill.ca

3.4. Workshop with social workers

There seems to be a general consensus amongst the participants from the different countries that elder abuse is an important community issue regardless of the geographical setting. Also **ageism**, in the form of disrespect and disregard of older people was a theme that was prominent in almost all groups. Nonetheless, **resources and community support are in most cases limited**. Insufficient engagement on behalf of the government affects all participating countries, expressed by prevailing health care-, social- and finance-related public policies which do not adequately cover or protect older people (Aus, Bra, Chi, C.R., Ken, Sp).

The participants discussed culturally specific risk factors for elder abuse and developed the following categories:

- **Family members who are involved in drug dealing** (Bra).
- **Living in a *favela***[38] increases the level of vulnerability and isolation, by restricting free movement due to the violent environment (Bra).
- Where **witchcraft accusations** are reported, it is always the older people who are suspected, not the young ones (for example among the Kisii). Consequently, many older women are burnt to death by the public with or without hard evidence (Ken).
- Different from other participating countries, the **low number of older people in the total population** vis-à-vis children in Kenya leads to a very limited amount of resources being allocated for older people.
- **Access to health care facilities and counselling services** is usually not available for older people living in remote areas as they cannot walk long distances or afford transportation (C.R., Ken).
- **Discrimination by health insurance funds**: In Kenya, for example, the National Health Insurance Fund accepts membership below 75 years only. In addition, insurance companies demand much higher premiums from older people thereby locking them out of insurance and putting them at great disadvantage.

There were also additional abuse categories mentioned that arose within the social workers' experience:

---

[38] Brazilian Portuguese for *shanty town*.

- **Decisions were made by family members and not by the older person**.
- Use of **cultural expectations** to justify abusive behaviour.
- The **threat of abuse and intimidation** can be a potent controlling force.
- **Withholding of information** to punish or to take advantage of an older person.

Policies, protocols and training on family violence exist in all participating countries, but not all institutions have access to guidelines or offer training facilities (Bra, Chi, C.R., Ken). Where there is, the training offered is often neither formal, standardized, systematic nor compulsory. Sometimes elder abuse is included in more general training and work protocols (Bra, Chi, Ken, Sp). As a consequence, social workers use their professional experience and training from the area of domestic violence of women and children, and adapt it to their work with older people. In Singapore, a lot of decisions concerning older persons require the family's consent. Frontline workers are therefore forced to judge situations from the perspective of the families. Furthermore, the inter-professional coordination is considered to be the key to intervention but is often in need of improvement or lacking (Sp).

The *Social Work Evaluation Form* was in general regarded by the workshop participants as a very comprehensive and detailed assessment tool.[39] Nevertheless, views about its applicability were mixed. The positive aspects outline the **extensiveness of the Form**, covering many factors, questions and themes which social workers needed to be aware of. It could therefore serve as a good prompting tool and a **resource for training purposes**.

The application of this evaluation form is in most countries (Aus, Bra, C.R., Sin, Sp, Swi) was considered to be infeasible. The **length** of the Form imposed the main challenge providing both practical and theoretical difficulties. Another key problem is the perception of the difficulty of getting **honest answers** to many of the questions; some people minimize their problems to avoid trouble. In some countries social workers schedules do not include regular home visits and it would therefore not be possible to verify a person's situation at home. A very solid, trusting relationship would be necessary between the person administering the questionnaire and the interviewed person that can be only built up over a period of time. Also some of the Form's wording and/or the style of the questions were considered as limiting or inapplicable in some countries (Chi, Sin, Sp, Swi).

In addition, the participants expressed their reservations regarding the **application of this form to cognitively impaired persons**. The **problem of over-assessing people** was brought up as there are already many assessment tools in use. It was also stressed that **labels such as 'abuse' or 'neglect' are not often used** by social workers. The goal of social work intervention was seen as improvement of an older persons' quality of life and not to accuse and label somebody 'abuser' or 'victim'.

Further doubts about the applicability of the Form concerned intervention issues. **How does the form relate to an intervention plan?** A manual that accompanies the Form to assess suspicion and a flow chart adapted to local intervention possibilities was considered to be necessary. The Form was viewed as limiting and not providing ample space for the social workers conducting the assessment to explore further. Moreover, possibilities for **intervention often depend on the existing legislation**. Intervention orders – where they exist - are frequently difficult to enforce due to reluctance on the part of the victim to continually report the perpetrator (often somebody close), the general physical vulnerability of the older person, and sometimes, a lack of police understanding and/or capacity to deal with the situation.

The following suggestions were made in order to make the Form more applicable:

- The **Form could be used over a number of visits** once trust is established.
- The **use of the Form should be individualised**, depending on the particular circumstances of the older person. Only the parts that are relevant to the social worker's suspicion (e.g. financial abuse) should be used. Its application could be

[39] Country specific concerns, suggestions and comments on questions can be found in Annex 4.

limited to specific areas such as *living conditions*, *family dynamics*, *addictions of any family members*, *degree of physical and economic dependence of the older people* and *social and emotional isolation*.

- For a crisis management/intervention situation like elder abuse, the **questions should be narrowed down** and focus more on analyzing the seriousness, history and frequency of the abuse.
- In order to shorten the Form, the **introductory part could be omitted** (up to Question 19) since this information is available from other sources, for example from medical records.

Apart from the Form, the participants thought that a number of initiatives were needed. **Preventive measures** should be in place, such as better support for carers, more professionals dealing with the issue, including the police, and a greater awareness in the community of elder abuse and its devastating effects. Older people should have **access to on-call 24 hour support** to report abuse cases or to obtain information. **Greater use of existing legislation relating to sexual abuse, assault and family violence**, which is currently not used or not sufficiently used in elder abuse, is recommended. **Interdisciplinary collaboration involving e.g. GPs, social workers and visiting nurses, is crucial** and could be improved by organising **round tables** for the different stakeholders, including the older people, to share experiences, disseminate information and offer solutions. The teams would hold case meetings and develop individual strategic plans to protect older people in their homes who were at risk, or had taken out intervention orders – where these exist - against an abuser. This would need to be accompanied by regular home visits in order to improve protection for older people.

3.5. Workshop with PHC professionals and social workers

The participants discussed existing assessment and intervention possibilities but also the barriers that can hamper the prevention and detection of elder abuse in the respective countries.[40]

Both professional groups (PHC professionals and social workers) have come across abused patients but reacted differently. The **social workers appear more willing to get involved** and would want to share with each other their experiences in handling and managing elder abuse cases. Social workers either interview the abused client and/or find out about the available and appropriate systems of support. **GPs/PHC professionals** usually refer the patients to social workers, when having the necessary information but **are more hesitant to become active** and **often feel powerless**. This reluctance may stem either from the lack of time that they have with their patients, the absence of follow up strategies or the expected role and responsibilities attached to each profession. In one setting (Sin) it emerged that older GPs could relate more to elder abuse than younger physicians.

Several problematic areas were pointed out that impede prevention and intervention efforts. The **awareness of policy makers of PHC professionals** needs to be increased in all countries. Another issue concerned the **legislation** in some countries (C.R., Ken, Sin) that does not adequately cover elder abuse issues. Brazil has mandatory reporting but concerns were raised on behalf of the PHC professionals as they were worried about their own safety. Further difficulties in the assessment of elder abuse included **a lack of** a) training on elder abuse; b) inter-professional communication and coordination; c) protocols for homogenous interventions; d) specific definitions and terminologies; e) social support for caregivers, and f) circulation of information regarding the existing institutional resources.

[40] Similar issues that were already mentioned in the workshop with the social workers are not repeated in this section.

In order to develop PHC professionals' and social workers' capacities to deal with elder abuse the following initiatives were suggested:

- **Sensitizing governments** about the issues of elder abuse is one of the priorities. The governmental support would help in engaging PHC professionals – especially physicians.
- GPs need to know how to refer patients to other professionals (such as social workers) for the management of suspected cases. The establishing of a local **continuing platform where frontline workers can share information** related to elder abuse is recommended.
- Not only professionals should receive training but also the community should be sensitized and **older people should be informed about their rights**, in particular in relation to abuse, neglect and exploitation.
- **Effective solutions need to include the perpetrator of abuse**.
- The **role of nurses needs to be reviewed**. In some countries they may have more capacity to deal with elder abuse than physicians.

It was considered that a manual with basic information on elder abuse for professionals dealing with the issue was necessary. Participants discussed the usefulness of the PAHO (Pan American Health Organization) manual[41] and its applicability in their respective countries. Participants agreed that the following points should be modified or added:[42]

1. Definition of the elder abuse
    a. Sexual abuse, abandonment, neglect and self-neglect should be separate categories.
    b. Physical abuse should include 'forced medical treatments or intervention'.
    c. *Emotional abuse* could be separated from *psychological abuse. Emotional abuse* focuses more on the outcomes for the victim, such as anxiety, depression, sadness and loneliness; *psychological abuse* includes also 'limiting the resources of a person'.
    d. The following categories could be added:
        i. Abandonment and institutionalisation;
        ii. Family and gendered violence, e.g. continuation of violence against women in later life;
        iii. Decision making by family members on behalf of the older person when this is not desired by the older person or is not necessary;
        iv. Financial motivation and family greed;
        v. Using fear of abuse, neglect, isolation or abandonment to control the older person.
    e. The risk indicators are portrayed as an individual rights based approach. This may not be suitable for societies - such as Singapore - that place more emphasis on familial than individual rights.

2. Basis of the diagnostic
    a. Under 'Risk factors in the family' it was suggested that one main set of factors that were missing were various types of vulnerability in the older person such as *disability*, *illness or frailty*, *high care needs*, *dementia* (or other behavioural issues that could trigger abuse); another area was *failings in caregiver behaviour* (e.g. lack of responsibility and greed), *history of long term conflicted relationships* and *mental illness/personality disorders in both the perpetrator and/or the victim*.
    b. Under 'Risk factors in institutions and community homes' *staff-to-patient ratios*, *overcrowding* and *lack of community and social interactions* might also apply.

[41] The relevant section of the manual, discussed here, can be found in Annex 3.
[42] Numbers refer to specific sections of the PAHO manual.

c. The GPs are not in all countries - for example in Australia - the 'first port of call' for elder abuse issues due to their lack of time and training; therefore, the suggested approach in diagram 1.1 needs context specific adaptation.
d. It is assumed in the manual that the older person will have physical symptoms of abuse which is often not the case.
e. A physician is nowadays not necessarily familiar with the patient's history, since some patients change their doctors with a high frequency and the same doctor may not always be available to see an individual.
f. It is implied that conflicts with a family member/caregiver is evident, but stressful relationships are often well hidden or denied.
g. There is no mention of cultural differences or likely needs for translators or interpreters to be present.
h. There is no procedure whereby physicians must ask consent before touching or physically examining older patients - this is especially important in cases of sexual assault.
i. The risk indicators are considered as a useful list but for physicians it would be adequate to call it a diagnostic guide as the indicators were not specific enough; greater preference was given for a checklist that could be used at the end of the assessment.
j. GPs and social workers recommend an adoption of a socio-medical diagnosis in table 1.2 (in 2.2 - Diagnosis of the problem).

3. Basis for treatment
    a. The flowchart's approach is too medicalised; using the word 'treatment' makes elder abuse sound like a disease. The focus should be on removing or lessening the harm caused to the older person by the perpetrators of abuse.
    b. In some countries 'Adult Protective Services' and mandatory reporting do not exist, nor are there specific intervention orders.
    c. Referral options vary from country to country and need to be adapted accordingly within specific contexts.
    d. A focus on the rehabilitation and education of the perpetrator often seems to be more appropriate than strategies being only directed at the education of the older person.
    e. The term 'intervention' can be replaced by 'options' or 'assistance' as an intervention may seem to remove the agency from the older person herself.
    f. An important issue that was not appropriately addressed in diagram 1.3 is the need to ensure the victim's safety and that appropriate safety planning takes place for individuals – particularly for patients who do not have the capacity to decide for themselves about accepting services.
    g. As for an intervention plan, it was suggested to create a hotline/helpline for PHC professionals; the flowchart (1.3) was viewed a slightly inflexible.

5. Suggested Readings
    a. The literature list needs to be updated.

The participants concluded that the PAHO manual was not considered appropriate for use in Singapore, Spain and Australia for the reasons outlines above.[43] In these three countries there are already follow-up strategies in place which seem to better reflect the country-specific realities. The Brazilian group thought that the manual would be used if it was shorter and adjusted to the Brazilian context - for instance, the flow charts need some adaptation - as it could raise awareness about abuse and neglect amongst PHC professionals. In both Costa Rica and Kenya there was a strong feeling that the PAHO manual's content and issues are appropriate and it could be readily used.

[43] The recommendations for the PAHO manual summarized in this section are mostly based on the reports from these three countries. More information can be found in Annex 4.

4. Recommendations and conclusions

Throughout the execution of this project WHO and CIG embraced an interdisciplinary and interagency approach with the objective of pursuing identification and prevention possibilities for elder abuse in the range of participating countries. The complexity of the research - tackling a highly sensitive topic on a global level and taking into account cultural differences - has shown that multiple steps are necessary in order to achieve appropriate elder abuse identification strategies in response to the call from the Madrid International Plan of Action on Ageing. In particular, it is crucial to include the views of the three main stakeholders: older persons, medical doctors and social workers.

The conclusions from the focus group and workshop discussions in the various countries corroborate the findings and recommendations from the EASI study in Montreal:

- An instrument with twelve questions is too long, considering that in most of the participating countries the standard consultation time of a GP is 10-15 minutes or even less. A shorter instrument covering all key dimensions of elder abuse has a higher chance of being accepted and applied by PHC professionals.
- Before applying such a questionnaire it is crucial to determine whether the patient shows significant signs of cognitive deterioration.
- These questions should only be asked when the patient is seen alone.
- It is becoming less likely that an older patient has a consistent and close relationship with a physician who knows him well. The questions should be therefore applied by a PHC professional over a few visits in order to establish a sufficient trusting relationship between the patient and the PHC professional.
- In case elder abuse is suspected it is essential to equip PHC professionals with follow-up mechanisms/referral strategies.

Further points mentioned were:

- Nurses could be important alternatives to physicians in applying such a questionnaire.
- A major challenge of the concept of such a tool arose: some of the questions (e.g. Question 11) are somewhat ambiguous as it is not clear whether a person was accidentally or unintentionally hurt. A caregiver may need training about appropriate lifting and handling an older person in order to prevent harm or injury occurring in future.
- Another difficulty pointed out by the participants is that some people may find it hard to answer these questions.
- The threat of violence and associated intimidation to an older person is an important issue which is not addressed in the bank of twelve questions.

An entirely accurate comparison of the results from the focus groups with older people and PHC professionals - and additionally across the countries - is difficult to achieve since the nature of the focus groups conducted and the number of participants varied significantly. However, the following conclusions can be drawn:

- In some countries - such as in Singapore - older people and the PHC professionals have both chosen an almost identical set of questions to be retained in the questionnaire but in other countries the selection differs widely.

- Questions 4 and 5 were chosen in all the relevant focus groups with older people as the most important ones, followed by Questions 6, 8 and 11 (with lesser consistency across the countries). The choices made by the PHC professionals were more uniform: preferences were mostly given to Questions 4, 5, 8, 11 and 12.
- A number of similar points were brought up in both groups – the older people and the PHC professionals:
    - The importance of a trusting relationship between the physician and the patient.
    - Most older people feel uncomfortable when asking for help.
    - Although there was a general agreement that the questionnaire needs to be shortened and the wording simplified, there was no consensus on the length of the questions. On the one hand, some thought that longer questions were more difficult to understand but the number of questions could be kept down. On the other hand, shorter questions might be more comprehensible but leading to a longer questionnaire; the more extensive the questionnaire would be – even if the questions are shorter – the higher is the chance to lose older people's attention.
- Some questions (e.g. Question 11) were considered ambiguous as it is not clear whether they address accidental or intentional harm.
- The importance of some questions - such as asking about alcohol problems or economic dependence - depends on the geographical and cultural context.
- The question on sexual abuse sparked the biggest controversy. Most older people considered this question too delicate or not as relevant enough, whereas PHC professionals thought that this item was necessary to include this question.

This project's main goal was to investigate the feasibility of developing an instrument applicable in different cultural and geographical contexts that could raise PHC professionals' awareness about elder abuse and neglect.
The results show that questions that are culturally sensitive - for example the question on sexual abuse - cannot be asked in all settings. More subtle ways have to be found to address this issue. It also revealed some discrepancies between the set of questions regarded as suitable by PHC professionals and older people. Based on the results of this study we cannot yet recommend the tool to be universally applicable because it cannot conform to cultural sensitivities in <u>all</u> settings. However, it might be possible to develop a tool which is sufficiently flexible in the core questions used that it could be relatively easily adapted for use in different geographical and cultural contexts.
Nevertheless, it is important to devise a strategy for this hidden and widespread societal phenomenon. The *Elder Abuse Suspicion Index* instrument together with other assessment techniques - such as an appropriate social work assessment and a manual containing information on prevention, identification and intervention approaches tailored to a variety of local contexts - offers an important ground on which future efforts can build. We recommend that such initiatives as these should be developed in all countries across the world as attempts to prevent abuse and to offer sufficient protection to those older people in need gather the necessary momentum to deal with this pernicious problem affecting many thousands of older citizens.

5. Essential references

1. **Acierno R, Resnick H, Kilpatrick D, Stark-Riemer W.** Assessing elder victimization. Demonstration of a methodology. *Soc PsychiatryPsychiatr Epidemiol* 2003; 38:644-53.
2. **Ahmad M, Lachs MS.** Elder abuse and neglect: what physicians can and should do. *Cleve Clin J Med* 2002; 69(10):801-808.
3. **Baker AA.** Granny-battering. *Modern Geriatrics* 1975; 5:20-24.
4. **Ewing JA.** Detecting Alcoholism. The CAGE Questionnaire. JAMA 1984; 252: 1905-1907
5. **Hudelson PM.** Qualitative research for health programmes, Geneva, WHO, 1994.
6. **Lachs MS.** Screening for family violence: What's an evidence-based doctor to do? (Editorial). *Ann Intern Med* 2004; 140(5):399-400.
7. **National Research Council.** Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Panel to Review Risk and Prevalence of Elder Abuse and Neglect. Richard J. Bonnie and Robert B. Wallace, Editors. Committee on National Statistics and Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. 568 pages, 2003, Washington, DC: The National Academies Press.
8. **Pan American Health Organization.** Guía clínica para atención primaria a las personas adultas mayores, Washington, PAHO, 2002.
9. **Pillemer K, Finkelhor D.** The prevalence of elder abuse: a random sample survey. *Gerontologist* 1988; 28:51-57.
10. **Rosenblatt DE, Cho KH, Durance PW.** Reporting mistreatment of older adults: the role of physicians. *J Am Geriatr Soc* 1996; 44(1):65-70.
11. **Ruiz Sanmartín, A, Altet Torner, J, Porta Martí, N, Duaso Izquierdo, P. Coma Solé, M, Requesens Torrellas, N.** Violencia doméstica: prevalencia de sospecha de maltrato a ancianos. *Aten Primaria* 2001; 27(5):331-34.
12. **United Nations.** Madrid International Plan of Action on Ageing (2002, up-dated). http://www.un.org/esa/socdev/ageing/waa/a-conf-197-9b.htm.
13. **United Nations.** Population Database (2004, up-dated).
14. **Vieillir en Liberté:** http://www.fep.umontreal.ca/violence/ (RIFVEL).
15. **World Health Organization**. Active Ageing - A policy framework, Geneva, WHO, 2002.
16. **World Health Organization / INPEA**. Missing Voices. Views of older persons on elder abuse, Geneva, WHO, 2002a.
17. **World Health Organization / INPEA**. The Toronto Declaration, Geneva, WHO, 2002b.
18. **Yaffe MJ, Lithwick M, Wolfson C**. A North American view on elder abuse. World Health Organization Symposium: WHO Approaches to the Prevention of Elder Abuse, 18th Congress of the International Association of Gerontology. Rio de Janeiro, Brazil, June 26-30, 2005.
19. **Yan, E, Tang, CSK.** Prevalence and psychological impact of Chinese elder abuse. *J Interpers Violence* 2001; 16(11):1158-74.

6. Project team

Project coordinators:

WHO:
Alexandre Kalache, Head Ageing and Life Course programme,
WHO, Family and Community Health, Geneva.

CIG-UNIGE/HUG:
Charles-Henri Rapin, Directeur adjoint, Centre Interfacultaire de Gérontologie de l'Université de Genève (CIG-UNIGE) and Médecin chef de service, Programme "Bien Vieillir" des HUG, Geneva.

CIG-UNIGE/WHO:
Ms Karina Kaindl, Centre Interfacultaire de Gérontologie de l'Université de Genève (CIG-UNIGE) and Ageing and Life Course programme, WHO, Family and Community Health, Geneva.

Ms Silvia Perel Levin and Ms Maria Casares were part of the project coordination and left both the team in December 2004.

Research partners and experts:

Mark S. Lachs, Professor of Medicine,
Division of Geriatrics and Gerontology, Weill Medical College of Cornell University, New York.

Ms Maxine Lithwick, Researcher and Social Worker,
Centre de santé et de services sociaux de René-Cassin et Notre-Dame-de-Grace/Montréal-Ouest.

Dr Mark J. Yaffe, Professor of family medicine and Chief, department of family medicine, McGill University; St. Mary's Hospital, Montreal.

Collaborating and piloting centres / country coordinators of the national studies:

Australia: Ms Gordana Marin, Department for Victorian Communities, Office of Senior Victorians, Melbourne.

Brazil: Ms Laura Machado, InterAge Consulting in Gerontology, Rio de Janeiro.

Chile: Dr Pedro Paulo Marin, Catholic University of Chile, WHO Collaborating Centre on Ageing and Health, Santiago.

Costa Rica: Dr Fernando Morales-Martinez, Hospital Nacional de Geriatría y Gerontología Dr Raul Blanco Cervantes, Calles 18-10, Avenida 8, San Jose.

Kenya: Ms Amleset Tewodros, HelpAge International, Africa Regional Development Centre, Regional Representative - Africa, Nairobi.

Singapore: Ms Susana Concordo, Tsao Foundation, Singapore.

Spain: Ms Mayte Sancho Castiello and Dr Antonio Yuste, Ministry of Social Welfare and Labour / Sociedad Española de Geriatría y Gerontología (IMSERSO/SEGG), Madrid.

Switzerland: Prof Charles-Henri Rapin, Hôpital de Loëx, Bernex/Geneva.

Report evaluators:

Terezinha Da Silva, Adviser and Trainer, Legal and Judiciary Training Centre, Maputo, Mozambique.

Bridget Penhale, Senior Lecturer, University of Sheffield.

Annex 1: Focus groups research protocol

Twelve questions for a *Suspicion Index*:

Question 1

Do you usually feel lonely?		
Yes	No	Did not answer

We only have about 5-10 minutes for each question; here is what we would like your thoughts on:

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 2

Question 2

When you need help, do you feel uncomfortable turning to people for help?		
Yes	No	Did not answer

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 3

Question 3

Do you depend most of the time on someone for help with your basic daily needs?
Yes No Did not answer
If "Yes": Are disagreements common between such people and yourself?
Yes No Did not answer

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 4

Question 4

Has anyone prevented you from having needed things such as food, medication, clothing, adequate living space, or health aids such as eyeglasses, hearing aids, etc.?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 5

Question 5

Has anyone close to you unfairly yelled at you, or talked to you in ways that you did not like, or made you feel especially sad, shamed, fearful, anxious, or unhappy – in a way that left you upset for a long time?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 6

Question 6

Has anyone close to you made you feel that you were being taken advantage of, or prevented you from doing things that were important for your well being, or interfered with you being with the people you wanted to be with?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 7

Question 7

Do you have anyone who is financially dependent on you?		
Yes	No	Did not answer

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 8

Question 8

Has anyone that you would trust used or tried to use your money, possessions or property in ways that you did not want, or forced you to sign documents that you did not understand or did not want to sign?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 9

Question 9

Do you live with anyone who drinks alcohol more than you think he/she should?		
Yes	No	Did not answer

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 10

Question 10

Do you live with anyone who has a history of mental illness?		
Yes	No	Did not answer

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 11

Question 11

Has anyone physically hurt you, for example has hit you, pushed you or has impeded your free movement?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

You may now turn the page to Question 12

Question 12

To a degree that it upsets you, has anyone touched you in ways you did not like, or made unwanted sexual approaches?

Yes No Did not answer

If "Yes": Was this an isolated event or has it occurred more than once?

Isolated More than Once

- How important is this item in detecting elder abuse?
- How do you like the wording of the question? Are there any words that cause problems? What could they be replaced with?
- Is there redundancy within the question?
- Do you think having several issues in one question is too complicated or problematic in any way?
- Is the wording too long – how might it be rephrased?

Suppose the instrument - the *Elder Abuse Suspicion Index* - could have only <u>five questions</u> - which five would you use? Please circle the five question numbers on the pages with the questions.

Please note:

The questions used above were mostly derived from a research project of the *Centre de santé et de services sociaux de René-Cassin et Notre-Dame-de-Grace* (formerly CLSC René Cassin), *McGill University*, and *St. Mary's Hospital* in Montreal, funded by the *Canadian Institutes of Health Research*. The intellectual property rights for them rest with the researchers Mark J. Yaffe MD, Maxine Lithwick MSW, Christina Wolfson PhD, and Elizabeth Podnieks RN.

Annex 2: Social work evaluation form

Evaluation Form

Subject No. _____ **Evaluator: _____**

Location of interview: Home ☐ **Other: _____**

Date Referral Received (yy/mm/dd):_____

Date of first visit (yy/mm/dd):_____

Date of second visit (if necessary) (yy/mm/dd):_____

Subject withdrew from study: Yes ☐ **No ☐**

Date of withdrawal (yy/mm/dd):_____

Reason for withdrawal: _____

_____

_____

_____

_____

_____

SECTION 1: <u>SOCIAL HISTORY: (occupation, marriage, divorce, grief, misfortune, education, immigration, moves, other major events.)</u>

In this section, ask subject to tell you a personal history. During this process, gather information on the above and fill it in below:

1. Sex: M ☐ or F ☐

2. Age: _____

3. Language used during the interview: _____

4. Occupation status (circle all that apply)

1. Retired Type of work? _____
2. Unemployed From what? _____
3. Unable to work for medical reasons
4. Employed full time as: _____
5. Employed part-time as: _____
6. Homemaker
7. Other: _____

5. Housing

1. Home/apartment ☐
2. Low cost housing/HLM ☐
3. Public housing/LTCF ☐
4. Residence ☐
   - Services ☐
   - No services ☐
5. Other, please specify: _____

- Are there any difficulties or specific problems that the subject has identified re: housing conditions (salubrity, space, security, satisfaction...)?
-

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

6. Country of birth: _____

If applicable, are you under sponsorship at this time? Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", what is your relationship to the sponsor? _____

If the subject is originally from another country, ask questions about any specific events that may have influenced their coming to this country (for example holocaust, war etc):

_____

_____

_____

7. Marital Status

1. Married ☐
2. Widowed ☐
3. Separated or divorced ☐
4. Single ☐
5. Common law ☐ → different-sex partner ☐
   → same-sex partner ☐
6. Significant relationship ☐

8. Living Arrangements
Check all that apply:

1. Alone ☐
2. With spouse ☐
3. With common law partner ☐
4. With roommate ☐
5. With child(ren) ☐ How many?_____
6. With grandchild(ren) ☐ How many?_____
7. With other relatives:_____
8. With paid caregiver ☐
9. Other:_____

- **How long have you been in the present arrangement? _____**

- **Is it problematic** (for example: family problem, needs more help, other)?
  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "Yes", explain:

  _____

  _____

  _____

9. Describe major life events in the last 12 months: *(circle all that apply)*

1. None
2. Death
3. Divorce (own or within family) / separation from partner
4. Physical deterioration of subject or the person with whom they live
5. Change in financial status
6. Child or grandchild moving in or out etc.
7. Moving in or out of child's or other relative's home.
8. Other, specify:_____

Explain: _____

_____

SECTION 2: **FAMILY DYNAMICS**

RELATIONSHIP WITH SPOUSE/PARTNER

10. If married, is this a first marriage? *(Apply same questioning if it is a common law commitment or long-term relationship.)*

1. Yes ☐ How long? _____
2. No ☐ How long in current relationship? _____
3. Not applicable ☐ *(Go to question 12)*
4. R/A ☐

11. Most couples acknowledge that there are, from time to time, problems that arise in their relationship. How often would you rate problems in yours, whatever your definition of problem is, using the following:

_____Never _____Occasional _____Often _____Very often

Explain:

_____

_____

_____

- **Does your spouse or partner have any specific health problem or emotional problem (include illness, handicap, alcohol or drug or gambling addiction, or mental illness)?**

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

_____

If applicable, explore the following questions:

- What is the impact of any difficulties in your relationship?

_____

_____

_____

- If there are any problems within the relationship, for how long has this been occurring?

_____

- Do you describe yourself as being mistreated within this relationship?

  Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

Is there any precipitating factor??

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

- Have things become worse in the last 12 months?

  Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

RELATIONSHIP WITH CHILDREN

12. Do you have any children? Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" go to question 14.

If "Yes" how many? _____

Explore the relationship between the subject and the child(ren). If there are any problems, with whom?

Please list relationship: A: _____

B: _____

C: _____

D: _____

Describe any problems:

_____

_____

_____

_____

_____

13. Does any child have any specific health problem or emotional problem (include illness, handicap, alcohol or drug or gambling addiction, or mental illness)?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

Does this person live with you? Yes ☐ No ☐ N/A ☐ R/A ☐

RELATIONSHIP WITH GRANDCHILDREN

14. Do you have any grandchildren? Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" go to question 16.

If "Yes" how many? _____

Explore the relationship between the subject and the grandchild(ren). If there are any problems, with whom?

Please list the relationship: A: _____

B: _____

C: _____

D: _____

Describe any problems:

_____

_____

_____

_____

_____

15. Does any grandchild have any specific health problem or emotional problem (include illness, handicap, alcohol or drug or gambling addiction, or mental illness)?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

Does this person live with you? Yes ☐ No ☐ N/A ☐ R/A ☐

OTHER SIGNIFICANT RELATIONSHIP(S)

16. Do you have any other significant relationships? Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" go to question 18.

Explore the relationship between the subject and any other significant person. If there are any problems, with whom?

Please list relationship: A: _____

B: _____

C: _____

D: _____

Describe any problem:

_____

_____

_____

_____

17. Does this person have any specific health problem or emotional problem (include, illness, handicap, alcohol or drug or gambling addiction, or mental illness?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

Does this person live with you? Yes ☐ No ☐ N/A ☐ R/A ☐

RELATIONSHIP WITH OTHER FAMILY MEMBERS

18. Do you have any other family members with whom there have been problems within the past 12 months? Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", what are they? With whom do they occur and how often?

_____

_____

_____

_____

_____

_____

19. Does any other family member have any specific health problem or emotional problem (include illness, handicap, alcohol or drug or gambling addiction, or mental illness)?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

_____

Does this person live with you?

Yes ☐ No ☐ N/A ☐ R/A ☐

SECTION 3: **QUESTIONS ABOUT ADL'S**

DEGREE OF DEPENDENCY

20. Are you:

1. Independent in all ADL's ☐ *Go to question 25*
2. Independent in some ADL's ☐
3. Totally dependent ☐
4. (If applicable) How many people provide assistance?_____

Please list relationships:

A: _____

B: _____

C: _____

D: _____

In this section, use the categories listed above and below to help you complete the grid. Subjects may have different caregivers for different tasks.

1. Unaided
2. With assistance from others
3. Totally dependent on others
4. Activity not performed

Activity	**Degree of Assistance (1-4)**	**For each item indicate if the situation is Temporary or Permanent**	**Who performs the activity? (see A-D, above)**	**Does the subject live with the caregiver?**
Bathing				
Dressing				
Toileting				
Medication Administration				
Housekeeping				
Meal preparation				
Eating				
Shopping				
Transportation				
Mobility				
Other				

21. ***Ask questions directly to the subject about the type of care that he/she receives and about the relationship with the person who helps him/her:***

- **Have there ever been any problems with the type of care you received in the last 12 months?**
  Yes ☐ No ☐ N/A ☐ R/A ☐

Describe:

_____

_____

_____

- **How frequently would you say that such a problem has occurred?**

  1. Only once 2. A few times 3. Monthly 4. Weekly

Explain:

_____

_____

_____

- **Do you ever feel that you are being deprived of things that you need? (For example: household goods, food, going to doctors, dentures etc.)**

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", describe:

_____

_____

_____

- **Has this person ever behaved in a way that upset you?** Yes ☐ No ☐ N/A ☐ R/A ☐
- **Have there ever been disagreements between you and that person?**

  Yes ☐ No ☐ N/A ☐ R/A ☐
- **Has this person ever handled you roughly?** Yes ☐ No ☐ N/A ☐ R/A ☐

  Do you have the food you want? Yes ☐ No ☐ N/A ☐ R/A ☐

  - The quality? Yes ☐ No ☐ N/A ☐ R/A ☐
  - The quantity? Yes ☐ No ☐ N/A ☐ R/A ☐

- **Has there ever been a day or longer when you did not have sufficient food?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **Does the person ever refuse to take you shopping?** Yes ☐ No ☐ N/A ☐ R/A ☐

- **Are you ever made to feel like you are worthless or a burden?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

- **Are you ever reluctant or afraid to ask for things that you want or need?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

22. Do you have any concerns either in:

1. Feeling secure that help will always be available Yes ☐ No ☐ N/A ☐ R/A ☐
2. Quality of the care that you receive Yes ☐ No ☐ N/A ☐ R/A ☐
3. Feeling indebted to the person providing the care Yes ☐ No ☐ N/A ☐ R/A ☐
4. Other

Explain:

_____

_____

_____

_____

23. Before you needed any help, were there ever problems in your relationship with any of your caregivers?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

_____

24. Does any caregiver have any specific health problem or emotional problem (include illness, handicap, alcohol or drug or gambling addiction, or mental illness?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

_____

If "Yes", describe the impact that it has had on you:

_____

_____

_____

_____

SECTION 4: <u>PHYSICAL AND MENTAL HEALTH STATUS</u>

25. Do you take any medication? Yes ☐ No ☐ N/A ☐ R/A ☐

26. Do you know what each medication you are taking is for? Yes ☐ No ☐ N/A ☐ R/A ☐

27. In the last 12 months has your consumption of medication increased?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

28. Do you consume alcohol? Yes ☐ No ☐ N/A ☐ R/A ☐

29. In the last 12 months, has your consumption of alcohol increased?

Yes ☐ No ☐ N/A ☐ R/A ☐

30. In the last 12 months have you felt increasingly sad or depressed?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes" explain:

_____

_____

_____

31. In the past 12 months, have you consulted or been referred to a psychologist, social worker, psychiatrist or any other type of therapist?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

SECTION 5: LIVING WITH A CARE-RECEIVER

32. Do you live with anyone who is dependent on you?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" go to question 34.

If "Yes" what it your relationship to that person? _____

Do you give any of the following types of assistance to the care-receiver?

- Bathing Yes ☐ No ☐ N/A ☐ R/A ☐
- Dressing Yes ☐ No ☐ N/A ☐ R/A ☐
- Toileting Yes ☐ No ☐ N/A ☐ R/A ☐
- Medication administration Yes ☐ No ☐ N/A ☐ R/A ☐
- Housekeeping Yes ☐ No ☐ N/A ☐ R/A ☐
- Meal preparation Yes ☐ No ☐ N/A ☐ R/A ☐
- Eating Yes ☐ No ☐ N/A ☐ R/A ☐
- Shopping Yes ☐ No ☐ N/A ☐ R/A ☐
- Transportation Yes ☐ No ☐ N/A ☐ R/A ☐
- Mobility Yes ☐ No ☐ N/A ☐ R/A ☐
- Other (Describe):_____

- **If "Yes" on any of the above, are there any problems between you and that person?**

Explain:_____

_____

_____

33. Does that person ever threaten or get aggressive with you (whether it is intentional or not)?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

SECTION 6: FAMILY AND SOCIAL ACTIVITIES

34. Are you involved in social activities? Yes ☐ No ☐ N/A ☐ R/A ☐

If "No", explain:

_____

_____

- **Do you feel that you have enough contact with the children, relatives, friends, neighbors, etc…?**

If "No", explain:

_____

_____

- **Are you involved in family activities as frequently as you would like to be?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **Are you involved in social activities as frequently as you would like to be?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

If "No", explain:

_____

_____

If not, what prevents you?

- Health ☐
- No one to take me ☐
- Not enough availability of the activities that I would like to participate in ☐
- Too expensive ☐
- Other ☐

Explain:

_____

_____

- **Has anyone close to you ever prevented you from participating in social activities?**

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

SECTION 7A: **FINANCIAL DEPENDENCY OF THE SUBJECT**

35. What is your perception of your financial situation?

1. Financially self-sufficient ☐
2. Partly self-sufficient ☐
3. Total financial dependence ☐
4. Unknown ☐

Explain:

_____

_____

36. Are your finances managed by:

1. Self ☐
2. With some assistance ☐
3. Entirely by others ☐
4. Unknown ☐

37. If "Yes" to number 36.2 or 36.3 above, what is your relationship to that person?

1. Spouse / common law partner ☐
2. Child(ren) ☐ How many assisting/managing finances?_____
3. Grandchild(ren) ☐ How many assisting/managing finances?_____
4. Niece / nephew ☐ How many assisting/managing finances?_____
5. Friend ☐ How many assisting/managing finances?_____?
6. Other:_____

- **Who is responsible for paying the rent (mortgage or property taxes)?**

  _____

- **Have there ever been any problems between you and the person managing the finances?** Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

38. Does anyone have <u>banking</u> power of attorney? Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", have there ever been any problems with this person?

_____

_____

_____

39. Does anyone have <u>total</u> power of attorney? (*notarized*)? Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", have there ever been any problems with this person?

_____

_____

_____

40. Have you ever signed any documents that you felt you were forced to sign?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", what was your relationship to that person who forced you?

_____

What was the outcome of this event?

_____

_____

_____

41. *Ask these questions to subjects who have assistance with managing their finances or have their finances managed by someone else (include those who have given power of attorney):*

- **Are you informed about all financial transactions?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "No", is this a problem for you? Yes ☐ No ☐ N/A ☐ R/A ☐

- **Have you ever had concerns or suspected that your money was not being managed as you would want?** Yes ☐ No ☐ N/A ☐ R/A ☐

  Has this been a problem within the last 12 months?

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **Are your bank balances what you think that they should be?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "No", is this a problem that has occurred within the last 12 months?

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **Has your money ever been used without your consent?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "Yes", has this been a problem within the last 12 months?

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **Are all your bills being paid regularly?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "No", has this been a problem within the last 12 months?

  Yes ☐ No ☐ N/A ☐ R/A ☐

- **If any problem has been identified in any of the above questions, what would you say is the frequency of this type of situation <u>within the last 12 months</u>?**

  1. Only once 2. A few times 3. Monthly 4. Weekly

Explain problems mentioned:

_____

_____

_____

_____

42. In general, do you ever feel that anyone is after your money?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

SECTION 7B: <u>FINANCIAL DEPENDENCY OF SOMEONE ON THE SUBJECT</u>

43. In the past 12 months, has anyone depend on you for money?

Yes ☐ No ☐ Sometimes ☐ N/A ☐ R/A ☐

If "No", go to question 49.

If "Yes", who?

- Spouse / common law / partner ☐
- Son(s) ☐
- Daughter(s) ☐
- Grandchild(ren) ☐
- Niece(s) ☐
- Nephew(s) ☐
- Other:_____

- **Does one of the above also manage your finances?**

  Yes ☐ No ☐ N/A ☐ R/A ☐

  If "Yes", who?_____

44. Does that person live with you? Yes ☐ No ☐ Sometimes ☐ N/A ☐ R/A ☐

45. To what degree is that person dependent on you financially?

1. Totally ☐
2. Partially ☐
3. Episodically ☐

Is this? Permanent ☐ Temporary ☐

Explain: (For example: presently unemployed, inadequate revenue, disability, other):

_____

_____

46. Does this person have any physical or mental health problem (Include illness, handicap, alcohol, gambling or drug addiction, or mental illness?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

47. Has there ever been a problem regarding finances between you and that person?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

48. Has this person ever mistreated you whether it was intentional or not?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes", explain:

_____

_____

_____

- **Is that problem still going on?** Yes ☐ No ☐ N/A ☐ R/A ☐

Explain:

_____

_____

_____

_____

SECTION 8: **SUMMARY QUESTIONS TO ASK THE SUBJECT**

Interviewer states: ("We are coming near the end of our questions and we just want to go over a few more issue")

49. Has there ever been a time when you have felt scared or threatened by any one close to you?

1. No ☐
2. Yes, already mentioned ☐
3. Yes, not mentioned,
   explain:_____

_____

4. If "Yes" to question 49.3, has this been going on within the last 12 months?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" to question 49.4, then when did this occur? _____

50. Do you believe that any one you know mistreats you in any way, whether it was intentional or not?

1. No ☐ (*go to question 51)*
2. Yes, already mentioned ☐
3. Yes, not mentioned,

explain:_____

_____

4. If yes to question 50.3, has this been going on within the last 12 months?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" to question 50.4, then when did this occur? _____

51. Do you ever feel that anyone close to you is harming you emotionally, physically (such as hitting you or handling you roughly), sexually, financially or neglecting any of your daily needs - whether they are aware of it or not?

1. No ☐ *(go to question 52)*
2. Yes already mentioned ☐
3. Yes, not mentioned, explain:_____

_____

4. If "Yes" to question 51.3, has this been going on within the last 12 months?
   Yes ☐ No ☐ N/A ☐ R/A ☐

If "No" to question 51.4, then when did this occur?_____

52. In general, are you satisfied with your relationship with the people that are close to you?

Yes ☐ No ☐ N/A ☐ R/A ☐

53. Is there anything that you would like to add that has not been mentioned before?

Yes ☐ No ☐ N/A ☐ R/A ☐

If "Yes" describe:

_____

_____

_____

_____

_____

_____

SECTION 9: <u>QUESTIONS FOR THE EVALUATOR</u>

54. Were you able to interview the subject alone? Yes ☐ No ☐ N/A ☐

If "No", who was present and why?

_____

_____

_____

55. Do you believe that the subject was being open and honest with you during the evaluation?

Yes ☐ No ☐ N/A ☐

If "No", explain:

_____

_____

_____

56. Was the subject able to fully participate in the interview?

Yes ☐ No ☐ N/A ☐

If "No", explain (For example: difficulty understanding, hard of hearing, not cooperative etc):

_____

_____

_____

57. During the interview, did you observe any of the following affective states in the subject? Check all that apply:

- Aggression ☐
- Anxiety ☐
- Shame ☐
- Depression ☐
- Fear ☐
- Hopelessness ☐
- Anger ☐
- Sadness ☐
- Other:_____

Comment:

_____

_____

_____

58. Did you observe any signs of abuse, neglect or mistreatment? (For example: subject being poorly kept, house in disorder, no food, smell of urine, any visible and unexplained bruising or other)

Yes ☐ No ☐ N/A ☐

If "Yes", explain:

_____

_____

_____

_____

59. Do you believe that this subject is being abused?

1. Yes ☐
2. No ☐
3. Don't know ☐

Explain your response:________

_____

_____

60. If the answer to question 59 was "Yes", did the subject:

☐ State specifically that he/she was being abused?

☐ Used words to describe the abuse?

Explain:

_____

_____

_____

61. On a visual analogue scale, how confident are you in finding of:

Psychological abuse

Unlikely 0 ---------- 1 Likely

Neglect

Unlikely 0 ---------- 1 Likely

Physical abuse

Unlikely 0 ---------- 1 Likely

Financial abuse

Unlikely 0 ---------- 1 Likely

62. On a visual analogue scale, how confident are you in your overall assessment?

Unconfident 0 ---------- 1 Confident

63. What were the signs and symptoms that you observed of psychological abuse, neglect (active or passive) physical abuse or financial abuse?

If applicable, explain:

Psychological:

_____

_____

Neglect:

_____

_____

Physical:

_____

_____

Financial:

_____

_____

64. Has the subject been able to confirm if they were: N/A ☐

Physically or sexually abused Yes ☐ No ☐ Unknown ☐

Explain:_____

_____

Psychologically abused Yes ☐ No ☐ Unknown ☐

Explain:_____

_____

Neglected Yes ☐ No ☐ Unknown ☐

Explain:_____

_____

Financially abused or exploited Yes ☐ No ☐ Unknown ☐

Explain:_____

_____

65. Is the subject in any immediate danger? Yes ☐ No ☐ N/A ☐

66. Does the subject need or want to be referred for any help?

Yes ☐ No ☐ N/A ☐

67. Additional comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Evaluator:_____

Date written evaluation completed (yy/mm/dd):_____

Duration of interview (hr: min):_____

Annex 3: PAHO manual

PART II:

Abuse (Mistreatment) and Neglect (Abandonment)

DIAGNOSTIC AND MANAGEMENT GUIDE I

PANAMERICAN HEALTH ORGANIZATION
Regional Office of the
WORLD HEALTH ORGANIZATION

OBJECTIVES

1. Analyze the problem of abuse and mistreatment by taking into account an epidemiological perspective, to take countering actions.

2. Recognize the distinct types of abuse and mistreatment.

3. Describe the associated risk factors.

4. Describe the clinical assessment of the victim and the perpetrator.

5. Describe the initial follow-up strategies.

1 – DEFINITION OF THE PROBLEM

Elder abuse is defined as any type of action, series of actions, or lack of actions, which produce physical or psychological harm, and which is set within a relationship of trust or dependence. Elder abuse may be part of a cycle of family violence; it may be caused by caregivers, or may be the result of a lack of training of social and health institutions, who cannot meet the needs of older persons.

Elder abuse and neglect may take diverse forms:

PHYSICAL ABUSE: to cause harm or injury, to coerce physically, as for example to impede the free movement of an individual without justification. Also included in this category is the sexual abuse of an individual.

PSYCHOLOGICAL ABUSE: to cause psychological harm, as for example causing stress, anxiety, and attacking the dignity of an individual with insults.

ECONOMIC ABUSE: to exploit the goods of a person, fraud, blackmail, as well as theft of money or the property of an individual.

NEGLECT OR ABANDONMENT: negligence or the omission of assisting or aiding an individual who depends on this help, or towards whom there exists a legal or moral obligation. Neglect or abandonment may be intentioned or unintentional.

Intentioned neglect is when a caregiver, due to bad will or irresponsibility, ceases to provide an older person with the help this person may need. Unintentional neglect is when the caregiver does not provide assistance, either due to ignorance or incapacity.

1.1 – Risk Indicators

Elder abuse may be represented through the four categories mentioned, and may manifest itself in different ways (Table 1.1).

Table 1.1 – Manifestations of abuse

Types of physical abuse	
• Shoving • Hitting • Forcing someone to eat or drink something • Forcing someone to be in an inappropriate position • To attach or bind someone • Pinching	• Burning (with cigarettes, fluids…) • Injuries or wounds • Breaking bones • Pulling Hair • Shaking • Putting or throwing food or water at someone • Sexual abuse
Types of psychological or emotional abuse	
• Threaten to abandon someone • Non-justifiable accusations • Harassment • Physical or verbal intimidation • Infantilizing the individual • Limiting the rights of an individual to:	- a private life - take a decision - medical information - vote - receive mail - communicate with others
Types of financial abuse	
• Using the resources of the older person for the benefit of the caregiver • Financial blackmail • To take possession of the property of an individual • Coercion to sign legal documents, such as wills, acts of property, etc.	
Types of neglect or abandonment	
• Neglecting the dehydration of an individual • Neglecting the good nutrition of an individual • Ignoring untreated ulcers • Neglecting the hygiene of an individual • Not healing open wounds or lesions • Maintaining an unhealthy environment • Abandoning the person in bed, the streets, or a public institution	

2 – BASIS OF THE DIAGNOSTIC

2.1 – Risk Factors

IN THE FAMILY:

- Caregiver stress
- Level of dependence of the older person
- History of violence in the family
- Personal and financial difficulties of the caregiver
- Alcoholism or other addictions
- A lack of information and resources concerning the attention required towards a person with incapacities
- Social isolation of the caregiver
- Lack of support and rest for the caregiver, who is responsible for a disabled or incapacitated individual 24 hours per day, seven days per week.

IN THE INSTITUTIONS AND COMMUNITY HOMES:

- The institution prevents or impedes contacts between the older individual and the community.
- This institution is not in an official registry and lacks appropriate accreditation. There is no control or surveillance by public authorities.
- These institutions may hire attendants, nurses or caregivers who lack the proper training to care for people who are fragile and incapacitated.
- It is difficult for the institutions to keep a good and necessary ratio between the staff and the patients, who may be severely incapacitated or suffering from dementia, in order to meet the basic needs of this vulnerable group.
- There may be an overcrowding and a lack of private space for the individuals in the homes.
- There is no evidence that the community participates in the activities of the home.
- The physical structure of the institution is not adapted to the individuals who may be incapacitated and have problems with their mobility.

2.2 – Diagnosis of the problem

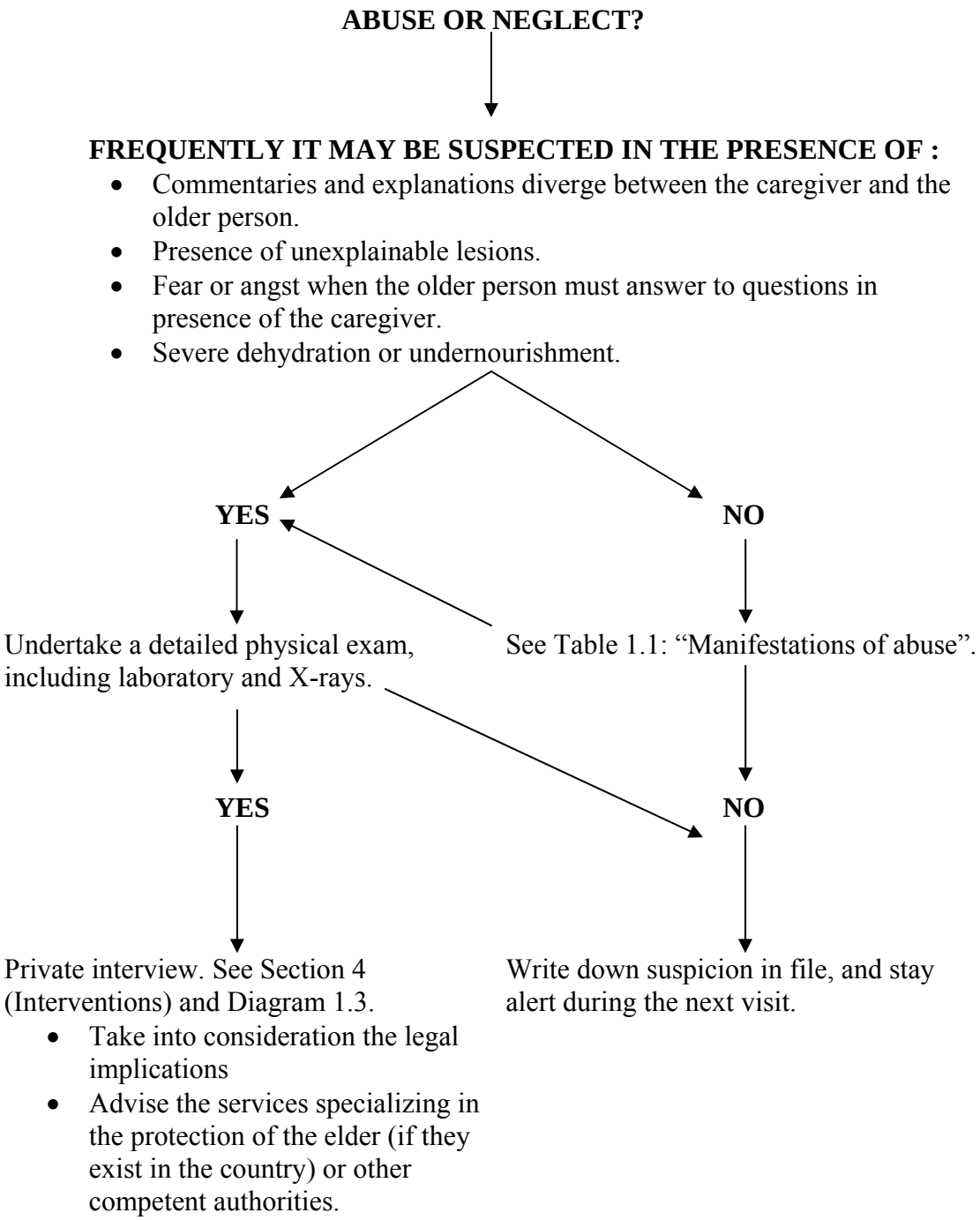
The symptoms of abuse and neglect of a frail or dependent older person may take on different forms, and it is recommended that should there be a suspicion of abuse or mistreatment, the doctor undertakes a thorough evaluation of the patient, both through a physical exam and a private interview. Table 1.2 presents the most common indicators of abuse or mistreatment. The critical paths of the diagnosis of the problem are presented in the Diagram 1.1.

Table 1.2 – Indications on the Possibility of Elder Abuse or Neglect[44]

Type	History	Physical exam
Physical abuse	Changes in the description of facts, which are in any case improbable or in conflict with the wounds.	Presence of lesions, especially multiple and with differing levels of deepness and healing. Dehydration or malnutrition. Fractures of undetermined causes. Presence of wounds which were not taken care of. Signs that the individual may have been tied, bound, or hit. Sexually transmissible diseases.
By medication	Frequent medical admissions or consultations due to medication mistakes.	Signs of intoxication due to overmedication, or under-medication.
Psychological abuse	History of conflict between the older person and the family or caregiver.	In general the commentaries and explanations diverge when the caregiver and patient are interviewed separately. It has been observed commentaries on the part of the caregiver which lowers the esteem or infantilizes the older person. It also has been observed that the older person has difficulty speaking in the presence of the caregiver.
Neglect	-Recurring episodes of illness, despite proper education and support. -Untreated medical problems.	Hygiene problems, undernourishment, hypothermia, untreated ulcers, under-medication.

[44] Modification of: Yoshikawa TT, Cobbs EL, Brummel-Smith K: Elder Mistreatment: Abuse and Neglect. In: Practical Ambulatory Geriatrics, p. 134, 1998 (2nd Ed.).

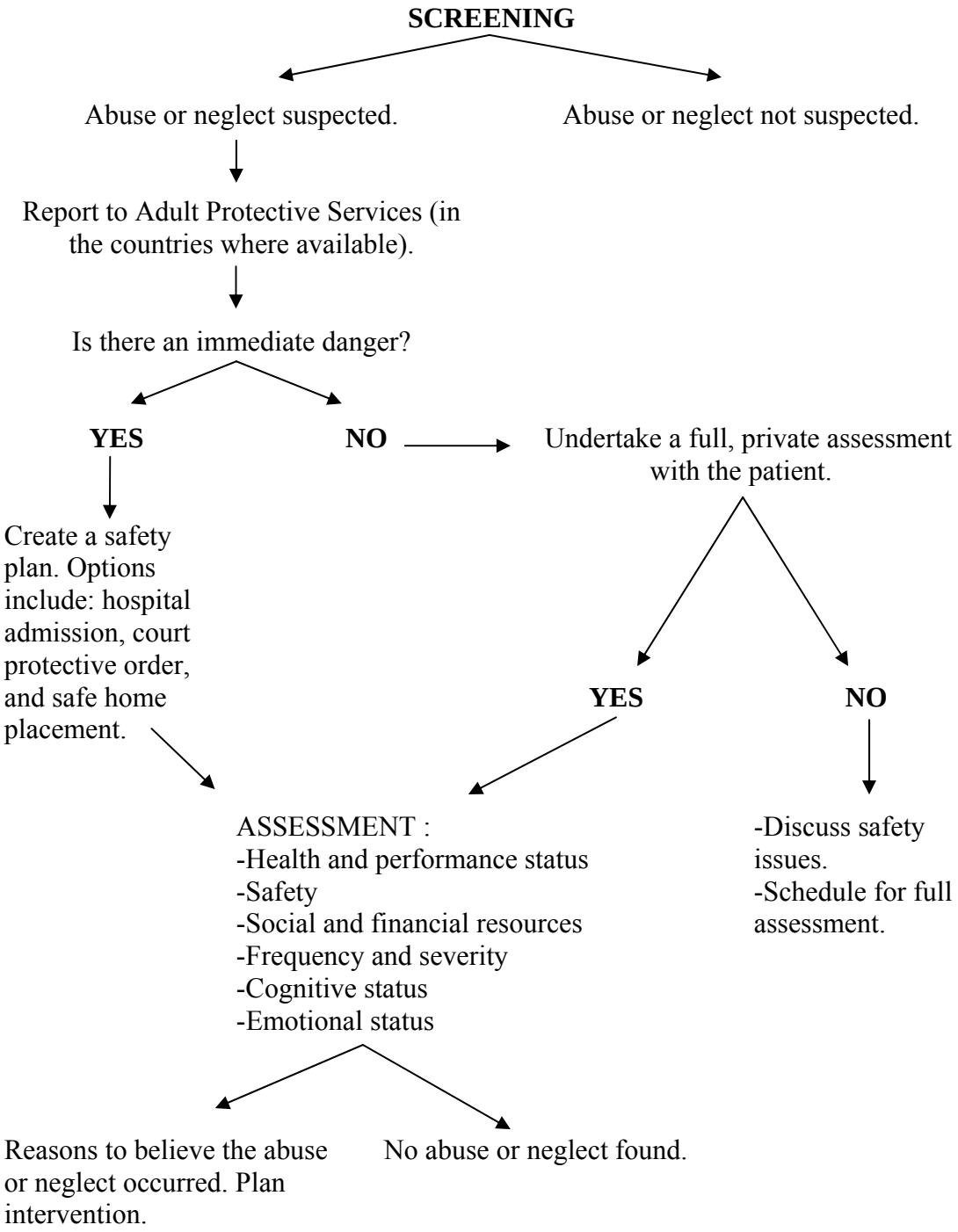
Diagram 1.1 – Diagnostic Guideline on Elder Abuse or Neglect[45]



[45] Taken from: American Medical Association: Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, p. 13, 1992, Chicago.

3 – BASIS FOR THE TREATMENT OF THE DIAGNOSIS

Diagram 1.2 – Treatment Guideline on Elder Abuse and Neglect[46]

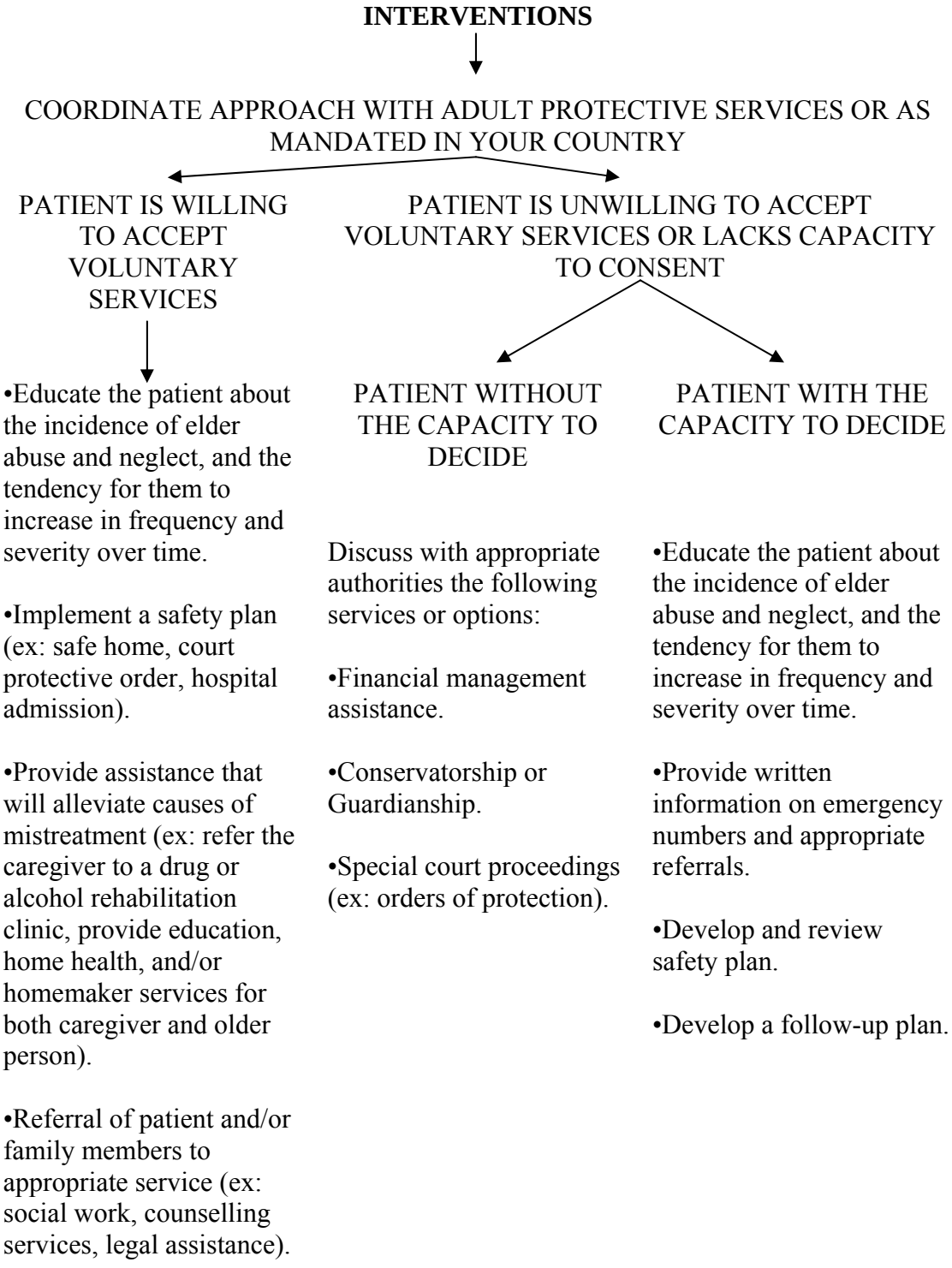


3.1 – <u>Intervention Plan</u>

In every case of abuse or neglect, the intervention will depend principally on the acceptance by the older individual of the offer of assistance, as well as the person's capacity to decide. The level of intervention will depend on the services for the protection of the elderly available within the country. We suggest a way to develop a general program in Diagram 1.3, and ask you to decide what path to take in your region.

[46] Taken from: American Medical Association: Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, p. 13, 1992, Chicago.

Diagram 1.3 –Intervention scheme in case of abuse or neglect



4 – KEY POINTS TO REMEMBER

- Abuse and neglect are problems which are little known within the health profession.
- They appear daily during geriatric consultations.
- They happen to older people.
- Psychological and financial abuse, with neglect and abandonment are the most common forms of abuse and mistreatment towards older people.

5 – SUGGESTED READINGS

American Medical Association: Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, 1992, Chicago: AMA.

International Network for the Prevention of Elder Abuse. www.inpea.net

Lachs MS, Pillemer K: Abuse and Neglect of Elderly Persons. NEJM 1995; 332:437-442.

National Center on Elder Abuse. www.elderabusecenter.org

World Health Organization: Missing Voices. Views of Older Persons on Elder Abuse, 2002, WHO/NMH/VIP/02.1. www.who.int/hpr/ageing/elderabuse.htm

Yoshikawa TT, Cobbs EL, Brummel-Smith K: Elder Mistreatment. Abuse and Neglect. In: Practical Ambulatory Geriatrics, p.134, 1998 (2nd. Ed.).

Annex 4: Summaries of country reports

Summary of report from Australia

Focus groups:

1. Focus groups with older people

This report is based on the views of 23 senior Victorians. Three focus group discussions were held, a mixed group of eight males and females, a group of seven females and a group of eight males, recruited chiefly from three seniors' organisations. Participants' ages ranged from 65 to 84 years.

A number of general and often related issues emerged from the discussions and are likely to have influenced responses to individual questionnaire items:

- A recurring theme in the mixed group was their awareness of the subtle and not so subtle changes in **the way society regarded them as being 'less of a person' as they aged**.
- It is becoming **less likely that older people have a consistent and close relationship with a doctor** who knows them well.
- The **questions** as written come across as somewhat **stilted, formal and sometimes too 'clinically' expressed**.
- Older **people's dependency on their carers** could militate against open and honest answers regarding abuse.
- **Not all GPs do have the skills to ask the questions** in a sensitive way that does not alienate, embarrass or potentially silence an older person.
- Pressures on GPs' time and cost to the patient were identified as potential problems. Participants thought that it is **unlikely that the twelve questions could be asked at one visit**.
- What are the **next steps for GPs** if they establish a suspicion of abuse? This was thought to be an issue which agency is best placed to support an older person.

The **most relevant questions** chosen by the groups were **Questions 8, 11, and 4, 5 and 6** equally (in order of relevancy).

Q4: There was general agreement that the question was an important one, especially when considered in the context of the whole set of questions. However, participants identified a number of problems with the wording of the item. The question was too long and came across as convoluted, principally because the list of examples given is too extensive. The GP could choose from the list of examples, those that were thought most appropriate. For instance, he/she would not ask about a hearing aid if it was clear that the person didn't need one.

'Needed things' sounded clumsy and should be 'things you need'. Although they understood that the idea of being 'prevented' from doing something was an important indicator of possible abuse, some suggested that it was likely to be very confronting and there may be other ways of encouraging people to open up. The question could be introduced by saying something like: *I'm going to ask you just a few questions about the things you need such as your food and any medicines you need, your clothing and living space …* then followed by: *Is it easy for you to get all you need in the way of food and medication and so on? Has anyone ever denied you these things?*

A number of suggestions for re-wording were made to overcome some of the problems mentioned:

Has anyone prevented you from having essentials necessary to your wellbeing?

If you needed/when you need …. Has anyone ever stopped you from getting them?

It was thought that the second part of the question was important but it could be asked more simply, e.g. *Does this happen often?* And then follow it up with further questions which encourage people to 'tell their own story'.

Q5: The participants' experience was that psychological abuse, intimidation, verbal abuse and bullying, which the question included, often had a profound effect on older people and was potentially very demeaning. It was difficult to prove as it could be so easily denied, especially if the older person had begun to suffer from dementia.

Most thought the question was too 'wordy' and included too many ideas.

Some suggested alternatives were:

How do you get on with your family or the person/people who care for you? (Followed by more specific questions, depending on the response).

Have you ever been intimidated by the people who are close to you/your family/ the person who cares for you?

Q6: Participants thought that the ideas embedded in this question were very important for detecting elder abuse. There was consensus that the wording was relatively clear, and all the ideas in the question were important. However, they also thought that there were at least three separate ideas in the question– *being taken advantage of*, *being prevented from doing things* and *being patronised or not taken seriously*. Each was very important and putting them all together in one question made it difficult to follow.

The forms of psychological abuse referred to in the question are sometimes very difficult to do anything about. Participants talked about their experiences of older people who covered up, denied, forgave or ignored some forms of psychological abuse for various reasons, but frequently because they did not want to lose the relationship they had with the person doing the abusing.

Q8: The question was regarded as important for detecting elder abuse, particularly as there is considerable potential for financial abuse of older people. Some argued that the two parts of the question should be separated as they were about different things.
It was stressed that some older people would not admit that they were being taken advantage of or being defrauded, especially by family members or someone close to them. Pride and fear were very potent motivations for hiding this type of behaviour.
There was a general feeling that the question was inappropriate and needed to be simplified. Asking about the unwanted signing of documents should come first, as it was thought to be less intimidating than the first part of the question. Furthermore, the words 'pressured' or 'persuaded against your will' should be rather used than 'forced' (or as well as 'forced') as they included more situations in which financial abuse could potentially take place.
'Has anyone that you would trust …' is clumsy; it ought to read, 'Has anyone you trusted …'.

Q11: Participants thought that direct physical abuse was a very important area to ask about. However, a number of important issues were raised in relation to the question as written:

- Should the question be asked irrespective of whether there was any evidence for doing so or at least a suspicion of physical abuse?
- Should the question be specific or general?

- Do doctors have the skills to ask this question in ways that will encourage people to be truthful and do elderly people perceive doctors as understanding and able to handle such matters?
- Should the threat of physical abuse be included in the question or should it be a separate part of the question?
- The wording needs to be simplified. 'Impeded your free movement' is too formal and clinical. An alternative is: 'restrained you or stopped you from moving freely'.

Other suggestions for rephrasing the question were:

Have you felt physically threatened by someone? Does this happen often?

Has anyone physically hurt you, for example hit you, pushed you or impeded your free movement?

Questions 1, 2, 7, 9 and 10 were considered to be the least important ones.

The twelve questions considered together:

The general feeling was that the **twelve questions were indeed comprehensive and covered all of the key areas of elder abuse**. Two people suggested that all items should be retained. However, it would depend on the doctor's understanding of the older person and the older person's particular circumstances as to which questions should be asked. Some questions may be able to be combined. For example Question 4 (being prevented from having access to things essential to health and wellbeing) could well be related to Question 5 (feeling intimidated; someone making you feel sad, anxious, fearful etc).
Some suggestions were made for a **different ordering of questions.** It was stressed that psychological abuse and intimidation of older people are likely to be the most common forms of abuse. Therefore, Question 5 should go earlier in the list. It might then set the context for other forms of abuse.
It was emphasised in all groups that there was a need for 'real conversations' between GPs and their patients and hence the **way in which the questions are asked** is very important.
The view was that **time constraints and lack of appropriate training** would make it difficult for many GPs to use the instrument effectively. Nevertheless, GPs are the front line of health care and there are strong arguments for any initiatives which increase their awareness and understanding of elder abuse. Initial training and ongoing professional development around elder abuse issues would be necessary.
Australia's population is **very culturally and linguistically diverse**. It would therefore be necessary to test out the effectiveness of the questions with different cultural groups, including the language used to refer to the various forms of elder abuse.
It is clear that participants favoured **wording** that was **simple and as straightforward** as possible. For this reason they tended to think that long lists of examples, as in Question 4, should not be included, although they realised that examples were sometimes necessary for clarification. In further refining the tool, it will be important to maintain a balance between clarity, simplicity and brevity. In reality, and used effectively, some of the examples in the existing questionnaire could be included as follow-up questions. Moreover, participants also thought that questions which contained more than one idea should be separated.
It was stressed that **questions referring to sexual and physical abuse would be very confronting** for many older persons and, as reported, should not be asked of all people.

2. Focus groups with PHC professionals

Two focus group discussions were held, one with nurses (seven females) and one with doctors (two females and two males). The nurses were all experienced in dealing with older patients, coming from hospital and nursing services and a university nursing department. Doctors were recruited from a community and private practice as well as two large public hospitals.

The **five (six) most important questions** were considered (mainly by nurses) to be **Questions 11, 4, 9, 12 and 8 & 6** equally (in order of relevancy). Three doctors declined to choose five items as a short questionnaire on the grounds that all areas covered were important, except for Questions 1, 2 & 7.

Q4: There was general agreement that this question was important. However, as with the seniors' focus groups, the health professionals felt that some older people who have experienced abuse might not answer this question sincerely, because they fear for example the loss of an imperfect caregiver who nevertheless helps them to be largely independent. As with all of these questions, **answers would depend upon the manner in which a health professional conducted the interview.**
Although they felt a list of examples was useful to inform the patient what was meant by 'needed things', it was thought this could be done more simply and less threateningly. The phrase 'adequate living space' was felt to be too complex and could be dropped.
Participants suggested some simplification of the wording of the question:

Have you ever felt that you have been prevented from having the things you needed, such as food, medications, glasses or hearing aids?

How often do you feel prevented from having the things you need (some examples)' - would you say 'never', 'sometimes', 'often' or 'almost always'?

Q6: Participants found the issues raised by this question were extremely important in the risk assessment for elder abuse. However, the question was too complex, as it was asking about (a) being taken advantage of (which could well mean financially), (b) being prevented from doing things (or wishes not being taken seriously) and (c) being perhaps socially isolated. The point was also made that sometimes it is life events or health problems that curtail the freedoms and choices of older people (such as advice from family or doctors to cease driving a car) but resentment can follow. These three issues were all very important but putting them all together in one question made it difficult to answer. Therefore, it was thought that they should be asked separately. Since there were financial abuse questions later on, the first part (a) about being taken advantage of, might be dropped in favour of the second and third parts (b) & (c).
The main discussions in both groups centered on simplifying the question, or separating it into two main components. There were also thought to be some unnecessary words such as 'close to you' and 'for your well-being'.
Suggestions for rephrasing were:

Do you feel that someone is stopping you from doing what you want to do?' and '*Is anyone stopping you from seeing people you want to see?*

Can you do what you want to do? Can you see who you want to see?

Are you prevented from doing things that are important to you by someone you know?

How often are you prevented from doing things that are important to you by someone you know? (is that 'never', 'sometimes', 'often' or 'almost always'?)

Q8: Participants thought the question was very important for detecting financial abuse, as it helps to delve into different aspects of financial dependence or abuse. However, the wording was again complicated and confusing and some argued that the two issues in the first part of the question should be treated separately as they were about different things: (a) misuse of money or assets and (b) forcing to sign documents. Some suggested splitting it into two questions, for example:

Has anyone used or tried to use your money, possessions or property in ways that you did not want?

Has anyone (you trust) made you sign documents that you did not understand or did not want to sign?

Are you able to access your own money when you need it?

Since a 'yes' to either of these would indicate suspicion, the doctors again felt the second part of the question (an isolated event or not?) was unnecessary.
It was mentioned that the wording of this question needed clarification. The phrase 'Has anyone that you would trust' seemed rather complicated and it was felt that perhaps the 'trust' element did not matter so much. In fact, someone commented that if the person was stealing from you or misusing your property you most likely no longer trusted them anyway. Also, a suggested alternative to the word 'forced' to sign documents was 'made' to sign, as this was less likely to imply a physical coercion.

Q9: The likelihood of alcohol-induced violence was considered a very important issue, but both groups strongly recommended that illicit drug use should be added. There were also concerns about the intent of the question because it implied that someone drinking too much was necessarily a case for concern. Participants felt that the more important element here was whether or not someone's drinking or drug-taking habits adversely affected their older patient. It was also stressed that the perpetrator of substance-induced abuse would <u>not</u> have to live with the older person to abuse them, so the first phrase was redundant.
Some participants were also very concerned about the effects of addictive gambling since this was pointed out to be an issue in Melbourne and could lead to financial, psychological and physical abuse. The consensus was that it would be good to cover all three risk elements: alcohol, illegal drugs or gambling in this question.
The main issues with the wording were making this question more comprehensive. Suggestion made were:

Do you live with (have contact with) someone who drinks alcohol or uses drugs in ways that cause problems <u>for you</u>?

Is there anyone <u>you know</u> who drinks alcohol, uses drugs or gambles in a way that causes problems <u>for you</u>?

Q11: This was considered a very important question. However, there were some concerns about how the question was written. Some doctors felt they would be reluctant to ask this question unless they could observe some physical evidence of abuse or symptoms of anxiety or depression. Important issues of **threatened** physical abuse and use of **chemical restraint** were missing from this question. Participants also noted that this question was somewhat ambiguous because it could include **accidental harm** (such as a fall or bruise when transferring someone into a wheelchair or bath) as well as **intentional harm** (being intentionally rough or violent).
Research findings were also quoted to the effect that older people feel ashamed and make excuses for relatives' behaviour. The experience of abuse will influence how people define their experiences.

On the other hand, visiting nurses had seen instances where older women who have suffered physical abuse all their lives then seek retribution in a caregiver role. These sorts of dilemmas could only be understood if the doctor or other health professional knew something of the present domestic circumstances as well as the history of both the patient and their caregiver.
The question was felt to be overly complex and there was some redundancy. The element of 'impeded your free movement' was felt to have been covered in Question 6, regarding stopping someone from doing things or being with people. However, if retained, it would need re-phrasing as 'restrained you in any way' or 'stopped you from moving around' or 'locked you in'. There were also suggestions for an overall simplification:

Have you (recently) been physically hurt by someone you have trusted?

Has anyone recently hit you, pushed you or stopped you moving around?

Q12: All agreed that this was also a very important issue. It could be associated with physical abuse, but having it as a separate question was more appropriate. However, as with most of the discussed questions, a level of trust in the practitioner is needed, and there is the issue of possible cognitive impairment of either the older person or their abuser, or both.
Some of the doctors thought that starting with a time frame such as *"Over the last few years …"* would be helpful in eliminating episodes which occurred decades ago. After a 'yes' answer, PHC practitioners would then need to follow up with questions about the duration and severity of any reported sexual abuse.
The doctors did not feel the second part of the question was necessary (*Was this an isolated event or not?*). The mere fact that any such abuse had taken place would trigger a more extended interview with their patient.
Participants wanted to drop the phrase 'to the degree that it upsets you'. This was redundant given the term 'unwanted'. Also, the word 'advances' was considered more Australian than 'approaches'. Nurses also recommended clarifying 'touched you' by adding 'touched parts of your body' as this would make the sexual context more implicit.
The following alternative was suggested for the Australian context:

Has anyone touched parts of your body in ways that upset you, or made unwanted sexual advances to you?

While sexual abuse was a real and serious issue for older Australians, several of these PHC professional cautioned about untrained people asking such sensitive questions. Thus, both training and appropriate referral services must be available when administering Questions 11 and 12.

The twelve questions considered together:

Overall, the **key areas of elder abuse were covered**, but **most questions needed rewording or simplification** and some could be excluded.

There were a few issues which were considered to have been missed. These were:

- The **risk factors associated with relatives' or caregivers' illicit drug-taking**.
- **Threatened physical violence** – which could be added to Question 11.
- **Chemical restraint** – giving older people inappropriate medication or too much medication, which ties into Questions 6 and 11.
- Not facilitating the older person's needs (i.e. **neglect**) as in Question 4.
- Social participation and involvement in decision making via control of autonomy - this could be picked up in Questions 3, 4, 6, 8, 11.

A number of general issues were brought up:

Several nurses felt that administration of the twelve questions by GPs would take longer than the standard consultation time (10-15 minutes). Community assessments and care plans are staffed by trained nurses and social workers rather than GPs. However, the extra costs to patients and time pressures on doctors were not considered to be impediments by the doctors.
It was stressed that a health professional first needed to determine whether or not there is **cognitive deterioration in the older person**, which would affect the ability to ask any of these questions directly. A related issue was the **ethical application of such a questionnaire**. Should it only be used for older patients who have ongoing contact with the same practitioner? Is it dangerous to use for older people who are seen only once, such as in hospital emergency wards or outpatients clinics? What are the **next steps for medical practitioners/nurses** if they establish a suspicion of abuse? Which referral agencies are most appropriate?
Several practitioners were concerned about **asking these questions in front of a carer** who might be the abuser. A related issue was that carers might be the ones being abused by the older people.
Some of the questions are phrased as in the present 'Do you…' and some in the past tense 'Has anyone ever …'? Some **consistency concerning the time frame** would be useful here. Should the main focus be on the present or recent situation rather than something which may have happened 10 or 20 years ago?

Workshops

1. Workshop with social workers

All six participants (five females and one male) were experienced social workers, working in urban and suburban public hospitals, local government, health and community services, dealing with patients aged 65+.
Several were concerned that, despite indications in the past that elder abuse was being recognised as an important community issue, both government interest and public consciousness of it tended to wax and wane. Others mentioned their awareness of increasing expectations on caregivers and consequent increased caregiver stress.

In addition to the abuse categories given in the definition used within the WHO-CIG project, specific examples of abuse from their social work experience are:

- **Decision making by family members on behalf of older people**. It includes, for example, subtle pressure not to sell the family home.
- **Use of cultural expectations and 'accepted ways of doing things' to justify taking control and making it 'alright' to hit or push older people around.**
- **Fear of abuse can be a potent controlling force,** not only when there have been actual threats in the past but also when there is the perception of threat from others.
- **Withholding of information, either to punish an older person or to take advantage of them**.

As for the participants' training and work situation, it appeared that the institutions participants worked at either had policies and/or some procedures concerning elder abuse, but the **institutional responses were not necessarily standardised, systematic or up-to-date.** In none of the institutions was training mandatory, although it was thought that in some institutions, examples of elder abuse may be included in more general training.
The interventions which social workers can make include existing legislative provisions and depend on the level of support and other resources available.

As for **the SWEF, it is much more comprehensive and detailed than the assessment tools currently in use** in the institutions where the participants work. Overall, their **views about the usefulness of the Evaluation Form were mixed**. The discussion below first identifies positive aspects of the Form then discusses problematic aspects:
Participants thought that the Form was **very comprehensive** and included a lot of the factors which social workers need to be aware of. **It could serve as a very good prompting tool**, helping workers to think about indicators of the different areas of potential abuse. In this respect, it would also be a good resource for training purposes. There was general satisfaction with the breadth of the areas covered, and no important questions or sections were missing.
However, social workers thought that **the Form would be very difficult to administer**. There was a general consensus that the **length** and **comprehensiveness** of the Form provided both practical and theoretical difficulties. Older people may not fully understand what is going on – cognitively, emotionally or intellectually. Furthermore, the participants thought that a key problem with the Form was the **difficulty of getting honest answers** to many of the questions (e.g. Question 51). To be really useful, **it would require a very solid, trusting relationship** with the older person, something that could only be built up over a period of time. For these reasons, various suggestions were made:

- The Form could be **used over a number of visits**, or over a period of time once trust had been built up.
- The **use of the Form should be individualised**, depending on the particular circumstances of the older person. Only the parts that are relevant to the social worker's suspicions e.g. regarding financial abuse or sexual abuse should be used.

Social workers raised two broader issues concerned with the Evaluation Form:

1. **How does the Form relate to an intervention plan?** It was suggested to have a manual with assessment and intervention information accompanying the Form.
2. **Problems with over-assessing people**. It was pointed out that minimising the number of assessment tools is encouraged in social work, so that people are not asked the same questions by different people again and again.

2. Workshop with social workers and PHC professionals

The PAHO workshop group comprised three females and two males. All five participants had experience of working with older people who had been subjected to violence. Their practice environments were quite varied, ranging from a public hospital, community health and aged care facilities to domestic violence and sexual assault resource centres.

Participants generally agreed with the WHO/CIG definition of elder abuse, but felt that **effective solutions often needed to focus upon the perpetrator of abuse** (relatives/caregivers) rather than just the older person.
They would add the following abuse categories:

- **Abandonment and institutionalisation,** i.e. used as a threatened or actual means of controlling the older person.
- **Family or gendered violence**, i.e. the continuation of violence against women into older age, usually by a partner or other family member.
- **Decision making by family members** on behalf of older people.

- **Financial motivations and family greed**.
- **Using fear of abuse or abandonment to control**.

Hospitals and social work services where the participants worked at were reported to have policies and procedures concerning elder abuse. However, institutional training was neither formal, standardized, systematic, nor compulsory. It was felt that it was largely up to the individual health care professional to keep her/himself up-to-date on these issues and practices. However, specific training in domestic violence and sexual assault was being provided by the community counsellor/activists' centres to health and community care professionals, and local government departments.
Formal guidelines on elder abuse for PHC professionals do not exist. GPs in private practices or clinics did not work from manuals or guidelines, but would assess an older patient in a general sense and refer them on to social work, aged care assessment or other government or medical geriatric services if there was some suspicion of abuse taking place. However, it was pointed out that such documents do exist and that all social workers are very aware of them.

Comments on the PAHO manual:[47]

1. Definition of the problem

In the definition section, some additional details would need to be added to make the manual fully effective:

- A separate definitional section for *sexual abuse*.
- Physical abuse should include 'forced medical treatments or interventions'.
- *Emotional abuse* could be separated from *psychological abuse.* Emotional abuse definitions should focus more on the outcomes for the victim, such as anxiety, depression, sadness and loneliness; psychological abuse should also include 'limiting the resources of a person (money, housing etc).

2. Basis of the diagnostic

2.1 Risk factors

Under 'Risk factors in the family', it was suggested that one main set of factors missing were various types of **vulnerability in the older person**, such as **disability**, **dementia**, **illness or frailty**. Another was **failings in caregiver behaviour** – such as lack of responsibility or greed.

Under 'Risk factors in institutions and community homes', there were concerns regarding **staff-to-patient ratios**, as these were only mandated for medical staff and not other ancillary staff in accredited facilities. **Overcrowding** and **lack of community and social interactions** could also apply.

2.2 Diagnosis of the problem

The general suggestion in the PAHO manual is that "the doctor undertakes a thorough examination of the patient, both through a physical exam and private interview" – followed by the detailed 'indications' of abuse in Table 1.2. This approach was considered largely unworkable because GPs were not considered 'the first port of call' for elder abuse issues, due to their lack of time and training, the nature of their practice settings, and a reluctance to get involved. Contact points would be Local Government, District Nursing and Aged Care services.

Diagram 1.1 - Diagnostic Guideline on Elder Abuse or Neglect

This 'Diagnostic guideline' flowchart had a number of limitations or legal problems which would make it largely unworkable in Australia:

[47] Numbers refer to sections in the PAHO manual.

- It assumes the older person will have physical symptoms of abuse, which is often not the case.
- It assumes knowledge and history of the patient by a doctor, whereas people often see a range of doctors or visit hospital emergency wards.
- It assumes that a conflictual relationship with the family member/caregiver is evident, which is often not the case.
- There is no mention of cultural differences or needs for translators to be present.
- There is no procedure whereby doctors must ask permission before touching older patients – this is especially important in cases of the sexual assault of older women.

3. Basis for treatment

Diagram 1.2 – Treatment guidelines

There were similar reservations about the usefulness of this flowchart:

- They were **too medicalised** in approach. Using the word 'treatment' makes elder abuse sound like a disease, whereas it is a social syndrome with many facets. The focus should be on removing or lessening the harm caused to the older person by the perpetrators of abuse.

- Referrals would be to a hospital or community social work department, aged care assessment team or in some cases to police or emergency services. Health professionals would not therefore necessarily be involved in 'court protective orders'.

- This was considered to be essentially a crisis model, whereas monitoring and prevention are also important, and, if possible, help via a change of living circumstances for the older person, or the re-education or removal of an abusive caregiver.

Diagram 1.3 - Intervention

The **focus on educating the victim was not felt to be as helpful as referral of the perpetrator to rehabilitation**, **education or corrective services**. Also, the preferred terms were a provision of 'options' or 'assistance', rather than 'interventions', as an intervention seemed to remove the agency from the older person herself.
Apart from the fact that there was no overall 'Adult Protective Services' system, a main issue not adequately addressed in Diagram 1.3 was that of **ensuring the victim's safety** - particularly for patients who did not have the capacity to decide for themselves about accepting services. It was also stressed that the whole picture and not an isolated event need to be assessed.

Regarding Section 4 – 'Key points to remember', the participants pointed out that elder abuse in all its forms is actually well known within the health profession in Australia. However, due to **funding constraints**, there are often not enough services to support interventions for both the victim and perpetrator of elder abuse.

The participants concluded that the PAHO manual was not considered appropriate for use in Australian conditions for the following main reasons:

- Inadequate definition of all forms of abuse – less comprehensive than Victorian usage.
- Rather simplistic medicalised approach focussing too much on physical symptoms.

- It appears to be essentially a 'crisis model'.
- There are no 'Adult Protective Services' in Australia and no mandatory reporting of elder abuse.
- Australia is very well aware of all facets of elder abuse and health care professionals do a more comprehensive assessment than is set out here.
- Often it is not a doctor or nurse who would assess or assist a victim of abuse. Aged care services are networked and complex in Australia.
- It does not advocate the provision for training and resources of health care practitioners in elder abuse.
- It assumes knowledge and history of the patient by a doctor, whereas people often see a range of doctors or visit hospital emergency wards.
- It assumes that a conflictual relationship with the family member/caregiver is evident, which is often not the case.
- There is no mention of cultural differences or needs for translators to be present.

Summary of report from Brazil

Only in the end of the 1990s the first studies on elder abuse appeared in Brazil. In 1997, an investigation was carried out in four Brazilian states (Rio de Janeiro, Minas Gerais, São Paulo and Paraná), replicating an Argentinean study on how older people (60+ years old) view elder abuse. The results showed that the issue was mostly perceived and experienced as societal abuse and abandonment by the families.[48] Later on, in 1998, there were surveys on elder mortality due to external causes (i.e. identified victims of violence). In the State of Rio de Janeiro, for instance, among people aged 60 years or older, violence ranks on position 6th of the most common mortality causes, encompassing traffic and transportation accidents for males, and falls for females.[49] Another study[50] on elder morbidity due to violence was carried out in two emergency care hospitals of the city of Rio de Janeiro. In one month, out of the 5,151 cases reported, 384 involved people aged 60 years or more. Falls were the main cause for admission, representing some 60% of the total.

In Brazil, there is no published prevalence study on elder abuse yet, even though data from some Brazilian adult protection services have confirmed the findings above, by verifying reports of complaints about public transportation, accidents and falls on streets, deaths from vehicles run-over, and traffic accidents (SOS/RJ, 1992; SUS, 2001).

High rates of unemployment combined with high rates of divorce make adults return to their parents' home. Quite many of them become their parents' caregivers and depend financially and emotionally on their older parents. Older people's risk of being abused increases, especially when the older person is the only source of family income.

The **government's omission in providing proper health care services for older people**, and the lack of social support put a burden on many Brazilian families. As a consequence, women need to work to contribute to the family income, but additionally have to take care of dependent older parents.

Considering the described reality older people face in the Brazilian society and the lack of training facilities in primary health care, there is a clear need for such a survey to be carried out.

Focus groups:

There were seven focus groups - four with health professionals and three with older people - and two workshops with physicians and social workers. The groups were held in the city of Rio de Janeiro. Inclusion criteria for the older people were being 65 years or older, with no mental impairment, and being literate. For health professionals, inclusion criterion was to be working in primary health care. The major obstacle for recruitment was the fact that family health practitioners, who see an average of twenty patients a day, had to be absent from work, to take part in this study.

[48] Machado, L et al. Paper presented at the XVI World Congress on Gerontology. Adelaide, 1997.
[49] Souza et al. Extremo da vida sob a mira de violencia: mortalidade de idosos no Estado do Rio de Janeiro. *Gerontologia*, 6 (2): 66-73, 1998.
[50] Souza et al. La morbilidad hospitalaria por violencia contra ancianos. Estudio de la atención de emergencia em dos hospitales públicos de Rio de Janeiro. *Cuadernos Médico Socialies* 76, noviembre: 66-73, 1998.

1. Focus groups with older people

23 older people took part in the discussions, split up in three groups, one of males (n=7), one of females (n=8) and one mixed group (n=8), living in urban or suburban areas. 96% had as mother tongue Portuguese, the remaining 4% were originally Spanish speakers.

Most of the **participants could not clearly understand the purpose of this survey**. Many of them thought they had to respond to the twelve questions, and therefore could not extrapolate if that question was important and/or was comprehensible. A general comment was that the **questions should be phrased in a simple way, short and straightforward**. Furthermore, it was mentioned that some questions such as Questions 1 and 12 require a relationship of trust; otherwise they would not be answered truthfully.
The **most important questions** selected by the older people were **Questions 4, 5 and 7** (same rank), **and 3 and 6** (same rank) (in order of relevancy).

Q3: The question was considered important but too long. Furthermore, the expression 'basic daily needs' should be explained in more details as it is otherwise not understood by most older people. It could be replaced by 'your day-by-day/daily needs/activities' or could be completed with some examples such as 'washing your cloths', 'taking a bath/shower' of 'preparing meals'.
A suggestion to rephrase the question:

In your day-by-day/everyday life, do you need anyone to help you?

Q4: This item was regarded as self-explanatory but should be split up because of its length.

Q5: This item was considered as very relevant, even though it is long and repetitive. The words 'sad', 'shamed', 'fearful', 'anxious', or 'unhappy' refer to different emotions and cause confusion.
A suggestion to rephrase this question:

Has anyone yelled at you, or spoke to you in a way you didn't like?

Q6: Although this question was chosen as one of the five most relevant ones some participants felt that 'being taken advantage of' is normal in the Brazilian context and therefore, a doctor should not bother asking this question.
An alternative to the question:

Do you feel anyone is taking advantage of you?

Q7: The participants felt that this question was one of the most important ones (in contrast to the PHC professionals who questioned the relevancy of this item), as it is in the Brazilian context often taken for granted that an older person contributes to the family income with his/her money. The expression 'financially dependent' should be replaced by 'is there anyone who depends on your money or who needs your money'.

The least important questions were #2, #10 and #12.

2. Focus groups wit PHC professionals

38 health professionals who worked in PHC settings took part in the study. As for their professional background, 28 were physicians and 10 social workers. 85% of the health professionals were female, 15% male. Most of them lived in urban areas (92%), the rest in the suburbs.

The physicians chose **Questions 4, 11, 5, 8, and 12 and 6** (same rank) as the **most relevant ones** (in order of relevancy).

Q4: The question explains what daily basic needs are. 'Adequate living space' was difficult to understand and could be replaced with 'place to live'. Regarding the second part of the question, 'isolated event' could be simplified with 'did it happen more than once'.

Q5: A very important question that needs nevertheless some simplification. 'Unfairly' should be replaced by 'for no reason'.
Some suggestions to rephrase this question:

Has anyone close to you yelled at you? Or spoke to you in a way you didn't like, or made you sad, shamed or afraid?

Is there anyone at your home who usually yells at you or lost his patience/temper with you?

Q6: The question contains three different aspects and should be rephrased and separated as all aspects are important: i) taking advantage of someone; ii) preventing somebody from doing things that are important for your well-being; and iii) interfering with you being with somebody you would like to be with. 'Well-being' should be replaced with 'to feel good' or 'things you like to do'.

Q8: Most participants felt that the question was relevant and well phrased.

Q11: In the Brazilian reality the concept of 'free movement' is not always feasible. Living in a *favela*[51] implies often for everybody - and not only for older people - living with restrictions of movement as drug lords and gangs control the community life.
The expression 'free movement' was considered difficult to understand. Also 'physically' should be replaced, for instance with 'has anyone ever hit you?' or 'has anyone assaulted, hit or pushed you?'
Some suggestions to rephrase the whole question:

Has anyone ever hit you, pushed you, prevented you from going in or out the house?

Has anyone physically assaulted you, for instance, hit you, pushed you or prevented you from going out?

Q12: This item was considered an important question by physicians but less essential by the older people. Those who considered it relevant felt that the phrasing should be more straightforward, and the older person should be asked directly, whether she/he had been sexually abused or harassed. The expression 'unwanted approaches' should be avoided. It was suggested that the word 'lately' was included; otherwise the incidence could be related to younger age.

The participants felt that Questions 2, 3, 7 and 10 can be eliminated.

In a comparative analysis of the results of all groups, Questions 4, 5, 11, 8 and 6 were the most relevant ones.

[51] Brazilian Portuguese for *shanty town.*

Workshops:

1. Workshop with social workers

The attending social workers emphasized their interest in the issue of elder abuse as they face a significant number of cases in their practice. The **provision of help does not follow any protocol or established system** nor did the majority of the participants receive any specific training on elder abuse. They mostly use their professional experience and training from the area of domestic violence (women and children) and adapt it to the work with older people. Other aggravating factors are the lack of standard tools, difficulties in the follow-up of cases, and the insufficient engagement on behalf of the government.
The entry into the system is almost always through the physician, and this makes it more difficult to detect elder abuse due to a lack of awareness among PHC professionals.

Many of the participating social workers see **elder abuse as a cultural and social factor**, due to the predominant culture of disregard and disrespect towards older people, expressed by flaws in health care-, social- and finance-related public policies.
Culturally specific risk factors for elder abuse in a Brazilian urban area are **family members who work in drug dealing**. Also living in a *favela* increases the level of vulnerability due to the violent environment mainly caused by drug trafficking. Together with the impediment of free movement these factors contribute to a higher isolation of older people and prevent action and intervention when there is a suspicion.

The *Social Work Evaluation Form* was not considered useful for the Brazilian context due to its length. Most of the consultations in the respective facilities/institutions have an established duration; a social work consultation takes at maximum 30 minutes. Questions 54, 57, 58, 61, 62, 63, 64, 65 and 66 are considered to be important. In order to assess elder abuse the older person should be asked about living conditions, family dynamics, addictions of any family members, degree of physical and economic dependence of the older person, and social and emotional isolation.

The social workers commented as well on the bank of twelve questions and considered Questions 4, 5, 6 and 8 as the most important ones.[52]

2. Workshop with social workers and PHC professionals

The participants considered abuse as health and social issue, as the two were interconnected. **Psychological abuse, neglect and abandonment occur more frequently than physical abuse**. Several mentioned a connection between culture, education and elder abuse: *"One must learn to respect the elders".*

Although Brazil has with the *Elderly Act* a law that mandates denouncing whenever there is a suspicion or proven case of elder abuse, the lack of training and guidelines becomes evident trough the statements of the health professionals. Some of them stated that they were able to identify physical elder abuse but they often didn't know how to follow up a suspicion. While the social workers emphasized the implication of this law (mandating), the physicians were concerned about their own safety.

The participants considered the PAHO manual as too long but would use it if it was shorter and adjusted to the Brazilian reality. As there are no guidelines available, this manual could raise awareness amongst PHC professionals. They concluded

[52] These results are not included in the findings in chapter 3.2. as only in the Brazilian groups the questions were discussed with social workers.

that a tool enabling PHC practitioners to identify elder abuse and neglect is extremely important as it would allow a prompt and counteracting intervention worldwide. However, due to the difficult reality of health professionals in Brazil - with the competences of a family health practitioner different from the ones of a primary care practitioner, and the short consultation time - they recommended two different versions of the protocol: one to raise the suspicion of abuse, comprising five questions, and a more comprehensive one as follow-up tool.

Summary of report from Chile

Elder abuse is in Chile a social problem that occurs both in the domestic and institutional setting. The estimated prevalence rate is 30%.

Focus groups:

1. Focus groups with older people

There were two focus groups with older persons both conducted in the Metropolitan region of Santiago. The participants of both groups (G1: female only, average age 75 years; G2: mixed, average age 70 years) had a lower middle socioeconomic background.

The older people did not understand the concept of commenting on the questions but shared their experiences regarding every item. It was emphasised that **isolation poses a greater risk of being abused**. Belonging to a seniors' group is an important protective factor, not only to avoid isolation but also to share advice and important information on older people's rights.
Common forms of abuse are **deprivation of food** and the **burden of child care**. Older people are often obliged to look after their grandchildren. They hardly try to defend themselves because they fear that their children would institutionalise them. **Children are often the perpetrators in elder abuse cases**.

2. Focus groups with nurses

The focus groups with PHC professionals consisted of 24 nurses, coming from different services in the Metropolitan region. Doctors were addressed to join the discussions but were not willing to participate because of time constraint. In the Chilean context, nurses are the PHC professionals who are receiving the older patients when they sign up at the surgery and are therefore the appropriate professional group to involve and address.
There were two focus groups with nine participants each; six nurses shared their comments in written form. Before attending the discussion each of the nurses applied the twelve questions to ten older patients.

The professionals selected **Questions 4, 5, 8, 9 and 11** as the **most relevant ones**:

Q4: This question was considered very relevant. However, its wording is not appropriate, since it is too long and needs to be more specific. Terms such as 'adequate living space' and 'health aids' are too technical. Furthermore, basic needs, such as food are mixed up with secondary needs (e.g. hearing aids). To simplify the wording, the question could be rephrased as follows (selection):

Has anyone denied you food, clothing and housing to live?

Do you feel that someone has intentionally denied you basic elements such as clothing and medication?

Q5: In order to detect psychological abuse this question is very important, considering the high frequency of psychological abuse on family level. But the question was considered to be too long and confusing. The following suggestions were made to simplify the question:

Do you feel that someone close to you has verbally abused you?

Are you shouted at in your home?

Has a family member treated you badly, shouted or raised the voice to you, used swearwords or has embarrassed you?

Has someone close to you spoken to you in a way that upset you?

Q8: This question can be combined with Question 6.

Q9: This question polarizes the participants. One part thinks that the question is essential as it tackles alcoholism which is one of the main sources of intra-familiar violence. The other part considers the question as very subjective in the sense as everybody has a different threshold of defining alcoholism. Some members of religious organizations consider drinking per se to be irrational. Others who have a drinking problem themselves regard any amount of drinking as reasonable.

Q11: This question is thought to be very important as it points to physical abuse. Some alternatives were suggested:

Has someone hit, pushed or ill-treated you?

Has someone hit and/or pushed you at home?

Questions 2, 6 and 7 can be eliminated.

Conclusions:
The **questions can be used as a basis for an instrument** applicable in the Chilean context. However, they must be **simplified and shortened**; otherwise they will not be understood. It is therefore important to **use a few examples that help illustrating the questions**, and to **address in each item only one aspect**. Some PHC professionals seem to be only familiar with physical abuse. The questions could therefore draw their attention to further abuse categories.

Workshop with social workers

Eight social workers attended the workshop and discussed elder abuse issues and the SWEF.

In Chile, there are **many cases of abandonment** reported by the community. Abuse of older people takes not only place within the family but also at societal level as they are the most vulnerable group in society being often discriminated and negatively connoted. **Older people don't have a strong lobby** representing them on the public agenda. Legal regulations and more financial resources could improve their isolated position.
Furthermore, there are neither specific protocols for elder abuse nor any training and evaluation tools offered at the institutions the participants work at.

The Form is considered long but comprehensible and could be used as assessment tool. The following adaptations were suggested in order to make the Form applicable to the Chilean reality. The introductory part (up to Question 19) can be omitted as this information is available from other sources such as the medical record. Furthermore, some specific sections need some revision:

- Relationship with grandchildren: some older people have 30-40 grand children. It is difficult to refer to all of them.
- Housing categories: add the categories of "allegados" (homeless families living in a home for families).
- Dependence: this section should also take into account that older people's dependence on somebody can lead to abusive behaviour.
- How to handle cases of cognitively deteriorated older people?

Summary of report from Costa Rica

In 1994, the authorities of the Health Sector in Costa Rica declared family violence as one of the fourteen health priorities, defining it as a Public Health problem. One of the emerging challenges has been to formulate a policy that tackles elder abuse and that increases public awareness regarding this issue. As in many other countries prevalence data specifically on elder abuse does not exist and has to be extrapolated from research focusing on other topics. In a survey carried out in 1996[53] 4% of the sample (n=328; 67% were older than 75 years) were physically abused on a regular basis, 13.8% were suffering from psychological abuse, 5% reported financial abuse and the rate for sexual abuse was 2.5%. One of the conclusions of the study was that the older people preferred to live alone due to bad relationships between them and their relatives.

Focus groups:

1. Focus groups with older people

There were three focus groups with 33 older people, broken down into one group of older women, one group of older men and one mixed group. Participants' ages ranged from 65 to 90 years. All of them came from urban and suburban settings.

The **five most relevant questions** chosen by the groups were **Questions 1, 3, 4, 5 and 9.**

Q1: Feeling *lonely* and *isolated* are common sensations among the older people as many do not have a good relationship with their families. Some older people isolate themselves because they were mistreated and fear further repressions from the perpetrator. But sometimes it is also the family who isolates the older person because they consider him/her useless. Therefore, the participants regard 'feeling sad' or 'feeling lonely' as good indicators of abuse.

Q3: The question is relevant for the detection of elder abuse since dependence is a source of tension and older persons often depend on other people. However the 'needs' should go beyond the level of 'basic' and comprise also a broader range of needed items. The participants express also their doubts about the usefulness of the question because everybody requests some kind of help/support at one point in life.

Q4: The participants consider the frequency of the event important. The second part of the question is therefore indispensable. The prevention of needed things is a kind of abuse that takes place not only in the domestic setting but also in institutions and in the public space.
The question should be simplified. The term 'adequate living space' is not well understood. Moreover, the question should be shortened by abolishing 'health aids such as eyeglasses and hearing aids'; 'food, medication and clothing' are essential elements.

Q5: The question was regarded as very useful for the detection of psychological/verbal abuse which - according to the participants - happens often in the family setting. Also all kinds of discrimination by institutions, authorities and individuals, i.e. when older people are humiliated/not helped when using public transport, fall into this category.

[53] Jiménez Rodríguez S (1998): Las Personas Mayores y el Abuso. Estudio realizado en el Hospital Nacional de Geriatría *Dr. Blanco Cervantes*, Costa Rica.

Q9: This question is important in the context of Costa Rica as alcoholism is a widespread issue in all social classes. Also drug abuse could be included in this question. The participants associate the issue with physical and verbal abuse. They felt that the question was well formulated, comprehensible, and the wording was appropriate.

Overall, the participants thought that the **questions were useful for the suspicion of elder abuse**.
They concluded that a good and stable family relationship was fundamental in the prevention of loneliness and isolation. However, the majority of the participants **preferred living alone as abuse happens more frequently when sharing their living space with their children**.

2. Focus groups with doctors

Four focus group discussions with GPs were held, comprising 26 participants (14 females and 12 males) working in urban and suburban settings.

The **doctors would include Questions 11, 5, 8, 12, 4** (in order of relevancy) in an instrument with five questions.

Q4: The question is considered as very long and containing too many different elements. Prevention from something can be an important indicator of abuse. However, if the children do not have the means/resources to satisfy the necessities of the older parent(s) this should not be interpreted as abuse. The question can be therefore confusing and should be more precise.

Q5: This item is indispensable for the detection of abuse. The part 'has anyone close to you unfairly yelled at you, or talked to you in ways that you did not like' covers already psychological abuse; the other elements of the question are less relevant. Also the last part of the question ('…in a way that left you upset for a long time') can be omitted because if abuse takes place it doesn't matter whether the victim was upset for a long or a short period.

Q8: Although the question is considered long and complicated, it is well outlined and covers not only the relevant areas of material but also of spousal abuse. The time horizon should be specified – is the question referring to the immediate present or to the past? A part asking about the relationship with the perpetrator should be added.

Q11: The question is very important and relevant for the detection of physical abuse. It is considered to be clear and comprehensible. A difficulty is to determine whether the abuse was intentional or accidental. The frequency of abuse needs further specificity.

'Hurt' could be replaced by 'injured' or 'attacked' to emphasize the physical aspect of the abuse. The question could be followed by 'What is your relationship with this person'.

Q12: This question is clear and very relevant for the suspicion of sexual abuse, as the participants agree that it is important to have a question on sexual abuse in the instrument. However, they have their doubts whether the interviewee would answer sincerely to a question that tackles such a delicate issue. Furthermore, this question requires a relationship of trust between the doctor and the patient and probably only be asked after several visits. When asking this question it is also absolutely crucial to have follow-up strategies in place to ensure an appropriate referral.
The second part of the question ('was this an isolated event…?') can help evaluating the person's risk.

The twelve questions considered together:

- The twelve questions are considered useful as the instrument is short and helps in raising awareness.
- To all questions a part could be added **asking about the relationship with the perpetrator**.
- A change of order was not considered to be important.
- The issue of **abandonment should be more explicitly addressed** in one of the questions.
- Some questions could be combined, for example Questions 5 and 11.
- Since the frequency of abuse plays an important role **categories such as 'always', 'hardly ever' and 'never' could be added** to each question.
- It was pointed out that such an **instrument could not be applied to cognitively impaired patients**. The question was brought up how to handle these cases if there is a suspicion of abuse.
- How should a PHC professional react if there is a suspicion of abuse but the potential victim is not willing to denounce the perpetrator or to be referred for further action?
- **Many older people feel uncomfortable when requesting help**, either because they want to stay independent or they are afraid of being rejected. This factor can hamper the detection of abuse.

Workshops:

1. Workshops with social workers

Nine social workers coming from PHC centers in San José participated in this workshop to evaluate the SWEF and to discuss training and assessment strategies in their work places.
Prevailing political and institutional policies do not cover and protect older people. Current economic and social conditions affect them – as a highly vulnerable group – directly. There is a **lack of resources** but also of **supportive networks** in the community to tackle the problem of elder abuse. Some institutions/associations carry out very valuable but isolated efforts, centered around the Greater Metropolitan area. A significant amount of the **older population living in rural settings does not have access to any counseling services**.

As for the Form, the participants felt that the questions were excellent but the questionnaire as a whole is too extensive. Awareness regarding the issue does already exist among the participants but the very limited amount of social workers impedes appropriate follow-up action or intervention. Also the coordination between the different institutions dealing with elder abuse is insufficient.

2. Workshop with social workers and doctors

The PAHO workshop group comprised nine women and one man, all coming from an urban setting.

None of the workshop participants has received any kind of training. It is therefore underlined that there is a need to **organise workshops to sensitize not only professionals working in the field but also the community**. The majority of participants do not have access to protocols on the evaluation of elder abuse and the physical and psychosocial needs of older people. Some institutions offer manuals with guidelines on intrafamilial violence, but a specific manual on elder abuse is not available. The **lack of an appropriate legal framework** is evident and makes intervention difficult. An important step would be to offer training facilities for professionals but also to **inform older people about their rights**. The creation of a network of supportive services is indispensable.

The **PAHO manual is a complete summary of concepts** already known and is understood as **valuable support to increase awareness of elder abuse**.

Summary of report from Kenya

Focus groups:

In total six focus groups were held: three with older persons (one with women only, one with men only and a mixed group) and another three with PHC professionals. The discussions with older people constituted of men and women (M: 10; F: 10; MF: 11) who reside in a suburban location of Nairobi city. They all come from the ethnic group of the Kikuyu and speak both Kikuyu and Kiswahilli.

The PHC professionals and social workers (for the focus groups and workshops) were selected from the Kenyatta National Hospital. The PHC professionals consisted mainly of dentists[54] who practice at the hospital as well as lecture at the University of Nairobi.

1. Focus groups with older people

The older people discussed their perceptions and views of elder abuse and its different categories. They also shared their experiences regarding each question but did not comment on the usefulness and the comprehensibility of questions.

Loneliness is a common problem experienced by all participants owing to the fact that the majority of their children have gone to look for paid employment while grandchildren spend most of their time in school. 'Resting on the chin' was identified as the outward expression of loneliness. Since older women experience more isolation than men loneliness has a gendered dimension.

Most forms of abuse relate or originate from the fact that the majority of older persons **seek for assistance** from other people. Reciprocal help is part of humanity and was cherished in the traditional African family. However, with ongoing social changes - especially related to urbanization - the idea is now disdained. According to the participants their seeking for help elicits abuse, disdain, name-calling, nicknaming and all sorts of emotional abuse.

Abuse of alcohol by close family members especially by sons is an important source of elder abuse since the elder parents are usually on the receiving end of their alcoholic sons' unbecoming behaviour, inconveniences and abuses. Therefore, in most households the young males are the main or only abusers of the older people.

The **burden of child care** on the older people is overwhelming. In virtually all households they take care of the needs of their grandchildren.

Financial insecurity is the **most important source of elder abuse** and where it is, it is sufficient to prompt suspicion of elder abuse. The older people have no reliable or known source of income to meet their basic needs. In spite of the financial insecurity they face financial dependence on older people is very high. The average household has four children or grandchildren fully dependent on the elderly for financial support for food, clothing, fees, and medical care.

Most of the abuse is emotional which has far reaching impact on the older persons. **Sexual abuse was not identified** as an experienced form of elder abuse. The issue of sex as a topic is too sensitive in an African context since it is not a matter to be discussed in public especially with "strangers".

Close family members are the main abusers of the older people. While the older women identify their sons as frequent perpetrators, the older men claim their wives and children to be their abusers. At the household level the older people reported the following misconduct and situations which characterize their living situation to warrant suspicion of elder abuse: **alcoholic sons, lack of respect for**

[54] As it was impossible to gather enough GPs for the focus groups dentists were addressed and invited to join the groups of PHC professionals.

parents, sons projecting their failure on parents, abandoned children, refusal to help in domestic chores and demand for food.

2. Focus groups with PHC professionals

The three focus groups with physicians chose **Questions 4, 5, 1, 8 and 12** to be the **most relevant ones** from the bank of twelve questions.

Q1: The item of loneliness is considered important in detecting elder abuse. This is because loneliness is a real issue among older members of society today. The question tackles only one issue and is therefore appropriate. It is also a confining, short and easily understandable question without any redundancy.

Q4: The item is important in detecting elder abuse. The examples provided make it comprehensible. The question guides the respondent in terms of what is required and there is no redundancy. The wording is clear and gives the respondent the opportunity to explore.

Q5: The item is important in detecting elder abuse. However, the question is too wordy and winding to the extent that an older patient would forget the beginning by the time one finishes asking the question.
A suggestion for rephrasing:

Are there times a person close to you unfairly treated you and how did you feel? If yes, has it happened once or several times?

Q8: The item can be used to detect elder abuse because it is a common phenomenon in the modern society. The wording is appropriate and self explanatory. There is no element of redundancy and the question can create an environment for discussion with the respondent.

Q12: Although the item is important in detecting elder abuse the question was regarded as very controversial. In the African context, sex is to the older people a rather sensitive topic, and the question may not be culturally appropriate since it will likely cause discomfort. Therefore the question may not be answered by many older respondents.
A suggested alternative was:

Has anyone touched you in ways you did not like or made unwanted sexual approaches towards, and if yes, was it once or several times?

Questions 2, 7 and 11 were the least relevant ones and could be eliminated.

In the opinion of the PHC professionals the questions are an important tool in assisting to detect elder abuse. The **items touch on the most critical aspects that the older people are subject to and experience in everyday social life**. Issues of loneliness, dependence on others for their basics, being mistreated, being vulnerable at the hands of the powerful, being taken advantage of, overwhelming financial responsibility and being caregivers in their state of fragility are critical issues today which the questions capture.

<u>Workshops:</u>

Two workshops were held: one with social workers (nine participants), the second one with social workers and PHC professionals (nine participants). The aim was to gather their views on elder abuse as a social and health care issue, and to test the SWEF and the PAHO manual.

1. Workshop with social workers

The participants agree that elder abuse is indeed a critical issue in both rural and urban Kenya. **The older population has risen tremendously, yet there are a neglected age group**. NGOs mainly focus on children and youth, not on older people. For example, there are homes for the abused or neglected children but older people who experience similar problems have no such facilities/support. This implies that elder abuse is not yet considered a critical issue.
There is also **lack of trained personnel** to deal with elder issues. The hospital participants are working at does not have specific policies addressing older people. **Routine follow-up is not available** as social work services at this hospital are only provided to inpatients.

There are some categories of elder abuse that occur specifically in the Kenyan context:
- It is always the older people who are suspected of **witchcraft**, not the young ones (for example among the Kisii of Kenya). Consequently, many of them are burnt to death by the public with or without evidence.
- There is **no access to health care facilities** yet older people cannot walk long distances.
- **Discrimination by health insurance**: the National Health Insurance Fund accepts membership below 75 years. Furthermore, they demand **much higher premiums** from the older people thereby locking them out of insurance.

The **main causes for elder abuse** tend to be **economic in nature**. This could be due to a lack of savings or because disabilities and needs often strain the finances of their providers leading to neglect. The emergence of the nuclear family contributes as well to the loneliness and isolation of older people.

The *Social Work Evaluation Form* was considered to be quite applicable and appropriate and would be therefore useful. The social workers expressed the need for intervention protocols, specific training, the strengthening of their role to advocate for older people's rights, and the increase of public awareness. The government welfare system for the older persons should be improved by providing homes, polices in institutions dealing with the older people and the law relating to the welfare of them, hospital policies that recognizes older persons as a priority, and training and sensitization of all professionals about elder abuse.

2. Workshop with PHC professionals and social workers

A session was conducted involving five social workers and four doctors to discuss intervention possibilities and to review the PAHO manual. **Institutional support is required** such as **clear policies** in place, **social workers to be posted in all hospitals**, **rescue centers for abused older people**, **sensitization** of all staff and **training** on issues of older people, and a **proper diagnosis** including a social history of older patients. Both professional groups acknowledged the importance of the PAHO manual as a guiding tool to assess the psychological needs of older people. The enactment of legislation on older people at national and institutional level is considered as a crucial factor to guide interventions related to elder abuse.

Elder abuse is a social work but also a health care issue. Social workers assist the abused and neglected older persons to find homes for placement. Since relatives tend to dump or abandon older persons in hospitals, also doctors have to take charge of the abandoned people.

Most doctors in Kenya are not aware of the magnitude of elder abuse unlike social workers who confront the issue on daily routines. The lack of doctor's awareness is attributed to the limited focus on elder issues right from training to work situations. The **low number of older people in the total population vis-à-vis children also makes the issue not recognized as such**. The consensus is that

elder abuse is a problem in Kenya but society is more focused on children and women abuse, hence forgotten the abuses that older people are subjected to. Both professional groups believe that the lack of awareness by policy makers is the main cause of this situation.

The majority of the participants have come across abused patients but reacted differently. Doctors feel powerless. Even though they sometimes refer patients at risk of being abused to social workers, they do in general little. Social workers either interview the abused client and/or look for the available and proper social support system. For both professional groups there are neither intervention protocols nor follow-up strategies available at the institution they work at. Therefore, there is a strong feeling that the PAHO manual's content and issues are appropriate and it can be readily used.

Summary of report from Singapore

Due to historical lack of discussion and understanding of elder abuse in Singapore, the term has a negative connotation in Singapore and elicits such fear and anxiety even among healthcare professionals that there may be a need to look for other terms that can be used to replace it. As Singapore ages, the government has been increasingly concerned that more cases of elder abuse and neglect may surface and the need for common definitions, systems and programmes have to be in place to address it. Thus, in September 2003 a multi-disciplinary team comprising professionals with knowledge in geriatrics, psychiatry, psychology, gero-counseling and social work, was established to manage elder abuse cases.

In adopting the WHO-CIG study in Singapore, the country coordinator had to modify some aspects of this study to suit the local context. The following changes have been adopted:
- The questions were translated into Mandarin, as the majority of Singaporeans are Chinese and the majority of the current cohorts of older people in Singapore do not speak English but Mandarin and its dialects.
- In Singapore, an older person is 60 years and above. National definition currently stands at 65 but in practice 60 is used by frail care programmes whilst 55 by active ageing programmes. The coordinator therefore followed such definition.
- The level of awareness among PHC professionals on elder abuse is very low as ageing is a relatively new issue in the country. PHC providers, not recognizing the problem of elder abuse, and the need for screening, were maybe reluctant to test the questions or join the focus group discussions. As a result the study coordinator could only organize two focus group discussions with PHC professionals. The rest of the feedbacks were given through written responses.

Focus groups:

The PHC professionals and the older people both have chosen an almost identical set of questions to be retained in the questionnaire. Both groups have also expressed similar feedbacks and views on most questions.

1. Focus groups with older people

Four focus groups were conducted with 45 older persons. They comprised three combined groups of older men and women and one group with older females only. One combined group was run in Mandarin and the female group consisted of Hokkien[55] speakers. The rest of the groups were conducted in English.

The general consensus among the 45 older people is to retain six questions rather than five. They identified **Questions 1, 4, 5, 6, 8, and 11** as they are the **most important ones** in detecting elder abuse.

Q1: The majority of them felt that the word 'sometimes' could replace the existing word 'usually'. Some remarked that the terms 'feeling alone by oneself' or 'isolated', or 'neglected' could replace the term 'lonely', according to the Singapore context.

Q4: Although the majority of the older people thought that this item was a relevant and useful question, the term 'prevented' came across as an improper word to ask, especially in the Asian context. It was suggested that 'deprive' would be a better alternative.
Some felt that the question was long-winded and requested for simplification of the wording for a better understanding, for example omitting words like 'health aids' or 'hearing aids'.

[55] Dialect group in Singapore

Q5: The participants thought that the question should be split into sections and sequenced. This would make it easier for an older person to understand what each section entails, since the existing question comes across as too wordy. 'Yelling' was not considered to show abuse. Moreover, the question uses too many adjectives. They also found no redundancy in the question but again urged for better clarity to prevent the item from being seen as complicated.

Q6: It was suggested using terms like 'has anyone disallowed you to do things you wanted to do' or 'has anyone cheated you or do you feel cheated' rather than asking 'have you being taken advantage of' for better clarity.
The majority of the older people strongly felt that the question was too long. The item would be easier understood if it was supported by a few examples. Nevertheless, they expressed the need to include the question in the instrument as it touched on restrictions on one's freedom and actions.

Q8: Most of the older people felt that the question was important to ask as it discusses financial issues but there were some shared feelings that it should have been divided into two parts. The first part could be on 'tried to use your money...' and the second part should look at 'forced to sign documents…' instead of lumping it together. A few of them were of the opinion that since the question indirectly refers to family members, it would sound better if the phrase 'anyone you trust or close to you tried to use your money' is used instead.

Q11: This question was considered necessary to be asked in order to detect elder abuse. Some concerns were raised about the sensitivity of the question. In an Asian context the older persons may not wish to relate their sufferings due to fear of losing face and especially if the physical injuries were inflicted by the family members. Suggestions were put forth to change the word 'impede' for a simpler term like 'restricted'. Some suggested that the GP should ask this question when seeing signs of bruises on the older person. It was pointed out that the second part of the question was needed to assess the degree of abuse.

Overall comments on the questions were:
- **Emotional abuse** of the older persons **needs to be considered** in the instrument and questions should attempt to address that.
- The twelve **questions have not addressed the neglect** component adequately and there is a need to do so.
- **Questions** designed **have to be culture-specific** and not tailored to suit the Western countries as certain questions are still regarded as sensitive to ask.

The participants felt that Question 7 can be eliminated.

2. Focus groups with PHC professionals

Two focus groups were held with twelve GPs. In addition, the questions were mailed out to GPs out of which eight sent back comments on the questions.
For the twenty study participants **Questions 11, 4, 5, 8 and 3** (in order of relevancy) were the five **most relevant** questions.

Q3: This question is considered a little vague as it is not clear what aspect of elder abuse is being focused on. There is a need to explain what 'basic daily needs' are. The question has a negative connotation, which might put off some older people and force them to deny a potential abuse. Furthermore, this question would be difficult to translate into Mandarin because there is no direct word for 'depend'. Some suggestions to rephrase this question:

Are there disagreements between you and the caregiver?

Do you usually need someone to help you with basic daily needs?

Who do you depend on most of the time for help with your basic daily living?

Are you independent? Or do you need help in basic activities of daily living (ADL)?

Q4: This question is an essential one. Examples should be provided to make it clearer. Too many different aspects are included in this item. There should only be one particular thing to be asked, otherwise it might be confusing. For instance, what is 'adequate living space'? How do you define 'adequate'? Does 'space' refer to bedroom or the whole house?
Needed things should be assessed separately as some are essentials and some are not.

Q5: This question is very long and complex. However, it is a good and direct question, and an important one to ask about physical abuse. 'Scolding' is a better word than 'yelling' as some older people have difficulty in hearing. There is a need to ask about one emotion at a time ('sad, shameful, fearful, anxious and unhappy'). The second part of the question (asking about frequency) can be omitted.
Some suggestions to rephrase this question:

Has anyone close to you upset you by yelling at you or scolding you?

Has anyone ever shouted at you? Followed by 'or say things that hurt your feelings?'

Has your family or anyone at home shouted at you or scolded you or talked about you in a way that upset you for a long time? If clarification is needed, ask 'make you feel very sad, worried, fearful, ashamed, useless and unhappy.'

Has anyone close to you unfairly yelled at you, or talked to you, or made you feel especially sad, shamed, fearful, worried or unhappy - in a way that upset you for a long time?

Has anyone close to you yelled at you or been unkind to you?

Q8: A very good question, relevant and simple. The second part is not required. Some examples for better understanding by an older person (e.g. property, objects, money, possessions, etc.) should be included.
Instead of 'sign documents' 'thumb print' could be used as most older people have no or low education. Maybe aside from family, relatives can also be included when one asks an older person about people they would trust.
Some suggestions to rephrase this question:

Have you been cheated financially by someone you trust?

Has anyone asked you to sign away your money and/or your house?

Has anyone you trust misused or tried to misuse you money, possessions or property, or forced you to sign documents that you did not understand or did not want to sign?

Q11: All GPs find this question relevant and important in detecting elder abuse as it is very direct and easy to ask.
A suggestion to rephrase this question:

Has anyone physically hurt you, for example has hit you, pushed you or locked/tied you up?

Questions 7, 9 and 11 were considered the least relevant.

By looking at all the questions together some final comments were made:

- For screening, there should be two prerequisites. One is **privacy** and the other is **reporting of the questions**. All these questions should be asked in a more conversational way rather than like a questionnaire or checklist. GPs could become very familiar with these questions and it would be then easier to include this as part of their consultation.
- As GPs only spend on the average 15-20 minutes with a patient, **twelve questions are more than enough**. GPs can also pick up those questions that are relevant to the condition of the older person.
- Asking these questions would also require **physical examination** as part of the screening.
- **Nurses could ask** all these **questions** rather than physicians.
- GPs can only ask these questions after a few times that the older person has visited the clinic.
- There might be a need to **re-order the questions** to get a better response. For example, asking Question 1 first might not elicit any response at all, whereas asking Questions 2 and 3 first might.
- **Older men are more reluctant to answer** the questions than women.
- Generally, it was **difficult to translate these questions** either into Chinese and its dialects or to Bahasa Melayu.

Workshops:

1. Workshop with social workers

A workshop was conducted with 18 social workers coming from different settings such as hospitals in Singapore and voluntary welfare organizations. The main purpose of the workshop, herein, lies in eliciting the social workers' perceptions and views on the applicability of the Social Work Evaluation Form in Singapore. Feedback included issues that were raised on the **wording of the evaluation form which was viewed as limiting** and not providing ample space for the social worker or doctor doing the assessment to explore further. The social workers expressed their **reservations about the usefulness and the length of the evaluation form** and thus not being able to focus on assessing the depth of the abuse. For a crisis management/intervention situation like elder abuse, it would be desirable to narrow down the questions and offer more emphasis to ask questions that analyzes the seriousness, history and frequency of the abuse. Furthermore, the participants demurred about the applicability of the Form to the Singapore context, bearing in mind that it was developed for a Western setting. **Questions need to be designed in a manner that takes into consideration the cultural sensitivities** specific to the different contexts.
The social workers came to a consensus that elder abuse should be viewed as having different categories and thus each category being accorded equal importance. This can be done by devising a **checklist with risk indicators for detection** of each different type of abuse and that point towards therapy and intervention.

2. Workshop with social workers and PHC professionals

A workshop was organized with ten participants (GPs and social workers) to discuss the applicability and relevance of the PAHO manual from the participants' occupational and contextual perspectives.

GPs and social workers noted that the definition of elder abuse in the PAHO manual is different from the definition provided by NCEA[56]. The latter comprises seven categories of elder abuse, and **sexual abuse stands as a distinct**

[56] NCEA: National Center on Elder Abuse.

category. Also **abandonment, neglect and self-neglect are three distinct categories** or types altogether. Due to the multi-dimensional nature of elder abuse, both the doctors and social workers emphasized the importance of adhering to one definition of elder abuse that is widely used, for example NCEA's.

As for the risk indicators, GPs and social workers stressed that **a lot of decisions concerning an older persons require the family's consent** and consultation in Singapore. This could be largely attributed to the cultural context of Singapore where familial values take precedence over individual rights and autonomy. The lack of resources tends to put the older persons' viewpoints in an unfavorable light and force the frontline workers to judge situations from the perspective of the families.
Overall, the risk indicators are useful as a list but for doctors, it would not be adequate to call it a diagnostic guide as the indicators were not specific enough. Greater **preference was given to a checklist** that could be used at the end of the assessment.

Furthermore, it was suggested that the **risk factors** identified in 2.1 should comprise the following as well: **mental illness; history of long term conflicted relationships; high care needs; dementia and other behavioural issues that could trigger abuse**.

For diagnosis of elder abuse, GPs and social workers recommended that Table 1.2 under 2.2 (*Diagnosis of the problem*) should adopt a socio-medical diagnosis. This would entail bringing in a pool of GPs and social workers with experience in medicine and social work respectively for a team discussion.

As for an intervention plan, it was suggested to **create a hotline/helpline for GPs** that they could call and make referrals when they suspect elder abuse cases. The lack of appropriate authorities to discuss on financial management assistance, guardianship and special court proceedings was stressed by the group. Furthermore, the flowchart in diagram 1.3 was viewed as slightly rigid.

Different professions see elder abuse differently. Whereas the **social workers are more willing to be involved** and would want to share with each other their experiences in handling and managing elder abuse cases, **PHC professionals**, on the other hand, are **more reluctant** to be involved, especially in asking all the twelve questions, unless they are older. This may stem either from the lack of time that they have with their patients or the expected role and responsibilities attached to each profession. There is a need to reach out to more PHC professionals in Singapore and to increase their levels of knowledge and awareness on elder abuse.

Having a set of questions in the form of the tested questionnaire is critical. However, **GPs need to know how they can refer to other professionals** (such as social workers) to be able to handle and manage suspected cases. There is also a need to review the **role of nurses** in this process of detecting elder abuse cases. However, there may be 'ethical' considerations in this area and current Singapore law does not require mandatory reporting.

There is a definite need to translate any instrument into the different languages that are in use in Singapore, otherwise, GPs or other healthcare professionals would find it difficult to ask an older person.

Follow-up strategies for detecting elder abuse cases do already exist in Singapore.[57] The strategies involve asking older persons suspected of abuse a primary question followed by a secondary question before the necessary intervention is assumed. A framework is being currently designed to be put in place in one to two years' time that takes on a multi-disciplinary approach to tackle elder abuse cases.

[57] Offered e.g. by specific agencies like PAVE (Promoting Alternatives to Violence) and SAGE Counselling Centre (Singapore Action Group of Elders).

Social workers and GPs recommend establishing a continuing platform/forum where frontline workers can share information related to elder abuse and journal updates on elder abuse research.

In terms of strategy, programmes should focus on **raising the level of PHC professionals' awareness as well as their level of knowledge on where to refer suspected elder abuse cases**. There is also a need to **involve the government** in this programme to build the PHC capacity to deal with elder abuse. Without governmental support, engaging PHC professionals is quite difficult.

Summary of report from Spain

Focus groups:

Altogether seven focus groups were held: three with older people and another four with PHC professionals. The majority of the groups did not discuss the set of twelve questions but the original EASI[58]. Only two groups with PHC professionals commented on the set of twelve questions.

1. Focus groups with older people

The three focus group discussions were conducted in different settings: a mixed group of nine males and females in a large city, a group of nine females in a small city and a group of seven males in a medium sized city. Participants' ages ranged from 65 to 75 years.
The older people referred mostly to their own experiences and found it difficult to discuss these questions on an impersonal level. In general, **the five questions were well understood** and the questionnaire was considered to be clear. Question 4 was thought to be the most comprehensible item, followed by Questions 1 and 2; although the latter were thought to be excessively long, addressing too many different issues, and should be therefore further specified. Questions 3 and 5 caused some confusion.

Q1: The question was felt to be **comprehensible** but nevertheless a bit **ambivalent**. Some participants thought that they were being asked whether they provided help to somebody, whereas some understood that the focus was on receiving any kind of help, and others comprehended that the question inquired about help - such as home help - offered to them from a public institution. The list of items was considered a good summary of older people's basic needs; 'going to the doctor' could be added. However, it was pointed out that **basic** and **secondary needs** were put together in the question. The item could be therefore divided into two shorter ones.

Q2: The wording of this item was well understood, but the meaning of the second part of the question 'has this happened more than once' needed further clarification as some thought that one or two occurrences of this type of prevention could not be regarded as abuse. To simplify the wording 'prevented' could be replaced with 'denied'. There was no redundancy in the question but some considered the question too long and suggested a division into several ones.

Q3: The participants agreed that this question tackled a particularly sensitive issue. Some mentioned that they had had these feelings (*threatened* and *shamed*) not only in the last twelve months but throughout their whole life. Furthermore, it was stressed that there was a significant **difference between** feeling '**threatened**' and feeling '**shamed**': *Shame* seem to signify a feeling of being embarrassed and should not automatically be connoted with abuse. It might be more accurate to replace 'shamed' by 'humiliated'. A *threat* can be imposed on a person without previous actions, and points more clearly to abuse. Once again, the question could be divided in order to ask about these two different issues separately. An important issue that could be included in this question is ***infantilization***.

Q4: The item was regarded as very clear addressing a frequent type of abuse. The word 'force' was felt to be very strong and could be replaced by 'manipulate'.

[58] See pp. 20-21.

Q5: The participants were unclear whether this question referred to **physical** or to **sexual abuse**. 'Touched' was not necessarily associated with sexual abuse. Both issues were very delicate and still a **taboo** for generations being older than 65 years. Nevertheless, a clear separation between these two abuse types could help getting more accurate responses. It was stressed that an honest answer to this item would highly depend on the **level of confidence between the doctor and the patient,** and on the **doctor's skills to ask** the question in a sensitive way.

2. Focus groups with PHC professionals (to discuss the EASI questions)

There were four focus groups with a total of 30 GPs in four different Spanish cities (Madrid, Málaga, Vilanova y la Géltru and Badajoz).
On the whole, the GPs found the questionnaire a **very useful tool for physicians** who did not know how to approach the issue of elder abuse. However, it was felt to be crucial to provide the PHC professionals with a clear definition of elder abuse or with a small introductory part since some participants did not understand the objective of the tool – to raise awareness and to generate a sufficient level of suspicion for elder abuse. It was also unclear to whom the questionnaire referred. Some thought that 'people', 'anyone', and 'someone' were too vague; others regarded this openness as chance to obtain an answer without forcing the older person to accuse somebody directly. There **was no consensus on the length of the questions**. On the one hand, some thought that longer questions were more difficult to understand but the number of questions could be kept down. On the other hand, shorter questions might be more comprehensible but leading to a longer questionnaire; the more extensive the questionnaire would be – even if the questions are shorter – the higher is the chance to lose an older person's attention. Participants requested further clarification on the **best place to apply the questionnaire,** since PHC settings are normally very busy leaving the PHC professional a very limited amount of time for each patient, and during home visits there is a risk that other people/the perpetrator are around.

Q1: This initial item was considered as "**ice breaker**" and general question **to detect a potential dependence** - an important risk factor for the occurrence of elder abuse. Some thought that the amount of help a person needed did not necessarily indicate an abusive situation. The item was therefore found to be of medium relevancy.
It was pointed out by some that the term 'people' should be further specified, others saw this ambiguity as opportunity to answer without making a personal reference.
A separation of the question into two parts (basic and secondary needs) might be useful. Activities that were felt to be less important were 'shopping' and 'banking'; 'going to the toilet' could be added.
In order to shorten the question the following alternatives were suggested:

Do you need help with something?

Do you need help?

Do you need help with the basic activities of daily living such as bathing, dressing, eating? And with… (secondary needs)?

Has anyone close to you helped you with bathing or dressing? Has anyone helped you with shopping or banking?

Q2: The words used in this question were regarded as clear but to simplify the question it was suggested to replace 'prevented' with 'impeded'. **Acts of omission and commission should not be put together in one item**. The combination of different circumstances (*social isolation* and *access to basic needs*) complicated the question.

The second part of the item ('has this happened more than once') caused some debate as 'more than once' was not considered concrete enough.

Q3: The participants felt that this question was essential to ask about psychological abuse. Asking about the **frequency of occurrence was considered quite important** in this question; the second part of the question should therefore be retained. The question as a whole seemed to be a bit vague as the group of people to whom the question referred (e.g. close people, neighbours, foreigners etc.) should be specified.
In order to shorten the item a number of suggestions for re-wording were made:

Have you felt annoyed because someone treated you in a way…?

Has anyone made you feel embarrassed or threatened…?

Has anyone treated you in a way that made you feel embarrassed or threatened?

Did anyone treat you in any way that made you feel embarrassed or threatened?

Q4: This question was well understood and regarded as very important, especially when taking into account the high frequency of economic abuse among older people. As with other questions, the second part ('has this happened more than once') could be omitted.

Q5: According to the participants, this item had highest relevance because it was asking about physical and sexual abuse. However, 'touched you in ways that you did not want' **could produce discomfort and make both the older person and the physician feel embarrassed**. Others commented that the question **comprised too many different issues such as threat, physical harm, sexual abuse and feeling frightened**. Therefore it could be useful to divide the question into two parts. One part could ask about physical the other about sexual aspects of abuse.
The following alternatives were suggested:

Has anyone threatened, frightened or harmed you physically?

Has anyone touched you in a way you didn't like? And afterwards*: Has anyone harmed you physically?*

Have you felt physically or sexually threatened on any occasion?

A number of alternatives comprised also the explicit inclusion of sexual abuse:

Has anyone harmed you physically? Followed by: *Has anyone tried to sexually abuse you?*

Have you felt physically or sexually threatened on any occasion?

Has anyone hit, threatened or frightened you physically? Followed by: *Has anyone sexually abused you or tried to abuse you?*

3. Focus groups with PHC professionals (to discuss the bank of twelve questions)

Two groups have discussed the bank of twelve questions. One group chose also the five **most relevant questions** which were **Questions 3, 4, 5, 8, 11**.
The questionnaire with twelve items was considered **too long**, causing difficulties to maintain an older person's attention. Question 1 was thought to be redundant. Several questions could be combined into one, for example Questions 2 and 3; Questions 6, 7 and 8 referred to the same question asking about a person's personal autonomy and should therefore also be put together. A similar debate arose for the last two questions. Although they tackled two different

abuse categories (sexual and physical abuse) older people might be more reluctant to answer a question about sexual abuse when it was posed more directly.
Some felt that the **style of the questionnaire** was **too Anglo-Saxon** and viewed the phrasing as inappropriate. The **time frame** should be also further **specified**. Moreover, the term 'basic daily needs' (Question 3) requested further clarification. Question 4 was not precise enough as it was not clear whether 'has anyone prevented you from…' referred to a person or an abstract body (for example the community). Question 5 contained too many different adjectives that described different states of moods and feelings. In any case, before applying the questionnaire, previous instructions/information would be required.

Workshops:

1. Workshop with social workers

Ten female social workers - chosen randomly from various Health Centres in the municipality of Madrid - participated in this workshop to discuss the *Social Work Evaluation Form* (SWEF) and further issues related to elder abuse. The Form was sent to them a week in advance to familiarize them with its content.
The social workers' clientele was made mostly of immigrants and older people covering all ranges of socioeconomic backgrounds. None of them had previously worked in the area of elder abuse but they received training, and information on child abuse and gender-based violence.

The participants mentioned the absence of specific protocols and guidelines concerning the prevention, assessment and intervention of elder abuse. PHC professionals who referred abuse cases to social workers did so because they were sensitized and motivated and not because they felt obliged to act according to guidelines. A significant shortfall pointed out was the **lack of coordination between social workers and other professionals** working in the same institution. **Inter-professional coordination was considered to be the key to intervention** which was often too slow and only accelerated if the case of abuse was related to gender-based violence. Some social workers went only once per week to a health center to exchange information, coordination and ultimately to strengthen the teamwork between the different professional groups dealing with elder abuse. The creation of a **round table for older persons** could offer an important platform for the different stakeholders together to share experiences, disseminate information and offer solutions.

The **application of the SWEF** was considered **inappropriate** in the Spanish context because of its **length**. The average consultation time a social worker had with a client was 40 minutes. The participants also believed that it was rather difficult for an older person to focus on answering questions during approximately 66 minutes. A possible solution could be **to administer the Form during several sessions instead of only one**. Apart from the time issue there were also linguistic problems with the Form as the literal translation from English into Spanish (e.g. of the term 'sponsorship') caused confusion. Some sections were thought to be unclear such as the one on housing putting housing types and characteristics together. Two aspects that were not adequately taken into account were a) the important role of informal networks of older people who did not have a family and b) the impact of the at times problematic aspects of the relationship between the older person and his or her relatives throughout the older person's life. It was further criticized that the Form could raise hopes in older people that could not be met since it asked about issues that were not under the competence of a social worker. In general, the **Form was thought to be too direct** and **negative**. In Spain, questionnaires tackling such a sensitive issue used more indirect questions. For example, asking older people whether there were any problems within the relationship to their children was a question that could not be asked. **A questionnaire with this type of questions would be rather administered by nurses** as they would have a more regular contact with patients. The best place where the interview could be conducted was not

necessarily the older person's home but probably rather the Health Center or a neutral environment.
However, it was stressed by the participants that the mere existence of such a Form was positive as a similar assessment tool did not exist. The Form could serve as a basis for evaluation techniques being more appropriate in the Spanish context. The administration of such a Form by social workers would also assign them with a role they currently do not have in the assessment of elder abuse in PHC settings.

2. Workshop with PHC professionals and social workers

The PAHO workshop group comprised five social workers and five primary care doctors, all coming from the metropolitan area of Madrid.
The participants considered elder abuse as a **social and health problem** that could have very different causes and consequences. However, it is rarely addressed in the institutions participants are working at. One of the main obstacles for doctors is the very limited amount of time they can dedicate to a patient. They often only intervene in extreme abuse cases. Furthermore, they are rarely familiar with a patient's living conditions since home visits by the doctor are not common. The social workers reiterated that it is **not the institution but the individual professionals who show an interest** in the issue of elder abuse. Professionals are familiar with the issue either through other abuse types - such as violence against children or women - or because they have come across some cases in their consulting room.

The main difficulties that were mentioned by the participants in the assessment of elder abuse are **a lack of**

a) Specific training on elder abuse;

b) Interprofessional communication;

c) The level of awareness and sensitization;

d) Protocols for homogenous interventions;

e) Specific definitions and terminology;

f) Social support for the caregiver;

g) Circulation of information regarding the existing institutional resources, and

h) General resources to tackle the issue.

For the assessment of elder abuse social workers use strategies they know from other fields of work; for example, risk factors analysis, and knowledge of patient's social history and family background. Since they do not have access to patients' social history forms in hospitals they miss useful information for the detection of potential cases. PHC professionals are probably in a better situation to get an idea of the patient's home and family situation as they often see the whole family in their consultation. The doctors pointed out that intervention strategies must be accompanied by training. It was also stressed that the decision making capacity of an older person has to be considered. In order to counteract elder abuse, the participants felt that social workers could apply intervention methods they know from abuse directed at other groups (gender, child) and doctors could focus on prevention and raising suspicion. The doctor sees the patient on a probably more frequent and personal level than the social worker. In any case, it was emphasised that the most complicated phase in the assessment process is the intervention as it can have drastic impact on the equilibrium of the family in which the older person lives.

The Spanish Society of Geriatrics and Gerontology and the Ministry of Social Welfare and Labour have published an action guide[59] that includes elder abuse

[59] *Malos Tratos a personas mayores*, Guía de actuación. Antonio Moya y Javier Barbero Gutiérrez (coord.), Edit. IMSERSO, SEGG, Madrid 2005.

issues. Since this guide was only published recently it has not yet been sufficiently circulated among PHC professionals. The participants felt that this publication is more appropriate for the Spanish context than the PAHO manual mainly because of linguistic reasons (the PAHO manual uses mostly Latina American and Anglo-Saxon terms instead of Spanish vocabulary), the form of its content (its tables and diagrams are difficult to manage and too schematic), the lack of preciseness' (for example in the definitions' section, the role of the caregiver), the missing emphasis on institutional abuse (the manual tackles mainly domestic but neglects institutional abuse) and the intervention possibilities (actions suggested in the PAHO manual seem to aim merely at emergency situations and do not include non-dependent older people). However, the PAHO manual could serve as a good basis which needs to be adapted to the specific country realities.

Summary of report from Switzerland

Focus group discussions

1. Focus group discussion with older people

One focus group discussion was conducted with 29 older persons (19 female and 10 male). Participants had a median age of 79 years.

The general consensus among the participants was to retain Questions 4, 5, 6, 8, and 11.

Q4: The majority of the older people felt that this was a relevant and useful question.

Q5: The participants found no redundancy in the question but considered the item as too complicated.

Q6: The item was thought to be too long. It would be more comprehensible if the question was supported by a few examples.

Q8: Most of the older people felt that the question was important.

Q11: The question was regarded as necessary to detect elder abuse. The older people felt that the second part of the question was needed to assess the degree of abuse.

2. Focus group discussion with medical doctors

A focus group discussion was held with eleven GPs (five men and six women). Participants' ages ranged from 34 to 65 years.

The five most important questions were considered to be Questions 4, 5, 6, 8 and 11.

Q4: This question was considered essential.

Q5: This item was regarded important to determine whether there is physical abuse as it was direct and could get a direct response. However, the question was felt to be very long and complex.

Q8: A very good question, relevant and simple. However, the item could also be shortened or rephrased. The second part was not required. Some examples for better understanding by an older person (e.g. property, objects, money, possessions, etc.) should be included.

Q11: A very direct and very easy to ask question. All medical doctors found this question relevant and important in detecting elder abuse.

Workshop

1. Workshop with nurses, assistant nurses and social workers

A workshop was conducted with ten nurses, assistant nurses and social workers (all female, with an age range from 26 to 65 years) coming from different settings and services in Geneva. The main purpose of the workshop lied in eliciting the nurses and social workers' perceptions and views on the applicability of the SWEF.

They also discussed the set of twelve questions and chose Questions 4, 5, 6, 8, 11 as the most relevant ones.

Nurses, assistant nurses and social workers raised concerns on how to define elder abuse. The social workers felt uncertain about how to identify a suspect of elder abuse and how to confirm it.
The group was concerned about the level of intervention: How much intervention is required especially if the older person has medical conditions like cognitive impairment or high care needs? It was also emphasised that older people with some disabilities should be included. The group stressed the need to adopt multi-disciplinary and multi-level assessment methods. Furthermore, it was mentioned that elder abuse and neglect should be viewed as having different categories and thus each category being accorded equal importance.
Issues were raised on the wording of the Form which was viewed as limiting and not providing ample space for the nurse, assistant nurse, social worker or doctor to explore further. In general, the group expressed their reservations about the applicability of the SWEF to the Geneva context.

Follow-up strategies for detecting elder abuse and neglect are being currently designed in collaboration with the Alter Ego association. They are based on a multi-disciplinary approach to tackle elder abuse and neglect. The need to review the role of nurses in the process of detecting elder abuse and neglect was also underlined. The groups recommend establishing a continuing platform/forum and a helpline, such as ALMA in France, where frontline workers can share and obtain information related to elder abuse and neglect.
Other propositions included the integration of these questions in clinical ethics, geriatric and gerontological curricula. The questionnaire could be also added to the "Vieillir en Liberté" internet platform, a program of community-based health care for older persons, centred on respect for human rights, autonomy and solidarity.