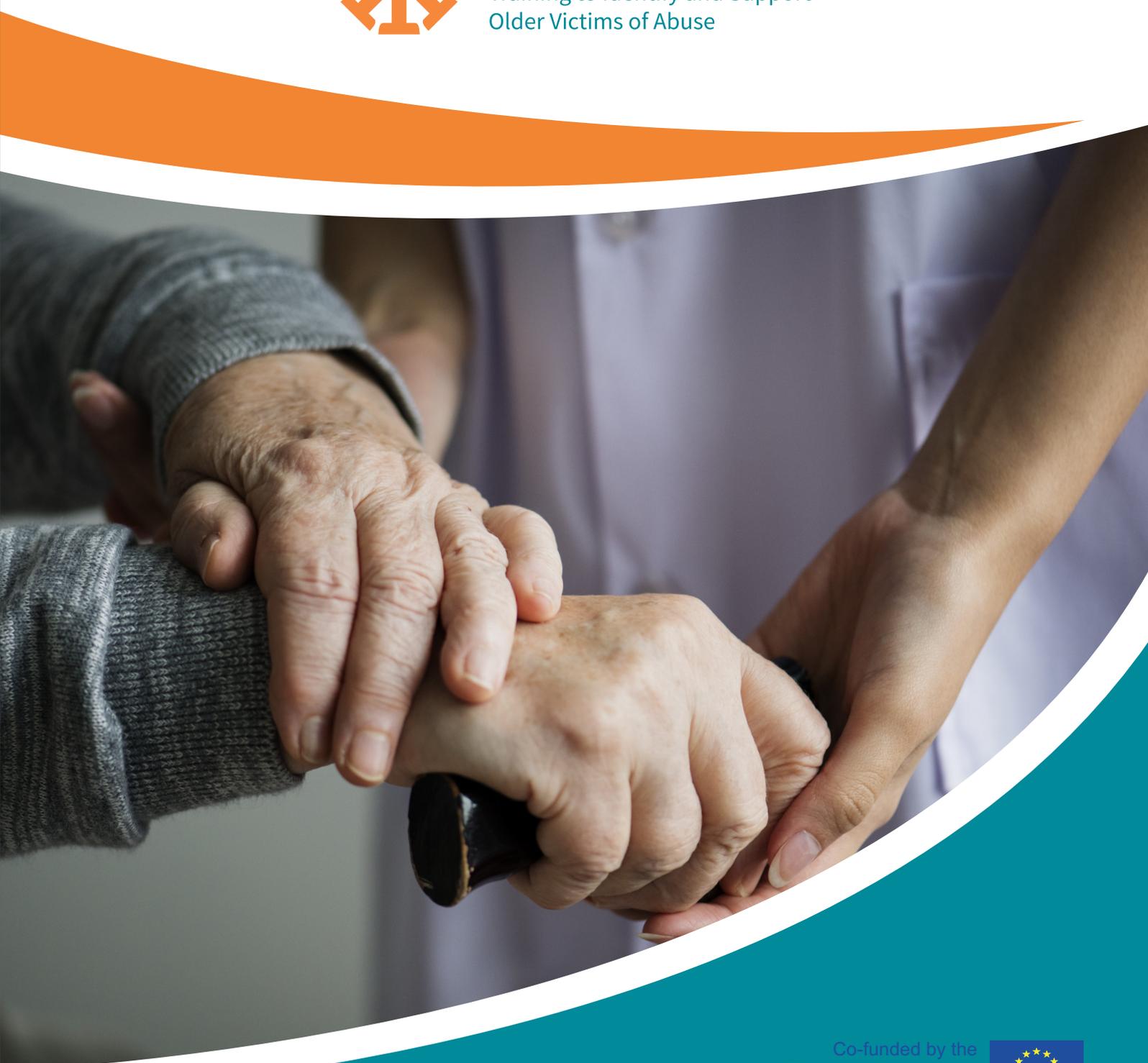




TISOVA

Training to Identify and Support
Older Victims of Abuse



Co-funded by the
Erasmus+ Programme
of the European Union



How to Identify and Support Older Victims of Abuse

A training handbook for professionals, volunteers and older people

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In cooperation with:



**Women's Support and
Information Center**

There is a way out of violence!



UNIVERSITY OF TARTU
Johan Skytte Institute of
Political Studies

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Training to Identify and Support
Older Victims of Abuse

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A training handbook for professionals, volunteers and older people

Tartu, 2020

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FOREWORD

TISOVA Project

This training curriculum was designed as part of the TISOVA Project, a three-year Erasmus+ project launched in September 2017. TISOVA (or **Training to Identify and Support Older Victims of Abuse**) is intended to establish associated and strategic partnerships with senior centers from each of the partner countries (Estonia, Austria, Greece and Finland) in order to counteract all forms of violence against elderly people, especially women. The project is aimed at disseminating information for identifying elder abuse, in addition to providing training and online education programs for three target groups: professionals and volunteers at senior centers who provide assistance to elderly victims of abuse, and seniors themselves. This curriculum will support the training of these groups.

The exercises included in this curriculum were piloted in all partner countries. The experiences of the trainers in working with social and health care professionals, volunteers and older persons are described in parts 2, 3 and 4 of this manual in the “How to conduct training” sections at the beginning of each part. The authors of this manual collected and wrote all theoretical knowledge in the manual. The country-specific information and chapters were written by the project partners: the Women’s Support and Information Center (Estonia), the University of Tartu (Estonia) and the Union of Women Associations of Heraklion Prefecture (Greece).

Overview: Who is the curriculum designed for?

This curriculum is designed for teachers and trainers to deliver education and training on the prevention of and response to violence and abuse against older persons. The target groups for training are health and social care professionals (particularly those working in service centers), volunteers and older people. To understand the educational needs of the target groups, trainers should have field experience working with older victims and survivors.

Curriculum guide: How to use the curriculum

The curriculum is divided into four parts, the first of which is intended for use by all target groups. The second part is designed for social and health care professionals, but it also takes into account the needs of volunteers. The short separate sections for volunteers and older persons focus on additional required knowledge to address their specific needs to minimize overlap with the section for professionals. The section for professionals includes guidance on how to train professionals and volunteers in this field and how to organize interventions for elderly people. Readers from the different target groups will need to refer to Part 1 (theoretical background) in order to fully comprehend the remaining material and exercises, although the section for older people (Part 4) also contains a brief summary of relevant content from the first section. This allows Part 4 to be used as a shorter and more accessible stand-alone document, but older people who are interested in further reading can refer to Part 1 for a deeper discussion of these topics.

The curriculum is divided as follows:

Part 1. Theoretical Background: this part will explain violence against older persons, including definitions, concepts and forms of violence against older persons. This section will also demonstrate how violence against older people is a violation of human rights and will outline how prevalent elder abuse is in Europe. Signs of elder abuse and neglect, characteristics and consequences of violence, and risk factors will also be explored to support professionals and volunteers in determining when/if abuse is taking place.

Part 2. For Health and Social Care Professionals: this part contains information relevant for health and social care professionals working with older people. After a brief outline of EU and national legis-

lation regarding elder abuse, ways to address and respond to elder abuse are explored, including principles of intervention, empowerment and communication techniques. Multi-professional cooperation, self-care and developing organization-specific guidelines and procedures are also identified as tools for ensuring holistic support to older people experiencing violence and for supporting the professionals who work with them.

Part 3. For Volunteers: this part supports volunteers in understanding the roles and responsibilities unique to volunteering with older people. Principles of volunteer work and the rights of volunteers are also outlined. Furthermore, communication skills, confidentiality, and other tools needed when supporting older people in situations of disclosure are also outlined.

Part 4. For Older People: this part will explain the concepts of ageism and sexism and how these factors can impact the lives of older people. The main goal of this part is to empower older people and to inform them of their human rights, and it therefore explains how elder abuse is a serious human rights violation and what to do to protect oneself from abuse and mistreatment.

Each part includes learning outcomes, notes for trainers and suggestions for training methods and exercises. Learning outcomes help trainers to concentrate on the key messages of the training. It is important that the trainer knows what they want the participants to achieve with each session and exercise. Notes for trainers give detailed information on the training content. Suggestions for training methods and exercises have been designed in line with the key topics covered in each chapter of the curriculum and aim to provide possibilities for interactive learning.

Learning goals and objectives of this training curriculum

The target groups of this curriculum are social and health care professionals and teachers/trainers, volunteers working with older persons and older persons themselves. This manual includes research and experience drawn from the TISOVA project, and it incorporates feedback from people—including older persons—involved in TISOVA project activities. The section for older persons is intended to be usable for interventions with older persons who experience or have experienced violence.

Learning goals of the curriculum:

- educate target groups about violence perpetrated against elderly people and about the experiences and specific needs of elderly victims of abuse
- support these groups in recognizing, preventing and intervening in violence against older persons
- raise awareness and provide information, resources and tools for all who interact with older persons affected by violence or most likely to experience violence

Objectives for social and health care professionals:

- increase understanding about violence against older persons, its special features, forms, risk factors and interventions
- emphasize the human rights perspective on violence against older persons
- give tools for recognition and intervention
- guide towards a multi-agency working model

Objectives for volunteers working with older persons:

- increase knowledge and understanding about violence against older persons
- provide advice on how to support older persons affected by violence
- guide towards cooperation with professionals

Objectives for older persons

- increase older people’s knowledge about human rights, civil rights and violations of those rights
- empower them to use their human rights
- help them to go through their life course and find resources for the future

Special considerations for teaching about violence

No professional work related to violence is free of values or assumptions about the phenomenon. One of the most important goals in educating people about elder abuse is to **become aware of attitudes and beliefs related to ageing and violence against older women**. It is also important that the teachers and trainers reflect on their own views and attitudes. This includes explanations of what ‘normal’ ageing is like, why violence happens and which kinds of goals and methods professionals should set and use in their prevention work. **Violence can be fatal**; hence, misconceptions and unsuitable working methods can jeopardize a victim’s life. Therefore, this curriculum contains materials to influence attitudes and correct the misconceptions of the training participants.

Violence can be fatal. Therefore, a clear stance against needs to be taken, while staying respectful and non-judgemental.

It is important for the teachers and trainers to remember that some of the participants may be victims of violence themselves—or perpetrators. Therefore, the language used should be respectful and non-judgmental; however, a clear stance against violence must be taken. Participants in the training may wish to share their own experiences either with the group or after the training with the teacher/trainer. The teacher should then allocate some time for such discussions.

Teaching about violence may also provoke anguish or resistance that may manifest itself as criticism or other expressions of disapproval during the course. Sometimes the issue is caused by a participant’s own difficult experiences that have been left unsolved. It is therefore crucial to emphasize the importance of working through one’s own experiences and seeking professional support when needed. The training is at its best when providing an example of **counteracting shame, secrecy and the culture of silence around violence**.

Assessing the needs of the training audience

Training is a process, not an event. Assessing the need for training; defining critical knowledge, skills, and attitudes; identifying barriers to transferring knowledge; and evaluating the impact of training are important skills that all trainers need to develop. A successful training should be preceded by an assessment to identify those who need training and what kind of training is needed, which helps to put the training resources to good use. For more information on how to conduct such an assessment, see e.g. HR-Guide, LLC (2018)¹.

The TISOVA project is informed by educational gerontology, a field of study and practice that includes three elements: education for older people to empower them to have control over their own lives and to maintain their independence, public education about ageing to improve general attitudes toward older people, and education of professionals by equipping them with knowledge and skills about learning in later life. Changing demographics have had a significant effect on the development of educational gerontology research and education methods².

GUIDE TO TRAINING METHODS AND EXERCISES

All four parts of this training curriculum contain various exercises and training methods. Below, you will find general instructions for how to carry out different exercises. More specific instructions, if needed, can be found within the individual exercises.

Teaching methods are tools for the facilitator to help participants access the content, explore the topic, understand key points and develop their own responses. **Teaching methods should be in accordance with the purpose of learning, your own style preference and the participants' needs.** The purpose of learning is for the participants to develop specific attitudes, competences, knowledge and skills.

This manual aims to describe teaching methods that involve “learning by actively doing”. Sometimes this is called experiential education. Experiential activities are meant to help participants gain new information, examine attitudes and practice skills. The manual includes a rich set of resources for further reading and learning. See examples of participatory learning methods in the Community Health Workers' Manual by PATH³.

Case study method

The case study method combines two elements: the case itself and the discussion of that case. A teaching case is a rich narrative in which individuals or groups must make decisions or solve a problem. Case studies used in teaching provide information but not analysis or conclusions. Participants are put in the position of making decisions or evaluations based on the information available. Effective cases are usually based on real events. They present complex, unstructured problems that may include extraneous or irrelevant information and often don't include every piece of information an analyst would like to have.

The discussion about the case can take many forms, such as closely directed questioning to draw out the information from the case and identify the central decisions or evaluations that need to be made. It can also involve more open-ended questions as participants evaluate options and weigh the evidence. Case studies can also be used in small group work or role playing (see below). Role playing a case study is a method that places participants completely in the case environment⁴.

Brainstorming⁵

Brainstorming is a group creativity technique used to generate ideas. Brainstorming encourages people to think in a free and open way with no restrictions. As a result, they often generate more possibilities than they would using a structured approach. In brainstorming:

- All ideas are welcome; there are no bad ideas in brainstorming.
- More ideas are better — you are looking for quantity; out-of-the-box ideas are welcome.
- As ideas are shared, people can build on each other's ideas.

For the brainstorming session, notes should be made visible to the group by displaying them using flip charts, a whiteboard or a computer that you can project onto a screen. The purpose of brainstorming is to solve a specific problem, so it is important to state the problem clearly. A good method is to write the problem at the top of the board. Explain the brainstorming rules.

Brainstorming can be done alone or in a group. Individual brainstorming is most effective when you need to solve a simple problem, generate a list of ideas, or focus on a broad issue. The participants individually write down their ideas to be displayed afterward, e.g., on sticky notes that are put on the flipchart. This helps eliminate anchoring bias (the tendency to rely on an initial piece of information) and encourages everyone in the team to share their own ideas.

Group brainstorming is often more effective for solving complex problems. Assign a person to take notes. The note-taker should write down whatever ideas are thrown out without comment or criticism. When

one member gets stuck on an idea, another member's creativity and experience can take the idea to the next level. The ideas can be developed in greater depth than they may with individual brainstorming. Another advantage of group brainstorming is that it helps everyone feel that they have contributed to the solution.

A good brainstorming session does not last forever. Depending on the problem, ten or even five minutes may provide adequate time. Once the brainstorming session is complete, the group can discuss the list of ideas; the facilitator can help participants to group or synthesize similar ideas to avoid repetition and to pick out the most promising ones and evaluate them. This gives them an opportunity to further explore solutions using conventional approaches.

Socio-drama

Socio-drama is a teaching strategy which combines a case study approach with traditional role-playing methodology to illustrate critical problems with various issues. Socio-dramas are dramatizations which enable participants to have roles that exist in real life. Socio-dramas may be applied, for example, to collective trauma, current events, social problems and prejudices⁶.

Socio-drama is based on the work of Jacob Levy Moreno (1889-1974). Moreno defined socio-drama as a deep-action method dealing with group relations. The group and individuals within it are moved toward a productive response to a new situation or a new response to an old situation. Through exploring the roles of people in the situations, the facilitator helps the group to identify where new responses may be possible and to practice the necessary skills to achieve a desired change⁷.

Socio-drama has two components: the theme and the creation of roles. For the purposes of this manual, the themes focus on critical problems in the social and health care arena. Themes can originate from the facilitator or the group members. The value of role playing in a socio-drama is learning by doing.

A socio-drama session involves four phases⁸:

- **First:** in the beginning of the session, the participants can explore the theme of the training on a deeper level, decide the critical issue of the theme and choose the roles they want to alter or change.
- **Second:** the action
- **Third:** the actors share their experiences, thoughts, feelings, questions and ideas both in character and as participants, and the audience members share their own
- **Fourth:** general discussion with the audience.

Role play

There is some overlap of methods between role playing and socio-drama. Although role playing is a simpler form of activity than socio-drama, it is an essential element of socio-drama. Of these techniques, role playing is the simplest to employ. Compared with socio-drama, role playing requires less preparation by the teacher and demands less instruction for the participants. Role playing and socio-drama are the methods that are probably most useful in training.⁹

Role playing simply refers to any activity that involves taking on a role and enacting behaviors related to that role. It is the practice or experience of 'being someone else'. It may be employed to enable a person to attempt to understand the situation of another person, or a participant may take on a fictitious role in which they seek to acquire deeper understanding about relationships or actions.

Role playing is an active learning method in which participants act out situations under the guidance of a trainer. It is a suitable tool for training because it can be easily utilized to illuminate themes across the curriculum. Role playing is the basis of all dramatic activity. It is a method that allows participants to explore realistic situations by interacting with other participants in a supported environment. De-

pending on the goals of the activity, participants may be playing a role like their own (or their likely role in the future) or could play the opposite side of a conversation or interaction. Both options provide the possibility for significant learning and to develop understanding about situations from other perspectives.

Role-playing exercises can be used to develop skills that are important inside the profession and to make the information learned useful in the real world. Many of these are very difficult to teach using more traditional methods, such as lecturing, teamwork or problem solving. There are many ways to use role playing as a training method. The participants may be given specific instructions on how to act or what to say, for example, as an aggressive client or patient in denial, or they may be required to act and react in their own way, depending on the requirements of the exercise. The participants will then act out the scenario, and afterwards, there will be reflection and discussion about the interactions, such as alternative ways of dealing with the situation. The scenario can then be acted out again with changes based on the outcome of the reflection and discussion.¹⁰

The ability to step into another character's shoes is not easy for everyone, nor is speaking in public. People may be embarrassed to speak or act in front of a group. For some, it is difficult to say things in their own words, and therefore they often prefer to memorize the words of someone else. Encourage participants to use their own words in role plays rather than simply parroting lines they have memorized. But go slowly. Help people gain confidence little by little. Start with role playing in the classroom or with a small group in which everyone takes part. This way, there is no audience. Or rather, all are actors and audience at the same time.

Role playing can also be a demanding task in training; therefore, it is best to take it one step at a time¹¹:

- Define objectives:
 - Which topics do you want the exercise to cover?
 - How much time do you have for the exercise?
 - What do you expect your audience to learn?
 - Do you want the students to role play separately or together?
 - Do you want to include a challenge or conflict element?
- Choose context and roles:
 - Decide on a problem related to the chosen topic(s) and decide on the characters. It is a good idea to make the setting realistic.
- Introduce the exercise:
 - Engage the participants in the scenario by describing the setting and the problem.
 - Provide them with the information you have already prepared about their character(s): their goals and background information.
- Preparation of the actors:
 - Why they are doing this in character?
 - Why did you decide to make this a role-playing exercise?
 - Actors need a few moments to look over their characters and get into their roles for the exercise.
 - If the participants have reservations about their characters, it is good to find this out before the actual role play — providing a safe environment is very important.
- The role play:
 - The actors need to sympathize with their characters and feel comfortable playing the roles.
 - For interaction, props can liven up the event, but they are not worth a lot of effort as they are usually not important to the educational goals.
 - The trainer may cut at a point where enough action has already occurred to provide a basis for discussion.

- Concluding discussion:
 - It is important that the actors can share their experiences and the audience (observers) can provide their feedback.
 - Trainers should summarize what the actors and the audience have learned.

Timeline method

Timelines are graphical representations of a time period on which important moments or events are marked alongside the dates when these events happened. They can be vertical or comparative, and they can include images, graphics, pictures and descriptions. Timelines can be drawn by hand or using a template. Timelines can be used not only in training about historical events but also when explaining a work process or to show the progression of a product or service. They can also be used for eLearning courses in order to create visually rich and highly informative experiences.

There are many possibilities to use timelines for:

- Highlighting personal details such as births, deaths, and other important dates
- Examining important events that impacted the topic of the timeline
- Pulling different dates and events together into a cohesive story that is interesting to read¹²

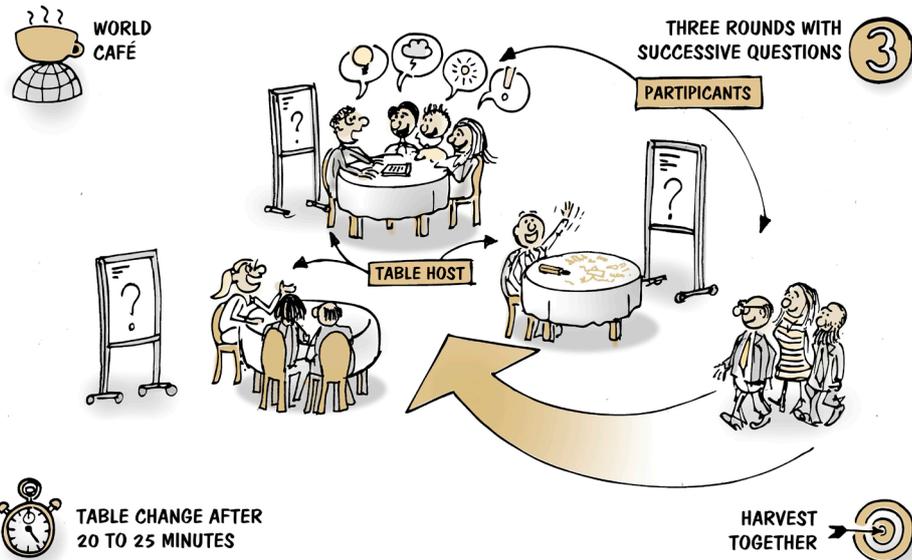
Continuum method

A continuum is a visual image of beliefs and facts. In practice, it is a set of things on a scale that demonstrates how they possess a particular characteristic to different degrees. It is a useful strategy in any context in which participants explore statements that can be based on beliefs and knowledge. The continuum method can be carried out as a paper exercise or as a physical activity in which people are asked to place themselves along a line in the classroom—the latter can be particularly helpful during the feedback stage. The aim is to encourage discussion of the statements and to support participants in gaining more awareness of the issues in the training. It helps participants to identify and clarify attitudes about the issues discussed in the training. The activity is especially helpful when participants have difficulty identifying the differences between opinions/beliefs and facts. There are many variations on continuum exercises.¹³

World Café Method

The World Café is a structured method to facilitate several rounds of small-group conversation. The emphasis is on creating a safe and welcoming environment for discussion. The World Café method is useful when a facilitator wants to explore a topic from multiple diverse perspectives and to ensure that everyone in a room contributes to the conversation. Participants should be familiar with the topic. The method is suitable for a large group (more than 15–20 people). Each table can discuss a different question, or multiple tables can discuss the same question. Each round of small group conversation on a new topic can be 10–15 minutes. A World Café session can last from 90 minutes to 2.5 hours, depending on the number of rounds of conversation desired.¹⁴

In a World Café, each table has a ‘host’ who remains at their table through the entire exercise. The host’s role is to welcome participants to the table, provide an overview of the discussion question, and summarize key ideas shared by previous guests at the table. At the end of the exercise, the host is responsible for sharing a summary of the discussion points from his or her table. (See the graphic on the next page).



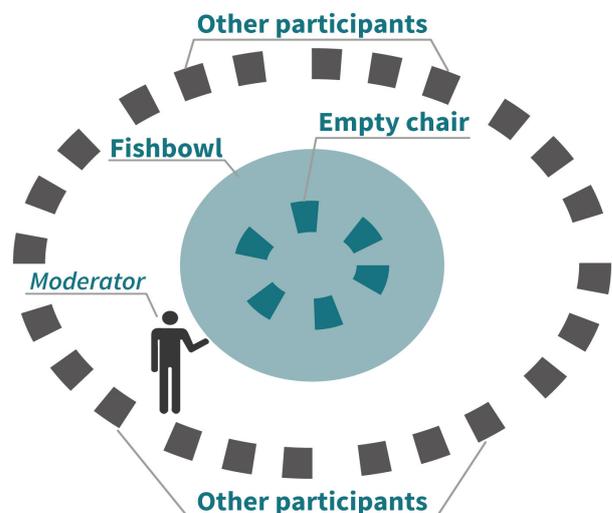
Fishbowl Method¹⁵

The fishbowl is a creative and dynamic method to organize presentations or group discussions. It involves a small group of people seated in a circle and having a conversation in full view of a larger group of listeners. This is done by arranging the room so that 2-4 participants are seated in the center of the room (= the fishbowl) with other participants sitting around them in a circle observing their conversation 'in the fishbowl' (see the graph below). This can be a closed discussion within the specific group 'in the fishbowl', or it can be an open discussion, meaning that one or more chairs are open to members of the audience to enter the fishbowl and participate in the discussion. These members can ask questions, make comments or contribute to the discussion. There are many variations on the fishbowl method; for example, PowerPoint presentations can be replaced by this method. In that case, participants in the inner circle are the presenters who introduce the content of the PowerPoint presentation. It also can be used as a way to interview a presenter.

Multiple Fishbowls: If the size of the training group is large, for example 20-30 participants, multiple fishbowls can occur simultaneously. Upon completion of the discussions, take one or two representatives from each fishbowl to present its perspectives in a new, central fishbowl. After this round of discussion, allow feedback from the observers or let the representatives return to their respective fishbowls for further discussion.

A Closed Fishbowl works best with smaller groups. The participants are divided into small groups of equal size. Half of a small group becomes the fishbowl, and the other half becomes the outer circle (observers). Each participant will have a chance to be both an inner and outer group member. Participants in the fishbowl are given a certain amount of time (e.g. five minutes) for discussion. Then the groups swap roles: the entire inner circle moves back to take the place of the observers, while the former observers move into the fishbowl to begin their discussion.

One of the observers takes notes in each round and presents the results for the whole group. During reporting, the rapporteur writes the key results of each topic on a flipchart.



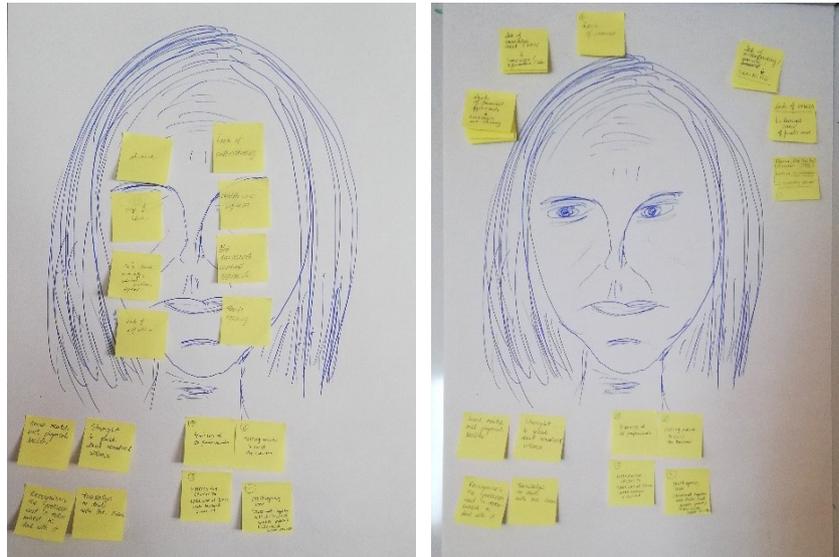
Fishbowl method

Brick wall¹⁶

In this exercise, it is necessary to have a poster of an older woman's face. It would be useful to laminate the poster so it can be used multiple times. Sticky notes can be used to represent bricks, which symbolize building services or barriers to services. It is also possible to use slips of paper that have been drawn on to look like actual bricks. Using paper that looks like bricks may take more time to produce but gives a more accurate visualization for the audience.

The poster of the face of the older woman needs to be attached to a wall where there is enough space for participants to come up and place their sticky notes. Instruct participants to write one strength, one barrier and one challenge per sticky note/brick and use as many bricks as they wish.

The bricks representing barriers will be put on the woman so that they cover the older woman's face. Peeling the sticky notes/bricks away will slowly make the older woman visible. The notes listing strengths will be placed below the woman's face so that the strengths are an image of a strong base to build upon. Challenges/opportunities will be placed above the woman's face. If you want to keep the exercise short, you can limit the number of 'bricks' the participants fill out.



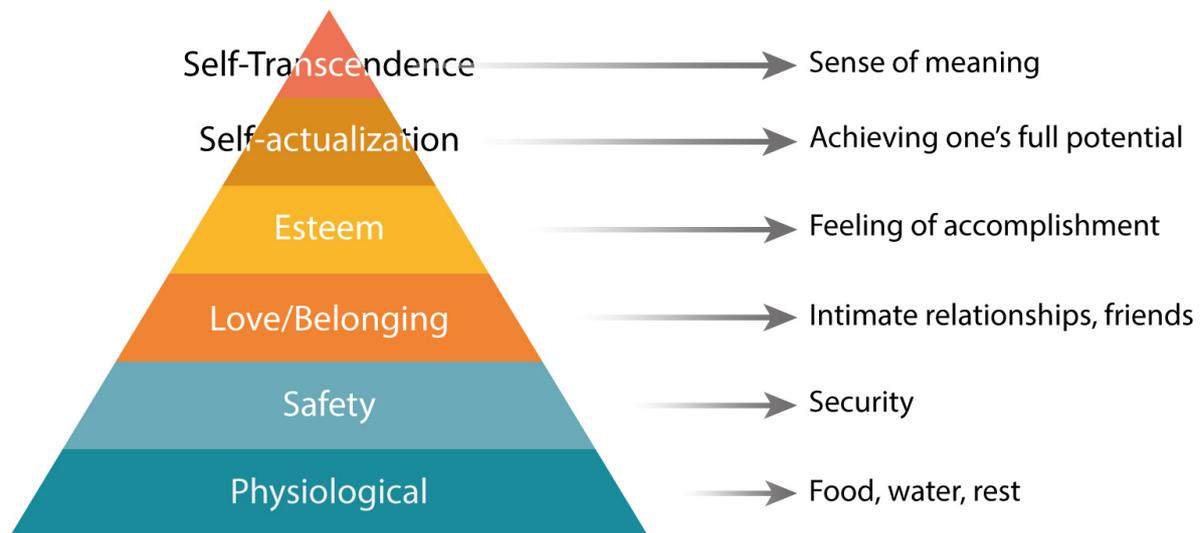
Remind the audience that the image of an older victim before them is only an example. Victims can come from a variety of racial, ethnic, religious and economic backgrounds. For example, some may be gay, lesbian, bisexual and transgender. Their abusers may be younger or older.

Using Maslow's hierarchy of human needs

Formulated by Abraham Maslow in 1943, the hierarchy of human needs outlines five basic categories of preconditions for human wellbeing: physiological (survival) needs, safety, love and belonging, esteem and self-actualization. According to the initial idea of Maslow's hierarchy of needs, physiological needs, which are universal and essential for survival, must be met first before a human being can move on to fulfil other levels in the hierarchy. Current scholars see these categories as overlapping rather than existing in a hierarchy, but this model remains useful to understand how different types of needs must be satisfied for a human being to be able to live a fulfilling life.¹⁷

Initially, the goal in Maslow's theory was for people to attain the fifth level in the hierarchy: self-actualization. According to Maslow, self-actualization is a state in which the individual becomes a mature and fully human person in whom the human potentialities have been realized and actualized. By potentialities, he meant that the individual would become autonomous, realistic, patient, compassionate, wise and courageous.¹⁸

Maslow already recognized at this early stage that his list was incomplete. Maslow explored further dimensions of the needs and argued that a human being finds the fullest realization in giving oneself to something beyond oneself—for example, in altruism or spirituality. He called this concept 'transcendence'.¹⁹ Transcendence refers to the purpose or meaning of life. This may involve service to others, devotion to an ideal (e.g., truth or art) or a cause (e.g., social justice, environmentalism, the pursuit of science, a religious faith), and/or a desire to be united with what is perceived as transcendent or divine. This may involve mystical experiences and certain experiences with nature, aesthetic experiences, sexual experiences, and/or other transpersonal experiences in which the individual gains a sense of identity which transcends or extends beyond the personal self.



Physiological (survival) needs: Air, water, food, shelter, sleep, clothing; the necessities of life

Safety needs: Personal, emotional and financial security, health and well-being

Love and belonging needs: Friendship, intimacy, family, sense of connection

Esteem needs: Respect, self-esteem, status, recognition, strength, freedom

Self-actualization: Desire to realize one's own potential, self-fulfillment

Transcendence: Altruism, spirituality, helping others to self-actualize

Applying Abraham Maslow's theory of a pyramid-shaped hierarchy to education is an ideal way to assess lesson plans, courses and educational programs. The idea of using the hierarchy of human needs in a training session is to start from the bottom of the pyramid and climb each level like the rungs of a ladder, considering the participants' needs on each level before progressing to the next level.

Step 1: Start with participants' physiological needs — food, clothing, shelter etc.

Step 2: Assess personal safety issues that participants may experience. To apply this step of the hierarchy, it is essential to create a safe learning space.

Step 3: Encourage belonging within the training group. Participants need to feel that they belong and that they are accepted members of the group.

Step 4: Promote self-esteem. Having participants feel that they are contributing and that they are valued as individuals can be done with the simple praise: "Well done!" or thanking them for ideas they are offering.

Step 5: Aim for self-actualization by discussing what it means to the participants to "be all that you can be".

Step 6: Generate discussion among the participants about their interpretation of "giving oneself to something beyond oneself"— for example, in altruism or spirituality.²⁰

PART 1: THEORETICAL BACKGROUND

Aims of the material

This material has been developed so that health and social care professionals, volunteers and older persons:

- understand what violence against older people is and the significance of gender in the phenomenon
- can name the forms of elder abuse and neglect
- can recognize characteristics and risk factors of elder abuse, particularly for older women
- understand the consequences of violence and its health effects on older people
- understand the meaning of protective factors from abuse
- understand the relationship between, and importance of, human rights and the care of older people

Contents of the programme

This part is divided into five chapters followed by exercises:

Chapter 1 – What is violence against older persons? Introduces definitions and concepts related to elder abuse and violence against older women and presents statistics about the prevalence of elder abuse, globally and within the TISOVA partner countries.

Chapter 2 – Forms and signs of violence against older persons: explores multiple forms of violence that older people can experience, including various forms of institutional abuse, and breaks down signs and indicators of elder abuse.

Chapter 3 – Characteristics and risk factors of elder abuse: explores the various situations in which abuse in later life can be identified (particularly older women's special situation as victims of violence) and the risk factors associated with such abuse at the individual, relationship, community and socio-cultural levels. Protective factors are also briefly described.

Chapter 4 – Consequences of violence: describes the societal, physical, cognitive and emotional consequences associated with elder abuse, including post-traumatic stress disorder.

Chapter 5 – What are human and civil rights?: briefly introduces the historical growth of the human rights concept, including explaining key tools such as the Universal Declaration of Human Rights and how the United Nations Principles for Older Persons and the Charter of Fundamental Rights of the European Union relate to the care of older people experiencing abuse.

Chapter 6 – EU and national legislation pertaining to elder abuse: identifies international tools and national legislation currently in place which protect older people from violence and abuse at various levels.

Training Exercises

Chapter 1: What is violence against older persons?

Defining Old Age

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes 'old'. Most developed countries in the world have accepted the chronological age of 65 years as the point when one becomes an older person. This is the age at which one can often begin to receive pension benefits. In developed countries, chronological age plays a central role; however, it is not equivalent to, for example, biological age. The United Nations (UN) generally uses 60+ years to refer to the older population; however, it does not use a standard numerical criterion.²¹

According to the 2012 Special Eurobarometer, in the 27 EU member states, the average age at which someone reaches 'old age' is 63.9 years. Opinions on the precise age at which one becomes an older person vary widely between different countries, with a difference of more than a decade between the 'oldest' and the 'youngest' older person. While respondents in the Netherlands, on average, thought that old age began at the age of 70.4, respondents from Slovakia answered that people became old at the age of 57.7.²²

There is no general agreement on the age at which person becomes 'old'.

There are many dimensions of old age. **Chronological age** is defined as the number of years since someone was born. **Biological age** refers to physical changes which 'slow us down' as we enter middle and old age. **Psychological age** refers to psychological changes, including those related to mental functioning and personality, which occur as we age. **Social aging** refers to changes in a person's roles and relationships, both within their circles of relatives and friends and within formal organizations such as the workplace.²³

Elder abuse

The concept of 'elder abuse' was first described in scientific journals in the United Kingdom (UK) in the 1970s and was referred to as 'granny battering'. In 1975, G.R. Burston expressed concern that not just babies and children, but also older people experienced battering: "Perhaps general practitioners in particular, and casualty officers especially, should become as conscious of granny battering as they are now aware of baby-battering."²⁴

Today, perhaps the most commonly used definition of elder abuse is from Action on Elder Abuse (1995)²⁵:

"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."

The Irish Working Group on Elder Abuse (2002) underlines the importance of elder abuse as an umbrella concept for the wide range of harm inflicted on older people. The working group further developed the above definition of elder abuse as follows²⁶:

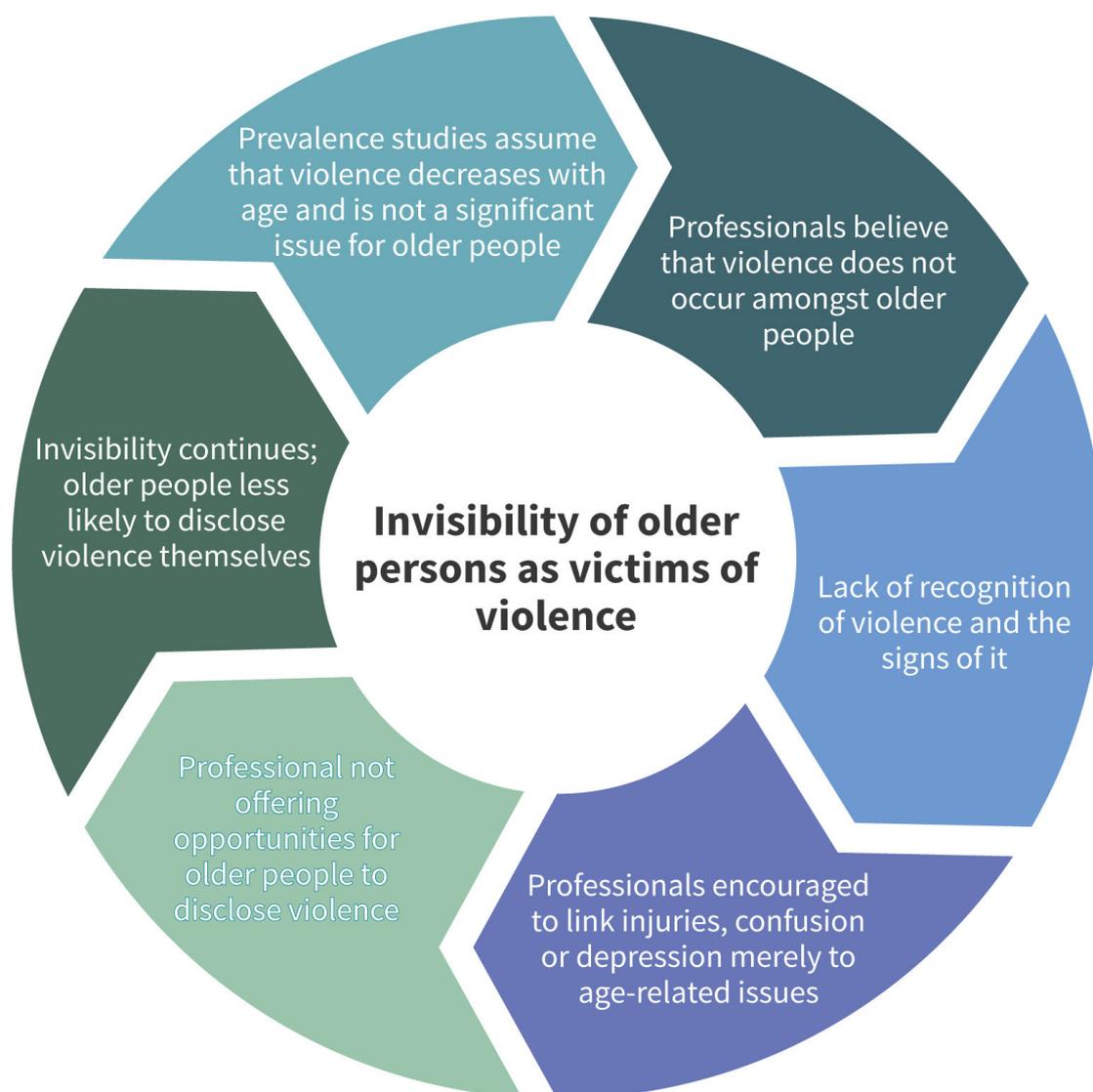
"A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights."

It has been debated whether the expression "relationship where there is an expectation of trust" should be a defining factor in the phenomenon. In some countries, for example in Italy, it is argued that in determining elder abuse, a relationship of trust is not always necessary. Abuse often occurs without any expectation of trust and in complete absence of a relationship between the offender and the victim, for example in cases of fraud and bag-snatching.²⁷ However, **for the purposes of this manual, the focus will be on situations in which there is a relationship (i.e. family) and/or an expectation of trust (i.e. senior care facilities).**

This manual uses the term 'violence against older persons' when describing the phenomenon in general. Sometimes the term 'elder abuse' is used; however, this term may imply ageism, which might lead to

viewing abuse of older people as a less serious form of violence in comparison to violence against other age groups. What should be underscored, therefore, is that **violence against older persons is part of a larger problem of violence against people of all ages**. Violence can occur at any time during a person's life – it is not a problem only for younger people.

As noted in this manual, signs of various disabilities and a need for assistance in daily activities put older people of both genders at risk of abuse. Therefore, **both older men and women can become victims of violence**. However, most victims are women, and they face certain specific challenges when dealing with the consequences of violence.²⁸ Following figure depicts the cycle of invisibility that influences the poor addressing of elder abuse.²⁹



Violence against older women

This curriculum highlights the gendered nature of elder abuse/violence against older persons. While men can experience violence, **women are more likely to become its victims, and most perpetrators are men, which applies to the older population as well**. Power and control play a central role in violence against women, and in older women's cases, this role can be even more decisive, with power and control taking diverse forms. Overall, inequality experienced by women intensifies with age, and discrimination on the basis of age and gender can result in situations in which women experience neglect and other forms of violence.³⁰

The phenomenon of violence against older women is rooted in the same gender inequalities and norms as violence against women generally. **Older women face a greater risk of physical and psychological**

abuse than older men due to discriminatory societal attitudes and a lack of protection for the human rights of women.³¹

The Violence Against Women and Girls (VAWG) Resource Guide adapts the World Health Organization (WHO) (2014³²; 2015³³) definition of violence against women to apply specifically to older women as follows:

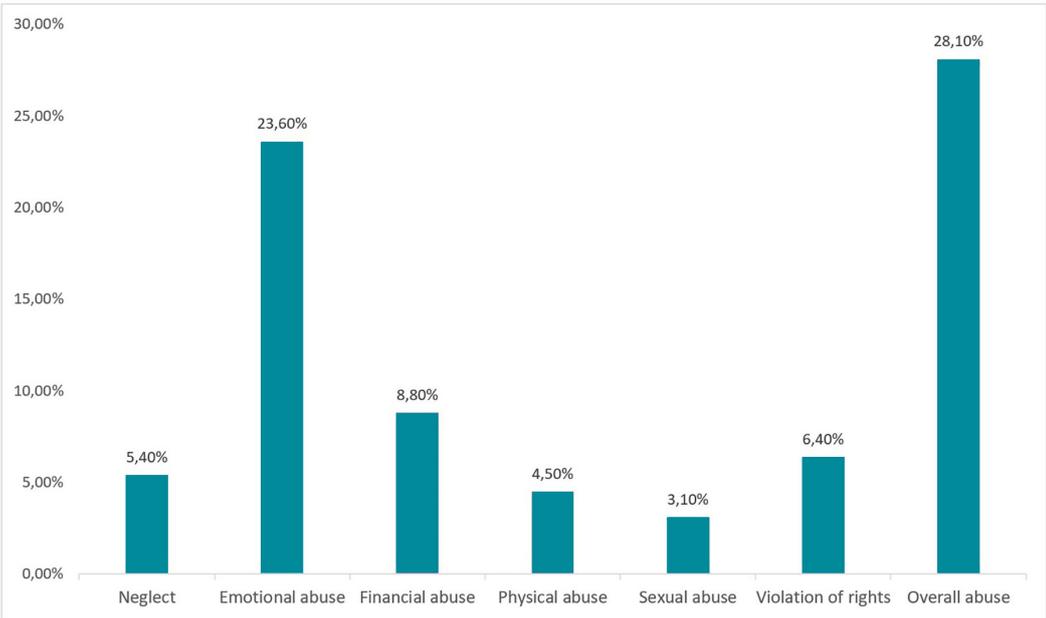
In line with the WHO, we define “violence against older women” as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering” to women aged 50 and older “including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.” This can also include financial abuse, exploitation or deprivation of resources, neglect, and abandonment.

Age is not the sole defining factor that causes abusive behavior to be labelled as elder abuse. An older woman may experience abuse by the same partner throughout her life. Younger and older victims of violence share the same **characteristics and consequences**, such as **fear of retaliation and stigmatization, desire not to leave home and to protect the abuser, emotional distress** and, in cases involving persons with decreased capacity, **difficulties in reporting the abuse**. However, despite similarities between types of abuse experienced at different stages of the life-course, there are profound differences in terms of what kinds of interventions are appropriate and what types of services are available for victims of different ages. Women’s shelters, for example, are generally designed, and staff are trained for, the needs of younger victims.³⁴

1.1 Prevalence of violence against older persons

It is hard to estimate the prevalence of elder abuse because it is **often underreported**. Furthermore, the results of prevalence studies depend on definitions, surveys and sample methods. Existing studies on violence against older persons estimate its prevalence to range globally between 1% and 35%. According to WHO, around 1 in 6 people who are 60 years and older have experienced some form of abuse in community settings during the past year. **An increase in elder abuse is expected, as many countries have rapidly ageing populations**. However, WHO assumes that these figures may reflect only a small number of the actual cases, and some experts believe elder abuse is underreported by as much as 80%.³⁵

The DAPHNE III AVOW Project provided the following prevalence rates for violence against older women aged 60 years and above in the participating countries (Austria, Belgium, Finland, Lithuania and Portugal).³⁶



According to the 2014 EU Fundamental Rights Agency (FRA) survey, the first survey of its kind on violence against women across the 28 EU member states, 2% of interviewed women aged 60-74 years had experienced physical violence by a partner in the 12 months prior to the interview.³⁷ In terms of the prevalence of violence against older people in the TISOVA partner countries, studies have found the following results in Finland, Estonia and Greece:

In Finland, figures vary depending on the studies reviewed. Kivelä et al. (1992)³⁸ reported that 9% of women and 3% of men between the ages of 60 and 75 experienced abuse, rising to 8.3% for women and 7.7% for men in those over 75 years of age in two Finnish municipalities.³⁹ Research by the AVOW project found that 25% of Finnish women over the age of 60 living at home had experienced violence or abuse during the previous 12 months.⁴⁰ Population-based surveys in Finland and in the Nordic countries show that between 4% and 6% of older people experience some form of abuse in home settings and that abuse and neglect in institutions may be more extensive than generally believed.⁴¹

In Estonia, according to the annual report on crime in 2018, there were 3,607 registered cases classified as domestic violence, an increase of 37% compared to 2017. A study on crime in Estonia stated that there was no increase in reporting, but there was an increase in registered cases. Slightly more than one in ten crimes recorded by police are domestic abuse cases, totaling 13% of total crime. Domestic violence constitutes 44% of violent crime. Of domestic violence cases, 83% were classified as cases of physical abuse,⁴² but some types of violence commonly experienced by older people may not be prosecuted as domestic violence, making it more difficult to account for them. Perpetrators were usually partners or ex-partners (69% out of all domestic violence cases), but they also included children or stepchildren (6%).

In Greece, there are no official data regarding older victims of domestic violence and elder abuse. According to the findings of the ABUEL study,⁴³ published in 2010, the prevalence of abuse in Greece in the previous 12 months was reported as follows: psychological abuse at 13.2%, physical abuse at 3.4%, sexual abuse at 1.5%, financial abuse at 4% and injuries at 1.1%. The same study states that in Greece, women reported higher figures in all types of abuse and injuries than men.



Chapter 2: Forms and signs of violence against older persons

Violence against older people can be divided into the following categories:

Physical abuse — infliction of pain or injuries on an older person, use of physical coercion and physical or drug-induced restraint

Psychological or emotional abuse — infliction of mental anguish on an older person

Financial or material abuse — illegal or improper exploitation or use of funds and/or resources belonging to an older person

Sexual abuse — non-consensual sexual contact of any kind with an older person

Neglect — failure by a caregiver or other responsible person to protect an elder from harm, or failure to meet an elder's needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and safety.

Institutional abuse — repeated or regular abuse performed in any institutional environment where service users are engaged with professionals (outside their own home).

In this chapter, different forms of violence against older people are described. Each of the following subsections is dedicated to one form of abuse and deals with its signs and consequences as well as strategies for preventing it. It should be noted that **some signs can actually point to different forms of abuse that an older person is suffering from**, and that **signs of violence can also be consequences of violence**. In addition, prevention strategies that different forms of violence require overlap, and older people might need several different types of support when they find themselves in an abusive situation.

While each type of abuse has signs that are detailed in each section below, **general red flags** that health and social care professionals should look out for when meeting older persons, particularly those with disabilities, include⁴⁴:

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

2.1 Physical violence

Physical violence can be defined as the use of physical force against an older person which can cause bodily harm, permanent impairment, or physical pain. This may include, for example, striking an older person with a hand or an object.⁴⁵

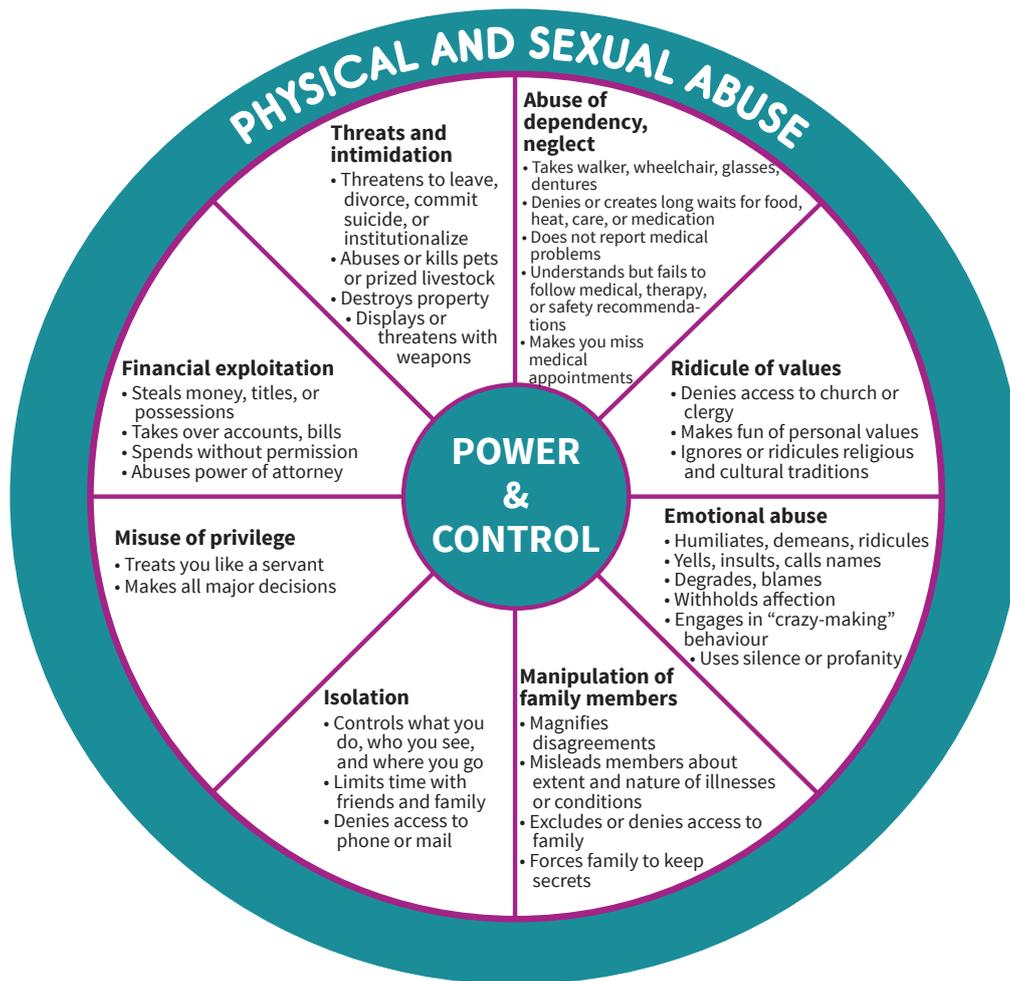
Physical violence can include:

Scratching, biting, slapping	Pushing, kicking
Burning	Choking or strangling
Throwing things at a person	Force-feeding or denying food
Using weapons or other objects to inflict pain	Physically restraining a person

In the Prevalence Study of Abuse and Violence against Older Women, which was conducted in 5 EU countries,⁴⁶ physical abuse was measured using four indicators: a) someone had restrained a woman in any way; b) someone had hit a woman or otherwise attacked her; c) someone had thrown a hard object at a woman or used a weapon against her; d) someone had given a woman too much medicine in order to control her or make her docile. According to this study, 2.5% of 2,880 respondents had been victims of at least one form of physical abuse. 50.7% of perpetrators were partners or spouses, and 16.4% were daughters or sons (including by marriage).

Domestic Violence in Later Life

As described by older battered women in support groups



SOURCE: Wisconsin Coalition Against Domestic Violence, Madison, Wisc. (608-255-0539)

Based on the Power and Control/Equality wheels developed by the Domestic Violence Intervention Project, Duluth, Minn.

Signs of physical violence include:

- Carer/relative is overly protective or controlling, tells conflicting stories, shows delay in seeking care or reporting an injury, does not leave the older person unattended; older person described as 'accident prone' or having a history of sustaining injuries
- Injuries in different stages of healing: broken bones, sprains, or dislocations, abrasions, welts, rashes, blisters, burns, lacerations, swelling; signs of being restrained, weight loss, hair loss, poor hygiene
- Lack of awareness, drowsiness, vagueness, confusion, sleepiness
- Cringing or acting fearful, agitation, catatonia, frequent requests for care or treatment for minor conditions, unexplained anger, fear or shutting down behavior around the carer or relative.
- Over-sedation, reduced physical or mental activity, grogginess or confusion
- Reduced or absent therapeutic response to prescribed treatment may be the result of under-medication or failure to fill prescriptions
- Pills scattered about may be signs of inappropriate use of drugs and/or alcohol
- Medical reports of drug overdose, prescription medication missing or not taken, poor management of medical conditions, repeated accident or emergency department presentation, frequent falls.

Consequences of physical violence include:

Bruises, wounds, abrasions, contusions, hematomas	Dental problems
Decreased hearing or deafness	(Permanent) disabilities
Increased risk of premature death	Physical pain and soreness
Decreased sight or blindness	Brain injuries

2.2 Psychological violence

This form of violence is **also called emotional violence**. Psychological violence consists of **systematic, non-physical actions which are intended to inflict mental pain, anguish and suffering** on an older person. While psychological violence is believed to be the most common form of violence, it is the most difficult form to identify since **it might not leave any physical signs**. Psychological violence can lead to mental distress, humiliation and fear. According to the FRA survey, 37% of women aged 60-74 years have experienced some form of psychological violence by a partner since the age of 15.

Forms of psychological violence include:

- Emotional manipulation or other cruel behavior
- Denying access to services, religious and/or cultural events
- Forcing a person to participate in and follow religious rules and customs against their will
- Non-verbal communication hints, such as facial expressions and body gestures, meant to intimidate, degrade, manipulate or insult
- Verbal intimidation, shouting
- Insults, scolding
- Humiliation, threats, denigration
- Controlling behavior
- Abandonment
- Harassment, stalking

The 2014 FRA survey took into account 17 forms of psychological partner violence and grouped them into four categories, three of which are relevant for older women⁴⁷.

Controlling behavior, such as trying to keep a woman from seeing friends or visiting her family or relatives, insisting on knowing where she is and whom she has spoken to

Economic violence, such as preventing a woman from making decisions about family finances or shopping independently, or forbidding her to work outside the home

Abusive behavior, such as belittling or humiliating a woman in public or in private, making a woman watch pornographic material against her will, threatening a woman with violence or threatening to hurt someone else a woman cares about

Power and control dynamics play a key role in how older women experience psychological violence, and perpetrators often take advantage of older persons' vulnerability. Threatening an older person with physical punishment or depriving them of satisfaction of their basic needs may include denying or delaying provision of food, medication or basic care. Preventing an older person from decision-making, falsely accusing them of misdeeds and controlling their freedom can result in isolation and emotional pain. Psychological violence can worsen depression, which an older person may already be suffering from, and it may aggravate other mental health issues. As a result, psychological violence may have more lasting effects than physical violence^{48, 49, 50}.

Perpetrators strive for power and control.

According to the Prevalence Study of Abuse and Violence against Older Women, emotional abuse was the most common form of violence experienced by older women in all participating countries. Nearly a quarter of older women surveyed in 5 countries (23.8%) reported at least one incident of emotional

abuse in the 12 months prior to the survey. The most common forms of psychological abuse reported were shouting or yelling at older women (14.1%), undermining what they did (14%) and doing something to spite them (14%). The most common perpetrators of emotional abuse against older women in all countries were current partners or spouses, children, or other family members.

Signs of psychological violence include:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Feelings of helplessness, shame, powerlessness • Loss of interest in self or environment • Lack of eye contact with a practitioner, carer or another person • Nervousness or other changes in behavior around a carer or another person • Paranoid behavior or confusion not associated with illness • Display of signs of trauma, e.g. rocking back and forth | <ul style="list-style-type: none"> • Depression, sadness, tearfulness • Changes in self-esteem, lack of confidence • Unusual passivity or anger • Agitation, disorientation • Isolation • Withdrawal, apathy • Fearfulness • Reluctance to talk openly • Insomnia/sleep deprivation |
|---|--|

Behaviors may fluctuate and may show improvement temporarily around some people, reverting when the abuser returns.

Psychological violence can lead to:

Long-term trauma symptoms	Depression and anxiety
Post-Traumatic Stress Disorder (PTSD)	Dementia
Increased mortality and suicide risk	Substance abuse

2.3 Financial violence

The most cited definition of financial abuse comes from WHO (2008): “*the illegal or improper exploitation or use of funds or other resources of the older person.*”⁵¹

Forms of financial violence include:

- | |
|---|
| <ul style="list-style-type: none"> • Controlling the use of money and property by an older person • Theft, use of coercion or fraud to (try to) obtain an older person’s money or possessions • Illegal or improper use of an older person’s money, property or assets • Exploitation of and pressure in connection with wills, property or inheritance • Fraud and internet scams |
|---|

Older people, especially those with cognitive impairment, often become victims of financial violence, and social exclusion contributes to this. In particular, older people are very likely to suffer from fraud enabled by new technologies (e.g. internet scams and identity theft). Financial violence against older people can also be accompanied by threats and intimidation. Financial exploitation has a destructive effect on older people’s lives and can result in fear, lack of trust and acute and chronic anxiety.⁵²

Signs of financial violence include:

- Individual expresses concern that they do not have enough money to cover their basic needs
- Individual is confused about funds missing from their accounts
- Confusion regarding assets, property and income
- Individual reports that furniture, jewelry, credit cards, documents or other items are missing
- Numerous unpaid bills or overdue rent that an older person should be able to afford or that someone else is expected to pay
- Lack of amenities, e.g. a TV, or appropriate clothing that an older person should be able to afford
- A recently signed will, or changes in a will, when an older person is incapable of drafting or signing it
- An older person 'voluntarily' giving inappropriate financial reimbursement for needed care and companionship
- Loans or mortgages obtained by an older person
- Being accompanied by another person when attending financial institutions or using ATM, and the other person is reluctant to allow a conversation with the older person regarding transactions

In the Prevalence Study of Abuse and Violence against Older Women, financial abuse was measured using four indicators:

- a) an older woman had been taken advantage of financially;
- b) she had been blackmailed for money or other possessions or property;
- c) she had not been allowed to make decisions about money or to buy things;
- d) her money, a possession or property was stolen.

According to the results, 8.8% of older women in all participating countries had experienced at least one form of financial abuse in the 12 months prior to the survey, and financial abuse was the second most prevalent form of abuse (after emotional mistreatment). 33.7% of perpetrators were partners or spouses, 28.7% were daughters or sons (including by marriage), 18.5% were other family members, 14.4% were other people known closely, 5.1% were neighbors and 9% were paid home help or caregivers⁵². In the FRA survey, financial violence was measured using two indicators: a) having been prevented from making independent decisions about family finances and from shopping; b) having been forbidden to work outside the home. Survey results indicated that 12% of women aged 60-74 years had experienced economic violence by a partner since the age of 15.⁵⁴

Financial violence:

- Worsens a victim's economic well-being and quality of life
- Deprives victims of their savings and assets and thus the foundation for their economic independence
- Creates barriers to leaving an abusive relationship/situation; e.g. lack of access to economic resources can render women financially dependent on abusers, which in turn, leads to increased risk of injuries and homicide
- Creates barriers to leading an independent life even after a woman has left an abusive relationship since she might be in debt or lack resources to rebuild her life

2.4 Sexual violence

Sexual abuse of an older person occurs when a **perpetrator engages in any kind of sexual behavior towards them, including physical contact of a sexual nature, without their consent**. This type of abuse, as part of domestic violence, can be experienced by a woman throughout her whole life, and it includes incestuous acts towards an older person/woman. It should be emphasized that some victims

of sexual abuse are unable to give consent due to a health condition, such as cognitive impairment.

Sexual abuse is the least reported type of violence against older persons for several reasons. On the one hand, older victims may choose to not report cases of sexual violence; for example, stigma and fear may keep them from doing so. On the other hand, some victims may be unable to report such cases due to cognitive impairment. In addition, some older persons might not view certain types of behaviors as sexual abuse or may deny the fact that sexual abuse has occurred.⁵⁵

Older women are as vulnerable to sexual violence as young. Sexual violence against older women is significantly underestimated. Therefore, it has been largely ignored and rarely discussed, with research on sexual violence against older women being relatively scarce. This has resulted in limited understanding of characteristics of this phenomenon and its impacts on victims, as well as a lack of knowledge about how prevalent this issue is. This situation may further reinforce the mistaken belief that only younger women become victims of rape and thus lead to disbelief and/or understatement of sexual violence against older women.⁵⁶

Older victims of rape do not fit society's stereotypes of what a rape victim looks like. Based on **ageist attitudes**, which see ageing as a process of gradual and continuous loss of value, society tends to view older people as asexual.⁵⁷ Older women are believed to not be interested in sex. At the same time, a common **misconception** is that sexual violence against women is based on male sexual desire; older women, however, are not viewed as sexually desirable. Consequently, they are not considered sexual subjects and therefore are not seen as potential or typical victims of sexual abuse and rape.^{58,59}

Contrary to common beliefs, **sexual violence is committed because of power and control issues rather than being motivated by the sexual desires of the perpetrators.** Sex offenders are attracted to vulnerability and use violent sexual acts to establish and/or demonstrate control over vulnerable persons. Perpetrators seek out potential victims whom they perceive as easy to overpower and manipulate and who would be unlikely to report an assault or whose reports would not be deemed credible. Like sexual assaults against younger victims, sexual violence against older people is believed to be motivated by anger and/or desire to control victims.^{60,61}

Older women who are victims of sexual violence may have experienced it for a long period of time, particularly in cases in which an abuser is a spouse or an intimate partner. Therefore, to fully understand the effects of sexual violence on older women, it is important to consider its duration over the course of a woman's life.⁶²

Forms of sexual violence include:

- Unwanted sexual contact, e.g. inappropriate touching, sexualized kissing
- Forcing an older person to watch sexual acts or pornographic material
- Forcing an older person to undress against their will, coerced nudity
- Cleaning or treating older person's genital area roughly or inappropriately
- Sexual assault and battery
- Forcing an older person to perform a sexual act
- Forced intercourse/rape
- Explicitly sexual photography
- Sexual remarks/suggestions

In the Prevalence Study of Abuse and Violence against Older Women, sexual abuse was measured using four categories⁶³:

- a) a woman had been talked to in a sexual way that had made her feel uncomfortable;
- b) she had been forced to watch pornography against her will;
- c) she had been touched in a sexual way against her will;
- d) she had been forced, or someone attempted to force her, into sexual intercourse/relations.

According to the study results, 3.1% of older women had experienced sexual abuse. 55.4% of perpetrators were partners or spouses, and 21.7% of perpetrators were other people closely known by a woman.⁶⁴

The 2014 FRA survey⁶⁵ used four questions to measure sexual violence: a) a woman had been forced into sexual intercourse by being held down or hurt in some way; b) someone had attempted to force a woman into sexual intercourse by holding her down or hurting her in some way; c) a woman had been forced to take part in any form of sexual activity against her will or due to her inability to refuse; d) a woman had consented to sexual activity out of fear of what may have happened if she refused. According to the survey results, 1% of women aged 60-74 years had experienced sexual violence and 3% had experienced physical and/or sexual violence by a partner in the 12 months prior to the survey.

130 cases of suspected sexual abuse of older people were investigated by Massachusetts Elder Protective Services Program caseworkers and/or supervisors, in consultation with Holly Ramsey-Klawnsnik, from 1993 to 2002 in the USA. 77% (N = 100) involved suspected sexual violence within a family; these cases in turn fell into two categories: marital sexual violence and incestuous violence. Ramsey-Klawnsnik found that marital sexual violence presented in three ways: long-term domestic violence, recent violence in a long-term marriage, and sexual victimization in a new marriage. Incestuous violence was committed by adult children and other relatives, including quasi-relatives.⁶⁶

Like other forms of domestic violence, violence against older persons in the family tends to be primarily a problem of male violence directed against female victims. **Common perpetrators are husbands and sons, while typical victims are wives and mothers.** In terms of age, spouses who are perpetrators are usually also elders themselves, and incest offenders are often middle-aged.

An adult child who perpetrates sexual violence against their parent is usually unmarried and has a poor social life, is unemployed or under-employed, lives in the home of an elderly parent and is financially supported by the parent. In addition, adult children who become abusers often suffer from mental illnesses or substance abuse. The older and more ill the parent gets, the more vulnerable they become, which is especially true for older women. Overall, cases of abuse by an adult child are often multifaceted and may include neglect, psychological and physical abuse and financial exploitation, as well as sexual abuse in some cases.⁶⁷

In incestuous sexual violence cases, perpetrators tend to be adult sons, while mothers usually become victims. It is rare for incestuous violence to be perpetrated by adult daughters, although the phenomenon does occur. Female perpetrators typically have serious mental health problems, substance abuse problems or both. Another rarely observed phenomenon is incestuous violence perpetrated by other relatives such as sons-in-law, grandchildren, siblings and nephews.⁶⁸

Sexual violence can have a devastating impact on older women, causing long-term physical suffering, such as incontinence and pain when urinating because of the injuries. Other consequences include weight loss, fear of having contracted a sexually transmitted infection, fear of leaving the house and loss of enjoyment from social activities (such as shopping), as well as fear of men.⁶⁹

Experiences of interpersonal violence can have a greater impact on women's health than general trauma experiences, such as natural disasters like floods, hurricanes or earthquakes. **Out of all traumatic experiences, sexual assault in adulthood is the most stressful one.** Changes in older people's lives that are related to ageing, e.g. retirement, widowhood, chronic illnesses, etc., may influence how older people experience (sexual) violence and cope with its consequences.⁷⁰

Sexual assault in adulthood is the most stressful experience.

The following can be signs of sexual violence:

- Urinary tract infections
- Unexplained venereal disease
- Depression or withdrawal
- Anxiety or excessive fear around a caregiver
- Unexplained incontinence (bladder or bowel)
- Fear of being touched
- Increased sexual or aggressive behavior
- Insomnia
- Increased interest in sexual matters
- Difficulty walking or sitting, or pain when toileting
- Bleeding, bruising, abrasions, infection, tenderness of the ano-genital area, thighs, and breasts

Consequences of sexual violence may include:

- Fear and unwillingness to live at home
- Severe psychological trauma, shame, guilt, self-blame
- Depression, anxiety, nervousness
- Suicidal thoughts, attempted or committed suicide
- Inability to sleep at night (e.g. having nightmares or flashbacks)
- Chronic pain, long-term physical and health problems
- Increased use of alcohol and other substances
- Distrust of others

2.5 Neglect

Neglect can be defined as a **failure by responsible persons to satisfy essential basic needs of an older person**, such as medical attention or necessary medication, food, hydration, hygiene and other basic daily activities, safety, clothing, etc., which results in serious health and safety risks. **Unintentional** neglect occurs when a carer does not have the skills and/or knowledge necessary for taking care of a dependent person who is unable to satisfy their needs on their own. In such cases, carers may not be aware of the types of support that are available to them, or they might be ill themselves and thus unable to provide care to an older person. Neglect is considered **intentional** (sometimes called active neglect) when an older person is intentionally harmed and/or abandoned or when others are not allowed to provide adequate care to an older person.

According to the Prevalence Study of Abuse and Violence against Older Women⁷¹, **different forms of neglect can take place during the following activities:**

- Washing or bathing, incl. getting in or out of the bathtub or shower
- Shopping for groceries, clothes or other things
- Taking care of older person's medication
- Getting to and using the toilet
- Preparing meals or eating
- Doing routine housework
- Travelling/transportation
- Getting in and out of bed
- Dressing or undressing

In the above-mentioned study, rates of neglect were calculated for those women who needed assistance with daily activities but were refused it. 5.4% of older women in 5 countries included in the study had experienced neglect in the 12 months prior to the survey:

- 3% of older women reported that they had been refused help to do routine housework
- 2.7% of older women (22.4% in Portugal and 1.1% in Finland) had been refused assistance with shopping for groceries, clothes or other things
- 2.4% of women had not received help with travel or transportation
- Other forms of neglect occurred very rarely

Neglect can take the following forms:

- Person is abandoned, left unattended for long periods of time or locked in the house alone
- Inadequate or inappropriate use of medication; person is over-sedated in the middle of the day
- Person is not provided with necessary aids, e.g. glasses, hearing or walking aids
- Immobility, person stays in bed almost all the time
- Inadequate food and drink
- Isolation; lack of mental, physical social contacts
- Lack of clean, appropriate clothing
- Restraints; person is tied up to the chair or bed
- Inadequate medical or dental care
- Exposure to unsafe, unhealthy, unsanitary conditions

Neglect can lead to depression and emotional suffering as well as infectious illnesses and premature mortality.

Signs of neglect include:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Pain, discomfort, multiple large bedsores • Unexplained weight loss, malnutrition, dehydration, constipation • Poor hygiene, unkempt appearance; an older person is dirty, smells strongly of urine • Poor or nervous interactions between an older person and caregivers/family | <ul style="list-style-type: none"> • Under- or over-medication • Hypothermia or overheating • Signs of withdrawal, depression, passivity • Absence of required assistive technologies • Lack of concern on the part of caregivers/family or overly attentive behavior in the company of others. |
|---|--|

2.6 Institutional abuse

Recently, a shift has occurred in perspectives on elder care, with more emphasis placed on community care as opposed to care in restrictive institutional settings, which might lead to institutional abuse. Many countries lack national data on the prevalence of abuse in institutional settings; local data from smaller-scale studies is more common.⁷²

There is no standard definition of institutional abuse. However, it has become common “to draw a distinction between individual acts of abuse in institutions and actual institutional or institutionalized abuse.” The term ‘institution’ covers a wide range of health and social care settings, as well as any setting where service users interact with professionals (outside their own home). This includes hospitals, nursing and care homes, day care (including health and social care), respite care (including health and social care), care provided by the voluntary sector and hospice care.⁷³

Abuse in institutional settings can take the following forms:

Restraints	<ul style="list-style-type: none"> • controlling the behavior of older persons, especially in hospitals and nursing facilities • mechanical restraints: e.g. Posey vests, wrist and ankle restraints • forcible confinement • excessive, unwarranted or unnecessary use of physical restraints • forcing a person to remain in bed or tying the person to a bed or chair • chemical restraint: unwarranted use of medication to control a person
Physical violence	<ul style="list-style-type: none"> • rough treatment, immobilization, coercion to do certain things • assault
Psychological abuse	<ul style="list-style-type: none"> • verbal: bossiness, criticism or punishment, use of inappropriate or childish language • ignoring the wishes or will of a resident, isolating them or leaving them alone against their will • belittling and ignoring a resident
Sexual abuse	<ul style="list-style-type: none"> • any kind of sexual contact which the resident does not wish for or which they do not understand and which they are incapable of consenting to
Financial exploitation	<ul style="list-style-type: none"> • misappropriation of the older person’s financial resources, belongings and assets or abusive use of financial control against the older person
Neglect of care and assistance	<ul style="list-style-type: none"> • poor standards of care, rigid routines and inadequate responses to older people’s complex needs
Violation of rights	<ul style="list-style-type: none"> • treatment which shows lack of respect for the dignity of an elderly person

Chapter 3: Characteristics, risks and protective factors of elder abuse

3.1 Victims and perpetrators of elder abuse

There are various scenarios in which abuse in later life may be identified or classified.⁷⁴ Understanding these different situations can be helpful in detecting potential abuse and in responding appropriately. They include:

Domestic violence grown old: situations in which abuse has occurred throughout a relationship or marriage, usually lasting for decades. As the victim and abuser age, physical abuse may decrease, while emotional abuse may increase. Conversely, the physical, sexual or emotional abuse may have increased in recent months or years.

A new life partnership or marriage which begins in later life: abuse may occur while the couple is dating or may begin shortly after the couple has moved in together or gotten married.

Late-onset abuse: Someone who has not been abusive in the past becomes abusive. One explanation for this form of abuse may be physical or mental health issues now manifesting themselves in combative behavior. Receiving a physical and/or mental health exam is an important first step in these cases. Another explanation may be that although physical abuse did not occur in the past, the victim may reveal that controlling behaviors have been present throughout the relationship, and this is truly domestic violence grown old.

Adult child, grandchild, or other family member: Adult children or other family members may become physically, sexually, or emotionally abusive. Financial exploitation is also a common form of abuse.

Abuse from caregivers: Caregivers may take advantage of their positions of power over care receivers to hurt, exploit or neglect them.

While they are similar to their younger counterparts, older women and their abusers have many unique characteristics that make detecting and responding to abuse more difficult. For example, even more so than younger women, **only a small proportion of older victims reach out for help.** One of the main reasons is reluctance to report violence due to **feelings of powerlessness, shame or guilt.**⁷⁵ This is particularly true in cases in which the abuser is an adult child whom the victim may want to protect rather than focusing on their own personal safety. Some older victims have physical or cognitive limitations/disabilities, which abusers may use to manipulate them. On the other hand, cognitive impairments may contribute to sexually inappropriate and/or aggressive behavior in an older person. Changing roles of family members may also have an influence; e.g. 'payback' violence and neglect may occur when an abusive parent becomes physically and psychologically dependent on their spouse or an adult child.

On the other hand, **perpetrators will often strive to exert their power and control over victims** so that they can **coerce or manipulate some benefit for themselves**, such as money, a place to stay, access to prescription medication, or sexual gratification.⁷⁶ Power and control dynamics are, however, not always clearly present. For example, sometimes an older adult is harmed by a well-intentioned caregiver who provides inadequate or inappropriate care. The concept of **'caregiver stress'** has been used to describe the burden family caregivers sometimes experience that **may lead to abuse and neglect.** In many cases, other contributing factors, such as financial difficulties, lack of respite care and lack of recognition for the role of carers, are also present. This additional stress on the carer appears to be a factor which can trigger abuse. Hence, adequate support services for caregivers is one key to preventing elder abuse.

3.2 The ecological model of abuse of older women

Efforts to respond to abuse benefit greatly from consideration of the broader context in which it occurs. In particular, there is a need for broader analysis to acquire a clearer understanding of how the econom-

ic, social and political status of women and the elderly, as well as the cumulative effect of ageism and sexism, contribute to violence against older persons.⁷⁷ **Ecological Systems Theory** has been increasingly applied to the complexity of violence against older persons since it identifies a large number of factors, which can arise at individual, relationship, community and societal levels that lead to violence. **The Ecological Model** was first developed by Urie Bronfenbrenner in 1979 to describe child development and well-being. When applied to violence against older persons, the Ecological Model suggests that violence and neglect occur within five systems or levels, as depicted below.⁷⁸

Individual level refers to the relationship between older persons and their caregivers and close family

Relationship level refers to the relationship between older persons and the wider community

Community level focuses on interactions between, for example, older persons and elder care services in the community and their impact on older people's well-being

Societal level refers to beliefs about and attitudes toward older persons – for example, how valuable they are considered to be in society

Institutional level⁷⁹ focuses on the impact of time on multiple levels and/or contexts of (potential) abuse (e.g. the effect of the length of residence in a nursing home on the likelihood of abuse occurring)

The Ecological Model brings to light the role that prevailing attitudes towards women and older persons can play in abuse situations. Most literature on violence against older persons does not pay attention to the significance of gender. Nowadays, many researchers criticize the use of gender-neutral terms such as 'elder abuse', pointing out the special circumstances and challenges of older women as victims of violence. Feminist research rarely pays attention to older women; the tradition is to concentrate on younger women or younger women with children. Furthermore, a lack of consistent definitions of violence against older women has been one of the problems that explains the lack of visibility of older women in the discourse surrounding the issue of violence and abuse.⁸⁰

Ecological Model helps to understand the complexity of violence against persons and plan appropriate protective measures.

Both women and men experience abuse and/or neglect in later life, particularly when showing signs of disability and becoming dependent on others for help in their daily activities.⁸¹ However, older women face a greater risk of physical and psychological abuse due to discriminatory societal attitudes and lack of recognition of the human rights of women.⁸² Most older victims of sexualized violence are women.

Ageism is central to understanding and confronting violence against older persons. Ageism refers to stigmatizing attitudes and behavior, which belittle and exclude people because of their age, deny their autonomy and dignity and create barriers to exercising their human rights. Ageism tends to be a socially permissive element for violence. Both men and women experience ageism in the form of stereotyping. However, **older women experience not only ageism but also sexism**; a combination of age and gender discrimination puts older women at an increased risk of violence and abuse.⁸³ The term 'double jeopardy' refers to the fact that women endure more disadvantages than men as they age due to the combination of sexism and ageism.⁸⁴

Older persons' own attitudes toward ageing can also have harmful effects on their health. Research suggests that older adults with negative attitudes about ageing may live 7.5 years fewer than those with positive attitudes.⁸⁵ Ageism has been shown to cause cardiovascular stress, lowered levels of self-efficacy and decreased productivity. Negative attitudes are also widely present even within the health and social care settings where older persons are at their most vulnerable.⁸⁶

The inequality and discrimination experienced by women intensifies with old age.⁸⁷ Ageism and sexism create a socially constructed dependency in old age of which the feminization of poverty is a key factor. These influences make discrimination and disadvantages seem inevitable. For older women, invisibility is symbolic of this process.⁸⁸

The Ecological Model is useful for examining violence against older persons because it offers a broader understanding of risk factors, prevention and interventions as **it deals with older victims, perpetrators, and contexts of caregiving as well as the broader societal context**. This theory explores the **interplay between individual and contextual factors and views violence** as a result of multiple influences on behavior.⁸⁹ Some of these are depicted below:

Individual roots of violence focus on individual characteristics which increase the likelihood of being a victim or perpetrator of violence. For example, substance abuse and a history of aggression and violence present risks at the individual level.

Relationship roots of violence emphasize relations with peers, intimate partners and family members and view the quality of the overall relationship as a causal factor. An example is intimate partner violence and violence by a caregiver towards a care recipient.

Community roots of violence focus on local conditions related to domestic violence, for example, social norms within a community about family privacy, norms related to male authority over women, traditional gender norms and social isolation in the community, which are viewed as both a cause and a consequence of abuse.

Societal roots of violence refer to cultural norms present in the larger society which see violence as an acceptable way of resolving conflicts, e.g. norms that support male dominance over women and children.⁹⁰

Institutional roots of violence refer to the way that facilities operate that can lead to abusive situations, such as overworking of staff/caregiver stress, burnout, lack of supervision, etc.

3.3 Risks and protective factors related to abuse

Identification of risk factors and signs of all kinds of abuse at each of the levels described above can play a **key role in (early) intervention and violence prevention**. This can include taking note of specific conditions in the living situation of the individual, physical marks or behavioral signs. They can **best be identified by a combination of (regular) screening as well as routine enquiries made both to the possible victim as well as to family members and caregivers**. Broader societal factors (such as living in a low-income, underserved community, having less access to support services, attitudes towards the elderly and women, etc.) can also reinforce these risk factors. Recognition of these elements is one important protective factor against violence. **A protective factor** is defined as a condition or characteristic that helps people deal more effectively with stressful events and that lessens the risk of vulnerability, such as skills, strengths, resources, support systems and coping strategies.⁹¹ Other examples include **safety planning** and **formal risk assessment**, as described below. **Awareness campaigns** can also contribute to preventing violence against older women, as they can alter their perspectives on the nature of their relationships and can possibly lead them to seek assistance.

Table on the next page gives an overview of the Ecological Model for understanding the risks and protective factors in elder abuse on different levels.

Ecological Model for understanding the risk and protective factors in elder abuse

Risk factors for older women	General risk factors of elder abuse	Added risk factors with dementia	The Protective Factors
<p>Cultural expectations, values and norms that tolerate violence as an acceptable behaviour against older women</p> <p>Cohort effects</p> <p>Period effects</p> <p>Aging effects</p> <p>Sexism</p> <p>“Double jeopardy” (combination of age and gender)</p>	<p>Criminality</p> <p>Poor psychological health, mental health (e.g. symptoms of depression, aggression), anxiety</p> <p>Low standards for health care in institutions, welfare services, and care facilities</p> <p>Health and social care staff poorly trained, remunerated, and overworked</p> <p>Policies in the interests of the institution rather than individuals</p> <p>Ageist stereotypes</p> <p>Erosion of bonds between generations in a family</p> <p>Cultural norms that marginalize elderly and do not venerate older people</p>	<p>Misunderstanding of dementia and its effects</p> <p>Stigmatization of dementia</p>	<p>Promoting positive images of older people</p> <p>A culture of respect that values the wisdom and contributions of older persons</p> <p>Appropriately trained health and social care workers</p>
<p>Social norms put family privacy above victim rights</p> <p>Male authority over women is accepted</p> <p>Inadequate/unavailable community-based services for female victims</p> <p>Systematic invisibility: Older female victims are ignored</p>	<p>Social isolation of older persons and their caregivers</p> <p>Inadequate/unavailable community-based services</p> <p>Lack of social support for caregivers</p> <p>Systematic invisibility: Older victims are ignored</p>	<p>Lack of assistance/services/training provided to people who take care of older persons with dementia</p>	<p>Community-based victim support services</p> <p>Accessible transportation, community facilities and housing</p>
<p>A shared living environment</p> <p>Living in large household</p> <p>Poor or conflictual relationships</p> <p>Victim dependency</p> <p>Long history of poor family relationships</p> <p>Long-standing power and control dynamics; male domination in the family</p>	<p>An abuser's dependency on the older person</p> <p>High levels of financial and/or emotional dependence of a vulnerable older person on their carer or vice versa</p> <p>History of domestic violence</p> <p>Lack of support from other family members</p> <p>Caregiver stress</p>	<p>Inappropriate/inconvenient household living arrangements</p> <p>Poor relationship between an older person and a caregiver prior to the onset of dementia</p> <p>Reciprocity of abuse: secondary symptoms of dementia might make elderly act violently towards their carers</p>	<p>Caring families</p> <p>Victims (and perpetrators) have a variety of healthy relationships with others</p> <p>Informal and formal social networks</p> <p>Respite care and support for family caregivers</p>
<p>Older person/victim</p> <p>Gender of victim (female)</p> <p>Low income/pension</p> <p>Functional dependency/disability</p> <p>Quality of relations</p> <p>Perpetrator of violence</p> <p>Substance abuse</p> <p>History of violence (e.g. witnessing or experiencing violence as a child; having perpetrated domestic violence in the past)</p>	<p>Poor physical/ mental health</p> <p>Low income/pension</p> <p>Past experiences of abuse and related trauma</p> <p>Characteristics of the individual that increase the likelihood of being a victim or a perpetrator of violence</p> <p>Inadequate coping skills</p> <p>Caregiving burden and/or stress</p> <p>Poor/inadequate preparation of a carer</p> <p>Assumption of caregiving responsibilities at an early age</p>	<p>Older person/victim who has dementia</p> <p>Secondary symptoms of dementia: dementia symptoms such as aggression and/or hypersexual behavior (e.g. sex talk or sexual acts)</p> <p>The care recipient's functional capacity, severity and stage of dementia, their physical assault behaviors, depressive symptoms, and their social contacts</p> <p>Perpetrator of violence</p> <p>Stress associated with caregiving duties</p> <p>The caregiver's anxiety, depressive symptoms, social contacts, perceived burden, emotional status, and role limitations due to emotional problems</p>	<p>Good coping skills</p> <p>Help-seeking behavior</p> <p>Personal safety plan in place and shared with trusted family member, neighbor or service provider</p> <p>Education and support that protects from violence</p>
<p>SOCIETAL</p> <p>COMMUNITY</p> <p>RELATIONSHIP</p> <p>INDIVIDUAL (VICTIM AND PERPETRATOR)</p>			

Chapter 4: Consequences of violence

The possible physical and psycho-social consequences of experiencing violence and abuse are numerous and varied. Few studies have extensively examined the long-term consequences for older victims and distinguished them from those linked to normal ageing. The following consequences are mentioned in most studies:

Cognitive and emotional consequences	Physical health consequences
<ul style="list-style-type: none">- Cognitive impairment/increased risk to develop memory disorders- Depression and anxiety- Post-traumatic stress disorder (PTSD)- Suicidal thoughts/attempts- Increased risks for developing fear and anxiety reactions- Learned helplessness	<ul style="list-style-type: none">- Increased risk for developing chronic diseases- Exacerbation of pre-existing health conditions- Increased susceptibility to new illnesses- Nutrition and hydration issues- Sleep disturbances- Substance use- Injuries, cuts, bruises, and broken bones- Bone or joint problems- Digestive problems- Chronic pain and soreness- High blood pressure or heart problems- Increased risks for premature death

Societal consequences

Elder abuse has harmful impacts at all levels of society, affecting public health, resources, and civic engagement. Older people who have been abused have a **300% higher risk of death** when compared to those who have not been mistreated, as well as **higher rates of hospitalization**. Lower health status caused by violence, as described above, is associated with **poorer overall life expectancy and greater health service utilization**.⁹²

Despite having lower reported rates of physical and sexual violence, the health consequences for older women are more severe, resulting in greater health service utilization, declines in overall health status and poorer life expectancy. Other health consequences can range from gastrointestinal disorders to chronic pain and heart disease.⁹³ Repeated psychological/emotional abuse co-occurring with physical abuse has been associated with an increased ratio of chronic pain problems, lung problems and bone or joint problems and depression or anxiety for women aged 55 and older.⁹⁴ Studies on intimate partner violence against older women show that risk of death is three times higher for victims than non-victims. Lower health status is associated with poorer overall life expectancy and greater health service utilization.⁹⁵

4.1 Traumatization caused by violence

The concept of trauma can be defined as follows:

*“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being”*⁹⁶

The impact of trauma on an individual is complex and not fully understood, and the risk of developing psychological problems after a traumatizing experience appears to depend on a combination of personal characteristics with elements of the event itself and the context in which it occurred. Interpersonal violence is more traumatic than many other types of violence; for example, it tends to be more traumatic than natural disasters, which are more likely to be seen as random acts of nature and not as intentional, personal violations that shake the victim's trust in others.⁹⁷

Trauma-induced PTSD is often left undiagnosed in older victims.

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

The three groups of **symptoms common to PTSD** are: repeatedly experiencing the traumatic event as nightmares or flashbacks, avoidance of trauma-related circumstances, and increased anxiety. Self-destructive behavior may also follow the experience of a traumatic event, such as alcoholism, substance abuse, self-harm, and suicidal tendencies. Depression, irritability, insomnia, and other complications may also arise as a result of PTSD.⁹⁸

Research shows that older women may be at a higher risk for developing PTSD than older men as a result of domestic sexual and physical abuse.⁹⁹ However, older women are usually under-diagnosed and are more often perceived as suffering from depression, anxiety or poor physical health rather than PTSD.

General PTSD symptoms in older people include:¹⁰⁰

- Insomnia
- Nightmares, difficulty initiating sleep, and frequent awakenings
- Avoidance
- Re-experiencing over time, re-awakened memories
- Psychotic symptoms associated with PTSD
- Personality changes

Role changes and functional losses (retirement, increased health problems, reduced income, loss of loved ones, decreased social support, cognitive impairment, functional decline) may make coping with memories of earlier trauma more challenging in old age. To manage PTSD symptoms in early and mid-life, individuals may engage in avoidance-based coping strategies, e.g. alcohol abuse. Adaptation and resilience may, however, develop over a lifetime and provide a rich source of coping resources.

Chapter 5: What are human and civil rights?

Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights are based on international agreements and treaties, whereas civil rights arise from legislation, such as a constitution. *Chapter 6.1 describes how older persons' civil rights are protected, e.g. by national laws.*

International human rights conventions define the obligations of governments to act in certain ways or to refrain from certain acts in order to promote and protect human rights and the fundamental freedoms of individuals or groups.¹⁰¹

The Universal Declaration of Human Rights is the most important global human rights instrument. It was adopted by the General Assembly of the United Nations on 10 December 1948. Its creation was motivated by the experiences of the previous world wars. The Universal Declaration represents the first time that countries agreed on a comprehensive statement of inalienable human rights. The Universal Declaration of Human Rights does not directly bind countries to legal obligations. However, its norms have had a strong effect on standards informing national constitutions and other legislation.

Universal Declaration of Human Rights¹⁰²

The Universal Declaration of Human Rights declares, for example:

Article 1: All human beings are born free and equal in dignity and rights.

Article 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 3: Everyone has the right to life, liberty and security of person.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 7: All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 25: Everyone has the right to a standard of living adequate for the health and well-being of themselves and of their family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Article 27: Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

At the EU level, the most important human rights instrument is the **European Convention on Human Rights (ECHR)**. Drafted in 1950 by the Council of Europe, the convention entered into force in 1953. All Council of Europe member states are party to the Convention. All new member states are expected to ratify the convention at their earliest convenience. The Convention also established the European Court of Human Rights. Any person who feels that his or her rights under the Convention have been violated by a state can take a case to the Court.

European Convention on Human Right¹⁰³

The ECHR declares the following rights for citizens of the European Union:

- Article 2: Right to life
- Article 3: Prohibition of torture and ill-treatment
- Article 4: Prohibition of slavery, servitude or forced or compulsory labor
- Article 5: Right to liberty and security
- Article 6: Right to a fair trial
- Article 7: No punishment without law
- Article 8: Right to respect for private and family life
- Article 9: Freedom of thought, conscience and religion
- Article 10: Freedom of expression
- Article 11: Freedom of assembly and association
- Article 12: Right to marry
- Article 13: Right to an effective remedy
- Article 14: Prohibition of discrimination in the enjoyment of Convention rights
- Protocol 1, Article 1: Protection of private property
- Protocol 1, Article 2: Right to education
- Protocol 1, Article 3: Right to free elections

Both the Universal Declaration of Human Rights and the European Convention on Human Rights address the rights of all humans without any distinction. However, over the past few decades, it has become clear that **certain vulnerable groups need more express protection of their human rights**. Such groups and specific human rights instruments include:

- **Women** (Convention on the Elimination of all Forms of Discrimination Against Women, into force in 1981)
- **Children** (Convention on the Rights of the Child, into force in 1990)
- **Disabled persons** (Convention on the Rights of Persons with Disabilities, into force in 2008)

Older people are not recognized explicitly under any of the international human rights laws which legally oblige governments to protect the rights of all people. However, the United Nations published its Principles for Older Persons in 1991 and recommends that governments incorporate the principles into their national programmes.

United Nations Principles for Older Persons¹⁰⁴

According to the principles, older persons should have the right to:

Independence

1. Have access to adequate food, water, shelter, clothing and health care through the provision of income, family, community support and self-help
2. Have the opportunity to work or to have access to other income-generating opportunities
3. Be able to participate in determining when and at what pace withdrawal from the labour force takes place
4. Have access to appropriate educational and training programmes
5. Be able to live in environments which are safe and adaptable to personal preferences and changing capacities
6. Be able to reside at home for as long as possible

Participation

7. Remain integrated in society, participate actively in the formulation and implementation of policies which directly affect their well-being and share their knowledge and skills with younger generations
8. Be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities
9. Be able to form movements or associations of older persons

Care

10. Benefit from family and community care and protection in accordance with each society's system of cultural values
11. Have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness
12. Have access to social and legal services to enhance their autonomy, protection and care
13. Be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment
14. Be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives

Self-fulfilment

15. Be able to pursue opportunities for the full development of their potential
16. Have access to the educational, cultural, spiritual and recreational resources of society

Dignity

17. Be able to live in dignity and security and be free of exploitation and physical or mental abuse
18. Be treated fairly, regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution

5.1 How are my human and civil rights protected through legislation in my country?

Estonia

The Estonian Constitution and legislation are in line with the European Convention on Human Rights. The Chancellor of Justice ensures that authorities and officials performing public duties will not violate people's constitutional rights and freedoms, laws and other legislation of general application, and the practice of good administration. On 20 December 1993, the UN General Assembly adopted the Principles Relating to the Status of National Institutions (the Paris Principles), which obligate member states to establish national human rights institutions in accordance with the principles formulated in the resolution. As of 1 January 2019, the Chancellor of Justice is the national human rights institution (NHRI) in Estonia. The NHRI works in close cooperation with the Advisory Committee. The Advisory Committee has 50 members and includes people from various walks of life across Estonia. The Advisory Committee helps to create a comprehensive overview of issues affecting people's lives and to find ways to improve the situation in Estonia in general.

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) was ratified by Estonia on 20 September 2017 and entered into force on 1 February 2018.¹⁰⁵ The coordinating body for the implementation of the Convention is the Ministry of Justice.

Estonia has a Strategy on Violence Prevention for 2015-2020¹⁰⁶ and Operational Programme for 2016-2020.¹⁰⁷ Implementation of this strategy is monitored by the Ministry of Justice with input from the expert group, who have meetings 1-3 times per year, and with input from other ministries. The new strategy for the coming years is currently being discussed and drafted.

Finland

In Finland, national fundamental rights and international human rights complement each other to form a system of legal protection. The 1999 reform of the constitutional provisions concerning fundamental rights brought national fundamental rights and international human rights closer to each other regarding both content and the ways in which they are interpreted and monitored. At the same time, their direct applicability in courts and by other authorities was increased, and the opportunities available to private persons to invoke their fundamental and human rights in situations of practical application of law were improved.

The Constitution of Finland provides the following protection of rights:

6 § Equality: Everyone is equal before the law. No one shall, without an acceptable reason, be treated differently from other persons on the grounds of sex, age, origin, language, religion, conviction, opinion, health, disability or any other reason that concerns his or her person.

7 § The right to life, personal liberty and integrity: Everyone has the right to life, personal liberty, integrity and security.

10 § The right to privacy: Everyone's private life, honor and the sanctity of the home are guaranteed. More detailed provisions on the protection of personal data are laid down by an Act. The secrecy of correspondence, telephony and other confidential communications is inviolable.

11 § Freedom of religion and conscience: Freedom of religion and conscience entails the right to profess and practice a religion, the right to express one's convictions and the right to be a member of or decline to be a member of a religious community. No one is under the obligation, against his or her conscience, to participate in the practice of a religion.

19 § The right to social security: Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population.

22 § Protection of basic rights and liberties: The public authorities shall guarantee the observance of basic rights and liberties and human rights.

The right to self-determination of an individual is a right closely linked with several provisions of the Constitution of Finland, even though the actual concept is not included in its text.¹⁰⁸ The right to self-determination is a multidimensional concept linked with several fundamental rights, such as the right to personal liberty and integrity and the right to privacy. The right to privacy covers, for example, the right of an individual to self-determination and to decide about their own body. The realization of the right to self-determination may also be influenced by access to adequate information, such as provision of information for a patient on available options, as well as by good governance and legal protection.

Greece

The Greek Legislation and Constitution is in line with the ECHR. In addition, Greece ratified the Council of Europe Convention on the Elimination of all Forms of Discrimination Against Women (Istanbul Convention) in 2018, and the Convention entered into force on 1 October 2018.

In the Greek Constitution, human rights are safeguarded and protected by Article 2 (1), which guarantees the defense and protection of human dignity as a prime value governing the Greek state. In addition, Article 4 of the Constitution guarantees legal equity, and Article 5 (1) guarantees the free development of the personality of all citizens and their participation in every aspect of life. Judicial protection is a right protected by the Greek Constitution. Article 20 (1) guarantees that everyone has the right to legal protection by the courts and may plead their interpretation of their rights or interests as defined by the law.

5.2 International human rights as the basis of violence prevention

Violence against older people is a form of violation of human rights. While the Universal Declaration of Human Rights applies to all persons regardless of age, age is not listed explicitly as a reason why someone should not be subjected to discrimination. No systemic and comprehensive regional conventions to protect older people's rights currently exist, which complicates efficient prevention of elder abuse. Older people's organizations throughout the world have for years promoted the need for a

Convention on the Rights of Older Persons, which would provide solutions for ageism and discrimination, which are predicted to increase as the world's population rapidly ages. The Convention is seen as the most effective way to make sure that all older persons can realize and enjoy their human rights, including their right to freedom from all forms of violence and abuse.

Supporting the human rights of the elderly supports their dignity, respect and empowerment.

A human rights approach to elder abuse accordingly captures and addresses acts which deny an older person any human right, e.g. freedom, privacy, safety and dignity. **To protect older people from poor treatment and practices and to empower them to speak up, many countries acknowledge that social policy must move from a needs-based approach to a rights-based one.** Increasingly, human rights are the foundation for practices of elder abuse prevention. For example, in Australia, the principles underpinning elder abuse strategies within many states are designed to empower older people by making them aware of their rights and giving them the tools to protect their rights through the development of charters of rights, e.g. the South Australia Charter of Rights and Freedom of Older People. **Rights-based approaches to elder abuse prevention are also needed at the European and national levels.**

At a societal level, a lack of understanding of the relationship between human rights and violence against older people and, at an individual level, not knowing what human rights are and how they work in day-to-day life, is a barrier to using human rights to improve the situation of older people at risk of abuse. A rights-based approach would empower older people to speak out and seek help. It would **reinforce the principles of dignity, respect and empowerment** that enable older people to make their own decisions and to live self-determined lives. Moreover, it would involve consideration of the need and value of possible new laws which would define elder abuse as specific offences that can be prosecuted.

Empowerment

Emphasizing empowerment in the rights-based approach means **“empowering people to know and claim their rights and increasing the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights”**.¹⁰⁹

There is a growing interest in empowerment theories and models and how to implement them in practice. Empowerment theories have been applied to many disciplines. In the 1980s, empowerment was framed as an outcome of participation that manifested as social justice, realization of rights, improved interaction between people and states, and balanced power relations.

In the 1990s, the concept was broadened by the rights-based approach that “empowers people to claim and exercise their rights and fulfil their responsibilities”. In application, programmes that use a rights-based approach do more than encourage participation; they “empower people to take control over their own lives as an integral part of understanding development and dignity as a basic human right.”¹¹⁰

Empowerment can be defined as **“a multi-dimensional social process that helps people gain control over their own lives.”**¹¹¹ It is a process, which fosters power (that is, the capacity to implement) in people for use in their own lives, their communities, and in their society, by acting on issues which they define as important. Furthermore, it is suggested that three aspects of empowerment are fundamental to understanding it: **empowerment is multi-dimensional, social, and a process**. It is multi-dimensional because it occurs within sociological, psychological, economic and other dimensions and at individual, group and community levels. Empowerment is a social process because individuals are empowered in relationship to other people.¹¹²

Underlying this process is mutual respect between participants, facilitators, advisory committee members and others involved. While we cannot give people power and we cannot make them ‘empowered’, we can **provide the opportunities, resources and support they need to become empowered**.¹¹³



Chapter 6: EU and national legislation pertaining to elder abuse

6.1 Protecting older people from violence and abuse at the EU level

The European Charter of the rights and responsibilities of older people in need of long-term care and assistance (2010)¹¹⁴ and **the European Quality Framework for long-term care services**¹¹⁵ have long been the key reference documents at the EU level in calling for older persons in need of care to be treated as rights-holders whose dignity and well-being need to be preserved. These voluntary documents list the rights of older persons in need of care as well as the principles which must guide the provision of quality care and dignified treatment in order to respect those rights. They show the need to protect the human rights and dignity of older persons who are dependent on others for their care and support and how to do so as a basic step towards safeguarding well-being and preventing abuse.

The Council of Europe adopted a recommendation¹¹⁶ in 2014 focusing specifically on the rights of older persons. Although non-binding, this recommendation highlighted for the first-time older people's right to receive care. The recommendation stressed the need to prevent and address elder abuse and emphasized the role of informal carers, as well as the responsibility of states to provide them with adequate support and training. It also addressed the areas of non-discrimination, autonomy and participation, and administration of justice. Although member states are not legally bound by this instrument, they have committed politically to do more to put the rights of older people in effect.

Recommendation on the rights of older persons: Part IV. Protection from violence and abuse¹¹⁷

16. *Member States should protect older persons from violence, abuse and intentional or unintentional neglect. Such protection should be granted irrespective of whether this occurs at home, within an institution or elsewhere.*
17. *Member States should provide for appropriate awareness-raising and other measures to protect older persons from financial abuse, including deception or fraud.*
18. *Member States should implement sufficient measures aimed at raising awareness among medical staff, care workers, informal carers or other persons who provide services to older persons to detect violence or abuse in all settings, to advise them on which measures to take if they suspect that abuse has taken place and in particular to encourage them to report abuses to competent authorities. Member States should take measures to protect persons reporting abuses from any form of retaliation.*
19. *Member States shall carry out an effective investigation into credible claims that violence or abuse against an older person has occurred, or when the authorities have reasonable grounds to suspect that such ill-treatment has occurred.*
20. *Older persons who have suffered from abuse should receive appropriate help and support. Should member States fail to meet their positive obligation to protect them, older persons are entitled to an effective remedy before a national authority and, where appropriate, to receive adequate redress for the harm suffered in reasonable time.*

In terms of elder abuse, the **Victims' Rights Directive**¹¹⁸ from 2012 established minimum standards for the rights, support and protection of victims of all crime and ensured that persons who have fallen victim to crime in EU member states are recognized and treated with respect. The provisions of the Directive developed **five essential needs of all victims: being recognized, being treated with respect and dignity, receiving support and protection, accessing the justice system, and having the right to compensation and restoration**. While not addressing elder abuse directly, the Directive considerably strengthened the general rights of crime victims and their family members to information, support and protection. It further strengthened the victims' procedural rights in criminal proceedings. The Directive also required that EU countries ensure appropriate training on victims' needs for those officials who are likely to come into contact with victims. EU countries had to implement the provisions of the Directive into their national laws by 16 November 2015. Upon full implementation, the Directive guarantees that,

in whichever European Union country the crime takes place, victims will be granted the same minimum rights.

The position paper “Victims’ rights: let’s not forget the victims of elder abuse!” from AGE Platform Europe (2017)¹¹⁹ took a step forward from the recommendations in addressing elder abuse once it has taken place—both at home/in the community and in care settings. In their paper, AGE Platform Europe suggested that many efforts were still needed to make the Victims’ Rights Directive relevant to victims of elder abuse, and they reported an overall lack of specific and comprehensive policies and actions across European countries to address elder abuse and protect victims. AGE Platform noted that attempts to tackle elder abuse appear to be in conflict with the financial cuts implemented in health and long-term care systems across Europe in recent periods of austerity: **it is clear that under-investment in services and the over-burdening of staff results in worse care and a higher prevalence of neglect and abuse.** Furthermore, the unavailability of affordable, quality care services, in both home and residential settings, often increases the burden on informal carers, which leads to situations of abuse and neglect in the family environment.

The following sections will take a closer look at the current legislative situation in the TISOVA project partner countries.

6.2 Protecting older people from violence and abuse at the national level

Estonia

In Estonia, there is neither a specific law on elder abuse nor a law on domestic violence. However, articles on abuse and violence are specified in the Penal Code. Cases of violence are under-reported, and reporting by older persons concerning mistreatment or abuse by their close family members is rare. An inadequate balance between pensions and monthly payments for institutional care makes older people dependent on their children and the local government.

In Estonia, children and grandchildren are obliged to take care of their parents. Article 96 of the Family Law Act stipulates that adult ascendants and descendants related in the first and second degree are required to provide maintenance. Children and other descendants or ascendants that require assistance and are unable to maintain themselves are, therefore, persons entitled to receive maintenance. Considering the financial situation of obligated persons, it is possible to receive compensation for taking care of parents and grandparents (Article 102(1) of the Family Law Act). The maintenance provision costs to the welfare institution should be covered by local government.

Article 5(1) of the Social Welfare Act stipulates social welfare coverage.¹²⁰ The local government authority of a person’s place of residence, as entered into the population register, is required to organize the provision of social services, social benefits, emergency social assistance and other assistance to the person. Rural municipalities and cities assess a person’s ability to pay for general care service (the so-called “care home” service).

The insufficient availability of social services and welfare options that meet people’s needs means that the obligation to assist and take care of an elderly person, a disabled person, or a person with special mental needs is often borne by a family member or someone close. Caring for elderly people can cause great mental stress. There is a vicious cycle: if children do not have enough resources to provide care and maintenance to their parents, and if the local authority has insufficient services and low capacity, an older person in need remains at home or stays with children or their families. The consequences could be neglect and/or violence against the older person.

The Chancellor of Justice has reported that the availability of care home places and living conditions in care homes have become the center of public debate in recent years. Among other things, this also means that awareness of both the needs of the elderly and of their next of kin has improved. Many elderly people are extremely vulnerable due to advanced age and/or deteriorating health. It can be difficult for older people to influence their living conditions and the quality of care services by themselves; therefore, the rights of people living in care homes need particular protection.¹²¹ The Annual Report

of 2018 of the Chancellor of Justice states that “the main problems in care homes relate to ensuring decent living conditions, the number of staff, proper preparation of care plans, unlawful restriction of people’s freedom of movement, and availability of healthcare services.”¹²² The report highlights that no care service has been developed that corresponds specifically to the needs of people with memory disorders and related behavioral problems.¹²³

Amendments to the Victim Support Act (VSA) entered into force on 1 January 2017.¹²⁴ The VSA provides the basis for state organization of victim support, organization of conciliation (Article 6.3) and women’s support center services (Article 6.5), compensation for the cost of psychological care paid within the framework of provision of victim support services and the organization of payment of state compensation to victims of crimes of violence. The victim support service, defined in Article 3(1) of the VSA, is a public service aiming at maintaining or enhancing the coping abilities of persons who have fallen victim to a criminal offence, negligence, mistreatment or physical, mental or sexual abuse. Estonia has a regulated women’s support service, and most shelters for victims of domestic violence are prepared to meet victims’ needs.¹²⁵ Article 6.5(2) of the Victim Support Act defines a victim of violence against women as “a woman against whom physical, sexual, mental or economic harm or suffering has taken place either in her public or private life by gendered violence committed against her or a threat thereof.”

Finland

There is no specific legal or policy framework in Finland for the prevention of and intervention in elder abuse. However, the processes with which the government responds to the special needs of elderly people are outlined in legislation and the quality recommendation of the Ministry of Social Welfare and Health (2017) concerning elder care. The Social Welfare Act (1301/2014) concerns older people in defining the needs to which social services are required to respond. As part of these needs, the Act mentions domestic violence, elder abuse and neglect. The services provided are to be tailored for each client’s needs. Every person has the right to receive the necessary social services demanded by one’s unique needs.

Furthermore, the Act on Supporting the Functionality of Older Persons (980/2012) requires that the assessment of an older person’s needs is to be made in a comprehensive way, considering both their functionality and safety. Services provided should support the well-being, health and functionality of an older client. The recommendations by the Ministry of Social Welfare and Health mention elder abuse as a risk factor for decreased functionality in older age.¹²⁶

According to the Social Welfare Act 1301/2014, social service providers should respond to support needs caused by family violence and abuse.¹²⁷ The purpose of the Act is to advance the rights of clients to good service and treatment in social care. Starting from early 2015, the Act has imposed an obligation on public and private sector organizations to create a self-monitoring plan. The plan should be written and publicly available. The aim is to secure the quality of services and to clarify actions taken, e.g. to guarantee the safety of clients/residents in cases of danger. The written plan helps individual units and health and social care organizations to recognize risk factors and defects in their services and to fix them accordingly. The self-monitoring process is based on the idea of risk management. Services and the processes related to implementation are evaluated based on their quality for and impact on the safety of clients/patients. Prevention of elder abuse is part of the required plan. The publicly available plan improves the safety of both clients/patients and the staff of the organizations.

From the beginning of 2016, based on the Social Welfare Act, it has been compulsory for workers in social services to confidentially report elder abuse or concerns about the safety of an older person to the municipal authority responsible for the service, provisions notwithstanding. If the risk is not promptly addressed, the worker must inform the Regional State Administrative Agency. Act No. 980/2012 on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons is also an essential operational guideline in helping individual staff members to report cases of elder abuse and provide required help for older people who are at risk of being abused or neglected. The Act stipulates that if a health care professional or a person employed by the social service system of the municipality, rescue services in the area, the Emergency Response Centre or the police has been informed about an older person in need of social or health care services who is obviously unable take

care of themselves, their health or safety in the future, the health care professional or employee must confidentially notify the authority responsible for municipal social welfare.¹²⁸

Greece

In Greece, there is no specific law on elder abuse. A law has been in place since 2006 (law number 3500/2006) for the prevention of domestic violence. Law 3500/2006 does not provide a specific focus on population groups (e.g. the elderly and children), but rather, it is a general law on domestic violence which also applies to the elderly. The law on domestic violence has been updated to include the ratification of the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention; law number 4531/2018).

The Code of Penal Procedure (CPP) protects victims by providing them with the right to file a complaint against abusers. However, the Greek legislation does not protect older people in practice, considering that the perpetrator is usually a family member, and it is rather difficult for the older person to officially report abuse. In addition to the above at a procedural level, the processes are slow, expensive and soul-destroying for victims of violence, and as a result, they are discouraged from asking for help. On the local level, legal reforms have also been adopted. More specifically, according to the New Code for Municipalities and Communities, municipalities and communities in Greece must provide support and consultation to victims of domestic violence.¹²⁹

Regarding elder care, Law 2345/1995, “Organized Protection Services by social care bodies and relevant provisions”, covers the organization and functioning of non-public social care bodies.



Exercise 1.1: Statements on violence against older people

Method of the exercise

- Individual work or
- Group work

Learning Objectives

- Increase interest in the topic of violence against older persons
- Increase participants' knowledge about violence against older persons
- Raise self-awareness of beliefs and attitudes regarding violence against older persons

Materials required

- The form below
- Pens

Time frame: 20 minutes

Instructions

Ask participants to go through the statements in the form and identify whether they are true, false or if it depends on the context. The participants should also be prepared to give reasons for their answers. Once everyone has filled out the form, each statement will be discussed to see if the participants can come to an agreement. The exercise can be used to raise awareness about violence against older persons at the beginning of the lesson.

	Statement	True	False	Depends on the context
1	Unintentional mistreatment and neglect by a family carer is abuse.			
2	Abusive behavior in a relationship can start at an older age.			
3	Both women and men can experience violence and neglect in later life, especially when they show signs of disability and become dependent on others for help.			
4	Elder abuse is a crime.			
5	Abuse is a private matter between the perpetrator and the victim; it is not something I should intervene in as a friend or a neighbor.			
6	As a professional, it is my duty to make the older victim leave the abusive relationship regardless of whether they want to leave.			
7	Psychological/emotional abuse is not as serious as physical abuse.			
8	Elder abuse and neglect are rare.			
9	Aggressive behavior by an older person with dementia toward their caretaker is abuse.			
10	Elder abuse is always related to substance abuse or mental health issues.			
11	Older women are more vulnerable to abuse and violence than older men.			
12	Violence can cause premature mortality in abused older persons.			

Exercise 1.2: Quiz on ageing, older persons and violence against older persons

Method of the exercise

- Continuum¹³⁰
- Statements
- Group work

Learning Objectives

- Increase participants' knowledge on ageing, older persons and violence against older persons
- Raise self-awareness of beliefs and attitudes on aging and older persons
- Become aware of stereotypes and simplifications and reflect on them critically

Materials required

- Posters that show the statements and the continuum line with numbers from 1-5 expressing 'Disagree' (1) to 'Agree' (5) (see the line example below)
- Sticky notes

Time frame: 30 minutes

Instructions

1. The training room should have empty walls to hang the posters.
2. Explain to the participants that you are going to give them a set of extremes (statements).
3. Put the posters up on the walls.
4. Introduce the exercise by saying that you are going to read and show the statements and ask people to use numbers 1-5 according to how strongly they disagree or agree with them.
5. Ask participants to write a number from 1-5 expressing their disagreement or agreement with the statement on a sticky note.
6. Place the sticky notes in a basket after each statement.
7. After all the participants have finished their sticky notes, place them along the continuum at the corresponding number.



8. Repeat for several statements.
9. After finishing the statement continuum, divide participants into small groups. Ask the participants to share their response to the following statements:
 - a) What statement was easy or difficult to side with? Were there any outstanding issues?
 - b) What kind of stereotypes are there about older women and men in your country?
 - c) What do you know about violence against older persons in your country?

List of statements

1. Most older adults will have dementia during old age.
 2. Declines in all five senses normally occur in old age.
 3. Intelligence declines with old age.
 4. Old age can often be characterized as a second childhood.
 5. Both women and men experience abuse and/or neglect in later life.
 6. Violence and abuse occurring in family settings or close relationships decreases or stops as people age.
 7. Most perpetrators of elder abuse are adult children.
 8. Dependence on care due to ageing and illness is the cause of violence.
-

Answers

1. Most older adults will have dementia during old age.

Answer: False — Contrary to popular stereotypes, dementia is not a normal part of ageing or inevitable. The biggest risk factor for dementia is, however, age—the older you are the more likely you are to develop the condition. According to Alzheimer’s Research UK,¹³¹ about two in 100 people aged 65-69 have dementia, and this figure rises to one in five for those aged 85-89. In Finland, approximately 10.7% of people over 75 years old experience some form of dementia while 35% of people over 85 years old do. These include moderate and severe forms of dementia.

2. Declines in all five senses normally occur in old age.

Answer: Mostly True — Some normal age declines are seen across different cultures and are clearly documented. For example, there are numerous changes that occur with vision that are highly correlated with age. Some changes are associated with an individual’s place of residency; for example, all five senses generally decline in old age for individuals living in the United States. However, the dramatic declines that may occur in the auditory system may be due more to the cumulative effects of noise than to age. Most individuals living in low-noise cultures (e.g. nomadic cultures and simple agrarian cultures) do not exhibit a loss of hearing with age.

3. Intelligence declines with old age.

Answer: Mostly False — Most older adults do not experience any decline in intellectual abilities with age. In fact, some forms of intelligence have been hypothesized to increase with age. However, some older adults do exhibit decline. There are several factors which may account for this decline. Firstly, some diseases may lead to intellectual declines (e.g. cardiovascular diseases). Thus, intellectual decline in those cases is the result of disease rather than age. Secondly, individuals who live in deprived environments demonstrate a loss of intellectual abilities (e.g. poverty, lack of intellectual stimulation). Of course, problems such as impoverished environments impact the intellectual performance of children as well.

4. Old age can often be characterized as a second childhood

Answer: False — The life span is unidirectional. Older adults are adults and should be treated as such even if they are incapacitated by illness. Popular misconceptions assert the reversal of roles between parent and child. Thus, the adult child who is caring for the unwell parent may say they have taken on the role of the parent, and the elder has become the child. However, caring for an unwell parent is not equivalent to role reversal. In fact, true role reversal is viewed as dysfunctional.

5. Both women and men experience abuse and/or neglect in later life

Answer: True — this happens particularly when individuals begin showing signs of disability and become dependent on others for help in their daily activities.¹³² However, older women face a greater risk of physical and psychological abuse due to discriminatory societal attitudes and lack of recognition of the human rights of women.¹³³ Most older victims of sexualized violence are women.

6. Violence and abuse which has occurred in family settings or close relationships decreases or stops as a person ages.

Answer: False — Violence can worsen with age. This is because power structures in a relationship/family often change with age. According to a report by Safe Lives,¹³⁴ victims aged 61 and over are much more likely to experience abuse from an adult family member or current intimate partner than those 60 and under. The false assumption derives from how women aged 66 or over are the group least likely to leave their abuser and seek help.

7. Most perpetrators of elder abuse are adult children.

Answer: False — In the United States, Israel, and Europe, the most common perpetrator of elder emotional and physical abuse is a spouse/partner.¹³⁵ This is particularly true for older women victims. Adult children are also common perpetrators, as most cases of elder abuse are perpetrated by known and trusted others, particularly family members.

8. Dependence on care due to ageing and illness is the cause of violence.

Answer: False — dependency is a risk factor of elder abuse but not the only or main cause of violence. There is no clear reason for abuse. Its causes are both complex and concealed. However, studies suggest that certain risk factors are related to abuse, and that the existence of more than one of these factors places an older person at high risk of abuse. Key risk factors include carer stress, dependency, family conflict, isolation, psychological problems and addictive behaviors.

Exercise 1.3: Human rights¹³⁶

Method of the exercise

- Group work based on Elma's case study

Learning Outcomes

- Become better able to analyze and recognize an older person's human rights which are in danger or have been violated

Materials required

- Case study form
- Case study analysis form with blank answer boxes (analysis of Elma's story from the perspective of human rights)
- Pens

Time frame: 20 minutes

Preparation for the exercise

Give the participants a lesson on human rights or give them references on human rights material they can read in advance.

Instructions

Organize participants in small groups of 3-5 persons, depending on the number of participants. Ask the participants to:

- read through the case study
- analyze Elma's story in the group according the questions in the analysis form and write the answers down in the empty boxes
- choose one person from the group to present the answers to the whole group by giving the justifications for each of answers

Questions for discussion with the whole group

- What human rights did you identify in Elma's story that are in danger or have been violated?
- What actions are needed to protect her rights?
- Who is/are responsible for carrying out those actions?

Case study: Elma

Elma is an 80-year-old woman who lives in her own house with her adult son. Elma's husband died a few years ago, after which the son moved to live with his mother. When the son moved in, he agreed to live upstairs while Elma would continue to live downstairs. Elma felt lonely after her husband's death, so she was happy when her son moved into her home. The upper floor was fully equipped for independent living, as Elma and her husband had been renting it earlier. The son became the caregiver of his mother because Elma had some cognitive and mobility issues.

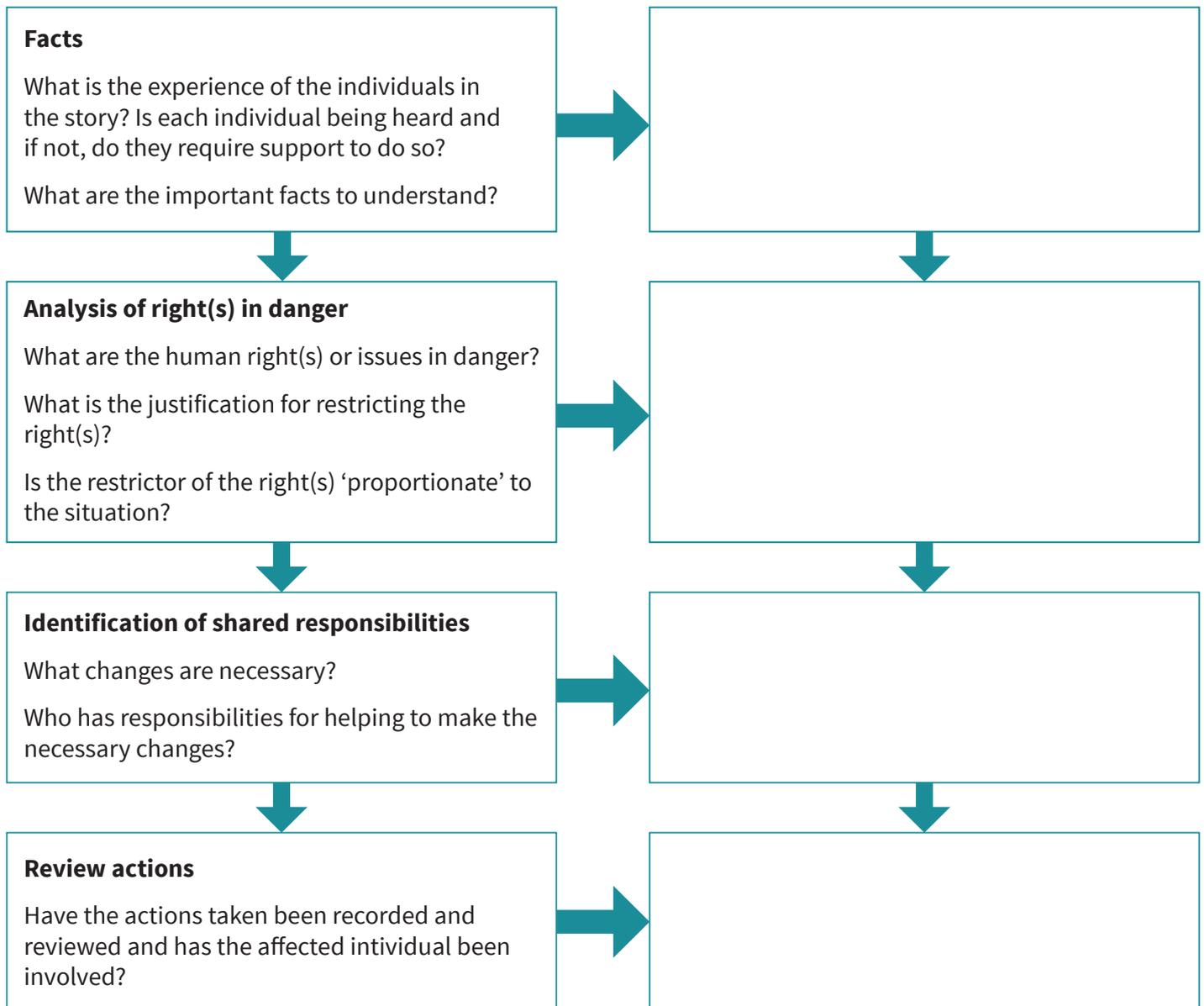
Elma was a home care client because she had medication which required follow-up and had wounds on her legs because of diabetes. Elma was happy to talk to the home health care workers, as she did not have a lot of friends. Her closest friends were in poor physical condition, but sometimes Elma was able to visit them with the help of her daughter. The daughter rarely visited her mother because she lived with her family in another city. The son who lived with Elma was on a disability pension because of rheumatoid arthritis, and he moved slowly because of it. The son was introverted and enjoyed being at home alone.

A home care nurse visited Elma three times a week to take care of her medication and treat her wounds. The home care nurse paid attention to the son's behavior: he insisted that nurses must come exactly at the agreed-upon time, the care had to be done in the agreed-upon room and the worker had to leave immediately afterwards. The home care nurse would have wanted to talk to Elma for a while, but the son did not allow it. He said it was of no use because of his mother's dementia.

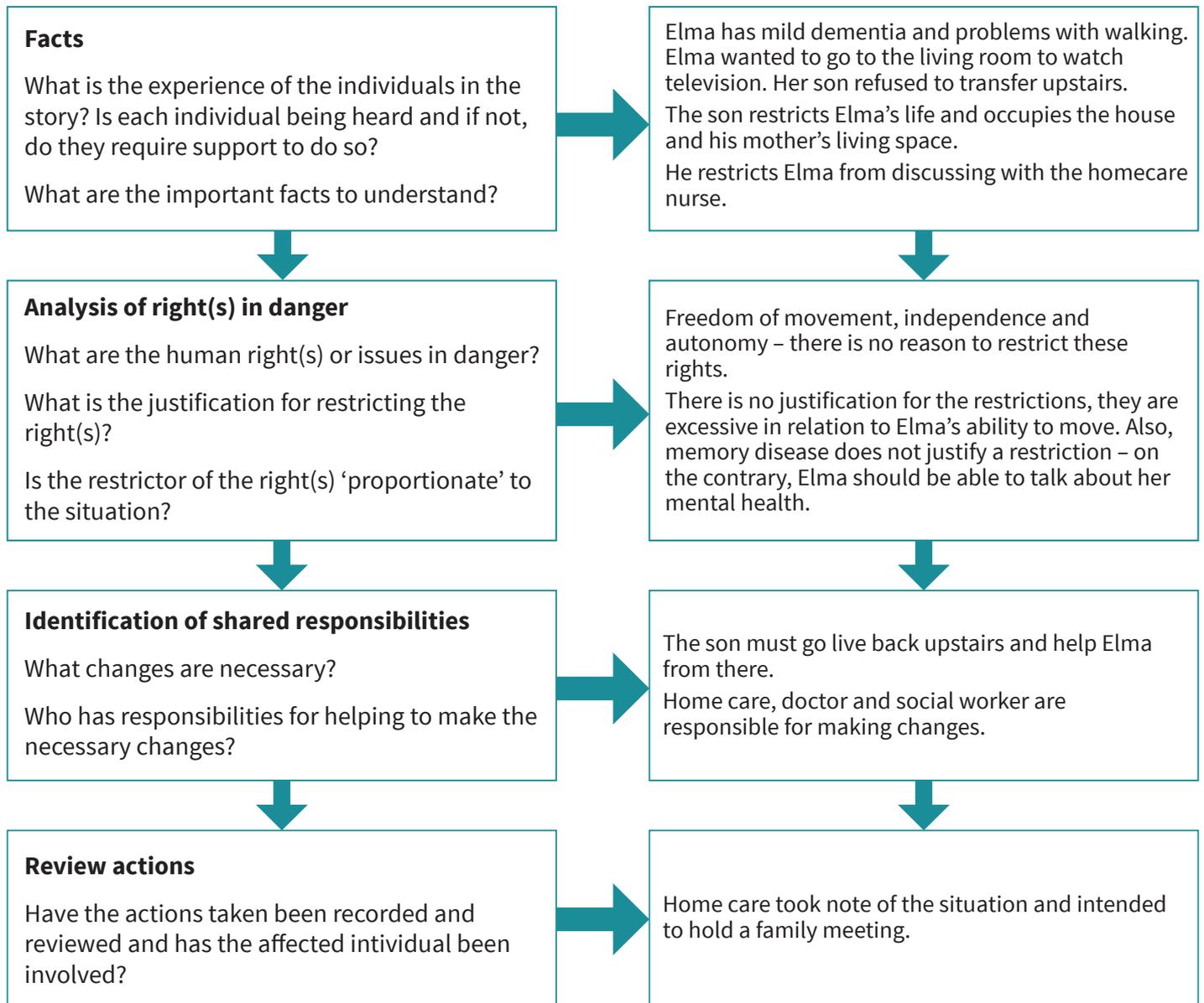
Home care also discovered that the son had gradually moved to live with his mother downstairs. Finally, the situation was such that the son restricted the movements of his mother. He justified it by being able to help his mother if she falls. He, however, made her to stay in her bedroom almost all of the time. Home care was very worried about the situation, and they decided to hold a family meeting on the issue.

One day, the home care nurse arrived at a different time than the son had demanded. The nurse was a temp who didn't know about the son's demands. The son was very angry, but he finally let the nurse enter the house. The nurse found Elma in bed and carried out the care procedures. She asked Elma if she was feeling ill or tired because she was in bed. Usually Elma was up and could move slowly by using the furniture for support. Elma said she wanted to go sit in the living room and watch television. The son closely followed the situation from the living room. He said that his mother must stay in bed, as she might fall if she moved. He was angry and told the nurse that she had no right to intervene in their lives and that his mother had everything she needed. He also said that it was not worthwhile talking to the mother because of her dementia. He approached Elma's room angrily, making the nurse leave the house.

Analysis of Elma's story from the perspective of human rights



Analysis of Elma's story from the point of view of human rights – Answers



Exercise 1.4: Brick wall

Method of the exercise

- Brick wall¹³⁷

Learning Objectives

- Learn to recognize risks and threats related to violence in older women's lives
- Learn to encourage older women's strengths — empowering approach
- Identify challenges older women face in seeking help
- Increase professional capacity to work with older women who are victims of sexual violence

Materials required

- Poster of an older woman's face
- Printed case studies
- Question sheets
- Pens
- Small sticky notes

Time frame: 45 minutes

Preparation for the exercise

Put the poster of an older woman's face on the wall ready to record the ideas which the participants present. Print the case study for the participants. In case you wish to divide the participants into smaller groups, distribute sheets with questions and sticky notes to record their answers. The idea of the exercise is to explore internal and external resources in the case study and to identify barriers and ways to overcome them. For that, it is possible to also use the SWOT analysis framework.¹³⁸

Instructions

- The exercise has two rounds of discussion.
- The first round of questions:
 - What are Maire's internal capacities and resources that could support a successful outcome in her case?
 - What are Maire's internal factors and barriers which jeopardize a successful outcome?
 - What are the external factors which would support a successful outcome in Maire's situation?
 - What are the external factors and barriers which could jeopardize a successful outcome in her situation?
- Ask the participants to write down the summary/results from the discussion and make sticky notes from the key results. The sticky notes represent bricks that can be used to show Maire's internal and external strengths and the internal and external barriers in her situation. Ask them to also write the challenges to overcoming these barriers on the sticky notes. The participants should write one strength, one barrier and one challenge per sticky note/brick and use as many bricks as there are key results.
- Start sharing the results by introducing internal and external barriers. Ask participants to read them out loud and place the bricks representing barriers so that they cover the older woman's face.
- Continue by introducing internal and external strengths. Ask participants to read them out loud. Place internal and external strengths below the older woman's face.
- The second round of questions:
 - Discuss in the group: What are the challenges for your organization and other service providers in Maire's situation?
 - Find methods or activities that would help your organization and other service providers to overcome the challenges you identified to serve Maire and other older women. Write the methods/activities on the sticky notes.

- Ask the participants to introduce the challenges that they and other service providers face.
- Ask the participants to introduce the methods/activities that could be used to overcome each challenge, and slowly peel the sticky notes/bricks away, explaining how the challenges could be overcome by the participants and other service providers.
- Gradually you can see the older woman's face by peeling the sticky notes/bricks away. This will make the older woman visible.

Discussion

- What could be a desirable outcome in Maire's situation?
- It would be helpful for participants to identify their own personal strengths and challenges before beginning a discussion on sexual abuse in later life. Specifically:
 - Do our own personal limitations or challenges prevent us from working effectively with older victims of sexual assault?
 - What makes us hesitant to deal with this issue affecting older women?

Case study: Maire

Maire and Jorma are an older couple who have been married for over 40 years. Maire is 70 years old and Jorma is 75 years old. They both have five grown children. Jorma wanted to have more children; however, the last two pregnancies were miscarriages. Maire has some hip problems and has therefore arrived at the health center for her appointment with her family doctor.

Maire is a quiet and reserved woman. The family doctor has known her and her husband for years because of Maire's pregnancies. Jorma has always been with his wife on doctor's appointments and seems to be a caring husband. However, this time Maire is alone. The doctor asks in a friendly way how the family and the husband are. Maire explains that her husband has started to have some memory problems, was tired and could not come with her. She also explains that a social worker visits them occasionally for those problems.

She then begins to describe her hip pain. The doctor asks her to lay down on the medical examination table. While examining Maire's hips, the doctor notices some black marks on Maire's stomach and buttocks. The doctor does not know what to ask or say. After the examination, the doctor tries to inquire how Maire sleeps and if she is tired or worried about anything. Maire explains that she has sleeping problems and would like to have some medication for that. She also needs some pain killers for the hip pain. At this point, the doctor asks about the black marks. Maire discloses that her husband is sometimes agitated and loses his temper. He has also started to drink. That is new and unexpected information to the doctor. Therefore, Maire is sent to a nurse for further discussion.

Maire is known to the nurse as well. Maire explains to the nurse in a few words that Jorma sometimes comes too close to her and tries to touch her breasts and buttocks. Nights are especially difficult and therefore Maire wants to sleep in another room against Jorma's will. This all causes very unpleasant feelings for Maire. The nurse knows that Jorma has memory problems. The nurse is very sympathetic and explains that this behavior is part of the dementia process. The nurse asks her to talk about this to the social worker.

Maire has already disclosed the sexualized violence she is experiencing to the social worker. The social worker explained that the behavior belongs to the illness her husband is suffering from and asked her to be patient. If the behavior gets worse, the social worker suggested she talk to the family doctor.

After discussing with the family doctor, nurse and social worker, Maire feels that she is not being taken seriously. She feels that they underestimate her situation and the sexualized violence. She feels that she is invisible to professionals.

Exercise 1.5: World café on interacting with PTSD

Method of the exercise

- World café based on case study¹³⁹

Learning Objectives

- Understand how PTSD influences interaction between a victim and professionals
- Become aware of one's own misinterpretations as a professional about the victim based on how the victim talks and behaves
- Understand what kind of special issues are influencing the wife's decisions (older women's special situation)

Materials required

- Case study in paper form for every table
- Large paper sheets – 2-3 for every table
- Pens/markers in multiple colors

Time frame: 60 minutes (depending on the number of rounds of conversation)

Preparation for the exercise

Move the tables to different corners of the room to create 4-top tables, one table per small group, each with chairs allowing the participants to sit around them. The room should be large enough to allow all participants to move freely. Put large paper sheets and pens/markers on each table. Identify the question(s) that participants will be asked to answer. The questions can be written on the papers in advance, or they can be presented as PowerPoint slides.

Instructions

- Divide the participants into small groups of 4-5 persons and assign a group to each of the tables
- Select participants who will serve as 'hosts' at each table
- Introduce the case study
- Provide question(s) on the tables

Each table has a different question pertaining to the topic of discussion. Each group provides answers to be written by the host on the paper, and after the round is finished, they rotate to the next table. Each group of participants writes their answers below the first answer of the previous group. Let them go around the room until all the groups have rotated to all the tables.

Regardless of whether the group focuses on one or more questions, it is recommended to have at least two rounds of discussion. Multiple rounds allow participants to dig deeply into the question and generate substantive comments and insights on the topic. Participants at one table can all move to the next table together, or they can spread out so that ideas spread around the room. The host should remain at their table to share insights from the first conversation with the next group. In the end, the written answers are all presented in front of all the participants and discussed as a group.

Discussion questions for the tables (one question per table)

- What kind of PTSD signs can you identify in the wife's behavior?
- Why did she refuse to have any help in her situation?
- How did the behavior of her husband influence her decisions?
- What would you have done in her situation?

Case study: Older couple

Police were alerted one evening to the home of an older couple. The neighbor had heard the cry of an old lady next door after a loud argument. The police calmed down the situation and noticed a bleeding wound on the forehead of the 87-year-old wife. There was also a large bruise on her leg. The wife seemed to be displeased and irritated by the questioning. The husband bustled around and tended to answer questions on behalf of his wife. The police took the wife to another room for the interview and proposed to take her to a shelter. The wife refused the proposal by explaining that her husband's health was not good, and she could not leave him alone. She did, however, allow them to take her to the emergency room. The husband insisted on coming along, explaining that his wife could not manage her dementia symptoms alone.

The police gave a short report at the emergency room and left the couple waiting for the doctor. While they were waiting, the nurse interviewed the couple about the injuries. Although the nurse directed the questions to the wife, it was the husband who answered them all on her behalf. The doctor invited the wife in, and the nurse asked the husband to wait for his wife outside the examination room. The husband refused that and said that he was worried about his wife's memory problems and wanted to talk about them with the doctor.

While examining the injuries, the doctor wanted to know what happened. The husband said that the forehead injury was caused by his wife's fall on the floor during an argument – he said that his wife lost her balance and hit her forehead against the table corner. According to the husband, the wife sometimes had dizziness and could lose her balance. The bruises on her leg were also caused by a similar fall.

The husband continued by explaining his wife's memory problems. The wife was sitting still and only nodded passively sometimes. She looked tired and did not seem to be interested in conversation. From the medical records, the doctor noticed that the wife had visited the emergency room before for similar injuries. For that, the doctor had tried to get in contact with her, but there was no response. The doctor persuaded the wife to agree to a home visit with a social worker the next day.

The next day, the social worker visited the couple to check on the situation and wanted to speak with the wife privately. During the interview, she looked uncomfortable and reserved. She repeated the same story as was told in the emergency room. The conversation was over quickly, as the wife did not want any help because there was apparently no reason for that.

Part 2: FOR HEALTH AND SOCIAL CARE PROFESSIONALS

Aims of the material

This material has been developed so that health and social care professionals:

- can understand the challenges and barriers for older people who experience violence, develop empathy and eliminate pre-existing harmful myths and stereotypes
- can determine and apply professional roles and apply ethical boundaries
- develop interpersonal communication and listening skills as a means of intervention and empowerment
- carry out safety planning and risk assessment in a professional setting
- develop a relevant multi-agency strategy and organization-specific guidelines/procedures which are victim-centered and safety-oriented

How to conduct training

Conducting a training begins with understanding the needs of the target group. For training professionals, **it is necessary to know participants' professional background and experience in the training area**. This can be explored, for instance, through a pre-training survey filled out by the professionals. An important starting point is to understand the goals of the organization regarding employee development, taking into account behavior, skills, knowledge and ethics. Many social and health care organizations have feedback systems that handle complaints. They provide valuable information to supervisors and managers about the service satisfaction of the clients/patients.

Since different people have different learning styles, it is good to combine a variety of methods, such as lecturing through presentations, watching videos and providing handouts. However, any effective training also enables **learning by doing**. That means adding exercises and activities to the session, such as group work, role-play and socio-drama. You may select exercises provided at the end of this section that are the best fit for the professionals' needs.

At the beginning of the session, it is good to give an overview of the content. It helps participants to get the whole picture of the issues to be discussed. To gain the attention and interest of the audience, it may be useful to start the session with a quiz (such as Exercise 1.1 or 1.2) or a video related to the topic.

It is important for the teachers and trainers to remember that some of the participants may be victims of violence themselves—or perpetrators. Therefore, the language used should be respectful and non-judgmental; however, a clear stance against violence must be taken. The participants may want to share their own experiences with the group or after the training with the teacher/trainer. The teacher should allocate some time for these kinds of conversations.

At the end of the session, **it is important to get feedback to improve future training sessions**. Evaluation forms can be created based on the goals set at the beginning of the training to measure the learning results of the participants. Anonymous feedback collected through forms with multiple choice and/or open questions can also give important information for future training sessions.

Contents of the programme

This part is divided into 5 chapters followed by exercises:

Chapter 7 – Identifying elder abuse: describes the help-seeking process for an older person and its challenges and outlines the numerous reasons why older persons do not leave violent relationships. Identifies techniques and methods for improving identification of violence against older persons, including an example of a screening tool.

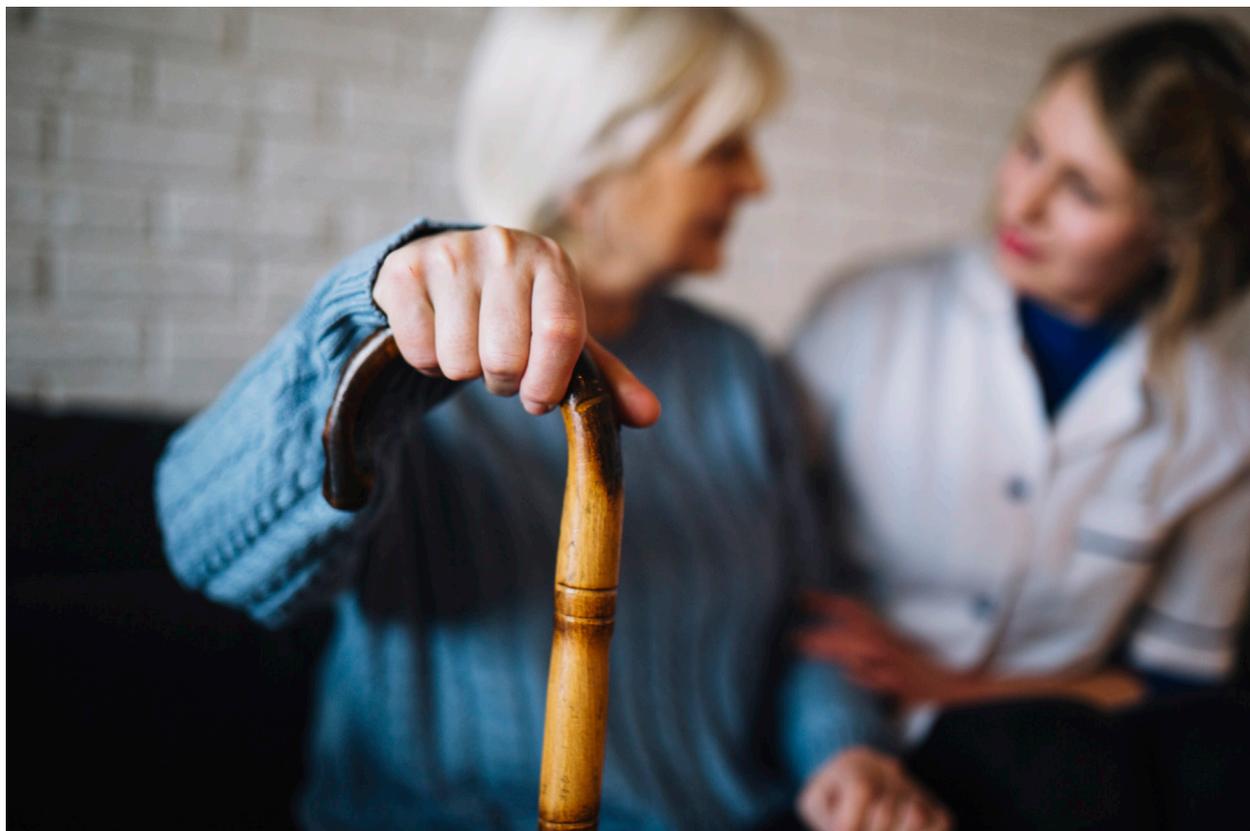
Chapter 8 – Principles of intervention and empowerment: outlines various tools for effectively supporting older women after identification of abuse. The first section describes key values and ethical principles for professionals and details how they can develop awareness and empathy towards other generations. Interpersonal communication and listening skills are described so that professionals can support an older person carefully and respectfully. A checklist for creating a safety plan is also provided. The last section describes how professionals can discuss abuse with older people with dementia and special considerations regarding ethics and respecting individual autonomy.

Chapter 9 – Services for older victims of violence: describes available country-specific services for older women who are victims of abuse, as well as for perpetrators.

Chapter 10 – Multi-agency and multi-professional cooperation: outlines the benefits of multi-agency cooperation when tackling violence against older people and how to utilize available expertise and agencies.

Chapter 11— Self-care and safety: explains the process of burnout and importance of self-care for professionals and volunteers working with older people who experience violence. Concepts such as compassion fatigue, burnout and secondary traumatization are explored, along with protective factors and strategies. To ensure the safety of employees and volunteers, this chapter describes how organization-specific guidelines and procedures can reduce risks and help organizations to manage incidents proactively.

Training exercises



Chapter 7: Identifying elder abuse

7.1 The help-seeking process for an older person and its challenges

The challenges and barriers older people face when seeking help or choosing not to seek help have been the subject of various studies. It has been noted that compared to older men, **older women may face additional barriers caused by societal and traditional norms rooted in ageism and sexism.** There is limited research specifically on older men as victims of violence, yet it is fair to assume that many of the main barriers to seeking help affecting older women also concern older men. For instance, compared to younger victims, older victims tend to have stayed in the abusive relationship for a longer time before accessing support, and a significantly lower proportion of older victims attempted to leave the abuser after receiving support.¹⁴⁰ For older victims, existing literature points to a range of structural, organizational and individual factors which influence their decision-making in the help-seeking process. This chapter will further explore some of these factors, particularly from the viewpoint of older women.

In a European study¹⁴¹, 30.1% of older women surveyed reported at least one experience of abuse in the past year, but less than half of the victims talked about it in an informal setting or reported it to any formal agency. Victims abused by current partners or a spouse were more passive in seeking help.

The following¹⁴² are **barriers that older women may face when seeking help:**

Attitudes and beliefs: older victims/survivors may not be believed if they speak out about domestic violence. The preconception is also that as a mature person, they should be more capable of coping with living with abuse.

Barriers related to emotions:

- fear of being alone after several years (or decades) of marriage or a long-term relationship
- fear of the unknown (some older victims/survivors have never lived alone before)
- fear of ‘starting again’
- feelings of shame in relation to disclosing abusive experiences to others
- feelings of loyalty, guilt and care for the abuser

Coping with violence: Many older victims/survivors develop coping mechanisms over the years of violence and accept violence as the norm and as part of everyday life.

Caring responsibilities: The status and role of the victim and perpetrator in terms of caring, illness and dependency is a barrier for some. There are also preconceptions that the other person would be unable to manage without the carer.

Having too much to lose: Loss in terms of fractured relationships with adult children and grandchildren, but also pets and the role that they have in an older person’s life, may prevent an older person from leaving.

Stigma and embarrassment: These may prevent older victims from contacting services or disclosing abuse to practitioners. Some older victims/survivors do not want to access services or share experiences with younger victims/survivors.

Unsuitable or lacking services: Many older women feel that the services are not appropriate or not meant for them, that the services are only for those who have experienced physical violence, or that they would be not accepted in that environment because these services are specifically designed for younger women with children.

7.2 Why don't older persons leave violent relationships?

While there can be various individual reasons for why an older person would choose to stay in an abusive relationship, research has uncovered some common traits. These can be categorized as follows (based on studies of older women)^{143, 144, 145}:

Cohort effects

Cohort refers to belonging to a group of people born at a certain period; in this case, the relevant cohort is the generation of women who are older than 55 years, many of whom raised children during the 1960s and 1970s. They share an upbringing which often reinforced traditional gender roles, including the submissiveness of women, marriage as a permanent bond, the importance of secrecy and privacy in families, and not seeking help from professionals. Older women have much to lose and overcome if they end a violent relationship, e.g. loss of a place that has been home for decades and fear of going into a nursing home as an alternative.

Period effects

Period effects mean the influence of history, events, and circumstances external to the individual, and they include individual and institutional ignorance about abuse during times in which child, domestic, and elder abuse were not discussed or even recognized. Many older women who experienced intimate partner violence as younger women did not have access to family violence services, which did not exist at that time; more recently, changes in laws and policies regarding women's rights, child abuse, elder abuse, and domestic violence have decreased tolerance for family violence. For those born before 1950, most came of age during a time when education and independence were not encouraged for women and when feminist ideas had not yet been incorporated into social and government institutions.

Ageing effects

The realities of ageing can take a toll, such as health challenges for both victims and abusers. Age effects are the consequence of physical changes associated with ageing and the influences of the internal development of the individual. Additionally, loneliness and fear of loneliness may increase with age.

Different values

Older women have been socialized with more traditional attitudes and values, particularly relating to gender roles, marriage and family. Older women were also generally taught to be submissive to their husbands and to silently accept their lot in life. Due to a strong care ethic, it can be extremely difficult for an older woman to leave a dependent, abusive husband. Older women were typically socialized with a keen sense of privacy about family matters and a strong commitment to family loyalty and solidarity—these values prevented them from discussing family problems with others, particularly given that domestic violence was viewed as a private family matter. Furthermore, older women grew up in an era when divorce was taboo, and this prohibition may be further reinforced by their greater commitment to traditional religious values. All these factors can make it more difficult for older women to seek help or leave abusive marriages.

Financial barriers

Although younger women often face financial barriers which keep them in situations of violence, these may be even greater for older women. Many older women did not have paid employment when they were younger, so even women in their pre-retirement years may be unemployable because of both ageism and lack of work experience. Due to various economic and societal reasons, it may often be the case that older women's lifetime savings are lower compared to those of men, making it more difficult for them to leave an abuser on whom they may be financially dependent.

Stigma and shame

Older women may be particularly likely to feel ashamed or embarrassed about experiencing abuse from their partners, and they may also feel shame that they have endured it for so long. Those starting a new relationship in later life may be embarrassed and ashamed to admit they have made a mistake.

Life stresses

Sudden changes in life circumstances or support networks, such as deaths of family or friends, may make it difficult for an older person to seek additional changes in their life, including leaving an abusive relationship.

In line with the above considerations, **professionals should reconsider what successful outcomes mean in the context of violence against older women**. The goal of extricating older women from their households is often not considered the best or most desirable outcome by the victim. **Preventing re-victimization and reducing risk may be more desirable outcomes** for older women experiencing violence, rather than removing them from abusive contexts.

7.3 Enablers for help

It is important for professionals to understand that violence against older women integrates power and control dynamics, which are gender-based and interconnected with gender inequality. Overall, a person-centered approach, with the understanding that **the individual is an expert on their own life**, is key to effective support and to combating ageist assumptions and stereotypes. This approach means, e.g. respecting an older victim's decision to not leave their home or relationship but also respecting their right to seek emotional and social support.

Power and control dynamics drive the violence against older women

According to Mahmud et al.,¹⁴⁶ **professionals working with older people should take into consideration the following factors when supporting older victims of abuse:**

- Health and mobility issues which can affect the victim's ability to access services
- The perpetrator may be the victim's caregiver (a caregiver can isolate them further from any family or professional support).
- The victim may have limited eligibility for housing, legal or financial support.
- There may be a long waiting list for adapted properties, and financial hardship may prevent the victim from leaving the perpetrator.
- The victim may be reluctant to leave or may have complex needs which make it difficult to do so.
- Slow involvement of services for this client group who may be at the end of their lives; vulnerability is increased because of their age and the impact of the abuse
- The perpetrator may also be an older person or may have health issues of their own (e.g. the perpetrator may have a memory disorder or may suffer from a condition which may make them violent), or perpetrator may be viewed as vulnerable and not capable of serious harm.
- If the perpetrator is the victim's adult child or grandchild: in such cases, victims are even less likely to report the abuse, may still love their child and want them to get help, and/or victims may blame themselves for the abuse because of how the child was raised.
- The perpetrator may also have complex needs, e.g. stemming from mental illness or alcohol or substance abuse.
- An older person's perception of abuse can be different from a professional's perception.
- Professional(s) may hold victim-blaming views if an older person has lived with violence for a long time.

7.4 Techniques and methods for identifying violence and abuse

Improving identification of violence against older persons should be a high priority for health and social care services. In different Western countries, rates of abuse identification by health and social professionals are usually low compared to the prevalence of violence against older persons reported in surveys. Older people may not initiate disclosure of the abuse but are more likely to talk about it when

asked by a trusted worker or professional. To support identification and questioning, various tools have been developed for screening for elder abuse.

Screening for elder abuse is defined as a process of obtaining information about violent experiences in a caring or family relationship from older or vulnerable persons who do not necessarily have obvious signs of violence, e.g. physical injuries. The rationale for screening among asymptomatic persons is that identification may prevent future violence and reduce the risk of future health impacts as a result of the violence. **Screening is considered particularly important for problems with serious health implications and where overall rates of identification are low.** This is certainly the case for elder abuse and neglect.¹⁴⁷ **Universal screening** means assessing everyone; **selective screening** indicates that only those who meet specific criteria are assessed.

Identification of (asymptomatic) victims helps prevent future violence

Screening tools for elder abuse **may be used with direct questioning** of the older person or caregiver. They may **also be used as self-reports by the older person or caregiver**. For screening tools which require responses from the older person, challenges arise in the context of their ability to respond competently, as there may be concerns regarding mental incapacity, frailty, high anxiety, fear or other factors. Screening tools which require the caregiver to respond may be complicated by inaccurate answers. In addition, it has been highlighted that **elder abuse screening tools need to be flexible enough to take cultural issues into account**. Nevertheless, it is important to remember that **screening tools for elder abuse do not provide definitive identification of abuse but rather highlight the risk of or potential for abuse.**¹⁴⁸

There are certain preconditions for using any screening instrument:

- Professionals are trained to use the instrument in a way that is safe, respectful and sensitive
- Professionals are trained:
 - on the topics of violence against older persons and the special situation of older women, relationship dynamics between perpetrators and victims, providing support, risk assessment and safety planning
 - on multi-agency work
- Professionals know the practical procedure/existing response protocols, including:
 - standard practices in their own workplace
 - local/regional response protocols
 - knowing each other's roles, responsibilities and limits of the roles
- There are opportunities available for support and consultations.

7.5 The Risk on Elder Abuse and Mistreatment Instrument (REAMI)

The Risk on Elder Abuse and Mistreatment Instrument (REAMI) is a good example of a **validated screening instrument that can be used by professionals** who know the older person and their family and social environment.¹⁴⁹ REAMI was tested and validated and includes both signs of abuse (e.g. suspicious bruises) as well as risk factors for abuse (e.g. history of violence and relationship problems between older persons and possible perpetrators).¹⁵⁰ REAMI is both brief and thorough, enabling accurate assessments to be completed in time-demanding work environments, and it can be used by formal carers (medical and non-medical) as well as health and social services. Unique to REAMI is that **it pays attention to different types of perpetrators**¹⁵¹, while also **referring to the physical, psychological and the social environments of older people**.

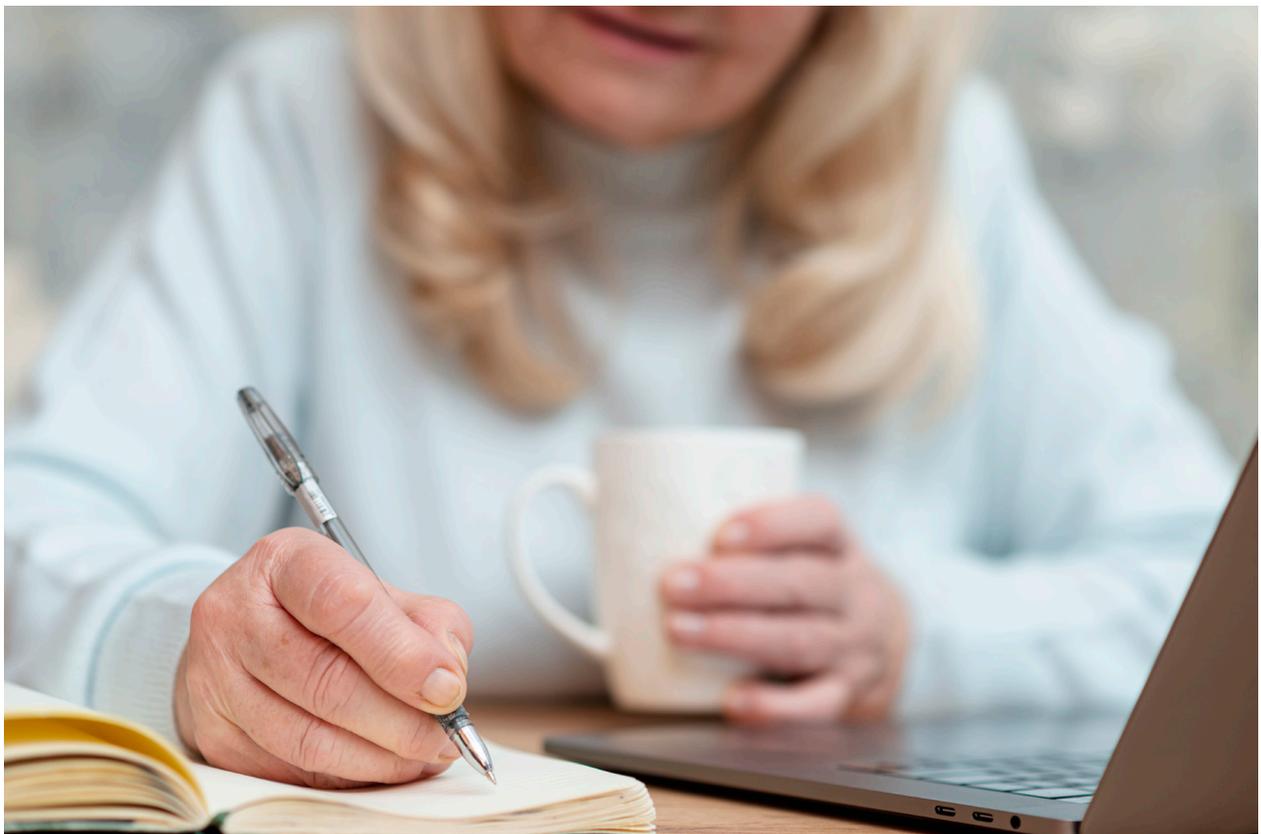
REAMI tool covers diverse signs and risks of abuse.

REAMI considers many possible perpetrators, with the concept of a perpetrator being left open to interpretation in the questions and instead referring to a 'key figure'. The **concept of key figure** is explained in the questionnaire as an important individual (within a caring context) in the victim's life (this may be a partner, a child (in-law), a neigh-

bor or a professional caregiver). A key figure is close to the older person and typically has a bond with them. Research has provided evidence of good internal reliability and internal validity of the REAMI and its utility in **assessing three dimensions of elder abuse**:

- 1) risk factors of the older person,
- 2) risk factors of the environment, and
- 3) signals of abuse and mistreatment.

In the REAMI-questionnaire, the professional is asked how strongly they feel that the proposed 22 statements apply to their client. Answer categories range from completely disagree (1) to completely agree (4). The 22 items were developed based on literature, experience from previous studies and three rounds of consensus meetings with experts (including academic experts, professionals dealing daily with elder abuse, and professionals from health care organizations).¹⁵²



Chapter 8: Principles of intervention and empowerment

In all actions taken to help an older victim and end violence, the following principles¹⁵³ should be taken into consideration:

Victim's safety

- **Safety must always be a priority**, and intervention should not worsen the victim's situation (e.g. leaving printed information where an abuser may find it, calling a victim when an abuser is at home, or leaving case notes at the victim's home can all risk the victim's safety).
- If the situation is life-threatening, action must be taken immediately to protect the victim.

Client's right to self-determination

- Mentally competent older people have the right to make choices that others may consider unwise or unsafe; making such a decision does not mean that an older person lacks mental capacity.
- The right to self-determination must be balanced against professional duties.

Cultural appropriateness

- Cultural sensitivity is vital to building trust between a victim and a professional; it facilitates communication and acceptance of an intervention.
- Professionals should be aware of their own values, beliefs and prejudices to understand other people's ways of life; however, cultural or religious beliefs can never justify illegal behavior.

Focus on the client

- Interventions must consider and meet the client's needs, even if abuse is unintentional or the client is an abuser.

Holistic approach

- Different aspects of the client's situation must be analyzed and addressed.
- Providing help to an abuser (e.g. referring them to a perpetrator's programme) or resolving the conflict by addressing the needs of both an abuser and a victim could improve a client's situation.

Access to legal aid and law enforcement systems

- Professionals must explain all options to a victim, including involving the police, and be ready to refer them to law enforcement agencies.

Respect for confidentiality

- Confidentiality must be balanced against the possible consequences of inaction and the risks that the client faces.
- Professionals must document all matters of concern and report them to the person in charge of the case/relevant department. (It should be remembered that confidentiality exists between the agency/organization and the client, not between the worker and the client.)
- Confidentiality cannot be used as a justification for failing to respond to abuse.
- It can be justifiable to share relevant information with other workers involved in the case if this can help them to better carry out their duties.

8.1 Ethical principles

The field of ethics is a philosophical discipline concerned with the morality of human behavior — with what is right and wrong and most valuable in life. **Alongside ethical values, every professional's daily activities can be affected by their likes and dislikes, attitudes and beliefs.** The health and social care professions are increasingly aware of the pervasive influence of cultural values on the personal and

professional values of health and social care professionals. Ethical codes for health and social care professions are intended to guide decision-making by informing professionals about specific rules, values and principles which are fundamental to the profession.¹⁵⁴

Ethical principles and considerations in the context of this manual exist to ensure the rights of older persons. In addition to becoming aware of the negative beliefs and stereotypes one holds as an individual, it is important to acknowledge the **general ethical considerations**, which apply with working with older victims of abuse¹⁵⁵:

- Older people should be involved in making decisions about their lives as much as possible. Empower older people based on values such as self-determination, informed choice and the right of adults to make their own decisions.
- Older persons have the right to receive support and help for carrying out conscious decisions.
- Work in ways which respect the older person's privacy and dignity.
- In identified or suspected cases of abuse, all interventions should be kept at the least restrictive level possible to maintain the individual's autonomy.
- The right to self-determination and freedom to choose must be respected, e.g. an older adult may choose to live in harm or even self-destruction, provided that they are competent to choose.
- A mentally competent person has the right to refuse any unwanted intrusion into their life. In these cases, professionals should assess the safety of an older person and give them safety information.
- If a situation is immediately dangerous for the physical safety of an older person, a professional should consult someone who can understand the situation and intervene, such as the police or a social worker, and take appropriate actions, even if this goes against the older person's wishes.
- If according to local laws, a crime has happened, or if the circumstances indicate that a crime has happened, the professional should follow the local and national laws and rules.
- Confidentiality must be respected but should not be a barrier for action.
- Cultural and religious issues, gender and abilities and recourses should be considered in all communication with an older person.

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

Older person's safety should be a priority with respect to their right to confidentiality.

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

Furthermore, it is important to note that violence against older persons may be abuse that is perpetrated deliberately, but it also may be unintentional abuse. This is particularly true in cases of neglect because **one form of neglect can be intentional and another unintentional**; i.e. the perpetrator may be doing their best but may not be able to provide the level of care and support that is needed, sometimes because they do not know what resources are available and sometimes because the local authority does not provide the support that is needed. From the perspective of an older victim, the experience of abuse is the same, but determining appropriate and ethical intervention methods is very much dependent on the active or passive nature of neglect.

8.2 Empathy and generational intelligence

The generational intelligence framework incorporates both interpersonal relationships and the wider social environment while regarding generational intelligence as a way of understanding violence against older persons. Generational intelligence includes the ability to reflect and act based on an understanding of one's own (and others') life course, as well as family and social history, and to place this understanding within its social and cultural context. In this framework, **relationships are viewed as an inter-generational space in which perceptions, attitudes and ideas about other generations and age groups are shaped by society and culture.**

To become generationally aware, one must become aware of personal generational identity, understand other generational differences (e.g. their values and needs) and build empathy towards other generations. Being generationally aware also means acting in a way that considers generational differences.¹⁵⁶ This framework suggests that the age-dominant generation (those in the majority) may have difficulty seeing beyond their own priorities and may view differences as threatening. At a societal level, **ageism takes place when the older generation's priorities and needs are considered less important than those of dominant age groups.**

Negative social attitudes towards older people are an element of elder abuse. **Social ageism therefore acts as an 'enabler'**, a factor which permits elder abuse to happen, as it creates a context or social space which makes the behavior possible or even more likely. In the context of generational intelligence, elder abuse is therefore seen as a form of damaged intergenerational relations due to ageism or dysfunctional organizational environments. **In the context of caregiving, generational intelligence opens opportunities to examine and promote positive interaction between younger and older people, e.g. through training professionals.**

8.3 Interpersonal communication and listening skills

Challenging feelings of the victim should be acknowledged, while encouraging them to open up about their worries.

If a professional has the feeling that all is not well with an older person, it is important to approach the topic carefully and respectfully, acknowledging the challenging feelings, such as shame and guilt, that are likely to arise. It is best to open the topic through a very general question regarding the older person's well-being and home situation, e.g. "How are things at home?" or "How do you feel about the place where you live?" This gives the older person the chance to open up about

issues that worry or upset them. **It is important for a professional to listen not just to what is being said but also to what is not being said.** An older person who is afraid of their caregiver(s) may give evasive answers. Another red flag is if a caregiver or a family member is always present when you meet or contact the older person; hence, always try to **interview the older person alone, if possible.**

If the older person confides in you about an abusive situation or event, follow up with questions aiming to provide the full picture of what has happened:

- Explore abuse or neglect: what, how, when, how often?
- Who is/are the perpetrator(s)?
- If the elder has sought help for the situation, what happened?
- Does the older person have someone whom they trust and can contact if the abusive situation re-occurs?
- How does the older person see the situation: do they want change and help? If yes, what kind?
- What would make them feel safer in the current situation?
- Do they require a safety plan?

How to ask specific questions to determine if abuse is occurring¹⁵⁷

Request family members to step outside the room, and interview the older person alone. Begin the conversation with the general question, “How are things at home?” and then follow with the more specific questions below, depending on what sort of abuse is suspected.

Physical and Sexual Abuse:

- Are you afraid of anyone at home?
- Have you been struck, slapped or kicked?
- Has someone touched you without your permission?
- Have you been tied down or locked in a room?
- Have you been forced to participate in or do something you do not want to do?

Emotional Abuse:

- Does someone scold or threaten you?
- Does someone call you names or humiliate you?
- Do you feel alone or excluded?
- Have you received the ‘silent treatment’?
- What happens when you and your caregiver disagree?

Neglect:

- Do you lack aids such as eyeglasses, hearing aids, or false teeth/dentures?
- Have you been left alone for long periods?
- Do you get enough to eat and drink? Are you always given water when you ask for it?
- Has someone refused to take you to the bathroom when you ask?
- If you need assistance, how do you obtain it?
- Do you always get help when you need it?

Financial Abuse:

- Does your caregiver depend on you for shelter or financial support?
- Has someone taken anything that is yours without asking?
- Has money been stolen from you?
- Has anyone had you sign documents that you did not understand or did not wish to sign?

8.4 Settings of mutual trust and respect

Settings for communication with older patients should be both respectful and effective for information exchange. In such settings there is mutual trust; both the professional and the older person want to work together toward a shared goal. **Professionals can encourage trust and increase the effectiveness of information exchange** in the following ways¹⁵⁸:

Use a proper, preferred form of address.

Establish respect right away by using formal language or ask the patient about their preferred forms of address, i.e., Mr./Mrs./Ms. or the person’s first name and use it consistently.

Introduce yourself, your role and the situation and its objectives to establish rapport.

Introduce yourself clearly and do not speak too quickly. Show from the start that you respect the patient and want to hear their concerns.

Try not to rush or look busy.

Older people may have trouble following rapid-fire questioning or torrents of information. Speak more slowly and give them time to process what is being asked or said. Feeling rushed or interrupted leads people to believe they are not being heard or understood.

Use active listening skills.

Face the older person, maintain eye contact, and when they are talking, use frequent, brief responses, such as “okay,” “I see,” and “uh-huh.” Active listening keeps the discussion focused and lets the person know that you understand their concerns.

Demonstrate empathy.

Watch for opportunities to respond to patients’ emotions using phrases such as “that sounds difficult” or “I’m sorry you’re facing this situation; I will help you to get through this.”

Write down take-away points.

It can often be difficult for patients to remember everything discussed during an appointment. Older adults can especially benefit from having written notes to refer to which summarize major points. However, in cases in which abuse is suspected, take into consideration the victim’s safety: avoid providing the older person any notes or material that the perpetrator may find and use against the older person.

Avoid jargon.

Do not assume that patients know medical or legal terminology. Introduce necessary information by first asking patients what they know and build on that. Check often to be sure that your patient understands what you are saying. You may ask the patient to repeat back the care plan in their own words.

Reduce barriers to communication.

Older persons often have sensory impairments that can affect communication. Vision and hearing problems need to be treated and accounted for in communication. Ask the patient if they would like any special needs to be considered.

Be careful about language.

Some words may have different meanings to older generations than to a younger generation. Words may also have different connotations based on cultural or ethnic background. For example, the word “dementia” may connote insanity, and the word “violence” may mean merely extreme physical brutality to some. Use simple, common language, and ask if clarification is needed.

8.5 Motivating abused older persons for change¹⁵⁹

Remember that change can occur when an older person allows you to enter their life, and it is possible to affect their motivation for change. **Provide the older person with different options to support them in deciding what to do.** Remember that you are responsible for working with the older person to ensure their safety, and the goal is also to help the abuser.

- Ask how the older person has coped with violence over the years.
- Search together for new ways to manage difficult situations.
- Be realistic, but try not to terrify the older person.
- Give them time to become motivated about change.
- Maintain contact and regularly address the topic of violence.

Guiding principles for working with older abused women¹⁶⁰:

- **Believe the victim.** Even if the victim says other things that seem unlikely, begin by assuming the older woman has been harmed or has experienced trauma at some point. If you have concerns about a memory disorder, depression or delirium, contact a health care provider.
- **Talk less and listen more.** Allow her to talk at her own pace.
- **Do not assume that stress, poor family communication, or poor caregiving are causing the problem.** Assume it is based on power and control unless until proven otherwise.
- **Focus on the victim's safety.**
- **Ensure that she has access to information, education, and other necessary social and economic support to make informed decisions,** which best reflect her interests and needs, placing power over decision-making in her own hands—**respect her decisions.**
- **Support the highest level of independence and autonomy possible.**
- **Empowerment is a process,** which will include women setting their own goals and professionals enabling access to resources, which will assist them in achieving those individualized goals.

8.6 Safety planning for older victims of violence

Older persons may decide to remain living with someone who physically abuses them. While this may be perceived as unwise or unsafe, as described above, a competent older person has the right to make such decisions. A care plan in such a situation should include helping them to develop a safety plan.

Perpetrators often isolate their victims and do not allow them to make their own decisions. **Safety planning restores power and control to older persons as they make decisions about how to enhance their own safety.** The first issue to assess is the urgency for safety, evaluating whether the situation is life-threatening and requires immediate action. There is also a need to think about the victim's physical and health status and their competence for making their own decisions; however, it is important to understand that **psychological trauma caused by violence is not the same as cognitive impairment.**

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

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

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

- Building rapport and helping the older person to feel safe through active listening
- Learning about what the older person fears from the perpetrator and what may happen if harmful actions or threats are carried out
- Asking what the older person wants to do and why. Learning about the motivation behind the older person's decisions can help to clarify their goals. You may be able to suggest other options for reaching the same goal.
- Brainstorming creative options and ideas together

Checklist for creating a safety plan^{161, 162}

- What experience has the older person had with safety planning and protection strategies?
- Which strategies worked?
- Which were ineffective?
- How did the perpetrator behave in the past? Is the perpetrator likely to re-offend?
- Does the perpetrator have access to weapons? Have weapons been used in the past?
- Is there a restraining order in effect? If so, what is the status? Ask them to tell this to friends, neighbors and service providers so those around them are aware.
- Can the victim recognize signals of violent acts?
- Review the living situation with the victim so that they can try to leave before the situation escalates to become more violent
 - how to leave: the safest way to leave the home; the safest room in the home with door locks and a window to call for help
 - where to go: agree in advance on a place to escape to
 - temporary living arrangements: agreed upon in advance
 - Where does the older person keep important phone numbers, personal documents (e.g. medication receipts, bank cards, ID-card, health insurance card, extra clothes, some money)?
 - If the older person is living with a disability, are there physical barriers in the person's environment which may prevent a safe exit or access to safety?
 - Have advance arrangements been made for the care of pets?
 - Has the older person practiced giving precise information on where they are and whether there is danger?
- Is the older person willing to move to a safe place (e.g. shelter)?
- Have they been advised to write down/document violent situations? (e.g. write the date and what happened; save text messages, emails and phone calls)
- What/who are the older person's community support and networks?
- Does the older person have information about different support services?
- If the perpetrator does not live with the victim, does the victim have a peep hole and safety chain and locks on the door?
- What challenges may affect the older person's safety or ability to follow through with a safety plan? These could include things such as substance abuse, mental health issues, or memory disorders.
- Is the older person comfortable with the safety plan and willing to live within its possible restrictions, at least in the short term?¹⁶³

8.7 Supporting persons with memory disorders

Studies have shown that **persons with cognitive impairments, e.g. dementia, are at increased risk of becoming victims of elder abuse.** Various international studies have measured the prevalence of elder abuse among people with dementia to range from 28% to 55%.¹⁶⁴ Older persons with dementia are less likely to be able to articulate their feelings and experiences and are often unable to remember or understand what has happened to them. They may also be less likely to seek help, advocate for themselves or have the mental or physical capacity to remove themselves from potentially abusive situations. Studies also show that self-neglect is associated with dementia.

Older person with dementia has increased risk of becoming victim of abuse and its severity should be addressed with care.

Having dementia does not automatically increase an older person's risk of abuse from their caregiver, but there are additional risk factors. In 2010, Wigglesworth et al.¹⁶⁵ found that **various characteristics of both the caregiver and care recipient can contribute to abusive behavior**, including:

- the caregiver's anxiety, depressive symptoms, social contacts, perceived burden, emotional status, and role limitations due to emotional problems
- the care recipient's functional capacity, severity and stage of dementia, their aggressive and physical assault behaviors, depressive symptoms, and their social contacts
- the income and education of the caregiver and care receiver

Elder abuse **interventions for persons with dementia are complex** because of additional concerns around cognitive capacity and decision-making. Dementia can impair a person's decision-making capacity in some areas of their lives. It is challenging for healthcare professionals to determine whether it is appropriate to act on behalf of older people with dementia, particularly in cases in which intervention is warranted but consent is not granted by the older person. **Healthcare professionals are bound by professional ethics to respect an individual's autonomy, but they are also obligated to protect vulnerable older people from abuse and neglect.** What complicates the matter more is that it is often difficult to make judgements about cognitive capacity or decision-making capacity, as a person's cognitive status may fluctuate, and a person may have decision-making capacity for some domains of their life but not for others.¹⁶⁶

Furthermore, given that **dementia can make it particularly difficult to detect abuse, as the symptoms of both can be similar** (e.g. reluctance to communicate, anxiety and withdrawal), elder abuse can be incredibly difficult to identify among those with dementia. In cases in which direct questioning of the older person with dementia is not possible, it is believed that screening instruments that rely on health and social care professionals' assessments of abuse may be more advantageous than other methods. In the course of an assessment, a health or social care practitioner can observe the interactions between the older person and the caregiver, talk to other family members and establish caregiving patterns. With this approach, a comprehensive multidisciplinary assessment may be conducted in cases of suspected abuse in order to assess warning signs to determine if they are indicative of abuse or attributable to the natural course of a disease.¹⁶⁷

Discussing abuse with older people with dementia¹⁶⁸

Direct, clear and emotionally non-threatening language is the most appropriate and effective way to elicit disclosures of abuse from older people with dementia. Appropriate interviewing techniques and accessible approaches that health and social care professionals can use (particularly with older people in the early stages of dementia) include:

- speaking slowly and clearly
- adopting a patient tone and demeanor
- using short, clear, direct and non-leading questions
- posing only one question at a time
- asking questions about who, what, when and where, but not why
- using language and terminology that is appropriate to the person being interviewed
- using visual aids

Health and social care professionals can also infer a lot from older people's body language and voice intonation in response to questioning related to abuse.

It is challenging for professionals to question informal carers about abuse, as they risk making the situation worse or causing the caregiver to isolate the victim. **A sensitive, empathetic and non-judgmental approach towards carers suspected of abuse is recommended as the best approach.** Interview techniques that build rapport have been suggested, such as asking the carer about the demands and difficulties of caring for the older person with dementia and about any feelings and frustrations they may have about their caring role before proceeding to direct questioning about abuse.¹⁶⁹ **Caregivers of older people with dementia need to receive adequate information and education about the clinical course of dementia and the care-recipient's needs** in order to effectively provide care and avoid further abusive situations.

Overall, working with older persons with cognitive limitations requires additional considerations, skills and knowledge from social and health professionals. Such requirements often end up being barriers to cross-referral and service collaboration among agencies specializing in elder abuse and those specializing in dementia care. **Known barriers** include limited training on either elder abuse or dementia, failure of agencies to establish appropriate protocols for collaborative service delivery, insufficient knowledge and trust regarding how other agencies work, and concerns about differences between agency philosophies. **Fear of eroding client rapport and confidentiality further contribute to underreporting of elder abuse cases.**¹⁷⁰ *For guidelines on multi-professional and multi-agency cooperation, see chapter 10.*

Chapter 9: Country-specific services for older victims of violence

In **Greece**, there are no services that deal exclusively with the abuse of elderly people. Women can refer to counseling centers, women's shelters and municipal social services to get help. There are also open day services and homecare visitors (run by municipalities) which are intended to support the elderly by helping them with their daily needs and offering them medical services and psychological and social support. Moreover, the social workers from these services may offer some counseling and psychological sessions to elderly people. In addition, there are two institutions/associations in Athens and one in Thessaloniki which provide services to elderly victims largely consisting of creative companions and activities; these organizations are mainly focused on individuals with dementia and Alzheimer's. Currently, there are no services that deal with perpetrators in a therapeutic context and offer psychosocial support.

In **Finland**, abused older persons can receive help and support from public social and health care services or from non-governmental organizations (NGOs). Abused older women use those services; however, the number of older users is small compared to younger abused women. Such services include shelters, helplines and chats, online and face-to-face peer support groups, and professional help and services from a personal support person.

In **Estonia**, there are no special, age-specific services for victims of violence. A national victim support helpline and victim support centers provide free assistance and counselling services to people who have been victims of an offense, negligence or ill-treatment or who have experienced physical, mental, economic or sexual violence. Also, local governments provide support for reducing dependency on informal caregivers. Women's centers specializing in helping victims of domestic violence provide support services across the country.

9.1 Country-specific special services for older women

In 2018, there were 27 shelters in **Finland**. Previously arranged by NGOs, the shelters became publicly funded and became the responsibility of the government in 2015.¹⁷¹ This reform has been expected to improve older people's access to shelter services. In 2018, 2.6% of clients in shelters were 65 years old or older.¹⁷²

Suvanto – For A Safe Old Age was founded in 1990 in Helsinki. Suvanto is a national non-governmental organization that strives to help elderly people and those close to them in times of need and motivate public discussion about and prevent the abuse of elderly people. The association can both help the elderly victims and give guidance to the professionals working with them. Suvanto maintains a helpline for elderly people who have experienced violence and for those close to them, and it offers professionally guided peer support groups and provides professional one-on-one support. In addition, Suvanto arranges courses, information meetings and events and compiles and disseminates information about the abuse of elderly people.¹⁷³

When the Council of Europe Convention on preventing and combating violence against women and domestic violence (also known as the Istanbul Convention) became effective in Finland in 2015, Nollalinja was founded as a response to the convention requirements. Nollalinja is a nationwide free-of-charge helpline for anyone who has experienced violence or the threat of violence in a close relationship. Nollalinja is also available for family members of victims and for professionals and officials who require advice in their work with clients. The helpline is open around the clock, every day of the year and provides service in Finnish, Swedish and English. Nollalinja phone service is organized by the National Institute for Health and Welfare (THL).¹⁷⁴

Women's Line in Finland started its services in 2002. The organization runs a nationwide free-of-charge helpline for women and girls suffering from abuse, threats or fear. It also provides chat, online help and women's peer group services. A professionally guided voluntary service, its volunteers receive continual training and supervision.¹⁷⁵

Victim Support Finland (RIKU) aims to improve the position of victims of crime, their loved ones and

witnesses of criminal cases by influencing and producing support services. The services of Victim Support Finland are also available for older people and their families and friends, including the services of a personal support person.¹⁷⁶

The Rape Crisis Centre Tukinainen provides support and guidance for people who have been sexually assaulted or abused and their families through a free helpline. It influences professional and legal procedures, as well as authorities and public opinion, to decrease and prevent sexual assaults. Tukinainen provides cooperation, consultation and training for professionals, authorities, organizations and educational institutions in a variety of fields.¹⁷⁷

In **Estonia**, there are no special, age-specific services for victims of violence. The Estonian Victim Support helpline 116 006 provides 24/7 free assistance to people who have been victims of an offense, negligence or ill-treatment or who have experienced physical, mental, economic or sexual violence. When there is a reported incident and the police arrive at the place where a violent act has happened, victims can contact the helpline in the presence of the police officers. Callers to the Victim Support helpline can remain anonymous, and assistance is provided in Estonian, Russian and English.

National victim support centers are located in all major cities in Estonia and provide free counselling services. When a criminal investigation is started, the victim and her or his family members are eligible to receive state paid psychological help in the form of counseling, psychotherapy or a support group. The need for this is assessed by the victim's support counsellor, who then calculates the amount of compensation. The amount of compensation for each person is a minimum monthly salary.

There are 79 local governments in Estonia. A local government must guarantee compulsory basic services for its residents. One of the main focus areas is reducing dependency on informal caregivers, which has a significant health-related, economic and social risk for individuals and their families. It is possible to ask for a support person and personal assistant service, social transport service, shelter and safe home service, and social housing. The main objective of these services is to ensure independent and safe coping of an adult in his or her home by maintaining and improving quality of life. Integrated care has become an important policy priority in Estonia.

Women's centers specializing in helping victims of domestic violence are located in 15 main cities, and services are provided throughout the country. Centers provide crisis help, temporary accommodation and psychological counselling, and their counsellors provide assistance in dealing with appropriate agencies like the police, social services or other state departments. Centers also work closely with lawyers who help with legal advice and information on handling legal matters like court processes. However, these centers do not offer special programs for older women.

In addition to governmental, professional, institutional, and for-profit interventions, community-based assistance by volunteers and non-governmental organizations is seen as providing promising resources for eldercare. In cooperation with the Estonian Ministry of Social Affairs and the NGO Village Movement Kodukant, a project involving volunteers was initiated and piloted in 2019-2020.¹⁷⁸ The main idea is to pay visits to homes and residential care houses in order to spend quality time with seniors in the volunteers' neighborhoods. Person-to-person communication helps them to get to know individual needs and problems: for example, volunteers can identify early signs of abuse and neglect in care-dependent older persons. Noticing signs of abuse is important for the prevention of violence. As an outcome of this project, community volunteering could be extended and introduced at the national level.

9.2 Country-specific services for perpetrators

In **Finland**, the Federation of Mother and Child Homes and Shelters' Jussi work runs services for violent men or men whose partners are violent. The main aim of Jussi work activities is to predict dangerous situations and prevent violence. The activities exist in many municipalities and include group work and counselling sessions.¹⁷⁹

The association of Lyömätön Linja Espoossa runs a violence prevention group programme for men who use violence or who are afraid that they may use violence in their families. The services are for the

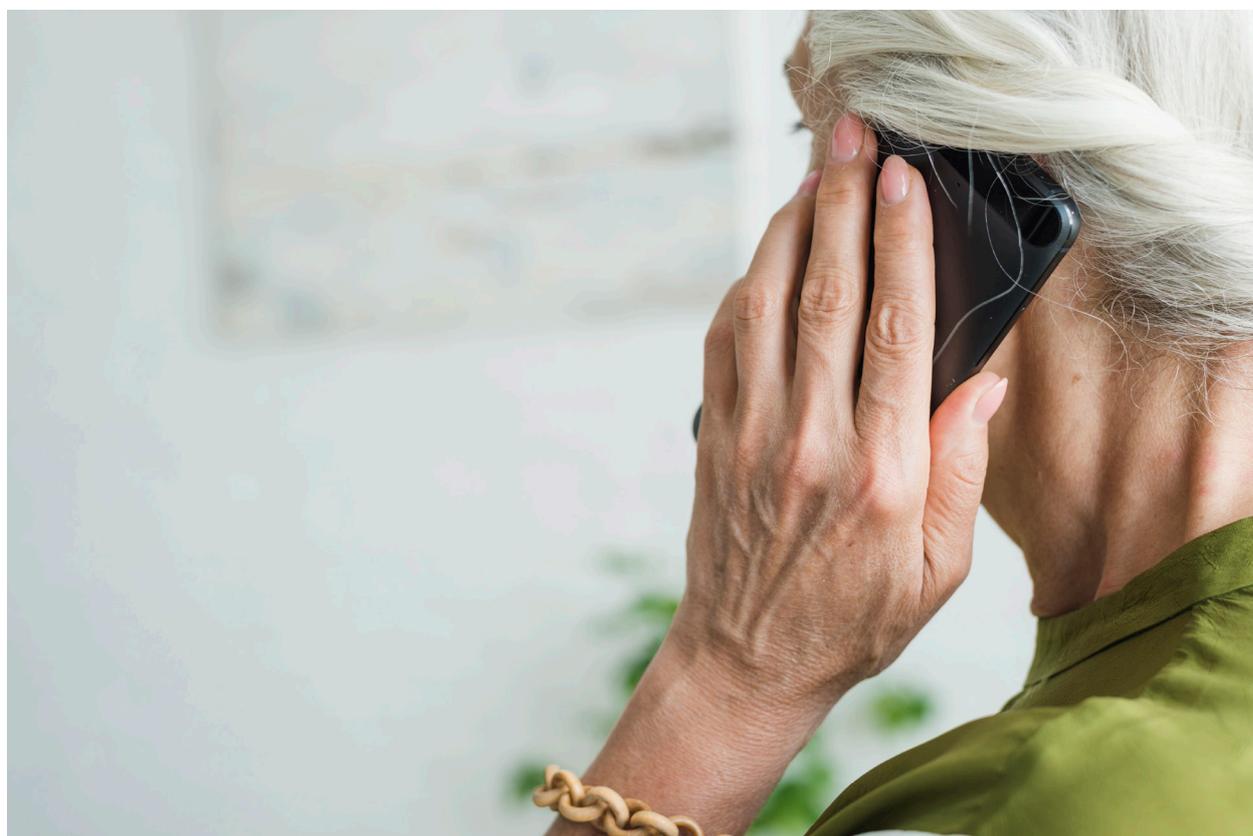
citizens of Espoo city. The association also offers services for immigrant men who use violence or who fear that they might use violence in their families or in other intimate relationship settings. The services include a violence intervention programme with individual and group sessions.¹⁸⁰

Another Finnish organization, Miessakit Association, runs crisis services for men and services for men who have used physical or mental violence against their intimate partners. The association's services include group and individual work.¹⁸¹ Maria Akatemia specializes in the recognition and treatment of women's inner ill-being and violence and has run the "Demeter programme" since 2003 for the prevention of violence by women. They also operate a helpline and chat as well as online and face-to-face peer support groups for women who use or are afraid that they may use violence.¹⁸²

In **Estonia**, the national strategy regarding work with perpetrators points out a need for cooperation and networking. The cooperation network includes the prison, the probation system, the police, the local government's social workers or child protection specialists, and victim support organizations. There is no work with perpetrators who have not been convicted, except men who participate in the fathers' program. Special programs for working with abusers of older people, often their parents or older relatives, have not been developed.

Some Estonian NGOs work with perpetrators. The Ministry of Justice and the Ministry of Social Affairs provide funding for some programs for stopping men from engaging with violence. For example, EELK Perekeskus (EELC Family Centre at the Estonian Lutheran Church) organized perpetrator violence-elimination groups. Group work called "Sisemine kindlus" is organized for perpetrators based on a model brought from Finland, "Lyömätön Linja". Groups are organized mainly in Tallinn and Tartu; if there is a need, they are also organized in Ida-Virumaa. Group work is organized in Estonian.¹⁸³

Estonia also joined the international movement of Caring Dads in 2018, which aims to help men build better relationships with their children and their children's mothers. The program does not specifically target elder abuse, but there is a potential to tackle it. Caring Dads uses motivational interviewing and cognitive behavioral techniques to address fathers' behavior. In Estonia, the programme runs in Tallinn, Tartu, Lääne-Virumaa, and in Pärnu and is coordinated by NPO Vaiter.¹⁸⁴



Chapter 10: Multi-agency and multi-professional cooperation

10.1 Building trust for multi-agency cooperation

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

Recruiting a multi-professional team made up of physicians, nurses, social workers, administrators, and a domestic violence expert(s) is essential to building support within the community. In a health care organization, the task is to find a nurse-friendly physician, a physician-friendly nurse, a social worker who is open to sharing their skills and resources, and an administrator who knows how to work as a part of a team. Each of the institutional 'players' will best understand how to reach and speak to their peers. It is their responsibility to divide up the work and the response in a way that makes sense within their own institutional framework.¹⁸⁵

Strategies without the commitment of the partners are useless. The importance of involving administrators in the multi-professional team cannot be stressed enough. **Administrators can turn a programmatic initiative into a policy, which is crucial to institutionalizing the desired response.** In addition, administrators either control or know how to access the 'purse-strings' of the institution, which becomes critically important if a team wants to develop and print resource materials for battered patients and protocols and training materials for hospital or clinic staff.¹⁸⁶

The role, which domestic violence organizations can play in the health care setting, is in bringing domestic violence expertise to the table. Domestic violence organizations need to show/express that **health care is an important part of any community-wide response to domestic violence.** Health care professionals will always see more battered older women than professionals from almost any other type of organization, yet health care providers are often left out of initiatives for community-wide cooperation on domestic violence.¹⁸⁷

Start networking by identifying relevant organizations to engage in the process, find the missing links, and involve the right people. When professionals with different backgrounds begin working together in multi-agency structures, this can initially cause difficulties. Practitioners practice their profession from their own perspective using their own (scientific) insights, experiences, values, justifications and terminology. However, over time and whilst building up trust, some of these difficulties can be overcome. **Trust is a crucial component within any multi-agency approach.** Therefore, the second step is to invest in mutual trust and understanding before further developing the structure.¹⁸⁸

Roles, responsibilities and expectations need to be clearly defined and specified. Transparent decision-making, participatory planning and continual monitoring and evaluation are key components of successful cooperation. Administrators can support staff to invest time and resources into collaborative activities. Funding needs to support the networks to cooperate on primary prevention as well as intervention activities.¹⁸⁹

10.2 Benefits of multi-agency cooperation

The main **benefits of multi-agency cooperation** are that it:

- contributes to enhanced and improved outcomes for older victims
- helps to build consensus and break down professional boundaries and attitudes
- promotes mutual support, encouragement and exchange of knowledge between professionals, leading to more manageable workloads
- aids in offering services that match those required by older people
- improves coordination of services, resulting in better relationships and referrals
- increases the level of trust between professionals and agencies; every partner agency knows what each can and will deliver

Effective prevention of violence against older persons and provision of support to older victims consist of three stages which complement one another¹⁹⁰:

- **General support services**, such as health, social and community services, support victims to recover from violence, e.g., through medical and financial assistance, housing/home care and referring victims to specialist victim support services
- **Specialist victim support services** provide one-to-one counselling, develop safety plans and provide peer support and advocacy for older victims. They may also provide practical support, such as accompanying the victim to the police or to court. These services include helplines, shelter services, crisis centers and NGOs that have specialist knowledge, skills and experience in supporting (older) victims of violence.
- **Effective multi-agency cooperation** between specialist and general support services as well as other agencies, e.g., the police, is required to protect victims and prevent further violence and abuse from happening.



For specialist services in your country, see chapter 9.

Multi-agency cooperation in the context of this manual refers to professionals from different disciplines working jointly towards a shared goal (i.e. an older person's safety and well-being). Cooperation facilitates **combining skills, knowledge and efforts in the common interest** and hence strongly benefits from multi-professional settings. Multi-professional cooperation has been proposed as a 'best practice' in cases of family violence, and the Istanbul Convention recommends cooperation between all relevant actors to prevent and combat violence against women and domestic violence.¹⁹¹ At its best, each professional performs their role with the roles of others in mind, ensuring that collective wisdom and diverse expertise is fully exploited in addressing a complex issue.

Multi-professional cooperation encompasses the **appropriate sharing of information and integrated thinking to enable comprehensive risk assessment and consideration of all matters pertinent to the victim's well-being**. It may include referrals, formal reporting mechanisms, case conferences, information-sharing and joint planning processes.¹⁹²

10.3 Prerequisites of effective multi-agency work¹⁹³

Building victims' trust in multi-agency teams

The trust victims have in organizations should not be taken for granted and must be constantly re-earned and maintained. Trust can be quickly lost if the victim feels disregarded, misunderstood or pressured.

Leaving the door open

It is important that organizations explicitly communicate to victims that they are welcome to contact them at any given time, even if victims have repeatedly missed an appointment or did not take the steps they were supposed to or had planned to take.

Dealing with power cautiously

Victims may be afraid of disclosing information to some professionals/organizations because they exert power over them, or the victims may be fully dependent on their help. For example, social service agencies have the power to grant or withhold social benefits and services. It is important to carefully deal with such institutional power and reflect on it regularly.

Unburdening the victim and providing care

Victims of violence are in a stressful situation that may provoke feelings of fear, shame and uncertainty. They may be traumatized and concerned for their family members, including perpetrators. In such a mental state, it takes a lot of energy to fulfil everyday chores and to go on with their lives. Sometimes even professionals expect victims to function 'normally'. Instead, victims should be reminded that it is not possible, and it may even be unhealthy, to function 'normally'.

In **developing an effective multi-agency strategy and network**, the following aspects should be considered¹⁹⁴:

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

Furthermore, any strategy should seek to place the older person at the heart of professional efforts. Important guiding **principles for developing a strategy** can include¹⁹⁵:

- Common visions and goals with the safety of victims as a priority
- Planned, thought-out approaches to confidentiality and privacy issues
- Understanding other professionals' roles, goals and constraints
- Respect for other professionals' skills, knowledge and roles
- Commitment to interaction, collaboration and timely communication
- Structures for planning and convening meetings, taking notes and distributing them, and making sure that working procedures and goals are monitored and reviewed

Chapter 11: Self-care and safety

11.1 The importance of self-care for professionals and volunteers

Working with victims of violence may cause uncomfortable feelings for a professional, provoking difficult experiences, memories and emotions in oneself. Working with an older victim may also cause ambivalent feelings in the professional, such as:

- feeling that one does not have adequate skills or support from co-workers to deal with client cases
- feelings of helplessness or withdrawal from the case
- fear (of a perpetrator)
- anger
- helplessness and frustration; for example:
 - “I do my best, and nothing happens”
 - “This takes too much time”
 - “Victims do not do as we agreed”
 - “The same things happen again and again – she may go back again after leaving the abuser/ she takes the abuser back again”
- omnipotence: “I know what should be done; I can solve the situation”
- ambivalent feelings (empathy – confusion – anger)
- overprotective attitude and behavior from the worker: many older victims lack the capacity to protect themselves (associated with feelings of helplessness in older persons)
- the worker feels and internalizes the feelings of the victim when dealing with their pain and suffering
- frustration about inadequate or non-existent (quality) services for older abused persons
- frustration when there are no simple and quick solutions

Having a safe and supportive working team and organization can help professionals when they work with victims of violence. Professional work can be influenced by one’s own experiences of violence and survival, one’s own experiences of help and support and awareness of one’s own fears, feelings and attitudes, leading to professional empowerment. *See section 11.4 for specific strategies.*

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

11.2 Compassion fatigue and burnout

Compassion fatigue and professional burnout are common among individuals who work directly with trauma victims, such as health care workers, psychologists and first aid responders. Fatigue and burnout are most common in the health care field; when health care professionals struggle with their responses to the trauma suffered by their patients, their mental health, relationships, effectiveness at work, and physical health can suffer. **Compassion fatigue** is **emotional and physical exhaustion**, which professionals experience due to the long-term use of empathy when treating patients who are suffering in some way. It may manifest suddenly, and the effects can extend to all areas of life, including

having an impact on family life and changing the professional's views about life and the world. Contributing factors in health care are, for example a 'culture of silence', lack of awareness of symptoms and poor training on the risks associated with high-stress jobs.¹⁹⁶

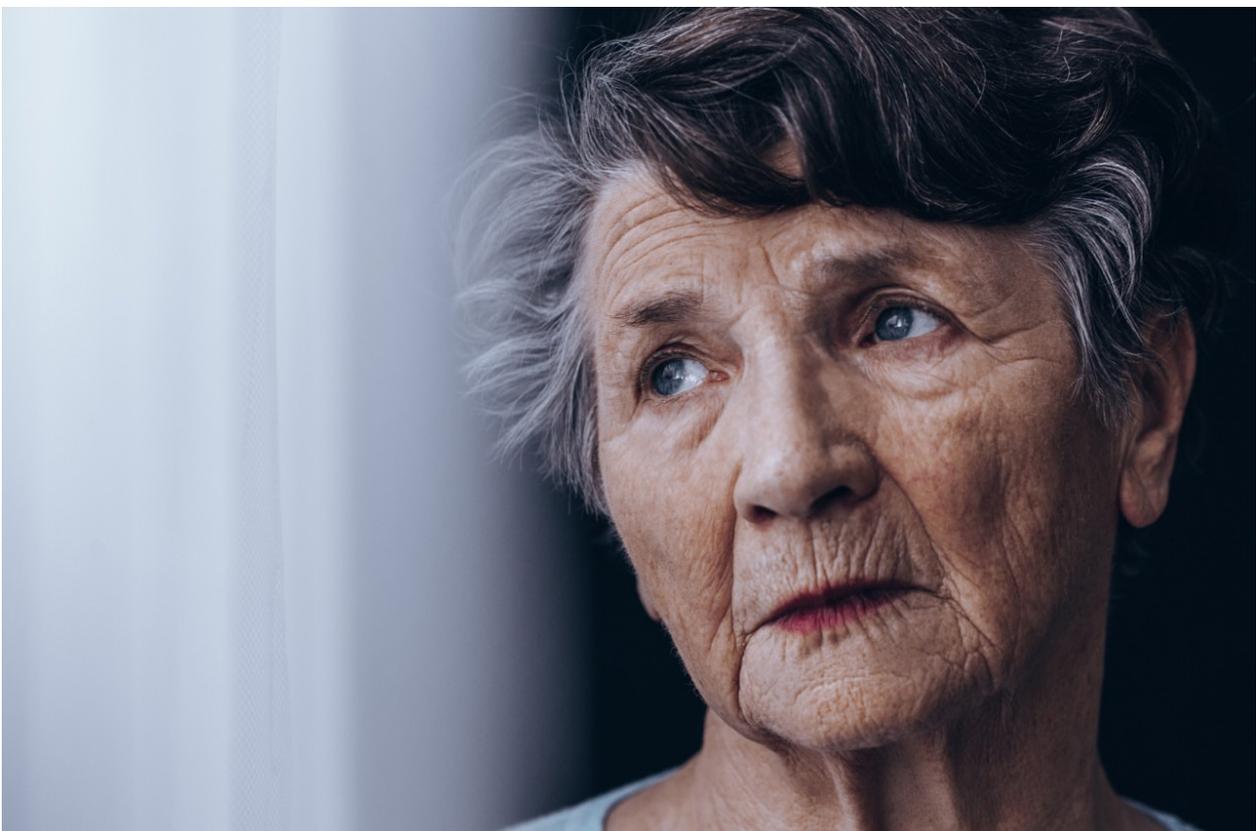
Symptoms of compassion fatigue may include:

Difficulty concentrating	Intrusive imagery
Feeling discouraged about the world	Hopelessness
Exhaustion and irritability	

Professional burnout, on the other hand, is a gradual and progressive process that occurs when work-related stress results in emotional exhaustion that is due to repeated use of empathy combined with day-to-day workplace difficulties and a fast-paced environment. **Professional burnout is similar to compassion fatigue; however, it does not require direct contact with trauma clients.** Professional burnout develops over time with contributing factors related to the individual, the populations served and the organization.

11.3 Secondary traumatization

Secondary traumatization describes the responses of professionals who work with survivors with traumatic experiences. Secondary traumatization **results from engaging in an empathic relationship with an individual suffering from a traumatic experience and/or bearing witness to the intense or horrific experiences of that person's trauma.** It involves helping or wanting to help a traumatized or suffering person. **Secondary traumatization manifests as behavioral stress symptoms,** which may also include a full range of PTSD symptoms.



Symptoms resemble those of survivors of trauma and can be divided as follows into physical, behavioral, and emotional/psychological warning signs:

Secondary traumatization warning signs¹⁹⁷		
Physical	Behavioral	Emotional/psychological
<ul style="list-style-type: none"> • Exhaustion • Insomnia • Headaches • Increased susceptibility to illness • Sore back and neck • Irritable bowel, gastrointestinal distress • Rashes, skin breakouts • Grinding one's teeth at night • Heart palpitations • Hypochondria 	<ul style="list-style-type: none"> • Increased use of alcohol and drugs • Anger and Irritability • Avoidance of clients/patients • Consuming high trauma media as entertainment • Avoiding colleagues and staff gatherings • Avoiding social events • Impaired ability to make decisions • Feeling helpless • Impostor syndrome – feeling unskilled in one's job • Problems in personal relationships • Difficulty with sex and intimacy • Thinking about quitting one's job • Compromised care for clients/patients • Engaging in frequent negative gossip/venting at work • Impaired appetite or binge eating 	<ul style="list-style-type: none"> • Emotional exhaustion • Negative self-image • Depression • Increased anxiety • Difficulty sleeping • Feelings of hopelessness • Guilt • Reduced ability to feel sympathy and empathy • Cynicism and anger at work • Resentment of demands • Dread of working with certain clients/patients • Depersonalization: spacing out • Disruption of world view or irrational fears • Intrusive imagery • Hypersensitivity to emotionally charged stimuli • Insensitivity to emotional material/numbing • Difficulty separating personal and professional lives • Failure to nurture and develop non-work-related aspects of life • Suicidal thoughts

11.4 Protective factors and strategies

Newell and MacNeil (2010)¹⁹⁸ divide the protective factors into organizational strategies and professionals' individual self-care strategies¹⁹⁹:

Organizational strategies for supporting staff
<ul style="list-style-type: none"> • Organizational culture (e.g. values and culture of an organization): supportive environment, permission for workers to take care of themselves, allowing taking time off for illness • Having a more diverse caseload (associated with decreased vicarious trauma) • Safe and comfortable work environment

- Trauma-specific education (diminishes the potential for vicarious trauma)
- Information to help individuals name their experiences and provide a framework for understanding and responding to them
- Opportunities to debrief informally and process traumatic material with supervisors and peers
- Incident-stress debriefing as a more formalized method for processing specific traumatic events, reducing stress and working with feelings which occur during and after interactions with a traumatized patient
- Regular supervision as a tool for prevention and healing of vicarious trauma
- Responsible supervision to create a relationship in which employees feel safe in expressing fears, concerns and insufficiencies (e.g. weekly group supervision in which traumatic material and its personal effects may be processed and normalized as part of the work of the organization)
- Available counselling resources, e.g. as peer support or group therapy with co-workers
- Possibility to have formal consultations with expert workers/organizations
- Arrange possible trips with colleagues
- Rotate duties of staff
- Create professionals' networks
- Management strategies: regularly use instruments to evaluate the extent to which these conditions exist within their workforce
- Evaluate organizational risk factors
- Include in teaching curricula: key features, warning signs and symptoms associated with professional burnout and secondary traumatic stress; self-care strategies and techniques as preventive practice behaviors
- Invest in a "cozy" work environment, so that staff feel comfortable and relaxed
- Encourage regular coffee breaks among staff
- Develop effective conflict resolution protocols

Professionals' individual self-care strategies

- Utilize skills and strategies for workers to maintain their own personal, family related, emotional, and mental/spiritual needs while responding to the needs and demands of their clients
- Set realistic goals about workload and client care, utilizing coffee and lunch breaks, getting adequate rest and relaxation
- Social support from colleagues after taking on a particularly difficult client or receiving emotional support such as comfort, insight, comparative feedback, personal feedback, and humour
- Develop individual coping strategies and coping skills
- For individuals experiencing secondary traumatic stress, psychotherapy may be a reasonable treatment option, particularly for those with a history of trauma
- Stay in touch with family, friends and colleagues and maintain healthy relationships
- Appreciate the precious 'little things' in life—small moments like sipping a cup of tea, hearing the wind in the trees or making positive connections with others
- Gather with people to celebrate traditions, rituals or ceremonies and mark transitions, celebrate joys and mourn losses

- Take time to reflect or express gratitude by reading, writing, prayer or meditation
- Express oneself through creative activities, e.g. journal writing, drawing, painting or sculpting, dancing, singing and making music
- Stay hydrated
- Set boundaries with oneself, clients, friends, family and colleagues
- Engage in physical exercise, e.g. hike in nature
- Find purpose beyond work/professional duties, e.g. engaging with the local community, attending festivals and gatherings
- Spend time with animals/pets
- Seek help if one needs it, and keep in mind that one cannot change the world
- Maintain a healthy emotional distance

11.5 Developing organization-specific guidelines and procedures

Every health and social care organization should have elder abuse protocols or guidelines in place. The objectives of such guidelines/protocols are²⁰⁰:

- to ensure the dignity of and respect for older people accessing services
- to protect and support employees and volunteers when abuse is suspected, witnessed or disclosed
- to clarify the roles and responsibilities of volunteers, staff and management when abuse is suspected, witnessed or disclosed
- to achieve a unified and consistent approach to the management of elder abuse cases
- to reflect inter-agency and multi-professional responsibilities of all agencies in responding to and preventing elder abuse

Developing guidelines is not enough — all new and existing staff members and volunteers should be trained about them at regular intervals. It is also recommended to include elder abuse as a permanent agenda item at relevant staff meetings and to review the guidelines regularly for any updates.

11.6 Safety of employees and volunteers

Health and social care workers experience the highest incidence of violence, threats of violence, and bullying/harassment at work of any sector. Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening or disruptive behavior which occurs in the workplace. It ranges from threats and verbal abuse to physical assaults and even homicide. Those affected by violence or harassment at work tend to report higher levels of work-related ill-health.

Measurements and actions which a health and social care provider can take to protect its employees and volunteers include²⁰¹:

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

When working or volunteering, employees and volunteers should²⁰²:

- Report all violent incidents promptly and accurately, no matter how minor they may seem.
- Understand and follow the workplace violence prevention program and other safety and security measures.
- Participate in employee complaint or proposal procedures covering safety and security concerns.
- Participate in safety and health committees or teams which receive reports of violent incidents or security problems.
- Take part in a continuing education program which covers techniques to recognize escalating agitation, violent behavior or criminal intent, and discuss appropriate responses.
- Hold employers accountable for any breaches and take care of their own well-being.

How to act in a violent situation at work²⁰³:

- Maintain behavior which helps to defuse anger by:
 - presenting a calm and caring attitude
 - not matching the threats
 - not giving orders
 - acknowledging the person's feelings
- Avoid behaviors which may be interpreted as aggressive, e.g.:
 - moving rapidly
 - getting too close
 - touching unnecessarily
 - speaking loudly
- If possible, keep an open pathway for exiting the room
- Trust one's own judgment
- Avoid situations, which do not feel right
- If being verbally abused, ask the abuser to stop. If the abuser does not stop, leave and notify the employer
- If control of the situation cannot be gained, shorten the visit and remove oneself from the situation
- If feeling threatened, leave immediately



11.7 Safety of clients and visitors

Health and social care workers can reduce risks to patients/clients, themselves and their colleagues when they manage incidents proactively and maximize opportunities to learn from adverse events and mistakes. Organizations should provide appropriate systems and support to enable their workforce to learn and apply the skills and knowledge required for patient/client safety.

Key aspects of client/patient safety include²⁰⁴:

- Communicating effectively
- Identifying, preventing and managing adverse events and mistakes by:
 - Recognize, report, and manage adverse events and near misses
 - Manage risk (assess, discuss, respond)
 - Understand health care errors (within one's own duty of care)
 - Manage complaints (within one's own work role)
- Using evidence and information by employing the best available evidence-based practices and guidelines
- Working safely
 - Be a team player (listen, provide information, give feedback, show respect)
 - Understand human factors (assess workplace risk, follow standard procedures, work within one's own limits)
 - Understand complex organizations
 - Provide continuity of care
 - Manage fatigue and stress (identify one's own limits, report issues/mistakes)
- Being ethical
 - Perform to expectations, maintain confidentiality, report issues
 - Know the code of conduct, maintain confidentiality, respect others' work roles and interact appropriately
- Continuing to learn by providing constructive feedback, sharing ideas and learning from others
- Addressing specific issues
 - Prevent errors (confirm client identity, report issues)

Exercise 2.1: Ideal services – dreaming of a perfect service for older persons

Method of the exercise

- Group work or
- Fishbowl method or
- World Café method

Learning Outcomes

- Learn to think ‘outside the box’ by imagining services with unlimited possibilities
- Develop curiosity and explore ideas—what would be the ‘ideal’ model of services for older persons (or victims of domestic violence)
- Plan services based on the needs of older persons (Maslow’s hierarchy of needs)

Materials required

- Maslow’s hierarchy of needs poster (see page 93 for full page poster that you can print out)
- Unbelievable Lucky Chance 1 or 2 form
- Large paper — one for each group
- Crayons

Time frame: 15-30 minutes

Preparation for the exercise

Arrange the room according the method you will use.

Instructions

1. Ask participants to read through the Unbelievable Lucky Chance 1 or 2 form. You can choose 1 or 2 depending on the workplace/profession of the participants.
2. Hang the picture of Maslow’s hierarchy of needs on the wall.
3. Ask participants to dream of a perfect service for older persons based on the hierarchy.
4. Participants can draw a plan of the perfect shelter/nursing home.
5. Ask participants to give an explanation about how their model fulfils older persons’ needs.

Unbelievable Lucky Chance 1:

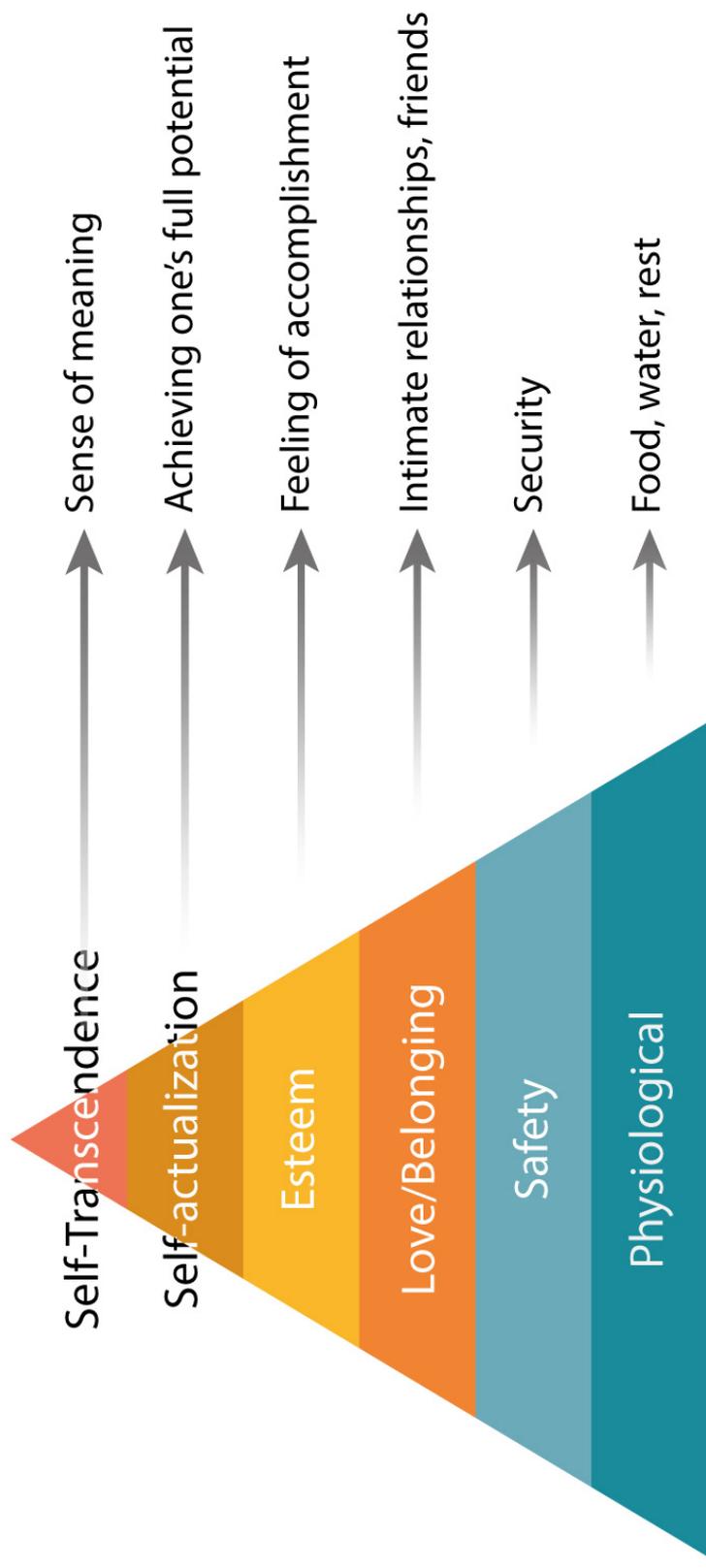
You work in a medium-sized women's shelter in a medium-sized town. One day, you are informed that a wealthy person has left a large amount of money for building an ideal place for older victims of domestic violence in your town. You are given the chance to completely plan your ideal place for older women who are victims of violence, with no restrictions. Develop a plan in your group based on these questions:

- Who will plan the space with you?
- Who will plan the service model with you?
- How will the place look?
- Where is the place located?
- What kinds of programmes will you have in place?
- Who would work in such a place? What are their roles and duties/responsibilities?
- What kind of food would you offer and how?

Unbelievable Lucky Chance 2:

You work in a medium-sized nursing home in a medium-sized town. One day, you learn that a wealthy person has left a large amount of money for building for an ideal place for older persons in your town who have physical disabilities. You are given the chance to completely plan your ideal place for older women with disabilities who are victims of violence, with no restrictions. Develop a plan in your group based on these questions:

- Who will plan the space with you?
- Who will plan the service model with you?
- How will the place look?
- Where is the place located?
- What kinds of programmes will you have in place?
- Who would work in such a place? What are their roles and duties/responsibilities?
- What kind of food would you offer and how?



Maslow's hierarchy of needs

Exercise 2.2: Risk on Elder Abuse and Mistreatment Instrument (REAMI) and safety planning

Method of the exercise

- Group work based on case study and using the REAMI instrument
- Socio-drama based on completed REAMI instrument, Safety plan form and My Safety Plan form

Learning Objectives

- Learn to assess risk factors of abuse by using the assessment instrument
- Be able to confidently develop a safety plan together with the victim

Materials required

- Case study form
- REAMI questionnaire (Appendix 1)
- Safety plan discussion form for the case study of Martta (Appendix 2)
- My Safety Plan form (Appendix 3)
- Pens

Time frame

REAMI part: 20 minutes

Safety planning part: 40 minutes

Preparation for the exercise

Give a lesson on different screening instruments, risk factors for victimization and recidivism, and the goals of safety planning and how to do it with a victim. Introduce REAMI and the My Safety Plan form.

Instructions

1. Group work based on the case study for completing the REAMI questionnaire:

Organize participants in small groups of 3-5 persons, depending on the number of participants. Ask the participants to:

- Read through the case study
- Assess Martta's situation in the group according to the questions in the REAMI questionnaire
- Count how many times A, B, C and D are answered in each part, and finally count the total REAMI scores and interpretation of Martta's situation
- Choose one person to present the answers to the whole group by giving the group's justifications for each answer

When each group has introduced their answers, discuss the following with the whole group:

- What risk factors did you identify in Martta's story (risk factors for victimization and recidivism)?
- What challenges did you encounter as a group when assessing the risks?
- Did the case study provide you with the required information to carry out a risk assessment? If not, what would you do as a professional in your field to receive the required information?

2. Socio-drama based on the completed REAMI form using the Safety plan form in Martta's case study and the My Safety Plan form:

- Ask the group to select a person to play Martta's role and one or two persons to play the professional(s).
- Give participants the Safety plan form for the professional(s) and for Martta.
- Ask the 'actors' to discuss each question in the form; after Martta's answers, draw conclusions about her situation and try to find solutions.
- Fill out the My Safety Plan form with Martta by determining actions to ensure her safety.

3. Questions and discussion after the socio-drama:

Ask the persons who played the professionals' roles the following questions:

- How did you feel about carrying out the safety planning process?
- What was easy/challenging while making the safety plan with Martta?
- Was it easy or difficult to find answers to the safety plan questions?

Ask the person who played Martta's role the following questions:

- How did you feel about carrying out the safety planning process?
- Were the professionals helpful?
- Did you feel that you understood the professionals' questions?
- Did you feel that you could follow the safety plan?

Discuss with the whole group the following questions:

- How did the professional(s) do in assisting Martta with developing the safety plan?
- Was there anything that the professionals could do in another way?

Key questions in Martta's situation:

- How to diminish the risk of recidivism – how to increase Martta's safety in practice
- How to support Martta emotionally (empowerment)
- How to support Martta to break the silence (empowerment)
- How to support Martta to create a social network

4. Discussion about Martta's situation

- What kinds of risks can you see in Martta's situation? (e.g. Martta can fall with serious results – i.e. getting a hip fracture and broken bones)
- How can she avoid risks such as falls, as she has physical disabilities (e.g. by sitting on a chair near the door or sitting by the door of the safest room that can be locked)?
- How do you create a confidential and trusting relationship with Martta? (discuss her feelings, concerns, relationship with her daughter and son, past family history, her husband's death, etc.)
- What do you do if Martta does not give permission to discuss her situation within your work team?

(Remember that you cannot promise to not tell anyone – the most important thing is to take care of her safety, and you have the responsibility as a professional to do that. This is important to explain and justify to Martta. Revisit the issue when visiting her again, do not push her, and give her time to process what happened and what you said to her.)

- What other professionals would need to be involved to protect Martta? (e.g. the doctor who examined Martta's injuries or a social worker)
- How would a meeting go with Martta's daughter? What other professionals could be involved in the meeting?
- Could Martta agree to have accessible buttons for emergency calls in her phone?
- Is there a possibility to have a safety wristband so that she can push the button for help?
- Is Martta mentally able to follow the safety plan when you plan her first steps? What issues could prevent her from following the safety plan?

Tips for the trainers:

You can work on the Safety Plan together with Martta by role playing what she would say to her daughter in cases when her daughter asks for money but Martta does not have any. Additionally, the other parts of the Safety Plan can be role played, e.g. when Martta feels insecure and wants to move away from her daughter.

Case study: Martta

Martta is a 78-year-old woman who has been living in a residential care home for 20 years because she has mental health problems and needs medication. She received early retirement for these mental health problems. Her husband had alcohol problems and died about half a year ago. Martta has mixed feelings – her husband’s death was a relief, but she also feels lonely. Martta receives home care services once a week to help with her medication. She has physical difficulties with walking and therefore also needs assistance when showering. The home care workers closely follow her mental health situation, as lately she’s been experiencing some memory difficulties as well.

Martta has two children. Her son lives in another town with his family and visits his mother occasionally. Martta’s daughter lives nearby and visits her mother at least three times a week. She helps Martta with grocery shopping and other necessities. Martta relies on her daughter because she is the only close relative visiting her. The daughter has her own problems—she recently lost her job and has financial difficulties. Her relationship with her grown children is not close; she hardly ever sees them. She also has no friends.

The home care workers know that Martta supports her daughter financially—sometimes so much that she has no money to pay rent or electricity bills. The home care workers feel that Martta tries to compensate for her children’s childhood because their father was violent when drunk. The daughter sometimes speaks rudely to Martta and behaves impatiently when Martta walks slowly and needs help.

One day when home care visited Martta, they found her on the floor before the bed. She did not open her eyes when they came in. When Martta did not open the door, the workers had to use their own key to go inside. Martta mentioned that she was feeling really tired. The daughter had just visited her, bringing some food, but Martta wasn’t hungry, and her daughter seemed to be upset.

The workers helped Martta into the shower. In the shower, they noticed black marks on Martta’s arm and that her arm was in pain. Martta explained that when she tried to make food, she had fallen and landed on her arm in the kitchen. The workers decided to take Martta to the nursing home unit for a check-up with the doctor.

The doctor examined her and concluded that the injuries could not have resulted from only a fall. Now Martta admitted that her daughter got nervous and frustrated when Martta told her that she did not have money to give her this time. At the same time, her daughter was trying to help Martta to the kitchen, but upon hearing that Martta was out of money, her daughter slapped and pushed her. Martta lost her balance and fell onto the floor. Martta explained that her daughter did not intend to hurt her—it was an accident. She explains that she always tries to keep money with her for her daughter, but sometimes she simply does not have enough. This makes Martta feel guilty and afraid about how the daughter will react.

The home care workers want to make a safety plan with Martta to increase her safety in the future. She hesitates but ultimately agrees.

Appendix 1 (Exercise 2.2):

Risk on Elder Abuse and Mistreatment - Instrument¹©²⁰⁵

Personal characteristics:

Date	
Gender	<input type="checkbox"/> male <input type="checkbox"/> female
Age	
Cohabiting?	<input type="checkbox"/> no, living alone <input type="checkbox"/> with partner <input type="checkbox"/> with children <input type="checkbox"/> with others

To which extent do you agree with the following statements about the older person and their environment? (please tick boxes)

A = I completely disagree

C = I rather agree

B = I rather disagree

D = I completely agree

PART 1

To which extent do you feel that:

	A	B	C	D
... the older person is dependent on one key figure ² ? (e.g. for care, finances, administration, housing, ...)				
... the older person is isolated?				
... there are signals that the older person cannot handle the situation anymore? (e.g. signals of overburdening, fatigue, emotionality, irritation, short temper, indifference, feelings of powerlessness, frustration, anxiety, ...)				
... the older person faces physical constraints, dementia, depressive symptoms, addiction, psychiatric or psychosocial problems?				
... radical and stressful changes in the life of the older person have recently occurred? (e.g. moving, death of partner, ...)				
... there is a history of violence in the family?				
Total (Count how many times A and B, C and D are answered)				

PART 2

To which extent do you feel that:

	A	B	C	D
... the relationship between the key figure and the older person is problematic? (e.g. stress, tensions, conflicts, ...)				
... the relationship between the key figure and their close environment is problematic? (e.g. stress, tensions, conflicts)				
... the key figure is dependent on the older person?				
... the care, provided by the key figure for the older person, is too much?				
... the care knowledge of the key figure is insufficient?				
... the key figure is isolated?				
... there are signals that the key figure cannot handle the situation anymore? (e.g. signals of overburdening, fatigue, emotionality, irritation, short temper, indifference, feelings of powerlessness, frustration, anxiety, ...)				

¹ Copyright: Vrije Universiteit Brussel, Belgian Aging Studies, liesbeth.de.donder@vub.be

² An older person often has a key figure in his/her community (particularly related to care). This person can, for instance, be a partner, an adult child (or his/her partner), a neighbour, or a professional. A key figure is someone close to the older person, and they share an emotional bond.

... the key figure faces physical constraints, dementia, depressive symptoms, addiction, psychiatric or psychosocial problems?				
... the key figure has financial problems?				
... radical and stressful changes in the life of the key figure have recently occurred?				
Total (Count how many times A and B, C and D are answered)				

PART 3

To which extent do you feel that:

	A	B	C	D
... there are signals of violation of rights? (e.g. hindered to read their mail, to meet friends or acquaintances, ...)				
... there are signals of emotional abuse and mistreatment? (e.g. feeling anxious, ashamed, threatened by accusations, being belittled, ...)				
... there are signals of neglect? (e.g. lack of getting dressed, groceries, meals, household)				
... there are signals of financial abuse and mistreatment? (e.g. forced to sign papers or to give money or goods, forced changes to a will, sudden unexplainable changes in the financial situation, ...)				
... there are signs of physical abuse and mistreatment? (e.g. physically injured, assaulted, ...)				
... there are signs of sexual abuse and mistreatment? (e.g. unwanted touching, obliged to undress, ...)				
Total (Count how many times A and B, C and D are answered)				

TOTAL SCORE OF THE REAMI

Note down the totals from the grey boxes in part 1, part 2 and part 3.

Multiply these totals by the corresponding number (1,10 or 1000).

Add these three numbers together.

Part 1:		X 1	=
Part 2:		X 10	=
Part 3:		X 1000	=
		Total REAMI score	=

TOTAL REAMI score	Explanation
0	The situation is good. There is no risk.
1 / 2 / 3 10 / 11	The older person has a low risk of elder abuse and mistreatment.
4 / 5 / 6 12 until 106	The older person has a moderate risk of elder abuse and mistreatment. At this moment, there may be no visible signs of elder abuse and mistreatment; however, there is a moderate risk. Further attention is required.
1000 until 6106	There are indications that the older person is being abused. There is a high risk of elder abuse and mistreatment.

Appendix 2 (Exercise 2.2): Safety plan form for Martta's case study

Scenario: Professionals arrive in Martta's home. They ask to discuss safety issues with her. They also ask her permission to do the safety plan together with her by showing her the My Safety Plan form. They explain why the form is important to do and how it will be carried out.

Interview questions by professional(s)	Answers by Martta	Conclusions/Possible solutions (for the professional(s) to write down)
What kinds of violent situations or threats of violence are occurring?	If I do not have money to give her – then I do not know what will happen. Also, when she tries to help me to move to go to the kitchen or toilet and I am not quick enough, she becomes nervous and irritated.	Dangerous situations: if Martta has no money if Martta moves too slowly How could these situations be avoided?
Has she been physically violent before?	She pushed me just a couple of times – but that has not been serious.	Has been violent before: risk for recidivism
What about her past – has she been violent to anyone else, e.g. towards her children, or has she been a victim of violence?	I do not know – her father, my husband, sometimes behaved frighteningly when he was drunk, but he never hurt the children. I was not in contact with her when her children were small.	There is a history of violence in the family: increases risk for recidivism
Do you know if she has been mentally unbalanced, e.g. having suicidal thoughts?	I do not know – we were not connected with each other when she had a young family. She didn't begin to visit me until after my husband died.	Not known
Has she ever threatened you?	No, never.	No, although perhaps just not verbally
Are you afraid of her, or are you worried about what could happen?	Well...I feel somehow distressed with her. I do not always know how she will react – sometimes everything goes ok, while sometimes she is already angry when coming to see me.	Yes, feels distressed/afraid
How have you tried to protect yourself? Do your strategies work?	By keeping cash with me that I can give her when she asks. If I have money, everything goes well. I also try to be quicker when walking and doing things because she gets frustrated easily and shouts at me.	Strategies: compliance and adaptation (gives what the daughter asks, tries to be quicker when moving). Does not always work. What other strategies might be useful?
How do you feel about your daughter's behavior?	(Martta hesitates) Well, I understand her – I am old and slow, and I forget things. That makes her irritated, but she has her own problems. And in any case, she tries to help me.	Tries to understand.

Supplementary material

Has your daughter's behavior changed recently?	(Martta pauses for a while.) Yes, maybe she has become more easily nervous because she lost her job and has not found a new one. But she has always been short-tempered.	Yes, it is worse: increases risk for recidivism
Can you see the signs of a violent act before something happens?	Well...she smokes more nervously and her hands tremble.	Yes, she can recognize the signs. What could she do after recognizing the signs? (She cannot run away due to her physical disabilities)
How have you tried to avoid the situation getting worse?	I do not ask or say anything. I try to move away from her or to go to another room.	Trying to be silent or move away. Are there any other ways to handle these situations?
Do you have a planned place to go if the situation escalates/becomes worse?	No. I cannot go outside because I do not walk quickly. I just try to handle the situation by staying at home.	Isolation; feels trapped because of physical disabilities: increases risk for recidivism
Do you know where to get help if needed?	No...I cannot go anywhere in any case.	Isolation; feels trapped: increases risk for recidivism.
Do you know other residents here? Could you think of somebody who you trust that you could talk about your situation with?	No, all of them are in their own apartments and rarely go out. All residents here are old and have physical difficulties.	Isolation; no social network in residential care facilities: increases risk for recidivism. What could be done to create Martta's social network?
Could you consider preventing your daughter from visiting you? You could have a peep hole in the door and a safety chain on the door.	No, if she doesn't visit me, I am totally alone.	No, she is afraid to be totally alone: increases risk for recidivism. Is it possible to intervene in the daughter's behavior without the risk of breaking up their relationship?
Are you afraid for your future or concerned about what could happen?	Yes, I am. I do not have a lot of money. I would like to give more.	Yes, she is afraid for her future.
What would you like us to do? How can we help you?	I do not want anybody to interfere. I do not know what my daughter would think if she got to know that I have told someone about her... I am sure she would not like it.	She is afraid of her daughter.
Could we try to think about what to do?	Well...why not. But that is just between us.	She wants to keep the situation secret because of fear of her daughter: increases risk for recidivism.

Appendix 3 (Exercise 2.2): My Safety Plan form for Martta’s case study²⁰⁶

My name: _____

The following steps are part of my plan to start protecting myself in case of further violence. I do not have control over the other person’s violence, but I have a choice about how I respond and stay safe. I made this Safety Plan with my home care workers. They can help protect me if they know what is happening and what to do.

Discussion date	
Date	I have discussed with the home care workers about how to find trustworthy friends or family members who I can talk with about my situation.
Date	I have practiced with my home care workers what to say to my daughter when she wants money from me.
Date	I have practiced with my home care workers about moving to a safer place, which is:
Date	If I see her become angrier and more nervous, I can protect myself in the following ways:
Date	If I feel that the situation is very serious, I can give my daughter what she wants. I must protect myself until I am out of danger.
Date	I have moving disabilities; therefore, I will set up an emergency care plan. I can contact the following places/persons:
Date	I will always keep my mobile phone with me. Quick buttons for emergency calls are set on my phone.
Date	I will check the Safety Plan regularly with my home care workers. The date of our next meeting is:

Supplementary material



TISOVA

Training to Identify and Support
Older Victims of Abuse

Exercise 2.3: Principles of intervention and empowerment

Method of the exercise

- Socio-drama

Learning objectives

- Explore the challenges of the health care service environment from the point of view of older persons and staff
- Formulate ideas about how health care organizations can ease the working environment in emergencies
- Find ways to encourage staff when they meet and talk with older suspected victims of violence

Materials required

- Six volunteers/actors: 80-year-old Martta, a doctor, a nurse, a paramedic (ambulance crew) and two patients in the waiting room
- Space for two scenes: waiting room and medical examination room
- Forms for group discussion questions

Time frame: 1–1 ½ hours

Preparation of the exercise

- Prepare the stage for two scenes. Take care that the audience can see and hear the actors.
- Ask the actors to speak loudly.
- The audience will be the observers.

Instructions

Divide the participants into small groups and distribute the group discussion questions (below) and the following warm-up questions:

Warm-up small group discussion questions before the socio-drama action:

- Do you have your own experience visiting the emergency room?
- What challenges did you have while in the emergency room or in another health care service environment?
- What are the main issues/points of this socio-drama?

The groups can choose who will be the actors.

Ask participants to share the group discussion results with the whole audience.

Important: Emphasize the rules of the exercise: safety, respect and confidentiality from the audience. Actors will not be assessed according to how well they play their roles. Avoid possible criticism from the audience, e.g. how the nurse responded/should have responded. All feedback and remarks must be respectful and constructive.

Ask the audience to write down observations and questions which were brought up during the socio-drama.

Discussion questions after the socio-drama:

- with the doctor:
 - How did you feel while speaking with Martta?
 - What kinds of questions came to your mind?

- with the nurse:
 - How did you feel while interviewing Martta?
 - How would you have liked to respond to her refusal?
 - What was difficult/easy? What were the challenges?
- with Martta:
 - How did you feel about the responses of the doctor and nurse?
 - What was helpful and not so helpful in their responses?
- with the paramedic:
 - How did you feel about Martta’s case when you took her from her home?
- with two patients in the waiting room:
 - How did you feel when seeing Martta being taken to the medical examination?
- with the whole audience:
 - How could you encourage the doctor and nurse to make it easier for Martta to disclose violence and approve help?
 - Assess what the ethical issues were and whether Martta’s rights were considered in the emergency room.
 - What kind of professional challenges did the doctor and nurse face when speaking with Martta?
 - If you were having a meeting with a nurse and a doctor, what would you like to say to them?

Case study: Martta in emergency room

Martta enters the emergency room of a general hospital because she has serious breathing problems. Her son called for the ambulance but could not come with her to the hospital. In the ambulance, Martta was given extra oxygen by the ambulance crew. Martta is soon taken to the examination room. The doctor does a medical examination, asking e.g. how long she has had difficulties with breathing, has had chest pain or pain in her neck or head, as well as whether she has had difficulties while sleeping and how she manages in daily activities. Martta explains that she has chest pain and sleeping problems. The doctor goes through her health documents and comments that Martta seems to suffer from chronic diseases (comorbidity) and has several medications (polypharmacy). The doctor also notices that Martta was taken to an emergency room half a year ago because of a fall, but fortunately her hip was not broken. According to medical examinations, Martta has a mild respiratory infection; however, it does not explain the serious breathing problems and chest pain she has now. The doctor decides, based on her medical condition, that Martta needs a closer assessment of her situation, so Martta is sent to a nurse.

Martta is an 80-year-old widow and seems to be mentally competent. Her husband died three years ago, and then her son’s family moved into her house. They wanted to move in earlier, but Martta’s husband did not allow it. The husband was strict and spoke harshly towards Martta and their son.

She explains that she is very tired because her son’s small children are noisy and run around the house. She has walking difficulties, and therefore she gets some help from her son’s family, e.g. in bathing and shopping. She is surprised when a nurse starts to ask more about her situation at home and how is she getting on with her son’s family. The nurse expresses that it may not be easy to live in the same household and receive help from the young family. Martta admits that it is not easy at home and sometimes they have arguments. The nurse tries to continue the discussion with questions about what kinds of arguments they have and what happens during arguments. These questions make Martta feel nervous. She says that she has experienced difficult things but does not want to explain more. The nurse asks if home care or a social worker may visit her sometimes, but Martta refuses everything. She wants to leave the emergency room immediately and asks to call a taxi.

Exercise 2.4: Historical timeline – generational intelligence

Method of the exercise

- Interactive exercise with the audience (can be used in a small group or with a larger audience)
- This exercise can be for both professionals and volunteers.

Learning Objectives

- Narrow the gap between older and younger generations by identifying commonalities and differences in experiences, hopes, fears, interests, values and thoughts between different generations
- Enhance empathy towards older generations
- Expand understanding about older victims' help-seeking behavior and decisions

Materials required

- Large historical timeline posters (see exercise 4.1)
- Pens/markers

Time frame: 30 minutes

Instructions

Tape posters on a wall before the training and arrange the room so that everyone can see the posters. Introduce the marked events in the timeline. Depending on what kind of events are marked in the timeline, you can:

- show traumatic events in history (e.g. wars) (in your country) and how they influence life today
- show the turning points in women's history (in your country)
- show changes in domestic violence awareness, services or legislation in society and how these affected the lives of families/victims in the past and currently

Ask participants to go to the timeline with markers and add other events which occurred at different points in time. Ask participants to mark when they were born. Give them an opportunity to look at the rest of the timeline.

A variation on this exercise is to have the display on the wall or as a PowerPoint and only refer to it during the workshop without having participants write additional comments on it.

Discussion

When everyone is seated again, point out the differences in experiences and generational values depending on when a person was born. Highlight, for example, that:

- 'family violence' was not defined and services for victims had not been implemented during a large period of older victims' lives. They did not have a chance to choose to go to a shelter because none existed
- women's rights in society have changed dramatically over time

Discuss how:

- events/turning points listed on the historical timeline illustrate the generational values of older persons/women
- generational values may impact the decision of an older woman to seek domestic violence services or not
- generational values may affect an older woman's decision to leave or stay in an abusive relationship
- services may be the same or different from those offered to younger victims of domestic abuse

Exercise 2.5: Responding to sexual violence against older women

Method of the exercise

- Group work

Learning objectives

- Learn how to support older women in family caregiving situations
- Recognize the signs of trauma caused by sexual violence against older women
- Understand the barriers older women can experience in seeking help

Materials required

- Copies of the case study
- Paper and pens

Time frame: 40 minutes

Preparation for the exercise

Sexual violence against older women can be a difficult issue for some participants; therefore, it would be good to first have a discussion or lecture on sexual violence and its consequences.

Instructions

Divide the participants into groups of 4-5 members.

Distribute the case study to each participant.

Discussion

- How did you feel when Elma tries to get help from different professionals?
- What kinds of help-seeking barriers can you see for Elma—from her side and from the professionals' side?
- What would be your solution to Elma's situation? On what grounds?

Case study: Elma

Elma is a 63-year-old woman who is her husband's caregiver. Her husband is 65 years old and has a speech disorder (aphasia) and movement difficulties after a stroke. He needs help dressing and bathing. In Elma's opinion, her husband has changed mentally, not only after the stroke but already before that. He loses his temper quickly if some things are not going according to his will—he starts to shout and blame Elma for not taking care of him. Since he has difficulties using his hands, he demands that Elma serve him by giving him food and drink by hand. He also wants to know where Elma is going and when she will be back. Elma has noticed that her husband surfs the internet to view pornography.

The worst problem is the sexual behavior of her husband. He is constantly making comments on Elma's looks—he says that Elma is too old and ugly for him and not sexually interesting anymore. He also wants to show Elma the pornographic pictures. Elma is anxious and feels ashamed. Thus, she never talks about her husband's sexual behavior to anybody. She feels that she is not able to take care of her husband anymore. She can no longer stand the situation.

As a family caregiver, Elma is entitled to have some home care and respite care services for her husband in a nursing home nearby. She mentions her husband's behavior to the home care worker, but she does not talk about the sexual harassment she is experiencing. The home care worker is understanding and recommends that Elma talk to a family doctor.

Elma talks with a family doctor about her burden and asks to have her husband sent to a nursing home. The doctor informs her that there are not enough medical reasons for her husband to be in a care home and refers her to a social worker. Elma feels frustrated and asks if the doctor could at least give a prescription for sedative medication for her husband. The doctor explains that it is not wise—under such medication, her husband will need her care even more.

Elma discloses to a social worker how tired she is. The social worker is very sympathetic but explains that it is difficult in her case to get space in a permanent nursing home. The only thing that could be done is to try to get more home care services. Then Elma decides to mention the sexual harassment she is experiencing. The social worker explains that this behavior belongs to the illness her husband is suffering and asks her to be patient.

After discussing with the home care worker, family doctor and social worker, Elma feels that she is not being taken seriously. She feels that they underestimate her caregiving burden and sexual harassment.

Exercise 2.6: Trust-building in multi-agency cooperation

Method of exercise

- Role play or
- Socio-drama based on the case study

Learning objectives

- Learn how to develop multi-professional and multi-agency cooperation between the professionals
- Understand the roles, responsibilities and limits of each profession

Time frame: 1–1 ½ hours

Preparation for the exercise

- Prepare a meeting scene with a table and 3 chairs. Have the audience observe.

Instructions

- Ask for three participants to volunteer as actors playing the roles of a social worker, GP and women's support group facilitator.
- Distribute copies of the case study to the actors and audience.
- Give time for actors to read about and discuss their roles.

Important: Do not allow any disrespectful remarks; the exercise tries to show that building cooperation is a challenge.

Discussion questions after the socio-drama:

- How well did the professionals listen to each other?
- How did they try to reach some mutual understanding of the family situation?
- Can you describe the process of building trust with each other?
- What were the challenges each of the professionals faced in the meeting?
 - The social worker has met all the family members and has seen them interacting.
 - The doctor only knows the medical situation of the husband and the son.
 - The facilitator from women's services has met only Helen.

Case study: Helen

Helen is a 72-year-old woman who lives with her adult son and her husband who has Alzheimer's disease. The husband behaved violently earlier in the marriage; however, since falling ill, he is mostly restless and in need of constant care. The adult son has mental health issues. He is suffering from delusions and is sometimes violent towards his mother. From time to time, a social worker visits the couple to assess the situation. The husband's condition and medication are checked regularly by a doctor in the nearby health center. The son's medication is also checked in the same health center.

Helen participates in a support group organized by a women's shelter. She has been doing that since her husband was physically violent in their marriage. Now, as the husband has Alzheimer's, the physical violence has become unpredictable, and Helen cannot recognize the signs anymore. Her husband yells, swears and uses sexually abusive language towards his wife, calling her old and an ugly whore. Helen feels deep shame, hurt and insecurity but tries to understand the situation by reminding herself that her husband is ill.

The facilitator from the support group is aware of Helen's experiences based on what Helen has said about her husband and son. The social worker is concerned about Helen's safety and therefore decided that the professionals need to have a meeting to search for ways to keep Helen safe from violent situations. The social worker asks for permission from Helen, explaining that it is good if all of the professionals involved know how to try to prevent violence towards Helen. The social worker also explains that only Helen's security issues will be discussed. Helen gives her permission for the facilitator from her support group to participate in the meeting. The social worker also contacts the doctor and invites them to the meeting. The doctor was not sure if it would be possible to attend because the meeting is just before their shift starts in the emergency unit.

Care meeting: participants include the social worker, a doctor from a health center and the support group facilitator.

The aim of the meeting is to discuss Helen's safety and how to prevent violence from occurring. The social worker and the support group facilitator are present, and the doctor informed them that they will be late. The social worker runs the meeting.

The professionals introduce themselves. Both share their own understanding of the safety situation of the family. The social worker has not witnessed the husband's violent behavior but has seen how afraid Helen is in her home. The support group facilitator begins to discuss what Helen has disclosed about husband's and son's behavior. At this moment, the doctor arrives and mentions that they have limited time for the meeting.

The social worker briefly summarizes what has been discussed. The doctor mentions that the wife has been present during her husband's health center visits, although she has remained silent. When the doctor asks how things are going, the husband says that everything is fine. The doctor is familiar with the son based on his medication check-ups. When the doctor is informed by the other professionals about the husband and son's violent behavior, the doctor states that their medication will be checked again. The doctor apologizes and rushes away from the meeting.

How would you continue the meeting? Keep in mind that:

Most battered women's advocates are not experts on health care and, conversely, most health care providers are not experts on domestic violence. We do not have to be 'experts' in each other's fields to strengthen the response to domestic violence, but we do need to recognize and benefit from each other's expertise. How do we do that?

Exercise 2.7: Mapping organisations for multi-agency cooperation

Method of the exercise

- Individual stakeholder mapping and
- Brainstorming in groups

Learning objectives

- Map stakeholders involved in and needed for efficient multi-agency cooperation
- Gain understanding of the roles, responsibilities and limits of other organizations participating in multi-agency cooperation

Materials required

- Printed stakeholder pyramid with instructions (picture on the next page), preferably in size A3
- Pens
- Tables and chairs for group discussion

Time frame: 45 minutes in total (10 minutes for individual work, 25 minutes for group discussion, and 10 minutes for reporting to the whole audience)

Preparation for the exercise

Divide the participants into four groups with six persons in each group. Ask the groups to agree on a person who will report the key results of the group discussion to the whole audience at the end of the exercise.

First, give a brief presentation about the prevention stages (primary – secondary – tertiary) and give each participant a copy of the prevention pyramid. Give participants ten minutes to fill out the pyramid exercise in line with the different prevention stages and the following instructions:

- 1) Please write inside the pyramid the actors/organizations already in your professional network that you can collaborate with in preventing violence against older women/people.
- 2) Please write outside the pyramid the actors/organizations that you still need in your network to efficiently prevent violence against older women/people.

When ten minutes have passed, ask the participants to share their maps to one another in the groups and to have a discussion according to the questions below.

Discussion questions

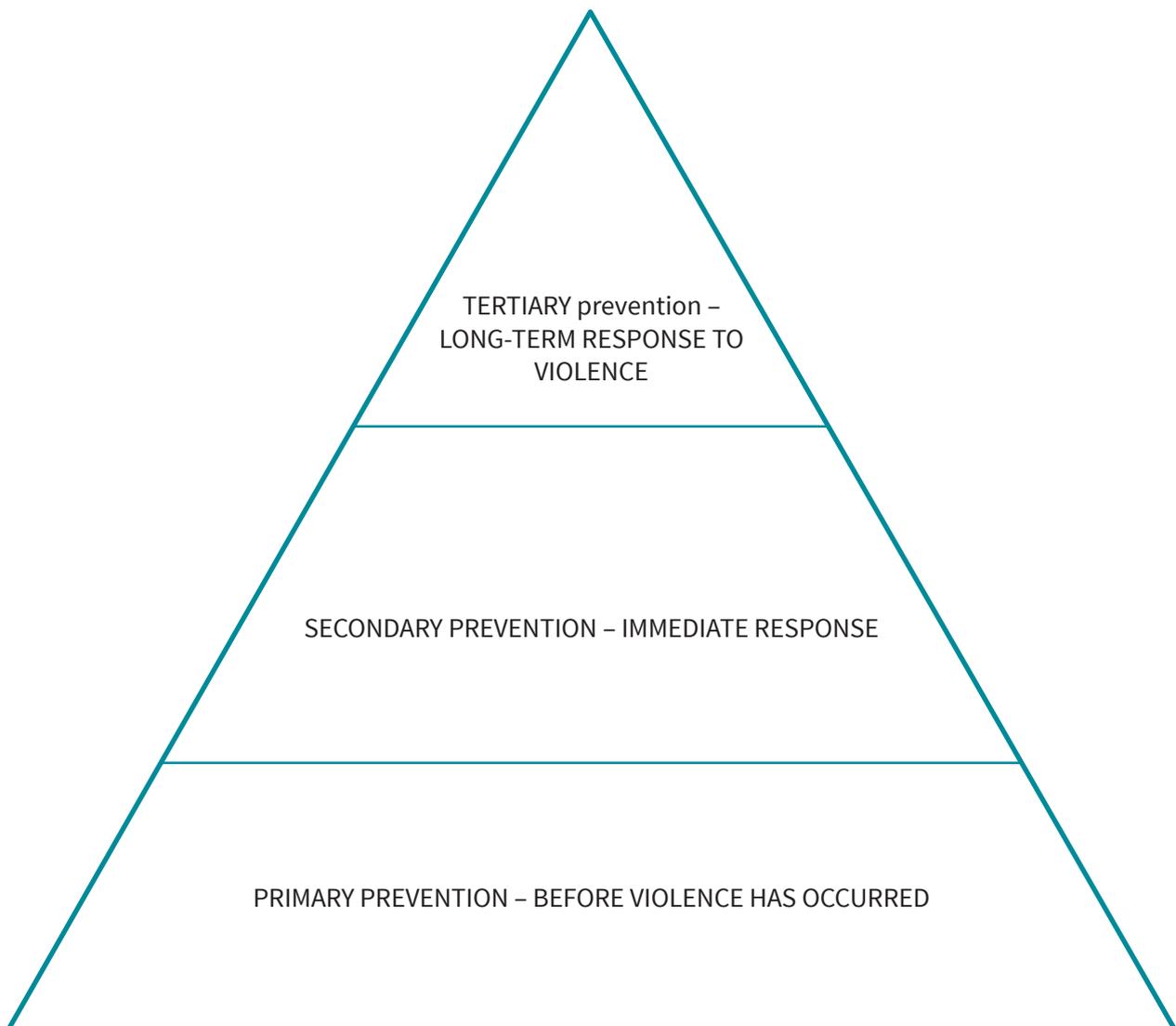
- What services do we already have in our networks, and what services were identified as needed in each level of the prevention pyramid?
- Different stakeholders practice their professions from their own perspectives using their (scientific) insights, experiences, values, justification, terminology, etc. How can we start cooperation and build trust with the services identified as needed for effective cooperation?
- Are there any best practices for multi-agency cooperation you could share with other participants?

At the end of the exercise:

Encourage participants to save the stakeholder maps and actively seek opportunities to come into contact with the organizations specified as needed for efficient cooperation.

Please write inside the pyramid the actors/organizations **already** in your professional network that you can collaborate with in preventing violence against older Women

Please write outside the pyramid the actors/organizations that you **still need** in your network to efficiently prevent violence against older women



Exercise 2.8: Protection from professional burnout

Method of the exercise

- Open fishbowl method

Learning objectives

- Learn from each other how to protect oneself from professional burnout
- Gain knowledge about protective factors at the individual, organizational and societal levels
- Engage all participants in the discussion

Materials required

- Chairs (as many as participants)
- Large room with space enough for participants to move
- Flipchart and markers for the note taker
- Note pads for all participants
- Microphones if needed

Time frame: 30–45 minutes (depending on how many participants from the outside circle join the conversation)

Preparation for the exercise

Identify 2-3 experts or participants who have experienced the issue to be discussed – they will be situated in the fishbowl

Organize a small circle of chairs surrounded by a larger circle.

- There can be 2-3 participants in the inner circle (fishbowl) with one or more empty chairs.

A note taker/rapporteur can be appointed to write down the key points of the fishbowl discussion on a flipchart.

Introduce participants to the fishbowl process:

- Explain the meaning of the empty chair(s); there can be one empty chair or more.
- Explain that you will give 5-7 minutes for each discussion period in the inner circle; after that, someone from the outside circle joins the discussion.
- It is also possible that participants from the inner circle are replaced after 5-7 minutes of discussion.

Open the session with experts in the inner circle

Discussion questions

- What are some individual (self-care) protective factors and strategies for professionals working with abused older persons? How can you as an employee support your own well-being?
- What are some organizational protective factors and strategies for professionals working with abused older persons? How can your employer support your well-being?
- What are some societal protective factors and strategies for professionals working with abused older persons? How can society support your well-being?

At the end of exercise, either write or have a note taker write a summary of the discussion.

PART 3: FOR VOLUNTEERS

Aims of the material

This material has been developed so that volunteers:

- understand the expectations for and rights of volunteers
- gain knowledge and practical skills in supporting older victims of abuse
- learn the limits of confidentiality as well as volunteer responsibility in cases of disclosure
- gain confidence in cooperating with staff of their host organization

How to conduct training

Conducting training starts by understanding the needs of the target group. For volunteer training, it is important to know what kind of voluntary work they do, who the people are that they support in their roles and what kinds of needs they have. These can be explored, for instance, through a pre-training survey filled out by the volunteers.

Since different people have different learning styles, it is good to combine a variety of methods, such as lecturing through PowerPoint presentations, watching videos and providing handouts. However, any effective training also enables learning by doing. This means adding exercises and activities to the session, such as group work, role play and socio-drama. You may select the exercises provided at the end of this section that are the best fit for the volunteers' needs.

At the beginning of the session, it is good to provide an overview of the content. It helps participants to have the whole picture of the issues to be learned. To gain the attention and interest of the audience, it may be useful to start the session with a questionnaire (provided at the end of the theoretical section of this manual) or a video related to the topic.

It is important for teachers and trainers to remember that **some of the participants may be victims of violence themselves – or perpetrators. Therefore, the language used should be respectful and non-judgmental; however, a clear stance against violence must be taken.** The participants may want to **talk about their own experiences with the group or after the training with the trainer.** The trainer should allocate some time for these kinds of conversations.

At the end of the session, it is important to get feedback from the participants to improve future training sessions. Evaluation forms can be used to measure the learning outcomes of the audience and can be tailored to reflect the goals of the session as they are outlined at the beginning of the training. You can also collect anonymous feedback via a form with multiple choice and/or open-ended questions, which can provide important information for future training sessions.

Contents of the programme

This part is divided into two chapters followed by exercises:

Chapter 12 – Volunteers' roles and responsibilities: explains the expected roles of volunteers, principles of volunteer work and the rights of volunteers in carrying out their work.

Chapter 13 – Supporting older victims of abuse as a volunteer: refers to background and theoretical information pertaining to elder abuse followed by confidentiality issues and how to handle cases of disclosure.

Training Exercises

Chapter 12: Volunteers' roles and responsibilities

Older people face many challenges brought on by the ageing process, such as physical limitations and changes in cognitive function, but they also have a lot to share and give to society. Hence, volunteering with older persons offers a critical opportunity to learn while making a valuable personal connection.

Volunteering has various benefits for an individual, including new skills, contacts and experiences which may help advance one's career. Giving to others can also help protect your mental and physical health by reducing stress and providing a sense of meaning. The benefits of volunteering in the health and social sector are also enormous to organizations and the whole community. Volunteers have specific roles, different from those of professionals, which come with specific responsibilities, as discussed in this chapter.

Learn while making a valuable personal connection.

12.1 Principles of volunteer work

Volunteering should always be professionally led. The host organization takes responsibility to ensure that the volunteers have **adequate training, guidance and support** to succeed in their role. Volunteers should be provided with a designated liaison person, such as a volunteer coordinator. All activities carried out are grounded in the host organization's values and principles; however, some suggested core principles concerning all volunteers working with older persons include:

Voluntary service

Every volunteer should participate of their own free will. Volunteers are driven by a sincere will to help older people and their families. Volunteering is an unpaid service which rewards individuals in ways other than financial compensation.

Non-professionalism

The role of a volunteer is to act humanely to another person/s. A volunteer does not need to be a professional of any kind—the knowledge and skills of an ordinary person are enough. A **volunteer is never to replace a professional**. Every volunteer brings their own life history, personality, knowledge and understanding to the service. As the volunteer and the older person spend time getting to know each other, one may start feeling more like a friend than a volunteer. However, a client-volunteer relationship is not a typical friendship. It is considered a good practice to not discuss one's own personal problems with a client, as this removes the focus from the older person and their needs.

Commitment

Volunteers should estimate their own resources so that they will not promise to do more work than they can. Volunteers have the right to define their own time commitment and set boundaries.

Equality and diversity

Volunteers, service users and professionals meet as equals, even though they occupy different roles. Volunteering requires **appreciating and accepting everyone involved just as they are**, regardless of their background, ethnicity, race, religion, sexuality and other identity factors.

Impartiality

Volunteering should **serve the best interests of the service user**. However, **volunteers are not allowed to make decisions on behalf of older people**. Their role is to listen and support a competent older person to make their own choices.

Confidentiality

Volunteering with older persons who may have experienced abuse requires full confidentiality. **Maintaining confidentiality means behaving in a way, which protects the client's privacy, identity and dignity**. Confidentiality is also an important part of developing trust in a care relationship. Volunteers commit to confidentiality, which does not end when volunteering does. Volunteers should also have the right to receive professional guidance and counselling for discussing challenging experiences and feelings.

12.2 Volunteers' rights and responsibilities²⁰⁷

Volunteers have the right to:

- Appropriate and meaningful volunteer assignments
- Adequate information, training and assistance
- Effective supervision and feedback
- Respect for their skills, dignity and individuality
- Respect for their feedback and suggestions
- Recognition of their contribution
- Confidentiality of their personal volunteer file, except for purposes of supervision

Volunteers have the responsibility to:

- Perform volunteer duties to the best of their ability and in the best interests of the older person
- Follow directions and guidelines of their host organization
- Meet time commitments
- Inform their supervisor if they suspect any kind of abuse or are concerned about an older person's well-being
- Adhere to the organization's rules and procedures
- Attend volunteer orientation as well as relevant trainings and counselling sessions
- Welcome supervision and be willing to learn
- Ask questions, be open-minded and non-judgmental



Chapter 13: Supporting older victims of abuse as a volunteer

As an introduction to the contents of this chapter, volunteers should have the chance to gain a basic understanding of the topics described in the following chapters of this manual:

Part 1: Theoretical Background:

- Chapter 1 – What is violence against older persons?
- Chapter 2 – Forms and signs of violence against older persons
- Chapter 3 – Characteristics and risk factors of elder abuse
- Chapter 4 – Consequences of violence
- Chapter 5 – What are human and civil rights?
- Chapter 6 – EU and national legislation pertaining to elder abuse

Part 2: For Professionals:

- Chapter 11 – Self-care and safety

Due to the fact that the **topic of elder abuse is treated as a taboo**, experiences of violence and abuse are often challenging for older people to disclose and discuss. This also complicates gathering data about the prevalence of violence against older people, which is estimated to range globally between 1% and 35%. **Abuse can happen to anyone, regardless of the person's age, sex, race, class, religion, or ethnic and cultural background.** Each year, hundreds of thousands of adults over the age of 60 are abused or neglected both in their own homes and in assisted living facilities or nursing homes. Hence, it may be possible that in your volunteering role you will encounter an older person who has experienced some sort of abuse or neglect. It may take time for the older person to learn to trust you before confiding to you. Or it may be that the emotions provoked by the experience are too strong for them to disclose at all. You may need to reassure an older person that any conversation on the topic will not be discussed with their spouse/partner, nor will it be discussed with any other member of their family, without their consent.

When disclosing abuse or neglect, an older person may experience a range of emotions such as:

Guilt — Victims often blame themselves for the abuse and may feel guilty for telling someone about it. This is particularly often the case when the abuser is the older person's child or grandchild; the older person may feel that they have failed as a parent or a grandparent and hence 'deserved' the poor treatment.

Shame — Older people are often ashamed of the abuse itself, particularly if it is sexual abuse.

Fear — Older persons may fear the perpetrator, that the abuse may recur, or that disclosing the violence will cause conflicts in the family. They may also be fearful of the consequences for the perpetrator (e.g. jail time). Fear of loss of independence is common with older people who live at home but need a caregiver. Because of fear that they will be forced into a residential facility, they often don't report abuse at the hands of family members or private caregivers.

As a volunteer, it is never your responsibility to investigate the situation and determine whether abuse is in fact happening — this is the duty of professionals. It is best to avoid asking leading questions regarding the abusive events to avoid provoking the challenging emotional reaction described above. **Your role as a volunteer is highly significant in providing a listening ear and empathetic presence to the older person.**

13.1 Limits to volunteer confidentiality

While maintaining client confidentiality, as described earlier, is of utmost importance, there are some exceptions to it. Health and social care professionals have a duty to report cases of elder abuse, so it is important to let them know of any suspicions you may have regarding the health or safety of an older person. As mentioned before, **it is not your responsibility to determine if abuse is in fact taking place, but rather to alert your supervisor of your concerns so that professionals can intervene and, if necessary, report the suspected abuse.** You can tell the older person who confides in you that you must discuss the situation with your supervisor because you care about them and are concerned for their health and safety. Never promise to keep it as a secret. This also concerns situations in which an older person discloses thoughts of suicide.

When an older person discloses abuse:

- Do not ignore or diminish their experiences
- Do not blame the older person for what has happened
- Do not share general advice
- Do not deal with the situation behind the older person's back
- Do not break trust—inform the older person about your obligation to share the matter with a supervisor
- Do not keep the matter to yourself—talk to your volunteer coordinator or supervisor immediately

- Listen, ask, talk directly to the older person
- Make sure that the conversation feels safe and respectful for the older person
- Tell the older person that the treatment they experienced is wrong
- Judge actions, not people
- Discuss with the older person how to seek help and to create a safety plan for threatening situations
- Assess the risks: what happens if you do not do anything — will the older person be in imminent danger?
- Encourage, motivate, be supportive
- Be trustworthy
- Draw up guidelines for difficult situations together with your supervisor and other staff from your host organization

Exercise 3.1: Reading time in a nursing home

Method of the exercise

- Socio-drama

Learning Outcomes

- Become aware of the responsibilities and limits of volunteer work
- Understand the role of volunteers in responding to the needs of older persons
- Be able to cooperate with the staff responsible for caring for older persons

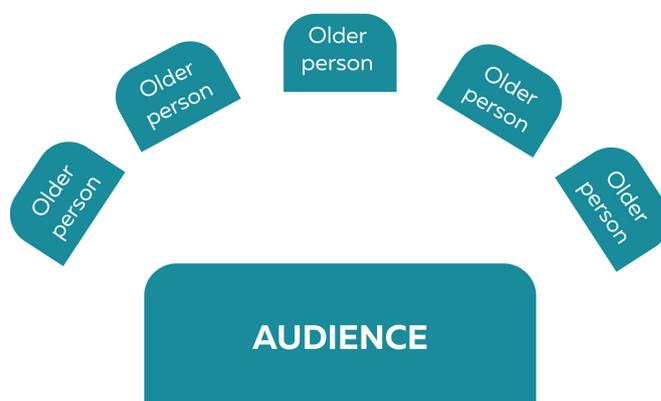
Materials required

- 5 actors; one plays the volunteer's role and the others play the roles of older care recipients in a nursing home
- Role cards for 1 volunteer and 4 older persons living in a nursing home
- 5 chairs
- A newspaper

Time frame: 30–45 minutes

Preparation for the exercise

Prepare the stage for a socio-drama with five chairs so that the volunteer's chair is located between the chairs of the older persons. Take care that the audience can see and hear all the actors (see the picture on the right).



Instructions

Give role cards to the actors and have them read them through. Ask the actors to speak loudly. The audience will be the observers. The trainer/teacher should introduce the topic, explaining that a volunteer has arrived at a nursing home for reading time. The volunteer reads from the newspaper about how things are going in another nursing home. The story relates an emotional experience of relatives visiting an older woman living there.

Ask the audience to write down observations and questions which come up from the reading time discussion, such as:

- how the volunteer responds to the complaints, stories and reactions of the older persons
- challenges the volunteer faces in their role
- what the volunteer should do after hearing their stories and comments

Questions and discussion after the socio-drama

for the volunteer:

- How did you feel while reading and during the discussion and comments from the older persons?
- What was difficult/easy?
- How would you have liked to respond, or what would you have liked to do after their complaints?
- What should the volunteer do?

for the older persons:

- How did you feel when the volunteer was reading the article?
- How should a volunteer respond to your discussion and opinions?
- How should a volunteer handle the situation?

for the audience:

- What should a volunteer do in a situation like this?
- What would help them to handle the situation?
- How are they responsible for the older people's safety and what does it mean?
- What is the difference between the responsibilities for volunteers and for staff in this situation?

Scenario:

You are visiting as a volunteer in a nursing home unit. A small group of older persons likes to gather and listen to the news you are reading from the local newspaper.

One day, there is a story about a nursing home in which the older persons' relatives shared their experiences about poor conditions. They explained that the staff had no time to feed, help to toilet or help dress or undress their care recipients. A woman disclosed how she found her grandmother sitting in bed in her nightgown in the early afternoon. The bed was wet because she had no help to go to the toilet. Another relative said that he had overheard a nurse complaining about their care recipients being too demanding and constantly ringing the bed bells. The nurse huffed that the bells should be taken off.

Relatives had made complaints to management about these experiences without any response. The reporter contacted the management of the nursing home, but they refused to say anything because of rules around confidentiality. The reporter then contacted local politicians by asking for their views and opinions on the stories of the relatives. The contacted politicians responded that they cannot take sides because they do not know the details of the case for that nursing home; however, the politicians said that in general, this kind of treatment is not acceptable. Then the reporter asked for feedback from the readers.

After the article is done, the discussion begins:

- Older woman 1 sighs: "Well, we are worthless in society..."
- Older man says loudly and angrily: "That nursing home should be closed, and the staff should be sentenced!"
- Older woman 2 tries to defend the staff by saying: "Taking care of all our needs is hard... some older people can be nasty. I have heard that the salaries of the staff are low; however, a low salary is not a reason to treat older people badly. My young niece is working in a nursing home, and she said that they are rushing around the whole day, and in the evening, they are totally exhausted at home."
- Older woman 3 responds angrily: "This kind of treatment is the fault of politicians – they tend to mostly take care of their own incomes! I would like to see them when THEY are old and living in a nursing home!"
- Older woman 1 responds: "Once I was rejected by a nurse here – she said that she had no time for me. I felt really hurt. She told that she would return to me later, but she didn't."
- Older man says: "My relatives try to inquire if everything is fine with me here – but I do not want to tell them anything; otherwise, I am afraid they might make complaints to the staff. And I do not know what happens then!"
- Older woman 1 says: "Once a cleaner took my full coffee cup back before I had even drunk it – I was on the phone!"
- Older woman 3 replies: "You should have complained about that. Did you do that?"
- Older woman 1 responds: "No, I didn't. The cleaner is always friendly anyway."

Volunteer’s card:

✂-----

- Try to listen carefully to the older persons.
- Try to be neutral and not take a stance on complaints.
- You can ask clarifying questions about their complaints and how they have been treated in the nursing home.
- Do not try to solve their situations.
- Ask what they would like to do with those experiences; could they e.g. tell them to staff?
- Say that you as a volunteer are responsible for their safety and ask what they would like to do.

✂-----

Role cards of older persons:

✂-----

Older woman 1: (sighing) “Well, we are worthless in society...”

✂-----

Older man: (angrily) “That nursing home should be closed, and the staff should be sentenced!”

✂-----

Older woman 2: (hesitantly) “Taking care of all our needs is hard... some older people can be nasty... I have heard that the salaries of the staff are low; however, a low salary is not a reason to treat older people badly. My young niece is working in a nursing home, and she told they are rushing around the whole day, and in the evening, they are totally exhausted at home.”

✂-----

Old woman 3: (heatedly) “This kind of treatment is the fault of politicians – they tend to mostly take care of their own incomes! I would like to see them when THEY are old and living in a nursing home.”

✂-----

Older woman 1: (complaining) “Once I was rejected by a nurse here – she said that she had no time for me. I felt really hurt. She told that she would return later, but she didn’t.”

✂-----

Older man: (complaining) “My relatives try to inquire if everything is fine with me here – but I do not want to tell them anything; otherwise, they might make complaints to the staff. And I do not know what happens then!”

✂-----

Older woman 1: (complaining) “Once a cleaner took my full coffee cup back before I had even drunk it – I was on the phone!”

✂-----

Old woman 3: (to woman 1) “You should have complained about that. Did you do that?”

✂-----

Older woman 1: (calmly) “No, I didn’t. The cleaner is always friendly anyway.”

✂-----

Supplementary material

Exercise 3.2: Recognizing financial abuse and cooperating with staff

Method of the exercise

- Group work based on a case study

Learning Objectives

- Help volunteers to recognize signs of financial abuse
- Learn how to give support to older victims of abuse
- Support volunteers to communicate with the staff responsible for the care of older persons

Materials required

- Case study form with questions
- Pens

Time frame: 30-40 minutes

Instructions

Organize participants in small groups of 3-5 persons, depending on the number of participants. Ask the participants to:

- read through the case study
- in each group, analyze the story of Reino, the volunteer's response and the response of the organization according to the questions in the form
- choose one person from the group to present the answers to the whole group by giving the justifications for each of the answers

Case study: Volunteer

You work as a volunteer for a service center for older persons. The service center has its own café and is surrounded by a beautiful park where the residents can walk around and sit on the benches. The residents of the service center are quite frail and need a lot of help. The staff is busy, so they are happy to have volunteers taking residents out for a walk.

Your job is to take 80-year-old Reino for a walk to the park. Reino is sitting in a wheelchair because of a stroke he had years ago. His wife died three years ago, and after that, Reino had to move to the service center unit. He has two adult sons. One is married and has his own family, and the second one is a bachelor who had been living with his parents his whole life. He never learned to take care of his finances. When his mother was alive, she took care of the household and paid bills. When the mother died and Reino had to move to the service center, the second son stayed at his parents' home. This son visits his father quite often, and sometimes he takes his father for a walk.

Today, you picked up Reino for a walk again. His son had just finished visiting him. During your walks, Reino likes to talk about his heavy work in building sites and about his family and two sons. This time he is quiet and in a sad mood for some reason. You try to talk with him, but he doesn't seem to listen to you. Normally, you go together to the café to have coffee. Now Reino says that he does not want to go because he forgot his wallet in his room. The policy for volunteer work is that both a volunteer and a client pay for their own refreshments if they have them. You know that going for a coffee is important to Reino, and he usually takes his wallet in advance to his table so that he would not forget it. This time you did not see the wallet on the table in his room. You recall thinking that this is very strange. You say that you didn't see his wallet on the table and try to ask where it may be, but Reino doesn't answer.

You return to the unit and his room after a short walk in the park. You propose to help search for his wallet, but Reino refuses. Finally, he admits that he gave his wallet to his son, who needed money. His wallet also has his bank card. You start to become concerned about what is going on. Reino does not

want to tell you any more about the issue. The policy for voluntary work is also that you are responsible for the safety of your clients. You say to Reino that you are worried about his situation and that you should talk about it with the staff. Reino knows that, so he does not prohibit it.

You try to find a staff member to talk about Reino's situation, but they all are busy working in the residents' rooms. You finally find the head of the kitchen unit and start explaining your concern. The head of the unit interrupts you and says that you should talk to a staff member who is responsible for Reino's care. Unfortunately, this nurse is not currently at work, so you need to contact her later.

1. What signs of financial abuse can you find in Reino's situation?
2. What should the volunteer do in Reino's situation?
3. What do you think about the response of the head of the kitchen unit?
4. Create a procedure or guidance about how this kind of situation should be handled.

Discussion

Discuss with the whole audience:

- how they as volunteers would like to cooperate with the staff
- the kind of experiences they have in cooperating with staff
- if they have had difficulties, how the difficulties were solved

PART 4: FOR OLDER PEOPLE

Aims of the material

The material has been developed so that older persons:

- can become aware of human and civil rights in an ageing society
- are able to recognize violations of human and civil rights and other abusive behavior
- can name the forms of elder abuse
- learn how to protect themselves from violence
- receive knowledge and skills to protect themselves from abuse and increase self-determination

How to conduct older persons' training

The starting point of planning a training is to understand the needs of the target group. Many older people work as family caregivers and have special needs related to their work. Older people may also have other special needs related to their health condition, such as memory disorders, vision issues and hearing issues. **When planning the training for older people, both their special needs as well as different learning styles should be considered.** The number of participants in a group should be guided by the appropriateness of the space and the specific requirements of the group. Older people, especially in smaller groups, may generally benefit more from guided group discussions and activities than from lecture-type presentations. It is also good practice to provide them with handouts to take home and return to later. This section of the manual has been written specifically for older people and to allow handouts to be easily made. For planning training activities, exercises are provided at the end of this section that you may select from based on the older persons' needs.

Principles for teaching and training older persons²⁰⁸

- Listen carefully: older people have a richness of knowledge, life experience and expertise; absorb it and use it.
- Show respect: say hello and be respectful—this is appreciated by people of all ages.
- Use all types of communication: many older people are online; however, some prefer traditional forms of communication, such as face-to-face, post/mail, newspapers, printed material and phone calls.
- Keep communication clear, open and in plain, respectful language; fonts need to be large and easy to read; try to avoid colors that are hard to read.
- Visual messaging: images, photos or short videos can tell an important story—more than can be expressed only in words
- Be as practical as possible, especially if the older persons have cognitive impairments.
- Notice barriers they may have to participating and try to overcome them.
- Be sensitive to the needs of older people by listening to them carefully.
- When possible, have decision makers actively participate in the sessions — it shows that the training is taken seriously by the organization.

Logistical considerations for teaching and training older persons:

- **Accessibility:** some older people may have challenges with mobility or may be frail; therefore, choose venues that are accessible.
- **Venue:** venues need to be physically and emotionally safe and comfortable. Suitable places are local and community venues that are often familiar to older people, such as service centers, halls,

pubs and cafes, and that may be equipped with important tools such as hearing loops.

- **Timing:** daytime activities may be more suitable for older people and those who use public transport. Allow ample time during breaks for people who may need assistance or extra time getting refreshments or using the bathroom.
- **Hospitality:** it is more enjoyable if you can offer coffee, tea and other refreshments.²⁰⁹

Education and training of older people can take many forms, such as general lessons for a larger audience or small group discussions and sessions. When planning training and education, determine what the purpose(s) of the training and education will be. Both forms have advantages and disadvantages. General sessions can be a starting point for raising interest in other forms of education, such as small group discussions; however, some older people may hesitate to participate in such activities. Small groups can involve a combination of sharing information and knowledge and giving and receiving peer-support.²¹⁰

General awareness-raising sessions

Good practices for general awareness-raising sessions for older persons

- Use presentation materials as little as possible.
- Use the dialogical method when sharing information.
- Try to make a connection with the audience.
- Reserve time for discussion.
- Reserve time for opportunities to share experiences and memories.
- Reserve time afterwards for private questions.
- Two hours is a suitable amount of time for one session (including discussions and questions).

The purposes of general lessons for larger audiences are to:

- raise awareness about human rights and violations of them
- share knowledge about abuse in later life
- distribute general information on resources for assistance in cases of human rights violations

Themes for awareness-raising sessions for larger audiences:

- general information about ageing today
- information and awareness about human rights
- elder abuse and its consequences
- how to protect oneself and others from abuse and other violations of rights
- information on how and where to get help and support

Small group sessions

The purposes of small group sessions are to:

- share personal experiences about ageing and violations of human and civil rights
- give opportunities to explore one's own life path more deeply—e.g. history, good and challenging experiences, current situation and expectations for the future
- receive and give emotional peer-support
- learn from others about different coping strategies
- become empowered to control one's own life

Good practices for small group sessions of older persons

- Select a target audience and tailor the content to the needs of participants, e.g. older women/men victims of abuse, family caregivers and widowed older women/men—this provides an opportunity to explore in-depth experiences, challenges and solutions
- Themes should be personally touching rather than general—e.g. ‘exploring human rights’ may not be personal enough; a good idea could be to choose only one or two rights for exploration
- Use practical exercises to get their attention and maintain interest
- If the participants have dementia symptoms, keep all content practical—consider what kind of verbal questions you can use or avoid; verbal questions may cause confusion and humiliation if they do not remember or understand the words. It is good to use, for example, pictures with questions to help participants express themselves.
- Use one theme per session, and do not hurry with the theme—this helps participants to explore themes based on their rich knowledge, life experience and expertise.
- Two hours is a suitable amount of time for one session; however, if participants have dementia symptoms, they may not be able to concentrate as long, so one hour may be the best amount of time.

To create a safe environment, it is important to discuss rules at the beginning of the group session. The group needs to give itself a framework for the training by setting up rules that all participants will follow. This is important because participants may share personal things, and therefore everybody needs to feel comfortable in the group in order to learn well. You can ask participants to think about what rules they want to follow that everybody feels comfortable with and that are helpful to empower them as a learning group. Note down their suggestions. While discussing, you can share **common ground rules**, e.g.:

- **Confidentiality:** anything said or noticed in the room will not be repeated or discussed at another time or place: “what you say in the room, stays in the room”.
- **Respect:** group members are expected to listen to each other without interrupting, take turns speaking, and speak without judgment or giving advice.
- **Agency:** everyone chooses what they want to share in the group—choosing not to speak should also be respected.
- **Language:** group members are expected to avoid offensive language.
- **Promptness:** meetings should begin and end on time.²¹¹

Contents of the programme

This part is intended to be used as an accessible stand-alone document for older people, and it therefore contains summaries of topics explored in depth in Part 1. Those who are interested in further reading about the issues presented here are encouraged to refer to Part 1.

This part is divided into three chapters followed by training exercises:

Chapter 14 – Ageing in today’s society: Discusses what it is like to age in today’s society and introduces concepts of ageism and sexism and how they affect older people. Introduces the concept of the ‘life course’.

Chapter 15 – Human and civil rights and older people: describes how concepts related to human rights can be particularly applicable to older people and how international and national laws and standards work to protect the dignity and quality of life of older people. This chapter also describes how elder abuse is a human rights violation.

Chapter 16 – How to protect oneself from abuse and mistreatment: outlines strategies for older people to care for themselves, look after their health and reach out for help and support.

Training exercises

Chapter 14: Ageing in today's society

Science and technology have increased the human lifespan to be longer than ever before. In EU countries, the population is growing progressively older, meaning that there are more and more older people in proportion to younger generations. This phenomenon, called 'population ageing', is often discussed in a negative light as a threat to the sustainability of traditional social welfare states and the economy. Newspapers regularly tell stories warning of the burden that the so-called baby boomers (people born between 1946 and 1954) are placing on our pension systems and the already-stretched health and social care systems. Stereotypical images of what it is to be an older person, often depicting loneliness, poverty and neglect, are widespread. Older people are presented as an expense to society, and old age is presented as consisting mostly of ill health, lowering physical and cognitive capacity and overall misery. While components of these stereotypes are real problems, and society needs to pay attention and provide resolutions for issues such as poverty, loneliness and neglect in old age, these solely negative perceptions of ageing are hugely problematic.

Negative perceptions of ageing support ageist attitudes, have a negative impact on younger generations' relationships with older people and cause deep anxiety about growing old and facing the future. Furthermore, since women live longer than men and outnumber them, especially in the oldest age group of the population, older women face the accumulated effects of ageism and sexism. They can find themselves facing dual discrimination in access to employment and pensions and to key goods and services. While poverty rates among men and women do not differ much during working life, the difference increases after age 65 and even more so after age 75.²¹²

What is ageism?

Ageism is stereotyping, prejudice and discrimination against people on the grounds of their age. Ageist attitudes lead to marginalization of older people within communities and have negative impacts on their health and well-being.²¹³

What is sexism?

Sexism is stereotyping, prejudice and discrimination based on a person's sex or gender. Sexism is connected to stereotypes as well as gender roles, meaning that the behavior is learned by a person as appropriate to their gender, which is determined by prevailing cultural norms. Sexism may include the belief that one's sex or gender is essentially superior to another.

Instead of only focusing on the negative aspects of ageing, what is needed is greater acknowledgement and awareness of the diverse ways that people can, and do, grow older. Old age is frequently defined as starting at the age of 60 or 65. This means that, officially, a person in their sixties and a person in their nineties are categorized in many ways as the same, although there may be huge differences in not just their functionality or health but also in their personal interests. They represent completely different generations with different aspirations and ideas about what constitutes a good life. Generalizing older people's experiences and needs does not serve anyone well.

Older people not only live longer than ever before but are also healthier than ever. Re-thinking old age as a life stage in which new skills can be learned is helpful. It shifts the focus from loss and decline to interests, experience and wisdom. Older people have a wealth of skills and experiences to contribute to society, and an **age-friendly society would encourage and value older people's contributions** instead of excluding them.

Questions to ponder individually or together:

- Do you feel generally respected as an older person? Why or why not?
- What kinds of stereotypes about old age have you encountered?
- Do you think you personally have some stereotypical ideas and views about ageing?
- How can we challenge stereotypical views in ourselves and in others?
- How can we build a better society for older people? What is needed at a practical level?
- How do you contribute to society? Is there something you would like to do but have not had the opportunity to do? What would need to change?

14.1 Life course and ageing

Re-thinking old age from stage of loss and decline to interests, experience and wisdom.

The term “life course” has a multiplicity of meanings, such as life course as time or age, life course as life stages, life course as events, transitions and trajectories and as human development over a person’s lifetime. It particularly focuses on the connection between individuals and the historical and socioeconomic contexts in which these individuals have lived.²¹⁴ The life course refers to the concrete char-

acter of a life in its evolution from beginning to end or a progression through time from birth to death. The life course includes all aspects of living: inner wishes and fantasies; love relationships; participation in family, work, and other social systems; bodily changes; good times and bad — everything that has significance in a life. The course of a life is not a simple, continuous process. There are qualitatively different phases or seasons. Researchers and theoreticians determine age-related developmental stages and processes differently. Age-related stages in this exercise are adapted based on descriptions by D. Levinson.²¹⁵

Changes during one’s life course can challenge a person to face fears or re-think their future. Changes that come gradually provide time to adapt. However, a sudden change is a crisis to most people. A crisis is a difficult life situation in which an individual’s learned coping strategies are insufficient or do not work. A crisis may make a person feel helpless and distressed. The feeling of basic security may weaken, and a person may feel that they are losing control over their life.²¹⁶

There are different kinds of crises, such as developmental, situational and existential crises.

- **Developmental crises** occur as part of the process of growing and developing through various periods of life. Sometimes a crisis is a predictable part of the life course.
- **Situational crises** are sudden and unexpected, such as accidents and natural disasters. They are events that are so shocking and sudden that they overwhelm normal coping strategies. Examples of situational crises include being the victim of a crime, accidents or sudden loss or grief.
- **Existential crises** are inner conflicts related to things such as life purpose and direction. Often, existential crises are related to situations in which a person experiences regret, the belief that life has passed them by or the realization that they will not reach goals they had set for themselves at a certain age. Existential crises are particularly common at life transition points, like turning 30, 40, 50 and 60 years old, when people make an ‘inventory’ of their life.

Every person has their own specific ways of coping with change. **Coping strategies** can involve directly facing the changes and being active in changing or correcting the matter. Passive coping means retreating, and it occurs when a person tries to deny that the event has happened, tries to steer clear of it, or hopes that it will be solved by doing nothing about it (so-called wishful thinking). It is important to think about what kind of support one wants and needs. Some events and memories may give rise to spiritual resources that may provide support and guidance.²¹⁷ It may be important to discuss these with older persons during training.

Chapter 15: Human and civil rights and older people

Human rights are universally agreed-upon minimum standards required for all individuals to live with dignity and to be treated with respect. They belong equally to everyone regardless of age or dependency level. Many older people are, however, unaware of their human rights and their relevance to everyday life. They may put up with being mistreated and discriminated against because they do not know that it is wrong. **Knowing about human rights allows one to recognize and challenge situations and practices of poor treatment for oneself and on behalf of others.**

Human rights are relevant to various everyday situations, such as making decisions about medical treatment and whether one wants to live at home or in a nursing home. They guarantee our right to participate in society and access public services. Human rights give us power to speak out if authorities who are responsible for the services we use are treating us unfairly or badly. Human rights are also important in protecting us from discrimination, abuse and neglect.

The human rights of individuals living in Europe are protected through several binding human rights treaties and other instruments, including the European Convention on Human Rights and the United Nations human rights treaties. *Please refer to Chapter 5 of this manual for descriptions of the instruments and rights covered by them.*

The instruments presented in this manual cover the full spectrum of human rights: civil, political, economic, social and cultural rights. **Some rights are non-absolute, meaning they can be limited or restricted under certain circumstances — e.g. to protect the rights of others. Absolute rights, on the other hand, can never be limited or restricted under any circumstances.** These include the right to life, the right not to be treated in an inhumane or degrading way, and the right to freedom of thought, conscience and religion.

While none of the human rights instruments presented here were designed to protect the rights of older people as a specific group, it does not matter, since **human rights apply to all human beings, including older people.** The conventions govern how states should act toward individuals. They provide the standards and values on which national policies and laws should be based.

While all human rights are potentially relevant to older people, some appear to hold more significance. Such is the case with the following categories of rights:

- Protection for life and liberty
- Protection from abuse and violence
- Protection of privacy and family life
- The right to be supported to live independently and be included in the community
- The right to enjoy the highest attainable level of physical and mental health
- The right to have an adequate standard of living
- The right to participation in all aspects of society (education, work, cultural life, recreation, leisure and sports)
- Equality and non-discrimination

For further details on these categories and which rights they represent, please see the booklet *My human rights: My wellbeing* by the Two Moons project (2019).²¹⁸ This booklet, which is targeted for older people, also provides instructions on how to report violations of rights through real-life case examples.

Please also see Section 5.1: “How are my human and civil rights protected through legislation in my country?”

15.1 Elder abuse as a human and civil rights violation

A majority of people live well and are safe as they get older; however, between 1%-30% of older people in the EU experience abuse or violence.²¹⁹ **Elder abuse causes harm or distress to an older person and violates their human rights because it violates the dignity, freedom, respect and/or equal status of an individual.** Elder abuse can be a single or repeated act or lack of action, and it happens in relationships of trust. Elder abuse can be intentional, but sometimes it is unintentional, as when a person does not realize that the consequences of their actions are distressing to the older person. This is sometimes the case, for example, with informal carers who lack the required skills and knowledge to provide adequate care.

Any person or organization may be guilty of abuse. Most often, it is someone well known to the older person, e.g. a family member, relative, neighbor, friend or care provider. Abuse can take place anywhere, but most abuse takes place in the home, whether the person is living alone or with family. It may also occur within nursing homes, day centers, hospitals, or other places assumed to be safe.

There are several **forms of abuse**. These include:

Physical Hitting, slapping, pushing, kicking, misuse of medication, restraint	Psychological/emotional Threatening, controlling, intimidation, coercion, verbal abuse, isolation, deprivation of contact	Financial Theft, fraud, exploitation, misuse of possessions or property, Pressure in connection with wills, property or inheritance
Sexual Sexual actions to which the older adult has not consented or could not consent, sexual assault, rape	Neglect Ignoring medical or physical care needs, failure to provide access to needed services, withholding necessities such as adequate nutrition, heating and equipment	Institutional Systematic practices by institutions of the state or care providers who fail to provide good care

Discrimination based on someone's age, race, sex, disability and other forms of harassment, slurs or disrespectful treatment may also be counted as abuse. The consequences of experiencing abuse are diverse, often affecting both mental and physical health.

Common consequences of abuse include:

Mental health <ul style="list-style-type: none">• Depression and withdrawal• Feelings of fear, guilt and anxiety• Feelings of hopelessness or helplessness• Inability to make decisions• Loss of interest and enthusiasm• Isolation, refusal to see or talk to others• Refusal to eat, drink or take medication	Physical health <ul style="list-style-type: none">• Injuries, cuts, bruises and broken bones• Chronic pain and soreness• Insomnia and lack of sleep• Increased risk for developing new illnesses and chronic diseases• Worsening of pre-existing health conditions• Increased substance use• High blood pressure or heart problems
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Chapter 16: How to protect oneself from abuse and mistreatment²²⁰

The following are strategies for you to **protect yourself from experiencing mistreatment**:

Look after your health

- Eat a balanced diet and get regular exercise.
- Engage in hobbies and activities that bring you joy and relaxation.
- Visit your doctor for regular check-ups.
- If you are receiving care, participate fully in all decisions related to your care.
- If you feel depressed or alone, talk to a family member, a friend or a social service agency that you trust. It is okay to reach out and ask for help, whatever the situation.

Stay connected

- Keep in regular contact with family and friends.
- If possible, stay active in your community by getting involved in local groups and organizations.
- Familiarize yourself with the local support services and how to access them, e.g. day centers, transport and home care.
- Keep control of your phone; and open and post your own mail.
- Be aware that there are risks involved in living with a person who abuses alcohol/drugs or has a history of violence. Have a plan to keep yourself safe, and explore different accommodation options if you are feeling threatened. You may also ask a social worker or another professional to help you draft a safety plan.

Keep track of your finances and avoid frauds and scams

- Keep track of your money, including cash. It may be useful to keep a spending diary.
- Avoid giving out your bank card or PIN. If you need to write your PIN down, keep it in a safe place separate from your bank card.
- Check all bank and credit card statements for any unauthorized activity.
- Where possible, set up direct debits or standing orders for routine household bills.
- Store all valuable documents and items of value in a secure place.
- Be aware of salespeople who use high-pressure techniques to get you to buy something. Ask for the details in writing and take plenty of time to review them.
- If you are hiring someone to do work for you, always get several estimates and check credentials and references. Never leave strangers unsupervised in your home.
- Do not pay for work in advance. Avoid paying in cash, but if you need to, always ask for a printed receipt.
- Be careful who you share personal information with, and never provide personal details over the phone.
- Beware of online scams that use email requests to ask for personal/financial information, even if the email looks authentic. Always check with the institution itself, and never respond directly to these emails.

Plan ahead for the future

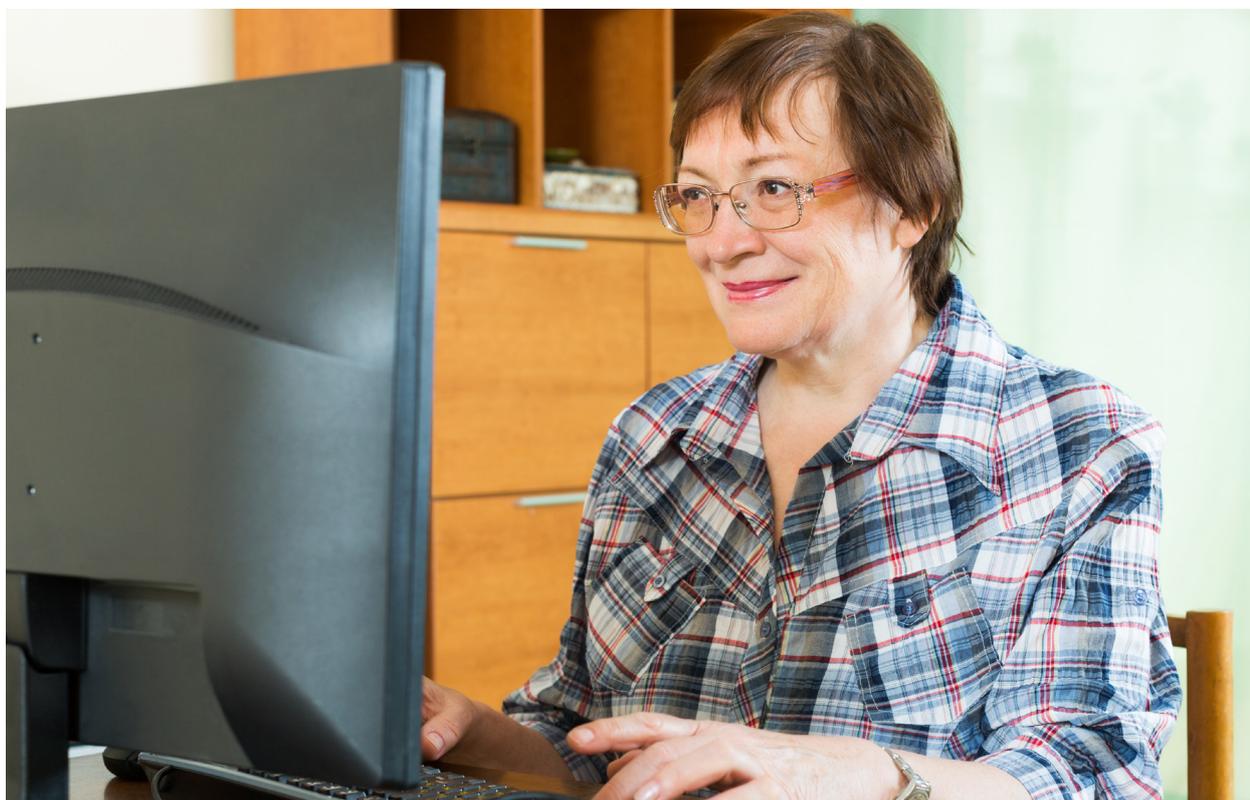
- Familiarize yourself with options related to potential future circumstances, e.g. locally available care and treatment options.
- Think about your preferences in the event that you may not have the capacity to make your own decisions about your care and treatment in the future.
- Write down your wishes and keep them updated. Make these known to family members, your doctor and close friends.
- Think about who you would like to act as your Power of Attorney in the future. Who do you trust to make decisions and act in your best interests in legal and financial matters?
- If you need financial or legal advice, seek professional advice – do not rely solely on the advice of family or friends.

16.1 How to get help and support

If you think you are being abused or harmed in any way, or if you know someone else who is, it is important to tell someone. Remember that it is your human right to be treated with respect and dignity. If the person who is mistreating you is someone you know well or trust, it can be particularly difficult to understand what is happening or why. It is natural to feel worried, anxious, scared or even embarrassed or guilty about the situation. Such feelings may make it hard to talk to someone about what is happening or to ask for help. However, you do not have to feel alone in your situation. If you have a friend or someone else you can trust, talk to them. There are various organizations and professionals who can offer you help and advice.

Please see “Services for victims” in Chapter 9 of this manual for more information.

You may also like to draft a safety plan to help prepare for abusive situations that may occur in the future. For examples and tips, see ^{221, 222}.



Exercise 4.1: Historical timeline

Method of the exercise

Interactive exercise with the audience (can be used in a small group or for a larger audience)

Learning Objectives

- Help participants to explore the impact of historical events on their life course
- Support them to understand themselves as women and men of different generations with different values and experiences
- Support them to value their life experiences and what they have learned

Materials required

- Large historical timeline posters (see on the next page).
- Pens/markers

Time frame: 30-40 minutes

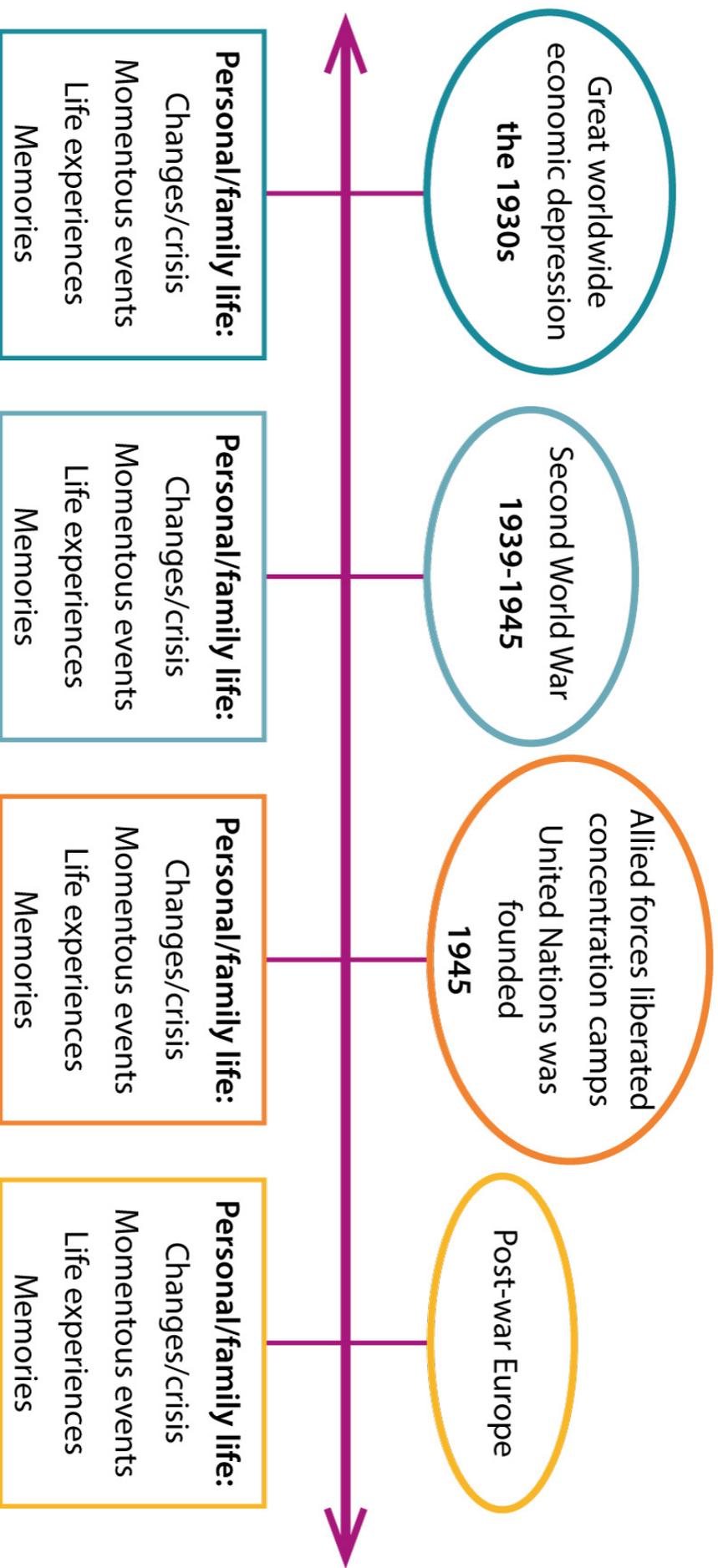
Instructions

Tape posters on a wall before the training. Arrange the room so that everyone can see the posters. Introduce the marked events in the timeline. Depending on what kind of events are marked in the timeline, you can:

- show traumatic historical events (e.g. wars in your country) and how they impact life today
- show the turning points of the development of human rights or in women's history (in your country)
- show changes in domestic violence awareness, services or legislation in society and how these affected the lives of families/victims in the past and today

Discussion

- Discuss how events listed on the historical timeline have affected/still affect people's lives.
- Discuss how events listed on the historical timeline illustrate the generational values of older people/women.
- Discuss how those generational values may have affected/still affect their lives as women and men.



Exercise 4.2: My personal timeline

Method of the exercise

- Individual work in a group

Learning Objectives

- Help participants to see their past on paper and express what they want in the future
- Help participants to discover essential turning points in their life course and meaning for their life
- Help participants to put their lives into a broader perspective

Materials required

- Copies of My personal timeline handout
- Pens/colored markers
- Crayons

Time frame: 60 minutes

Instructions

Organize the room so that all participants have space on a table to write, draw and color. Give everyone a copy of the personal timeline handout. Ask them to fill in the figures on the paper with important memorable dates and/or events as they come to mind. They can also add plans for the future in the figures. They can use colors or symbols to help categorize them (for example, a heart to represent their wedding date, a sun to represent happy events, a tear to represent sad moments, and so on). Some examples of milestones that would be a good addition to their timeline can be:

- The birth or death of a family member or friend
- The beginning or end of a romantic relationship
- Graduation from high school or college
- Moving to a new location
- An illness or injury
- An important friendship

A timeline is a unique way to tell one's life story. It is a contemplative exercise which provides an opportunity to capture the positive and negative shifts of the life path. The timeline exercise also gives an opportunity to create new, potentially healing plans for the future.

Discussion

After the participants have recorded the most significant events on their timeline, ask them to read them out loud in chronological order to the group. Ask them to tell:

- Which memories make them smile with nostalgia or affection?
- Which memories make them shake their head or cringe in embarrassment?
- Which memories still cause pain or feelings of regret?
- Which events do they think changed them the most?
- Which do they see in a different light now than they did at the time?
- What do they wish they could change or add to their timeline?
- During the exercise, did they remember some new events/feelings they had forgotten?
- What are their future plans/expectations/hopes/dreams?
- Did they learn something new through this exercise?

Appendix 4 (Exercise 4.2): My personal timeline (handout)

MY PERSONAL TIMELINE



Exercise 4.3: Life course and changes

Method of the exercise

- Discussion in a small group

Learning Objectives

- Explore which events and changes in each participant's life course have significantly influenced their life or their family life
- Explore how significant events and changes in each person's life have influenced their thoughts and values
- Find resources that the participants have gained through their experiences over the life course

Materials required

- Life course figure on paper for each participant (see next page)
- Pens

Timeframe: 40 minutes (depending on the size of the group)

Preparation for the exercise

It may be good to explain the term “life course” and talk about changes and crises, as introduced in Section 14.1. This helps participants to concentrate on thinking about their own life course and its events and memories.

Instructions

Ask each participant to think back on their life course, for example, from the point of view of historical changes and events in society (refer to the historical timeline). Each participant can write their thoughts, events and memories on the life course figure. They can also draw their life course figure on their own on the paper if they wish. They can ask themselves questions such as:

- Which events and changes in my life course have significantly influenced my life or my family life?
- What kinds of memories do I have from my life course?
- How have the significant events, changes and memories over my life course formed my own thoughts and values?
- What do I think about my life now as an older person?

Discussion

In the discussion, it is important to try to discover resources and strengths that the participants have gained through significant events and changes, even painful ones, and how they could use those strengths in the future.

Appendix 5 (Exercise 4.3): Figure of the life course

Historical events/changes in your country and/or over the world

Late Adulthood 61+

Changes/Crisis
Significant events
Experiences and memories

Middle Adulthood 41-60

Changes/Crisis
Significant events
Experiences and memories

Early Adulthood 20-40

Changes/Crisis
Significant events
Experiences and memories

Youth 16-19

Changes/Crisis
Significant events
Experiences and memories

Childhood under 15 years

Changes/Crisis
Significant events
Experiences and memories

Exercise 4.4: Older people and human rights

Method of the exercise

- Discussion in a small group

Learning Objectives

- Become aware of human rights
- Learn to notice if one's own human rights are violated
- Become empowered to claim one's own human rights

Materials required

- Human rights handouts (outlined below)
- Pens

Timeframe: 30–40 minutes

Preparation for the exercise

It may be good to first introduce the European Convention on Human Rights, the United Nations human rights treaties or the United Nations Principles for Older Persons ([see Chapter 5: What are human and civil rights?](#)) because many older persons are unaware of their human rights or what human rights are. You can also introduce or refer to the constitution or other legal binding human rights instruments of your country.

Offer each participant the questions below. Each person can write their thoughts, or you can discuss them in the group. You can also choose just one or several human right(s) for the group to consider.

- What do human rights mean for you, and how can you claim those rights?
- Are some rights in danger?
- What kind of support would you need to realize these rights in your life?
- How do you know if your rights are being violated?
- How do you recognize abusive behavior?

Human rights to be discussed:

1. The right to life or the right not to be subjected to inhuman or degrading treatment
2. Independence—the right to be able to reside at home for as long as possible
3. Participation—the right to participate in decisions which affect the older person's well-being
4. The right to receive physical and mental health care with respect for dignity, beliefs, needs and privacy
5. Self-fulfilment—the right to be able to proceed with opportunities for full development of potential
6. The right to be able to live in dignity and security and be free of exploitation and physical or mental abuse

Discussion

In the discussion, it is important to emphasize that all people have the right to a safe and secure environment. Because human rights are strongly connected to the prevention of abuse and neglect of older persons, it may be necessary to describe the forms of abuse in the discussion. You should also be prepared to provide advice on how and where to get support and help in abuse cases. You can have, for instance, brochures for further help.

Notes for the trainer

You can also introduce human rights issues from the women's rights perspective. See: The Convention on the Elimination of All Forms of Discrimination against Women or the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)²²³.

Exercise 4.5: Empowerment of older people

Method of the exercise

- Individual work or
- Group work

Learning Objectives

- Explore one's life path and life now: feelings, achievements, strengths and challenges
- Find ways to go through difficult experiences and solve difficult situations
- Become aware of resources the participants have (e.g. family, friends and outside support)

Materials required

- Copies of the form with sentences to complete (see next page)
- Pens

Time frame: 60 minutes (depending on the number of participants)

Preparation for the exercise

Explain the goals of the exercise to the group and how the intention is to share their experiences after completing the form. Give participants time to read through the form. Participants should be guided to complete the sentences on the form below.

Discussion

- How was this exercise? What was easy? What was hard?
- How did you feel when you shared your experience? What was easy? What was hard?
- Did you find common issues/experiences, and how did you feel about that?
- What is empowerment?

Notes for the trainer

Addressing elder abuse requires educating and empowering older adults themselves, not only professionals. Empowerment refers both to a psychological sense of personal control or influence and a concern with actual social influence, political power, and legal rights. It is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights. Empowerment as action refers both to the process of self-empowerment and to professional support of people, which enables them to overcome their sense of powerlessness and lack of influence and to recognize and use their resources.

Empowerment as a goal must work towards developing an 'empowerment process' as a means of gaining a sense of control of one's own life. This process means that persons set individualized goals so that empowerment can serve as a protective factor against traumatization. [See Section 5.2 for a description of empowerment from the perspective of human rights for older people.](#)²²⁴

Appendix 6 (Exercise 4.5): Sentences to complete:

Getting older means to me

.....

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.....

As a woman/man, I need

.....

.....

.....

I say to myself when I am upset/angry (self-talk)

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.....

I feel good when.....

.....

.....

.....

I am pleased/happy when.....

.....

.....

.....

I feel security when.....

.....

.....

.....

Exercise 4.6: Hopes and visions²²⁵

Method of the exercise

- Individual work or
- Group work

Learning Objectives

- Strengthen the sense of hope, dreams and visions for the future of the participants
- Understand the meaning of hope for the life course
- Identify resources for future life and experiences
- Find practical things that participants can do for the future

Materials required

- Copies of the form with questions to complete
- Pens and crayons
- Magazines, scissors and glue

Time frame: 60 minutes (depending on the number of participants)

Preparation for the exercise

Discuss with the group the ability to dream and imagine a better future—a characteristic that we, as human beings, all share. Reflect together on the nature of hope. What other words and expressions are used to describe hope? What do we mean by a “dream” or “vision”?

Hope is something that you want to happen or to be true. It can be a feeling of optimism or a desire that something will happen in the future. Hope can also be a verb that means to “strive for or wish”. It can describe a feeling of trust or confidence about what will happen in the future.

Vision can mean the ability to think about or plan the future with imagination or wisdom, or it can be a mental image of what the future will or could be like.

Explain that we will explore what our hopes, dreams and visions are and their meanings in our lives. Participants can write down the answers on the form below, or they can draw their hopes and dreams. If the group has difficulties in writing and/or drawing, you can offer them old color magazines, scissors and glue to make a collage of their hopes and dreams. Alternatively, you can invite people to present their vision as a short drama (sketch). Any method which facilitates creative and spontaneous expression is preferable to using only written or verbal communication.

At the end of the exercise, ask them to present their drawings or conclusions to the whole group. Continue by asking them to individually identify three concrete things which prevent them from pursuing their aspirations and three concrete things that they can do to get a bit nearer to seeing their dreams come true.

Discussion

Ask participants to share the feelings they experienced while doing this activity and to say what they enjoyed about the exercise. Also ask:

- Was there anything that surprised you?
- Do you think that everybody should have the right to pursue their own hopes and desires at any age?
- Do you feel that some people may have more chances than others? Who and why? Is it fair?

Appendix 7 (Exercise 4.6): Form to complete

My happiest memory is

.....

.....

What does “hope” mean to me in this moment of my life?

.....

.....

.....

What is your hope for your future — how would you like things to be in the future — in terms of family, hobbies, housing, personal development, civil rights, etc.?

.....

.....

.....

.....

What are your visions/dreams? Why these visions/dreams?

.....

.....

.....

.....

Name three things/issues preventing you from pursuing your dreams and visions:

.....

.....

.....

.....

Name three things you can do to get closer to your dreams and visions:

.....

.....

.....

.....

Exercise 4.7: Tree of Life²²⁶

Method of the exercise

- Individual work or
- Group work

Learning Objectives

- Participants will become aware of resources they have gained in their life course
- Explore the life path in the family and in relationships
- Assess the effects of the life path on their current life

Materials required

- Copies of the picture of the Tree of Life
- Pens and crayons

Time frame: 60 minutes (depending on the number of participants)

Preparation for the exercise

The Tree of Life has its origin in religious symbolism and mythology. This exercise is based on the idea of using the tree as a metaphor to tell stories about one's life and to help participants to reflect on their own lives so that they can better understand how they became the people they are today.

Give each participant a copy of the Tree of Life. Explain that trees represent 'life' in many cultures. Participants are invited to think of a tree, its roots, trunk, branches, leaves, buds, fruits, flowers and thorns and imagine that each part of the tree represents something about their life. The tree serves as a visual metaphor for the life of a participant and the various elements that make it up—past, present, and future.

Explain the symbols of the tree:

Roots: where you come from (village, town, country), family history (e.g. origins, family name, ancestry and extended family, culture, names of people who have taught you the most in life). How were you raised as a child?

Ground: the ground represents the place/situation where you live now and activities that you are engaged with in daily life, e.g. things you do on a weekly basis on the ground.

Trunk: your life now as an older person; how the roots have affected your life now, how you experience getting older, etc. What are your skills and values?

Leaves: names of those who are significant to you in a positive way, such as your friends, family, pets and heroes.

Thorns: challenges, threats and difficulties in your life

Flowers: what makes you special and your strengths

Branches: the branches of the tree are hopes, dreams and wishes for the direction of your life.

Fruits: the fruits of the tree represent the gifts you have been given, but not necessarily material gifts: gifts of being cared for, of being loved and acts of kindness. They also represent achievements (small or large) in your life, e.g. raising children.

Buds: your ideas and hopes for the future and their potential

Another alternative is to give an opportunity for participants to draw their own tree, or they can add to the picture on "My Personal Tree of Life" (see Appendix 9).

Discussion

- How was this exercise? What was easy? What was hard?
- How did you feel when you shared your experience? What was easy? What was hard?
- How did you feel when you were listening to someone else talk about their Tree of Life? What was easy? What was hard?

Ask the participants if they noticed similar experiences in each other's lives.

Notes for the trainer

If you are running a group that will be coming together more than once, you can explore the Tree of Life in additional group sessions. For example:

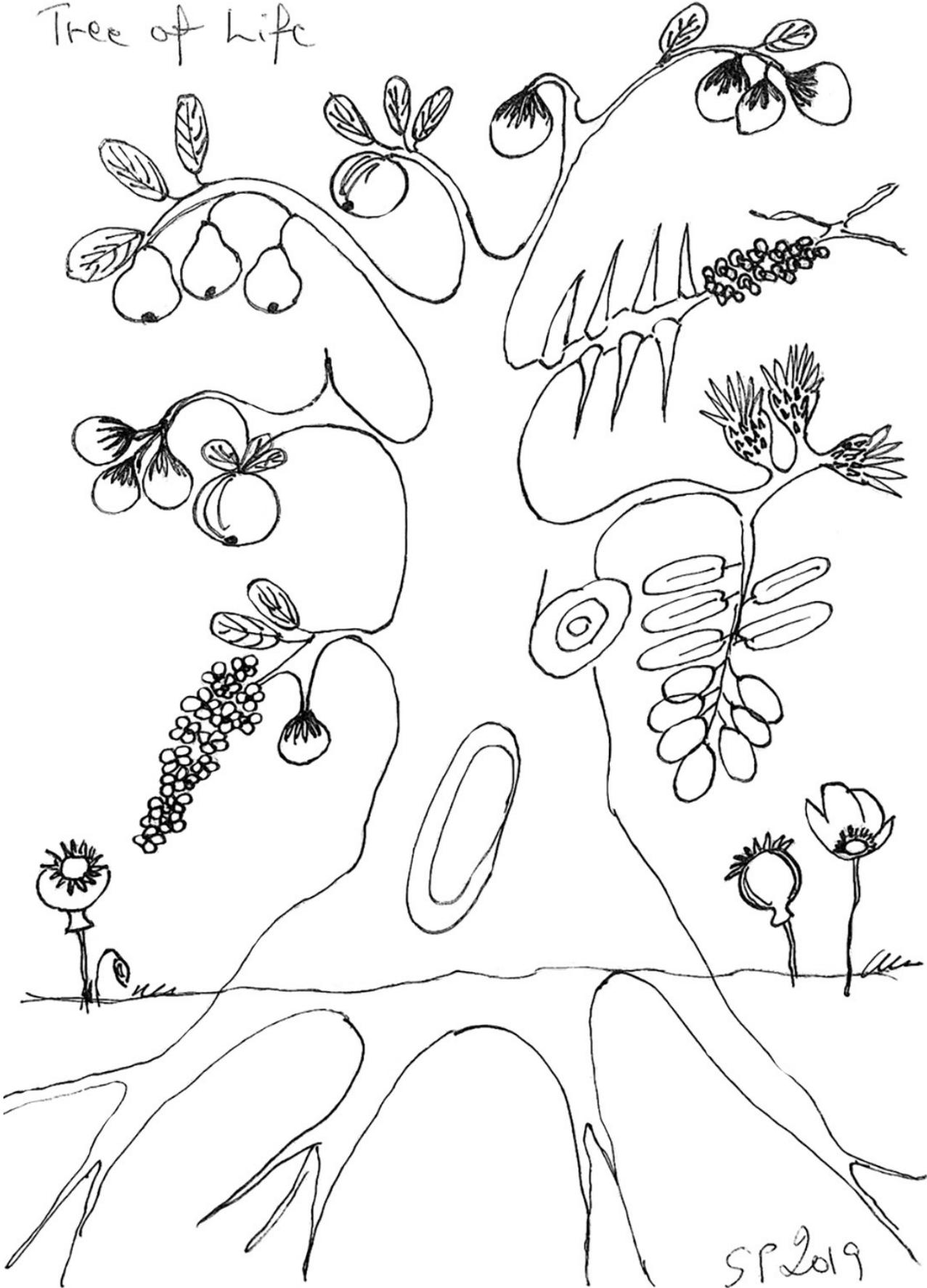
The first session can include getting to know each other, setting the group rules (e.g. confidentiality), the introduction of the Tree of Life and reflection on roots, trunk and ground.

The second session can include reflection on the leaves, thorns and flowers to explore the present and find empowering issues in the current lives of participants. You can use the Tree of Life and Exercise 4.5: Empowerment of Older People.

The third session gives an opportunity to explore the future by using the symbols of branches, fruits and buds. You can use the Tree of Life and Exercise 4.6: Hopes and visions.

Appendix 8 (Exercise 4.7): Tree of Life graphic

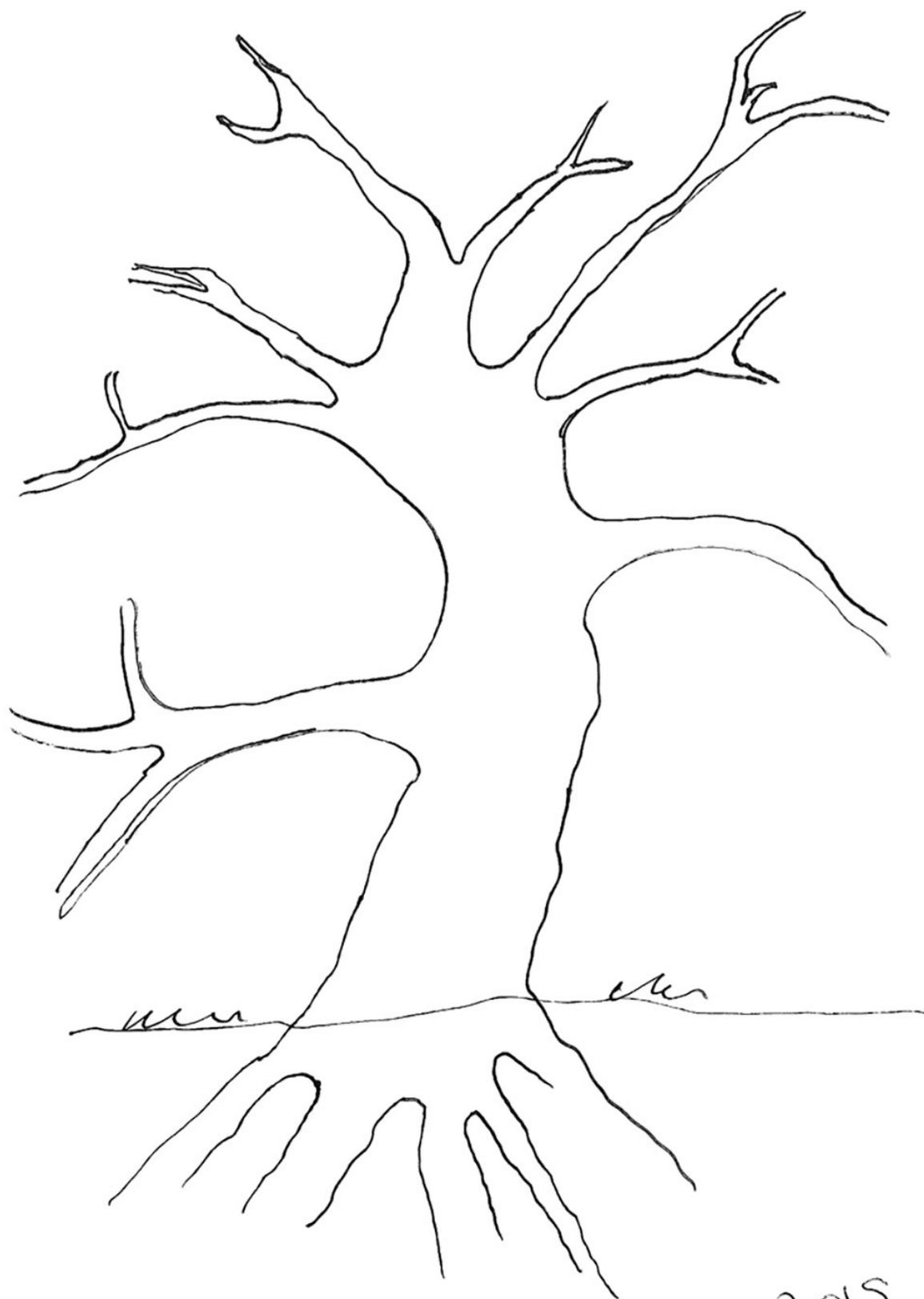
Tree of Life



SP 2019

Appendix 9 (Exercise 4.7): My personal Tree of Life graphic

My personal tree of life



SP 2019

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