











BREAKING THE TABOO

Violence against older women in families:
recognizing and acting



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PREFACE

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CONTENTS

1. INTRODUCTION	05
2. WHAT WE ARE DEALING WITH	08
3. RISK FACTORS FOR VIOLENCE AGAINST OLDER WOMAN WITHIN FAMILIES	12
4. RECOGNIZING ABUSE	14
5. STRATEGIES FOR STAFF MEMBERS	18
6. STRATEGIES FOR LINE MANAGERS	22
7. SUMMARY AND OUTLOOK	28
8. LINKS	29



1 INTRODUCTION



IS VIOLENCE AN ISSUE FOR HEALTH AND SOCIAL SERVICE PROFESSIONALS?

Violence happens. It happens every day and it is directed against men, women and children of all ages. In many cases it does not happen “on the street” but in victims’ own homes. Some of these types of violence or abuse within the family, e.g. against younger women and children, are quite known nowadays and well represented in public. As a consequence, some measures on political, legislative and organisational level have already been taken in different countries, although others are still necessary.

There is a common understanding in all European countries that violence – also against one’s own relatives – is an offense against human rights. Every European state has a legal framework to

combat violence in families. But the issue of violence against older women is quite new on the agenda. So, many of the means used to help other victims of domestic violence, like younger women, are not really suitable for them. This is especially the case for situations where older women are in need of help and/or care by their relatives. Little is known about tools and strategies for detecting abuse in this field, for coping and helping in an adequate way.

Many times staff members of health and social service organisations who work in people’s own homes are the only ones – besides the family – that have contact to older women who are victims of abuse. So violence in this context is and has to be an issue for these members of staff and for their organisations too.

IS VIOLENCE AGAINST OLDER WOMEN A RARE EXCEPTION?

In fact, there is not much detailed information on the frequency of violence against older women, neither on European nor on national level. But most available statistics point to a rate of elder abuse in general of between 6 and 9 per cent. The fact that there is so little public information on this shows that violence against older people – especially older women – within their own families in all its forms is still a taboo all over Europe.

"I have this feeling, we are considering only the top of an iceberg. The public opinion doesn't have the adequate sensitivity to understand the importance of the phenomenon, the gravity of the phenomenon." (Medical, Italy)

Some recent studies document that older people are victims of violence and abuse. A large proportion of this abuse occurs within families – mainly in the home of the older person. In nearly all these cases, there is a very tight emotional and long-lasting relationship between perpetrator and victim: In approximately 70 per cent of elder abuse cases, the perpetrator was confirmed to be the child or spouse/partner of the older person.

WHY IS THE FOCUS PUT ON OLDER WOMEN?

Data show that generally women are more often the victims of violence against older people than men. One reason for this is their longer life expectancy, which leads to the simple fact that there are more older women than men. But also the poorer health status of women in comparison to men, often linked with chronic conditions, and increased levels of disability, can lead to multidimensional dependency and thus to increased vulnerability. Finally, gender roles and power relationships built along the life course tend to result in a more vulnerable situation for older women. For this reason in this brochure we are explicitly talking about older women – knowing that many aspects are relevant for the problem of violence against older men in quite (but not exactly) the same way.

WHO SHOULD READ THIS BROCHURE?

This brochure is on the one hand for professionals working in the field of home care (home nursing, home help and other domestic services), especially with older people. This group is important because often they are the only continuous contact persons that do not belong to the family and often they have a good, trustful relationship with their clients. So willingly or not, they are sometimes the only people who have a possibility to report cases of abuse of older clients or patients.

On the other hand the brochure is for the line managers or coordinators, who are responsible for the daily organisation of services, for the support and training of professional staff, and for their physical and psychological well-being. They have to deal with reported cases and find the right partners and procedures to achieve adequate and effective solutions in often quite delicate situations.

Additionally, this brochure might give people coming from other professional perspectives (like members of victim protection institutions, shelters for women, and also managers on higher level or political decision makers) some insight on this issue and so might help to bridge the gap between different sectors and levels of social responsibility.

WHAT IS THE AIM OF THE BROCHURE?

What we intend to achieve with this brochure – and with our project activities in general – is to break the taboo by raising awareness among staff members and line managers of health and social service organisations and give them some ideas and guidelines on how to deal with the issue of violence against older women within the family.

The brochure should help to deal with these often very complex and difficult situations and to support older women who are in need as well as health and care professionals who have to cope with being witnesses. When the taboo is broken – within teams, within organisations and within the public – it will be much easier to succeed in improving the situation of the hidden victims and of the often overburdened "perpetrators" – which often means the family carers themselves – too.



Social and cultural norms all over Europe tell us to treat older people (at least!) as fairly as younger people. They have the same rights. In every culture and tradition they should always be treated with respect and empathy. The same applies to women in general. This applies in theory, but as we all know, being a woman and being old are two factors that can make a person more vulnerable and subject to discrimination.

Violence, mistreatment or abuse against older women in families includes all types of violent or abusive behaviour, on the part of family members and/or caregivers. It is directed against the woman and violates human, socially and politically defined rights (e.g. to take part in public life or to dispose of one's own belongings).

WHAT IS VIOLENCE?

The definition most commonly used was introduced by the World Health Organisation and describes violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."

It is important to underline that violence also includes forms other than purely physical violence. In this context we would like to point out that the words "violence", "abuse" and "maltreatment" or "mistreatment" which have different connotations in different countries and are hard to define distinctly will be treated as synonyms in this brochure.

Furthermore: Our focus in identifying violent situations is not just to have them identified per se, but to find links to what health and social care workers and their organisations can do to stop or to prevent violent incidents.

WHAT DOES VIOLENCE IN FAMILIES INCLUDE?

Violence in the family, or domestic violence, includes all forms of violence where an advantage of any kind is used against family members, threatening their rights and individual integrity, leading to suffering and harm.

Actual violent behaviour against an older woman in the family might have been an essential part in a long lasting family history or in the relationship of a couple from the beginning on. In this case there is very little reasonable chance for people from the outside like health and social professionals to change this in old age.

But violent behaviour can also be a result of health and age related demanding changes in a family's daily life. This can include changes in family roles as well as new and sometimes converse mutual dependencies. Completely new challenges can arise, often characterized by extensive demands and limited possibilities of support. In these cases there are many starting points for interventions by professionals working in the field of home care.

WHICH FORMS OF VIOLENCE AGAINST OLDER PEOPLE ARE THERE?

Violence against older people, or elder abuse, includes according to the American National Centre on Elder Abuse any knowing, intentional, or negligent act – or lack of appropriate action – by a caregiver or any other person that causes suffering, harm or serious risk of harm to a vulnerable adult. There is a special emphasis on the fact that it mostly occurs in relationships where there is a deep expectation of trust combined with a state of health related dependence.

Some acts of violence are intentionally carried out by the perpetrator. Other acts of violence are not intentional and sometimes they are even not felt as being violent by the relative who is trying to care for his or her relative as well as possible. Violent behaviour can for example result from a lack of awareness and knowledge as well as from physical or psychological stress.

"An 84 year old woman lives together with her son. She is widowed since the last year. Until the painful death of her daughter-in-law, her life had been calm and the family relationship, too. Due to that event the son started to drink heavily and became an obsessive gambler. Because of this he started to force his mother to give him money. In a polite way at first and then more and more violently. Every night he came back home drunk and used to beat his mother. The older woman suffered physical violence as well as psychological violence. The old woman, with the help of the social services, eventually reported the son at the local police station." (Social worker, Italy)

This example is typical as it shows the complexity of different violent acts, caused by an accumulation of stress factors. Nevertheless: Unintentional or comprehensible violence is also violence!

! ATTENTION

- The following forms of violence against older people/women rarely appear alone. Usually several forms of abuse occur together and are interrelated.

Physical abuse

This refers to actions carried out with the intention of causing physical pain or injury. Physical abuse is focused on inflicting, or threatening to inflict, physical pain or injury on a vulnerable older person, or depriving her of a basic need.

Examples: slapping, hitting, striking with an object, administering too much tranquilizing or neuroleptic medication

Psychological/emotional abuse

This includes all actions carried out with the intention of causing an older person emotional pain, anguish, or distress.

Examples: isolation from family and friends, humiliation, accusation, defamation, or infantilisation of the older person, refusal to communicate, threat of abandonment or institutionalisation

"There is mental abuse as the daughter belittles her mother's needs. She will not take a stand and the mother suffers. The daughter treats the mother as if she didn't mean a thing to her. The daughter comments and belittles; for example, when the mother wanted to go out, the daughter asked "Why should you go out as you don't even see anything." The mother wanted to feel the summer although she doesn't see. The mother was admitted to a nursing home and the daughter demanded that she should be brought back home even if she doesn't take care of her." (Home nurse, Finland)

Sexual abuse

This covers all types of non-consensual sexual contact and non-consensual sexual acts. Sexual contact with any person incapable of giving consent is also to be considered as sexual abuse. Sexual abuse often occurs under circumstances concealing the violent and abusive character of the action. It is a popular misconception to think older women cannot be sexually abused.

Examples: non-consensual sexual intercourse, talking about or showing sexual things or acts (e.g. pornographic films or pictures) to the person against her will

"There was this one case of a disabled women whose husband was unhindered in continuing to have sex with her whenever he felt the urge." (Manager, Poland)

Financial abuse

Financial abuse includes all actions where money or property is taken illegally and/or the older person's funds or assets are misused or concealed.

Examples: relatives or others use an older person's pension or care allowance for themselves, relatives sign or change the older person's will or other legal documents, misuse of custodianship

Neglect and abandonment

Neglect reflects the failure of a designated care giver to meet the needs of a dependent older person. Neglect is defined as the failure by those responsible to provide food, shelter, health care, or protection and also emotional support for a vulnerable older person. The transition to different degrees of abandonment is not always easy to define.

Examples: withholding food or necessary medication, person and/or home are dirty and extremely untidy, lack of rehabilitation treatment, disregarding pain, infrequent care

RISK FACTORS FOR VIOLENCE AGAINST OLDER WOMEN WITHIN FAMILIES

An act of violence usually does not occur from one moment to the next. It is the result of a more or less long process of cumulation. There are several well known risk factors which make it more probable that violence occurs sooner or later. It is important to keep an eye on these aspects, and thus be able to intervene at a very early stage or to help prevent the occurrence of violence.

ATTENTION

The following risk factors do not necessarily lead to violent behaviour. However, they can increase the probability and help to raise awareness for possible violent behaviour. Usually several risk factors occur together.

WHAT ARE TYPICAL RISK FACTORS?

Family history

Abusive behaviour may have a long tradition as a, more or less, conscious strategy for solving conflicts within the family. Also, a history of marital violence may predict abuse in later life (sometimes with change of roles).

Mutual dependency of family members

Mutual emotional as well as practical dependency can trigger conflicts which have been latent for a long time. Unwilling and unaccustomed dependency can lead to abuse. Mutual emotional dependency between the victim and perpetrator increases the risk of domestic violence, as does the financial dependency of the perpetrator on the victim.

Sharing the apartment or house

A shared living situation provides a greater opportunity for tension and conflict. In such circumstances, caregivers and older persons must deal with a lack of privacy. Also, caregivers might have to be available twenty-four hours per day without the possibility of being alone. Such situations can sometimes serve as the backdrop for cases of abuse against care receivers.

Physical and/or psychological burden placed on caregivers

Poor health, disability, and functional and cognitive impairment in older persons can make them very demanding "patients" for the family. This leads to extraordinary physical and/or mental stress on the side of the family caregivers. Abuse may – but does not have to – occur in a care giving situation, when the caregiver cannot cope with the victim's physical and mental incapacity, as well as his or her own lack of perspective and freedom.

Additionally illnesses such as dementia can result in change of character and habits. Family members may find these changes difficult to deal with and feelings of helplessness, frustration, and desperation can arise. Exhaustion and burn-out are factors which can – but do not have to – be linked to violent behaviour.

Social isolation

Social isolation can promote the risk of becoming a victim by increasing dependency and stress. On the other hand social isolation reduces the likelihood that abuse will be detected and stopped. Social isolation can also be a result of abuse: Families might refrain from social contact, afraid that others might suspect maltreatment within their family. On the other hand emotional support and having a supportive social network are essential to caregivers and older persons alike. A missing supportive social network or a lack of social control might also, in turn, lead to or enforce abuse.

Alcohol dependency, other addictions and undiagnosed mental disorders

Abusive behaviour directed against older persons may be caused or enforced by alcohol or drug abuse or other dependencies. It can directly result from the health consequences of this dependency (e.g., mental disorders, mental illness). Besides physical violence also the problem of financial violence can arise in the context of expensive addictions. Abusive behaviour also may result in connection with undiagnosed mental disorders in abusers.

"The daughter was alcoholic, she did not initiate physical abuse but indeed emotional abuse, called her a bad mother until the day her mother died. For her, everything that happened was her mother's fault." (Home nurse, Austria)

Additional factors causing stress

High levels of violence in social relationships can also occur together with poor socio-economic conditions, poor living conditions (e.g., overcrowding), and/or socially stressful life events (e.g., unemployment).

Besides the socio-economic situation, several general societal factors can also be involved, such as changes in the family model, women's progressive entry into the labour market, an insufficient access to health and social services and the weakening of close supportive networks.



4 RECOGNIZING ABUSE

Health and care professionals as well as social workers or other staff members of health and social service organisations working in older people's homes are in a unique position to identify domestic abuse and to ensure that appropriate help is provided. Early identification and intervention can improve the quality of life as well as physical and psychological health conditions of older victims (e.g. chronic pain, headache, depression). Early intervention can also reduce their being dependent on support by others.

HOW CAN VIOLENCE BE RECOGNIZED?

Staff members are often confronted with a slow suspicion and concern that "things are not right" with the client. It is important that they first of all trust their intuition and follow-up these concerns for the well-being of the client.

Recognizing situations of violence against older people is not easy. Most abusive acts do not occur in the presence of health and social service staff. So abusive behaviour is usually not observed directly.

Two important leading questions to help staff members to recognize indicators of abuse are:

- Why is this situation causing my concern?
- What exactly am I observing?

Additionally, some forms of violence might be considered as "normal", due to the individual biography of the victim or due to the specific social and cultural context, in which perpetrators, victims and/or staff members live.

"It is very difficult to explain to a victim that they do not have to be completely subject to the will of their children – the perpetrators of violence – and that they also have rights." (Manager, Poland)

! ATTENTION

- Sometimes abuse is not recognized (or sometimes "over recognized") because client and staff members have different perceptions and sensitivity for violent behaviour. This might have to do with different cultural and social backgrounds. Abuse might also not be recognized due to difficult communication with the client, e.g. if she suffers from dementia. Also, it might not be clear how certain symptoms like bruises have come about. Recognizing involves both dialogue and observation – and reflection, too.

General ways to recognize violence are:

- Observation of actions and signs of previous actions
- Observation of the behaviour of the client
- Talking to the client
- Talking to others involved

WHAT SIGNS MIGHT INDICATE ABUSE?

Signs for possible physical abuse

Bruises, pressure marks, broken bones, scratches, abrasions, ripped hair, burns, refusal to undress, repeated accidental injuries, anxious behaviour when somebody approaches a person

Signs for possible psychological/emotional abuse

Client is emotionally upset, appears isolated, unexplained withdrawal from normal activities, insomnia, fear of people, a sudden change in alertness and/or in appetite, unusual depression, belittling and/or threats by family members

Signs for possible sexual abuse

Bruises around the breasts or genital area, unexplained venereal disease or genital infections, unexplained vaginal or anal bleeding, torn, stained, bloody underclothing, anxious behaviour when getting undressed or being touched

Signs for possible financial abuse

Sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the older person; unexplained sudden transfer of assets to a family member or someone outside the family; unexplained disappearance of funds or valuable possessions, sudden inability to pay bills; food scarcity at home; absence of prescribed medicine

Signs for possible neglect or abandonment

Unusual weight loss, dehydration, malnutrition, untreated bed sores, poor personal hygiene, unsanitary and unclean living conditions, unattended or untreated health problems, lack of social contact. Abandonment as an extreme form of neglect: leaving an older person alone in a hospital for a long time or unattended at home.

If any of these signs occur, it is important to investigate where they come from. One important step, if possible, is to talk to the older person and/or the family care giver.

HOW TO TALK ABOUT POSSIBLE SIGNS OF ABUSE?

! ATTENTION

- First of all: An older persons' own report of abuse of any kind should always be considered as a "red flag" (= something to listen and watch for)!

Staff members who identify any injuries should carefully ask about how they occurred. Explanations of injuries that are inconsistent with observation or multiple injuries in various stages of healing should be discussed.

! ATTENTION

- If possible, talking with a potential victim should take place in private, without an accompanying family member. The client should have the opportunity to talk freely and confidentially. Maybe she needs several conversations to become confident enough to speak. A sign for possible abuse might be, if the client is not left alone with the staff member by her relative even for a minute.

WHICH ASPECTS SHOULD BE ADDRESSED IN A FIRST CONVERSATION?

When talking to a potential victim the following issues can be the background for leading questions:

- Explore the exact meaning of the potential victim's complaints: What does the potential victim mean when complaining about the way she has been treated by someone else?
- Try to get a comprehensive understanding of her well- (or ill-) being: How does she feel in general?
- Capture new important events or trends: What has happened in the last days? What have been important (positive and negative) events?
- Stimulate comments on the quality of social relations and the client's participation (or isolation): Is there some news on relatives and friends (e.g. how things are going with spouse, children and so on)?
- Exclude "natural" reasons for physical injuries: Where do signs of possible abuse (e.g. scratches) come from?
- Identify reasons for mental changes: Where does a different state of mood come from (e.g. why does the client seem to be so upset, so anxious, so sad-faced)?

- Find out if the client's administrative and financial issues are in place: Does she need or wish any support in managing her financial affairs? What happens, when person needs new things, who buys them?
- Find out about food and eating habits: Does the client have enough to eat? Can she eat and drink things she likes?

! ATTENTION

- How questions will be asked, which words have to be used, and so on, depends on the situation, on the cultural context and on the personal preferences of the client and the staff member leading the conversation.

HOW TO DEAL WITH DOUBTS?

To have doubts about the signs one observes and about the statements one hears is a normal process. General guidelines in dealing with these doubts and responding cautiously to these signals can be:

- Observing closely and registering each incident
- Examining one's own conscience
- Objectifying suspicions by consulting colleagues or other persons
- Trusting one's own intuition

! ATTENTION

- Members of different communities or cultural groups (e.g. migrants) do not necessarily think of elder abuse, law enforcement, and the legal system in the same way. It is always necessary to make sure that client and staff member understand each other. In some cases it might be helpful to take along a trained interpreter. This should be a neutral person not a family member or a friend of the client or family carer.



Recognizing and identifying abuse are the first steps in dealing with such a situation and a prerequisite for further action. To break the taboo is indispensable for getting any further help. And help is needed by the victim, by the perpetrator and by the witness of abuse as well. In cases with immediate danger immediate action is needed. The service to alert in acute danger is of course the police. In every case the line manager has to be informed. Every further action has to be agreed with him or her.

! ATTENTION

- There should be an agreement in each organisation that a staff member who reports something that turns out to be a "false alarm" is not to be blamed – and that it is better to report and check once in vain than to miss out on an action that could preserve somebody's physical and psychological health.

WHAT MAKES IT DIFFICULT FOR STAFF MEMBERS TO REPORT ABUSE?

Commitment to the task as well as feelings of fear, denial and powerlessness can be barriers to reporting abuse. Helplessness can hinder intervention: Staff members often feel frustrated when they see abuse and feel that there is not much they can do to make it stop. They may be worried that if they bring attention to the abuse, the family may ask for the staff member to be barred from providing care to the client.

Staff members also might be reluctant to actively meet such challenges due to lack of time or lack of skills or experience.

"In theory many symptoms may occur. Theoretically all of them can be discussed with reference to an abusive situation. The most important problem is the lack of time. We would need more time to understand and to investigate the real situation (...)." (Home nurse, Italy)

These aspects can induce feelings of inner conflicts and strain when a suspicion cannot be followed-up and reported.

Also the victim might deny abuse, as she does not want to blame the perpetrator or is scared that the abuser might seek revenge. Furthermore, older people often are afraid of being transferred to a residential care facility as the only alternative. And some victims do not perceive abusive behaviour against themselves as being abusive.

An additional obstacle is the difficulty to communicate with older people suffering from dementia as information about abuse might not be valid. Also staff members often try to avoid conflicts with family carers and with the person being cared for. They attempt to stay neutral as they are afraid of being replaced when clients blame them for causing trouble.

Sometimes the single staff member feels unable to react to situations of abuse if no clear procedures are defined by the organisation. These procedures entail whom to contact in the first place to be sure that further action will be taken.

HOW CAN STAFF MEMBERS OVERCOME DIFFICULTIES TO REPORT ABUSE?

- Talk to the victim and build trust.
- Be aware that physical, sexual, and financial/material abuse are crimes like assault, battery, rape, theft.
- Realize the unique position of the health and care professional to report abuse. This is also connected to a certain responsibility.
- Talk to the line-manager and colleagues about the situation and about one's own feelings.
- Take a colleague along to meet the client to get a second opinion.
- Ask for supervision of work.
- Know about services that can help in such situations.

Another very important strategy is to follow a standardised procedure, if this is available (like the "ideal" procedure described in Chapter 6). Here is an overview on the first three points from the perspective of the staff members working directly with the client.

1. Reporting to line manager and team

Usually one staff member needs to deal with a situation before the issue becomes a collective effort, managed by the organisation. Thus, the individual staff members' preparedness to cope with a situation is crucial at the beginning of the process.

"I want to help those people in that situation. I do not try to single out who is guilty, since I do not know all the background information. I just try to find out what has happened. I do not feel anxiety or fear or anger ... my own professional competence is that I always try to help." (Home nurse, Finland)

In most cases a staff member recognizes an abusive situation and then the case is discussed with the line manager and the team. Further strategies (e.g. the involvement of a social worker or other specialists) are discussed then.

2. Cooperation with the team and external specialists

After reporting and discussing the issue with the manager and in the team different actions are taken, depending on the type of situation. This may also involve bringing in other members of staff and/or organisations. Support for the victim is given.

In this phase the staff member who was involved at first, often plays an important role as a bridge between the experts (e.g. internal social workers or other adequate organisations, external social workers or other organisations) and the client. He or she also plays a crucial role in monitoring the ongoing situation. In case nothing changes, he or she might have to report again.

3. Caring for oneself

At times the staff member is personally involved in a situation to such an extent that he or she "can't just do his or her job". Feelings of sorrow and thinking about cases do not end, not even after work and at home.

"... I think 'Horrible, I do not want to go there anymore' ... or: 'How could this problem be solved?' And I take the problems home with me." (Home nurse, Austria)

! ATTENTION

■ To communicate one's own feelings is the first key to coping! To confide in colleagues and also good friends (e.g. spouse) can be very helpful. In the latter case, of course: names or facts that expose the identity of the people involved must never be mentioned!

By reporting and documenting the issue it becomes an object of concern also for other colleagues and organisations. Peer support and discussions in teams or with team leaders, especially non-directive counselling as a coping strategy, are very important:

*"At the Centre, we receive continuous training for dealing with victims of violence and we have access to a psychologist-consultant, with whom I can discuss a particular case, or when I feel I will not be able to handle a case, make the intervention together. At times, the psychologist may take over a case."
(Home nurse, Poland)*

In cases where no solutions are found staff members have to bear the fact that they can not help. This can be very difficult psychologically. The staff members should not hesitate to talk about their problems and search for help for themselves. Sharing the burden can be a relief.

STRATEGIES FOR LINE MANAGERS

Usually professionals in the field of health and social services receive little information on the issue of violence against older people during their vocational training. Therefore it is even more important for organisations to develop standardised procedures to support staff in reacting to cases of domestic violence. Most managers in health and social service organisations already have a kind of informal procedure they follow, but this is mostly not a systematic one.

To guarantee the quality of services and the well-being of the clients (and staff) health and social service organisations should develop clear policies. These should include a common organisational understanding of violence as well as guidelines on how to deal with situations of domestic violence. Additionally it should include preventive and structural aspects.

! ATTENTION

- An organisational policy should entail:
 - A common understanding of what violence is, including definitions
 - Commitment to combat abusive situations in families
 - Commitment to prevention
 - Clear codes of practice for taking action
 - Readiness to invest in preventive and supportive structures

CAN PREVENTION BE OUR JOB?

Not all "perpetrators" are innately violent personalities. Often the use of violence against older people can represent a coping strategy for stress. This stress can be at least partly a result of the care situation itself.

Of course, one has to keep in mind that violence can never be justified. However, a focus on the causes and risk factors that can be influenced opens the way to solutions as well as to preventive measures.

These kinds of (potentially) violent situations are a good field for helpful intervention at a very early stage. Health and social care organizations can help to de-escalate and even to avoid the development of some of the risk factors (see Chapter 3) from the beginning!

People who actually resort to violence or are at risk to do so should receive support. Some of them should also receive psychological help to better cope with anger and impatience during care giving. And of course they should receive practical relief.

! ATTENTION

- The crucial question is how to act in a preventive way, to anticipate violence and abuse and to take steps before escalation occurs.

Prevention should be one of the central aspects in the agenda of health and social services. But what can health and social services really do?

In the ideal case prevention starts at the beginning of family care relations, when first patterns of care (procedures, communication, etc.) are developed. In this stage adequate information about support services and possibilities of relief for family carers can have a long lasting preventive effect.

Support can be given by:

- Appraising the specific risk dimensions
- Offering information to family care givers about adequate support services (e.g. day care centres, visiting services, short term care ...)
- Talking to the client and the family care giver about the situation (e.g. about presumable changes within the family system and about economic consequences)
- Offering training courses and/or consulting services
- Providing information about possible consequences of permanent strain to the care giver's health (and his or her capability to care for the relative on a longer run, too)
- As far as possible and necessary: strengthening mutual trust in the family
- Involving general practitioners to reveal abuse at an early stage
- Suggesting to take up more professional support

WHAT SHOULD BE DONE IF THERE IS SUSPICION OF VIOLENCE?

Action and responsibility should be clear and shared: The provision of a clear procedure that staff should follow helps to systematically deal with violence and guarantees a high quality of service. Though each case of abuse involves specific circumstances a general procedure defining communication flows and action chains can become an important instrument. First of all, staff should be provided with precise answers to the question: **Which person or institution do I have to contact and inform at which point?**

Additionally the staff members should have a general idea of the foreseen procedures that might start with this first announcement. The following chart shows seven "ideal type" steps to deal with domestic violence against older people in their homes. In reality these steps have to be adapted to the national, regional and organisational framework and to the individual situation.

Step	What to do	Who is involved	Why to do this
1	Recognizing signals of abuse <ul style="list-style-type: none"> Screening the situation systematically according to risk factors and possible signs 	The staff member who is working in the family (or doing the first assessment)	All "risk factors" or "signs" can be warnings but do not necessarily prove the existence of violence.
2	Focusing on the signals <ul style="list-style-type: none"> Observing closely and recognizing single incidents Clear documentation of incidents 	The staff member who is working in the family – maybe already in agreement with the line manager and informing other people working in the same household	It is important to carefully observe and to clarify suspicious incidents, before taking next steps.
3	Talking about suspicions in your own organisation <ul style="list-style-type: none"> Informing the line manager Objectifying suspicions by consulting colleagues or other people 	Staff member, line manager colleagues (the team)	Sharing the burden can be relieving. In the interest of the client it is often very important to get a second (and third) opinion.
4	Checking suspicions with victim and perpetrator <ul style="list-style-type: none"> Entering into discussion about the problem in a careful and respectful way, if possible through an expert. (It is important to talk to the victim alone without any accompanying family member.) Clarifying the cause/origin of abuse Figuring out the requests and needs of those involved 	Staff member and team If needed, experts (agreed with the line manager) Victim (client) Perpetrator Family care giver and other family members as far as possible	To check what is possible within the boundaries of the specific situation. The staff member should ideally have a trustful relationship with the client – and the expert has the adequate means. To know the origin of the problem is necessary to set adequate interventions.

Step	What to do	Who is involved	Why to do this
5	Discussing possible interventions within the organisation with the involved care team <ul style="list-style-type: none"> Reporting to and cooperation with local social service centres and victim protection organisations Developing an intervention plan how to deal with the problem 	Team Line manager Experts like social workers, psychologists, psychiatrists Maybe "higher" management Maybe other involved persons or organisations (other service organisations, police ...)	Because of the complexity of a situation, often a set of interventions is necessary. It is necessary to get all involved people/institutions into one "boat" to get all available information and to avoid contradictions or overlaps.
6	Suggesting an intervention plan to the family care system <ul style="list-style-type: none"> Discussing the intervention plan and if required, adapting the plan Coming to an agreement with the client and the family care giver Committing to the intervention plan 	Team Line manager Experts Victim (client) Perpetrator Family care giver and other family members, as far as possible!	All involved people need to agree in order to carry out an intervention plan adequately. (If this is not possible, solutions need to be found to help the victim without the cooperation of the family members.)
7	Realisation of the intervention plan <ul style="list-style-type: none"> Coordinating the intervention activities among the involved organisations Monitoring the situation If necessary adaption of the plan 	Team Line manager Victim (client) Perpetrator Family care giver and other family members as far as possible Consulting experts as far as needed	Continuous communication with the family system and continuous monitoring of the "signs" is necessary to see if the measures are effective and to improve the situation.

WHAT CAN BE DONE ON THE LONG RUN?

Preventive and supportive structures have to be developed and implemented to guarantee the sustainability of all actions, measures and interventions. All these structures reflect the important role of the staff members in this context. Their capacity has to be strengthened.

"If for example, we install a hotline to collect the older people's complaints and then we are not able to give appropriate answers ... it would be completely inadequate. First of all we must be able to give answers. Then we can think how it is possible to help the persons." (Manager, Italy)

General training for staff

The provision of continuous internal training raises service quality in general. Trained staff acts according to standards, and knows how to behave adequately. Knowledge and information give orientation and the feeling of doing the right thing.

"What we need is open discussion, education and training. If there is a case of physical abuse, I would not notice it, I do not know how to detect or recognize it and I do not know whom to contact." (Professional, Finland)

The correct identification of symptoms and their causes demands expertise and holistic thinking – even in case of physical abuse as, for instance, bruises can also be caused by medication, by falls or by other non-violent events.

Staff members need:

- Basic expertise concerning the recognition and documentation of abuse
- Communication and conflict management skills, including skills to establish a trustful relationship with the victim
- An understanding of the further steps which have to be taken after having recognized an abusive situation

Following aspects should be part of the training:

- How to recognize signs of violence
- Risk indicators for domestic violence within care relations and possibilities of prevention
- Possibilities of assistance and relief for the family care givers
- Information on mental health problems, alcohol abuse and illnesses like dementia and their implications on behaviour
- Communication skills to enable victims to speak about their experiences
- Conflict management

"Somebody must be able to manage the conflict. The violence usually stays behind a social conflict. Behind a disrupted social context. We need professionals able to activate a mediation. Able to analyze the social context. We need a lot of competences. These are impossible to embody in a single professional." (Social worker, Italy)

ATTENTION

- Especially young staff members need adequate further training. They do not have enough work experience to compensate their limited know-how on the issue!

"At the beginning, I think for someone, who is newly confronted with these problems, it is very difficult ... because a high level of pressure develops." (Social worker, Austria)

Further support for staff

Working conditions in the field of home care are challenging. Organisations can contribute to improving working conditions e.g. by developing and providing:

- Guidelines for appraising symptoms of abuse
- Appropriate standardized procedures to deal with domestic violence
- The possibility to be accompanied by an experienced colleague, to get a second opinion
- Special guidance for young staff members
- Team structures to enable communication and discussions within the team, as one of the main coping strategies
- Non-directive counselling
- Support through external staff like psychologists/psychiatrists
- Mobile crisis intervention teams
- Voluntary work

"More visiting-services (would be fine) ... a lot of them are thankful for just having someone to listen to them. A lot of them start to tell ... tell what has happened ... or go for a walk and thereby start chatting. (It is necessary) that someone is just there for the person ... to confide in someone who does not care about the time." (Home nurse, Austria)

7

SUMMARY AND OUTLOOK



We have been focusing on the important role of staff members as well as line managers who are directly involved in recognizing and acting in cases of violence against older women within families. We also mentioned the possibilities for organisations to improve their structures and framework conditions in dealing with these cases. We mentioned the importance of preventive interventions using the provisions that already exist within current framework conditions.

But: Not only health and social services can improve action in this field, it is also the responsibility of policy and decision makers to act. Examples for courses of action are:

- Opening the public discourse on domestic violence against older people and raising awareness for society's responsibility to provide a high quality care system for older people
- Offering more resources for health and social care for older people
- Integration of the issue in existing further training and basic vocational training of relevant professionals (e.g. physicians, health care professionals, social workers, police force)
- Adaption of the existing legal framework – which is often tailored to combating violence against younger women or children – to meet the demands of older victims
- Improving cooperation structures between health and social services and victim protection organisations

More detailed policy recommendations can be found in the advocacy paper which will be developed within the "Breaking the Taboo" – project. The following section provides links to organisations dealing with violence against older people and/or older women and it contains some information on related DAPHNE-projects.

8

LINKS

ORGANISATIONS DEALING WITH VIOLENCE AGAINST OLDER PEOPLE AND/OR OLDER WOMEN

WHO – Prevention of Elder Abuse

www.who.int/ageing/projects/elder_abuse/en/index.html

Council of Europe

www.coe.int/t/dc/campaign/stopviolence/default_en.asp

International Network for the Prevention of Elder Abuse (INPEA)

www.inpea.net

National Centre on Elder Abuse (USA)

www.ncea.aoa.gov

National Committee for the Prevention of Elder Abuse (USA)

www.preventelderabuse.org

AGE – European Older People's Platform

www.age-platform.org

WAVE – Women Against Violence Europe

www.wave-network.org

RELATED DAPHNE-PROJECTS

Daphne Toolkit

The Daphne Toolkit is both an archive of projects supported by the European Commission's Daphne Programme and an active resource for those planning new projects in this field. In the Daphne Toolkit, you will find presentations of about 460 projects financed under the Daphne Programme between 1997 and 2006, with descriptions of their objectives, actions, results and the lessons learned from them, as well as related links and resources. Furthermore publications, reports and presentations can be found.

http://ec.europa.eu/justice_home/daphnetoolkit

Care for Carers

The project aimed to exchange good practices on the prevention of hidden violence by women caregivers against older women suffering from Alzheimers' disease. Results were good practice guidelines, the adaptation and translation of the Italian Caregiver Manual' in three languages and their dissemination at European level.

<http://www.careforcarers.eu/en/index.aspx.htm>

Recognition, Prevention and Treatment of Abuse of Older Women

This project aimed to define the nature of the problem of violence/abuse of older women – particularly those with cognitive impairment – in four Member States of the European Union. The project further reviewed legislative frameworks relating to this issue and responses by social actors in the four partner states. Finally, good practice examples were identified and findings from these were shared.

http://ec.europa.eu/justice_home/daphnetoolkit/html/projects/dpt_2001_215_w_en.html

Prevention of Violence against Women and Children – Training, Sensibilisation of Professional Groups in the Framework of WAVE

The project focused on the prevention of violence against women through the publication of a training manual and brochures on prevention of domestic violence against women in Europe, including a European Survey and Good Practice Models. It consisted of a training programme aimed at enhancing the understanding of law enforcement, judicial, medical and psycho-social professionals on violence against women; and produced a publication on prevention of domestic violence against women in Europe, including a European Survey and Good Practice Models.

http://ec.europa.eu/justice_home/daphnetoolkit/html/projects/dpt_1999_288_wc_en.html

Development and Testing of a Module Concerning the Role of Health Care Providers in Assessment and Intervention of Intimate Partner Violence (IPV)

This Daphne-project aimed to develop a training module for future physicians in order to improve their knowledge, reinforce their skills in addressing and dealing efficiently with victims of abuse.

http://ec.europa.eu/justice_home/daphnetoolkit/html/projects/dpt_2003_120_y_en.html

