Monitoring in Long-Term Care – Pilot Project on Elder Abuse

MILCEA

Final Report

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Progress Report – Structure

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This project has been funded with support from the European Commission. This report reflects the views only of the authors, and the European Commission cannot be held responsible for any use which may be made of the information contained therein.

Summary

This report provides information on the goals, the methodology and the results of the MILCEA project (Monitoring Elder Abuse in Long-term Care – Pilot project on elder abuse), which was funded by the European Commission and conducted between December 2009 and the end of March 2012. The declared goal of MILCEA was to contribute to the prevention of elder abuse (EA) in long-term care (LTC). In the course of the project, the LTC systems in different Member States of the EU were systematically analysed for elder abuse, using a mix of scientific methods (focus groups, stakeholder analysis, literature analysis, interviews, etc.). The main thrust of the MILCEA project was to provide a framework for EU Member States on how to put in place the structures needed to monitor elder abuse. The framework has been developed for use in all EU Member States.

1 Introduction

1.1 Background

After spouse and child abuse had gained greater awareness by professionals and public, the abuse of elderly and frail people was “discovered” (Medicine Encyclopaedia, Aging Healthy, Part 2). In 1975, almost at the same time, Butler and Burston wrote about the phenomenon of elder abuse in the USA and UK; however, they still named it differently. Butler described the phenomenon as “granny battering” and Burston named it “battered old person syndrome”. Although awareness of this problem was rising around this time, it can be assumed that elder abuse has a longer history (Medicine Encyclopaedia, Aging Healthy, Part 2). After the “discovery” of elder abuse in the USA and UK, attention to the abuse of elderly people grew worldwide. In 1985, the Council of Europe explored violence in the family and made recommendations to the member states (Council of Europe, 1985), also concerning violence against elderly people (Council of Europe, 1992). In most European States there was still little awareness of the phenomenon, and no structures were in place to tackle this problem. The topic elder abuse overlaps with gender equality, ageism and human rights issues that in parallel also gained more attention (WHO, 2002a). A further milestone is the “Madrid International Plan of Action on Ageing” that was formulated by the United Nations (UN) in 2002 for its member countries. It recommended a multidimensional strategy for the prevention and elimination of elder abuse. On the one hand the importance of measures for preventing elder abuse are pointed out, on the other measures are also demanded that encourage professionals in the health care sector as well as the general public to report a suspected elder abuse. The World Health Organization (WHO), together with the International Network for the Prevention of Elder Abuse (INPEA), in 2002 drew up the Toronto Declaration, where elder abuse was described and identified as a global problem. The project “Global Response to Elder Abuse” by the WHO and INPEA was the first international project aimed at finding a global strategy to tackle the problem

(WHO/INPEA, 2002b). In order to meet the responsibility toward older people and an aging society the European Commission initiated several projects with different approaches to prevent and combat elder abuse.[1] More recently, the European Charter on the rights of older people was developed by AGE Europe[2] and 11 partner organisations assisted by the European Commission's Daphne III Programme. The charter serves as "a reference document setting out the fundamental principles and rights that are needed for the well-being of all those who are dependent on others for support and care due to age, illness or disability". In 2008 the project "Abuse of Elderly in Europe" ABUEL was initiated by the European Commission to examine the prevalence, nature and determinants of elder abuse by means of an empirical collection of representative data in seven Member States.

Beside the different projects that contribute to raising the awareness of elder abuse, recent developments might also reinforce this trend. In the USA, Mickey Rooney, a famous actor, reported in testimony to the Senate Special Committee on Ageing about being abused by members of his own family (ABC News, 2011). For the first time, a celebrity admitted having been affected by elder abuse. This public disclosure may trigger further reaction also in other countries.

As described above, the European Commission has already launched several worthwhile projects to find strategies to combat elder abuse and to identify its causes and determining factors. In 2009, it announced funding for two projects aimed at prevention of elder abuse. The Medical Advisory Service of Social Health Insurance (MDS) applied to run one of those projects, to focus on the monitoring of elder abuse in LTC. The aim of the proposal, which was accepted by the European Commission, was to find strategies to systematically and regularly monitor elder abuse – and ultimately to prevent it from happening at all or repeating itself. Those countries that have participated in the project, which is called MILCEA include Germany, Luxembourg, Spain, Austria and the Netherlands. The other project to win funding was EUROPEAN, which set out to develop a reference framework of best policy practices to prevent elder abuse (www.preventelderabuse.eu).

1 E.g. ABUEL, Breaking the Taboo I and II, EUSTaCEA
2 Age Europe is a network of around 150 organisations of and for people aged 50+ representing directly over 28 million older people in Europe.

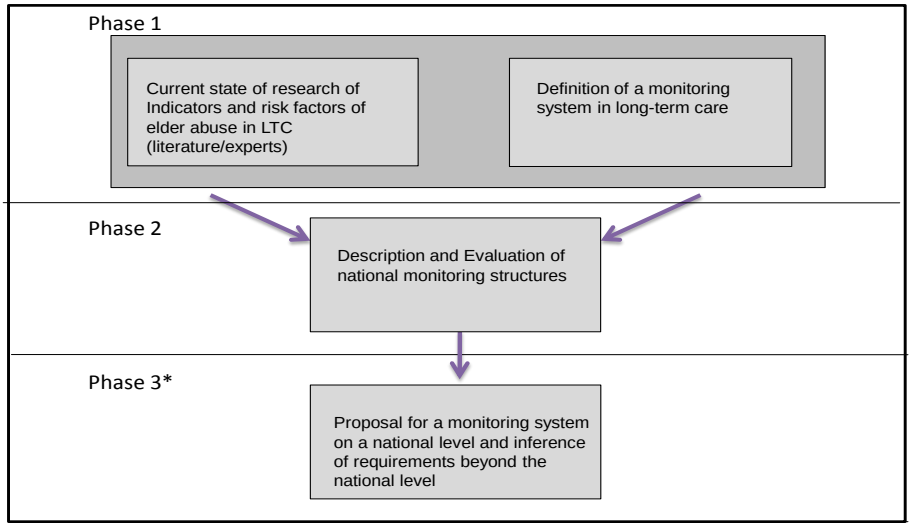
1.2 Objectives of MILCEA – The three phases of the project

MILCEA aimed to contribute to systematic monitoring of elder abuse in each participating country, and furthermore, to identify a common framework of monitoring on an international level. Detailed goals of MILCEA were:

- Description of monitoring systems installed in the Member States as part of their health care and LTC systems
- Promotion of an exchange of experience between those national bodies that have competence for these monitoring systems
- Development and promotion of mechanisms for a regular screening of all persons in need of LTC (e.g. distribution of a check-list to general physicians on whose basis deficiencies in LTC and risks of violence against older people can be detected)
- Development of a general reference framework including a list of measures and indicators to be used for improving national monitoring systems in terms of the quality of LTC, as well as promotion of the practical implementation of this reference framework
- Identification of factors that may increase vulnerability, such as handicap and sex, ethnic, social and cultural background, and suitable delimitation and separation of these factors

With a view to implementing these goals MILCEA was focusing on older people in LTC both in an informal and formal care setting. After all, it is mainly the older people in need of LTC who run an increased risk of becoming victims of elder abuse due to their permanent and progressive dependence on the care by and attention of others. That means that the description and further development of systems to monitor elder abuse in LTC was at the centre of the project. While no framework for systematically recording elder abuse in LTC has as yet been established in any of the Member States of the European Union, there are various actors in the different countries that are in regular contact with potential victims of elder abuse and thus have a possibility to identify and record acts of abuse. Moreover, there are initiatives and projects in nearly all of the European Member States meanwhile that are devoted to the prevention of elder abuse and focus their activities on individual aspects or expressions of an abuse. There are also those actors who – within the frame of quality assurance in LTC – might be able to supply clues of and document elder abuse. The structures in the countries participating in the MILCEA project are very heterogeneous when comparing the goals and tasks of these actors and the recording methodologies they employ.
That is why description was part of this project in order to supply a comprehensive picture as possible of these national structures. Systematisation of such structures was among the main goals of the project. The first step here was to define what a monitoring system actually is or which requirements any meaningful monitoring has to meet.

First of all, the analysis of national structures calls for an operationalisation of the different forms of elder abuse in LTC. This was achieved on the basis of international research work and the results of expert opinions. The outcome then was a list of indicators and risk factors on whose basis the project partners analyse structures for identifying and recording abuse in their respective countries. Key questions were: *Which actors are there in LTC? What access do they have to older people in need of LTC? Which are their possibilities to identify and record elder abuse – and where are their limits? Which legal outline conditions apply to them?* Departing from this analysis of structures and the requirements to be met by a monitoring system each partner country made recommendations as to a national routine recording of elder abuse in LTC. Furthermore, major factors that stand in the way of or promote a national monitoring system had to be highlighted. Thereafter, the partner countries jointly examined the legal, institutional and socio-cultural frame for monitoring elder abuse in Europe. The individual steps, each next following building on the foregoing, are shown in the following graph (Figure 1).



*The intermediate report shows one additional phase 4. In further course of the project it became more logical to combine phase 3 and phase 4 in one phase. The proposal for a monitoring system on a national level serves as a precondition to find common requirements for a monitoring system beyond the national level.and thus it is no single phase.

Figure 1: Description of the 3 phases

1.3 The participating countries

The MILCEA project was coordinated by the German Medical Advisory Service of Health Insurance (MDS) and subsidised by funds from the European Commission, DG Employment, Social Affairs and Equal Opportunities DG. The project partners were the Austrian Red Cross, Maastricht University, School Caphri, Department of General Practice and Department of Health Services Research (Netherlands), the Evaluation and Orientation Agency of LTC Insurance (Cellule d'évaluation et d'orientation de l'assurance dépendance (CEO)) and the Public Research Centre Henri Tudor in Luxembourg as well as the Ingema Institute in San Sebastian (Donostia), Spain. The partners cooperated within the project share the common experience that old age and the need for LTC are viewed as societal and welfare-state tasks in their countries that have already triggered concrete action. There are organisations in the health care and LTC systems of all countries participating in the project which are in contact with potential victims of an abuse. In many cases, these organisations already collect data that may be indicative of a potential abuse. The organisations are linked with each other to an extent, intensity and with a bindingness that differs.

In addition to the project partners who met at regular intervals to exchange information on the status of work during the project, each of the partner countries also called on the contribution by experts from the worlds of science, practical work and politics in its own country. These experts advised the individual partners at the national level. This procedure was also to ensure that the national debate of the matter, which in some countries is only rudimentary, is duly considered in the work for the project. The project partners and national expert advisory councils of the individual countries are presented in the following.

Germany: Medical Advisory Service of Health Insurance (Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V. - MDS)

Project participants: Uwe Brucker, Nadine Schempp, Dr. Andrea Kimmel

The Medical Advisory Service of Health Insurance (MDS) advises the National Association of Statutory Health Insurance Funds (GKV) in all medical and LTC issues. It also coordinates and promotes the cooperation of the Medical Advisory Services of Health Insurance of the different German federal states (MDK). As external quality auditors commissioned pursuant to the Social Security Code XI, these regional medical services audit the LTC institutions and outpatient care providers in their territory. The auditing process extends to processes and structures of the care-providing facility and the result of the care provided. A judgment of the quality of care given to the people in need is in the foreground. To this end, the state of health of the every tenth person in need of LTC is checked, and people receiving LTC are interviewed about their satisfaction with the care-giving facility. What is the general condition? What about personal hygiene? Are efforts made sufficient to guarantee adequate nourishing and supply of beverages? These are important criteria for judging just how much of LTC provided is actually

received by the persons in need of care. The persons to be subjected to this test are selected at random.
Audits and interviews of occupants are based on a standard questionnaire that is binding for all of Germany and includes over 300 questions. The data generated by the audits of 10.029 licensed nursing homes and 11.529 out-patient nursing services (figures according to the German Federal Statistical Office, 2007) are combined in an anonymised form at MDS. The law obliges MDS to issue a report on the state of quality in German LTC at three-year intervals. From 1996 to late 2008 the MDKs performed more than 45.000 audits.

Through their LTC appraisals and quality audits of nursing institutions, the MDKs gain a comprehensive insight into the nursing care provided to older people.

Dr. Valentin Aichele, Deutsches Institut für Menschenrechte (German Institute for Human Rights), Berlin

Prof. Dr. Thomas Görgen, Dt. Hochschule der Polizei (German Police University), Münster

Prof. Dr. Dr. Rolf-D. Hirsch, Rheinische Kliniken (State Hospitals), Bonn

Prof. Dr. Dr. Gisela Zenz, Johann-Wolfgang Goethe-Universität (Goethe University), Frankfurt am Main

Christine Sowinski, Kuratorium, Deutsche Altershilfe (KDA), Köln

Gabriele Tammen-Parr, Beratungs- und Beschwerdestelle (Consulting Point and Ombudsman), Berlin

Prof. Dr. Susanne Zank, Dr. Elisabeth Philipp-Metzen, PURFAM - Universität Siegen (Siegen University), Siegen

Irene Lambrecht, Heimaufsicht der Stadt Essen (Care Homes Inspectorate of the Municipal Health Authority), Essen

Figure 2: Expert Advisory Council Germany

Austria: Austrian Red Cross
Project participants: Charlotte Strümpel; Monika Wild; Gudrun Haider

The Austrian Red Cross (ARC), founded 1880, is a private independent NPO. It is guided by the fundamental principles of the Red Cross Movement, and its volunteers and employees engage in many humanitarian activities to help the most vulnerable in society, both nationally and internationally. ARC is active in the field of ambulance service, health and social services, blood programmes, disaster relief, tracing services, education and training, humanitarian law, youth and first aid.

The Austrian Red Cross is one of the major providers of social services and care for older people living at home in Austria. The Health and Social Services department within the headquarters has extensive experience in conceptual work on social services and care for older people. It supports the provincial Red Cross organisations with developing their services in adequate and future-oriented ways, carries out a variety of projects and offers advanced training. Furthermore, it develops and publishes standards and guidelines on community care and has been working on issues of quality assurance and development internally and externally together with other care providers for many years. The Health and Social Services Department has also become one of the major players in the last few years in the area of addressing and

preventing elder abuse in Austria through its activities within the national Platform against Violence within the Family and through the coordination of EU projects on ageing and the coordination of the DAPHNE-project “Breaking the Taboo” on raising awareness of violence against older women within the family.

Heidemarie Haydari, Representative of the seniors’ department of the Federal Ministry of Labour and Social Affairs

Irma Freiler, Representative of the competence centre that is responsible for the quality assurance of informal care within the Social Insurance Agency of Farmers.

Renate Gabler-Mostler, Representative of the department inspecting home help and care and residential care within the Lower Austrian Provincial Government

Gabriele Allmer, Representative of the Viennese Office for Patient Advocacy (Patientenanwältin), Lawyer

Dr. Josef Hörl, Professor for Sociology, University of Vienna, leading expert in Austria on elder abuse and LTC, has recently published a study on elder abuse in Austria

Maria Rösslhumer, WAVE, Verein Autonome Frauenhäuser, has long-standing experience in the area of domestic violence against women and victim protection and has led several projects on training health professionals (esp. nurses and doctors) on how to recognise domestic violence against women

Eva Reithner, EURAG Austria, Austrian project in the EUROPEAN project

Figure 3: Expert Advisory Council Austria

Spain: Fundación Instituto Gerontologico Matia-INGEMA
Project participants: Javier Yanguas, MA, PhD; Prof. Gema Pérez Rojo, PhD; Mayte Sancho

Fundación Instituto Gerontologico Matia-INGEMA was created in 2002, and this non-profit entity became part of the Basque Science and Technology Network. Moreover, the Fundación acts as a Health Research Unit and as an Associate Unit devoted to the issue “Ageing process”. It is also part of the Spanish National Research Council. The objective of the research work is to maximise personal autonomy, independence, health and quality of life of older people and disabled people and their caregivers. The main research lines are: promotion of active ageing and dependency prevention within the frame of a study of lifestyles (nutrition, physical activity…) and emotions of older people; generation of new techniques for rehabilitation and compensation for frailty and for situations involving handicap and/or dependency; design and development of innovative, high-quality and efficient care services which increase care quality and real quality of life for these people; and promotion and creation of innovative products and techniques and development of new approaches to improve the autonomy and changes of older people.

The Ingema research team comprises an interdisciplinary team of qualified professionals, which includes geriatricians, neurologists, neuropsychologists, sociologists and pharmacists. This enables the Fundación to undertake projects on a global level, whilst incorporating different perspectives and applying the results of the research carried out. Ingema has established

a network of different players active in the field of health care including universities, technological and research centres. All this enables Ingema to have: a) broad and extensive experience with older people; b) direct contact with end users at gerontological centres, hospitals, and in the community; c) different scenarios in which to carry out usability and user-centre design experiments and d) extensive experience in aspects related to privacy, personal data management, elder abuse and ethics.

Antonio Moya, GP, Expert Bioethics and elder abuse

Professor María Izal, PhD in Psychology, Expert in elder abuse

Professor Carmen Prado, Psychologist

Diego Trinidad, Coordinator of nursing homes and day centers

Montserrat Lázaro, Geriatrician

Stephan Biel, Gerontologist and Nursing-Scientist; Expert in dependence assessment

Mª Carmen Valdivieso, Doctor, Expert in geriatrics, Head of inspection of Residences in Castilla la Mancha.

Figure 4: Expert Advisory Council Spain

Netherlands: Maastricht University, School Caphri, Department of General Practice and Department of Health Services Research

Project participants: Prof. Jos Schols, MD, PhD; Michel Bleijlevens, PT, PhD

The Department of General Practice (section Elderly Care Medicine) and the Department of Health Services Research of the Faculty of Health, Medicine and Life Sciences (FHML) of Maastricht University participate in this project. Both departments are also part of the School for Public Health and Primary Care (CAPHRI).

The aim of CAPHRI is to perform high-quality research and teaching focused on health care innovation, ranging from prevention to rehabilitation and integrating the patient, professional and societal perspectives. Research and teaching in the School are devoted to contribute to improvements in the area of public health, primary care and chronic care. CAPHRI focuses on interventions in the chain of care, starting with prevention and primary care, and ending with aftercare and rehabilitation. The aim of the research is to get insight into the effectiveness of specific interventions and their adequacy for meeting prospective patients' needs (Special attention is paid to the implementation of evidence-based interventions. Interventions are evaluated from an economic perspective (Health Technology Assessment) as well as a normative perspective (e.g. consequences for professional caregivers and patients and responsibilities). CAPHRI's research is organised in research programmes. A research programme is a coherent group of research projects, supervised by a team of senior researchers.

Activities performed for the MILCEA project are part of the research programme Innovation in Health Care for the Elderly. The three main challenges for the future in this area of research are (a) to disentangle the role of medical, environmental (including technology) and psychosocial factors in trajectories of disablement in older persons, (b) to investigate determinants, prevalence and consequences of specific health care problems in older persons (e.g. pressure

ulcers, malnutrition, falls, fatigue, pain, dyspnoea) in clinical settings (including nursing homes) and community-based settings, and (c) to develop and evaluate innovative, client-oriented, and targeted health care arrangements which handle these health care problems and maximise independence, social participation, quality of life and quality of care and reduce disablement in older people with health problems. The mission in this research programme is, therefore, twofold; firstly to develop and disseminate knowledge and expertise on psychosocial, clinical and environmental determinants (including the organisation of health care arrangements and technology) of health care problems, need of care, social participation, independency and quality of life among older persons, and secondly, to develop and evaluate innovative health care programmes and interventions for older persons to slow down processes of disablement and to improve the socialisation of health care. In addition, the implementation of research evidence in daily practice in home care, nursing homes and hospitals, and the place of these institutions in the chain of care, has the programme's interest. The research programme includes observational research (related to the first part of the mission) as well as intervention research (related to the second part of the mission).

The programme takes a multidisciplinary approach. Therefore, different basic disciplines are involved, such as nursing science, gerontology, sociology, psychology, health care technology, health promotion, epidemiology, and (nursing home) medicine.

Mrs. M. van Bavel, MOVISIE, senior advisor combating elder abuse
Mr. T. Royers, Vilans, senior professional empowering the client and the client system
Mrs. M. van Dongen, Chair of LPBO and National Ambassador STOP elder abuse
Mrs. A. Mulder, ACTIZ, policy advisors related to client, quality of care and innovation
Mrs. G. Ubels, ACTIZ, policy advisors related to client, quality of care and innovation
Mrs. A. Jonkers, Health Care Inspectorate, programme leader elderly care
Mrs. A. Tiems, Ministry of Health, Welfare and Sports,Senior policy advisor

Figure 5: Expert Advisory Council Netherlands

Luxembourg: CEO and CRP Henri Tudor
Project participants: Pierre Guernaccini, CRP Henri Tudor; Andrée Kerger, CEO

In Luxembourg, two agencies are involved in carrying out the MILCEA project: The Evaluation and Orientation Agency of LTC Insurance (Cellule d'évaluation et d'orientation de l'assurance dépendance (CEO)) and the Public Research Centre Henri Tudor (CRP Henri Tudor).

The CEO is part of the Luxembourg Ministry of Social Security. It is briefed with determining and measuring the degree of dependency of people for the purpose of granting aid and long-term nursing care appropriate to their needs. The tasks of the agency also include the auditing of the quality of benefits granted and the determination of the quantity of help for the individual dependent person. Some 80% of the population having LTC insurance is made up of people

from 60 years up. In view of its mission and the population mix found, the Evaluation and Orientation Agency is in a privileged position to observe all phenomena associated with frail elderly people.

The Public Research Centre Henri Tudor deploys its activities in several directions, including the research into information and communication technologies. One of the services the CRP Henri Tudor provides is a centre for normative and technological monitoring. This centre makes its processes and experience in the fields of economy and enterprise available for purposes of the MILCEA project.

Andrée Kerger, Cellule d'Évaluation et d'Orientation (CEO), Deputy head of direction of the evaluation and information unit of LTC insurance

Nico Schneider, Cellule d'Évaluation et d'Orientation (CEO), Regional Manager (south region)

Jacques Luck, Cellule d'Évaluation et d'Orientation (CEO), Doctor, Regional Manager

Paul Wagner, Hellef Doheem, professional home care service, manager of the organisational development cell

Jacqueline Becker, Ministry of Family (MIFA), graduate nurse

Murielle Weydert, Ministry of Family (MIFA), graduate nurse

Figure 6: Expert Advisory Council Luxembourg

1.4 Overview

The structure of this report is parallel with the structure of the project as described, Chapter 2 informs about the theoretical foundation of MILCEA (*Phase 1*). Here definition uses are discussed. On this basis one of the main research questions of MILCEA "How do the participating countries deal with elder abuse" is on the focus of Chapter 3 (*Phase 2*). Chapter 3.2.2 presents the recommendations for European countries about how to put monitoring structures in place (*Phase 3*). The final report ends with discussing the main results of MILCEA and provides a view on further steps for prevention of elder abuse (Chapter 5).

2 The theoretical foundation of MILCEA (Phase 1)

In order to achieve the goal of developing and improving strategies to monitor elder abuse in LTC, the subject matter had to be defined and put into operation. Thus basic terms like "elder abuse" of people in need of LTC and "monitoring elder abuse" had to be defined. Likewise, in order to provide strategies for the prevention of elder abuse, it was important to define how elder abuse can be recognised. First of all, the methods used in Phase 1 will be described. Secondly, the limits of the subject matter will be defined. Finally, the operationalisation of the subject matter – how elder abuse of older persons can actually be identified – will be presented.

2.1 Methods

To provide the theoretical foundation of MILCEA, a combination of methods was required. A literature review was employed whenever possible. An extensive search of the literature was carried out in order to come up with a definition of “elder abuse” (of persons in need of care) and to show how it may be recognised. Since the term “monitoring” is not yet defined in the literature in the context of elder abuse, some other approach was needed. Here, the partners held focus-group discussions with their respective national experts, in order to arrive at an appropriate definition.

2.2 Definition of the limits of the subject matter

2.2.1 Definition of “elder abuse”

Before we embark on defining elder abuse, a brief outline is given of how elder abuse is perceived and valued as a topic in each participating country. Furthermore, the different cultural views on older people, old age and the need for LTC that exist in the partner countries will be explained. This is important to ensure that there is common ground in any discussion of elder abuse.

The relevance of the topic of elder abuse in the participating countries

In order to approach the topic of elder abuse, each partner discussed the issue with its country’s national experts. Thus the specific cultural views and perceptions concerning elder abuse and older people in the various countries had to be elaborated. National expert rounds were convened, so that specialists could offer their views on this issue and on several points that may influence the cultural definition and risk of elder abuse. At this point, it should be noted that the following results are based on the subjective opinions of the experts in the national expert rounds, and are thus of limited validity. But the methodology used is appropriate to give a rough first impression of cultural differences regarding the topic. In the following, the outcomes of the expert meetings are described. A more detailed summary of the results of the first national expert meetings may be found in Appendix A.

It can be assumed that the relevance of the topic elder abuse and the openness to discuss this in public differs between the countries. This assumption could be confirmed by the descriptions of the experts concerning the relevance of this topic in their countries. In the Netherlands and Spain there is a general interest for this topic nowadays. In the Netherlands elder abuse is already for a long time discussed as a part of domestic violence rather than as a separate topic. Today, agreements on combating elder abuse are part of the coalition agreement of the current government. In Luxembourg it is still considered a taboo to discuss elder abuse. According to the Luxembourg experts, one reason is the mentality to keep family issues within the familial circle. German experts have the impression that it is not a taboo topic anymore and that it has arrived in the public discussion and the media. But reports restrict themselves to

spectacular occurrences, mainly in nursing homes. In Austria, elder abuse as a topic has been gaining in importance in the past few years at the expert and policy levels, but is barely perceived by the general public. Concerning LTC institutions, Spanish Experts see a real interest in LTC facilities to introduce prevention measures in order to avoid complaints. Quite contrarily, experts in the Netherlands notice a general lack of awareness regarding elder abuse in LTC service institutions, partly due to a denial the phenomenon of elder abuse in the professional care sector.

Comparing the results of the national expert rounds in the partner countries, Spain and Luxembourg seem to have more positive attitudes toward older people than the other countries. This may be attributed to traditionally strong norms to respect older citizens. Luxembourg experts point out that due to the relatively small size of Luxembourg intergenerational relationships are still rather close. In Austria the deficit model of old age emphasises physical and cognitive restraints connected to old age. On the other hand these negative views are slowly being replaced by positive images such as acknowledging the knowledge and expertise that older people can contribute to society. According to the German experts the image of old age is more flexible now than in the past. Old age as a discrimination factor is on a decline, but that depends on the fitness of the old people. The ideal still seems to be a young and athletic woman or man. Older people with physical and mental impairment are valued rather negatively within the society, however. These cultural differences have to be kept in mind, when defining elder abuse. One might suggest that rather negative values of older people can increase the risk of elder abuse.

The results also indicate that the pressure on family members to take care of their frail and elder parts is still very high in all participating countries. Though, this pressure appears to be even higher on family members in Spain than in the other countries due to strong family values. In the Netherlands, on the other hand, the use of LTC services is generally accepted, while, according to the national experts, the other three countries (Germany, Luxembourg and Austria) range somewhere in between the two earlier mentioned countries. In Germany and Austria, there is still a strong pressure on family members to care for their elders. According to the national experts, it appears to be still decisive whether they are living in rural or urban areas. The pressure on family members in rural areas is considered to be higher than in urban areas. In Germany, the priority of informal and professional homecare over institutional care is defined by law, and there is a choice for the applicants of the options of cash and non-cash benefits. The cash benefit is taken by families that cannot afford the payment in kind, because the German LTC insurance provides financial contributions to the costs of LTC. Luxembourg experts point out that the origin of the older person in Luxembourg is crucial in this respect. The Portuguese culture with its strong traditional bias and a sometimes poor financial situation lead to more commitment to taking over the care for family members than would be the case if the people were of Luxembourg origin. A strong pressure on family members may thus force them to keep caring although they may be overburdened or their relationship with the older adult may be negative. Hence, it could be hypothesised that a higher risk for elder abuse ex-

ists in countries, where older people are valued rather negative, than in countries where older people have a positive image. Furthermore the experts assume a correlation between social conditions in the families and the extent of elder abuse.

Literature search

To present a review of literature in English and German on the topic “elder abuse”, a literature research of the data base named “Deutsches Institut für Medizinische Dokumentation und Information” (DIMDI) by the terms “elder abuse”, “elderly abuse” and “Gewalt” was conducted. Beside the definition of elder abuse, the goal of literature research was also the operationalisation[3] of elder abuse. The results on the latter will be presented in Chapter 0. To gain information on these two aspects, further search terms were determined. There were defined three groups of search terms. If at least one term of each group appeared the abstract was requested. The terms group 1 were “dimension”, “indicator”, “Indikator”, “theory”, “Theorie”, “measure”, “acquisition”, “Erfassung”. Group 2 contained the terms “aged” and “middle aged” and group 3 “family”, “Familie”, “LTC”, “volunteer”, “Ehrenamt”. This search came up with 63 articles. After reading the abstracts, 60 articles were requested, since three articles were devoted to another topic than elder abuse.

Before reading the articles, exclusion criteria were defined. An article was excluded from further analysis if it did not contain information on at least one of the following criteria: definition of elder abuse, different dimensions in which elder abuse can occur and indicators and risk factors of elder abuse. Furthermore it was excluded if the abusive behaviour was between residents of a nursing home, if it was directed against persons younger than 60, or if it was directed against people not in need of LTC. By this method 21 articles were excluded because they were focused on violent behaviour between residents, four because they were not related to abuse of persons in need of LTC. Two articles were no longer available, supposedly because of their editing date. 33 articles from the data base research were included in the literature analyses as were additional articles which were found to be essential for this topic.

After the first literature search a second search was conducted, since it appeared that most of the articles and studies of first literature search were focused on an abuse of older people by family members. Only a few articles were devoted to indicators and risk factors of elder abuse in nursing homes and elder abuse by professionals of professional home care services. This was the reason for a second literature search with search terms only related to elder abuse in the settings of 1) nursing home and 2) private home with the older person receiving care by professional caregivers.

3 The goal of Phase 1 is to define elder abuse and to summarise, by which factors elder abuse can be recognised (indicators) and which factors and circumstances can lead to a higher risk for elder abuse (risk factors).

The literature search was again conducted of the data base DIMDI by using three groups of terms. If one term of each group was found in the article, it was taken into further consideration. The first group of search terms were as follows: “elder abuse”, “elderly abuse” and “Gewalt”, “elderly mistreatment”, “elder mistreatment”, “elderly neglect”, “elder neglect” and “inadequate care”. The terms of the second group were: “LTC”, “nursing home”, “home care”, institutional care”, “chronic care”, “outpatient care”, “mobile care”, “ambulant care”, “day care centre”, “residential home”, “ambulante Pflege”, “ambulanter Pflegedienst”, “Pflegeheim” and “Pflegeeinrichtung”. “Indikator”, “risk factor”, “indicator”, “Risikofaktor”, “monitoring” made up the last group of search terms. 138 articles were found by this procedure. Before reading the abstracts, exclusion criteria were defined. If the article did not contain information about elder abuse in one of the described two care settings, it was not requested. By this method, 39 articles were requested. The exclusion criteria were defined further. An article was excluded, if it did not contain information about indicators or risk factors of elder abuse by professional caregivers in nursing homes or at a private home. Finally, 28 articles were considered for further analysis.

Results of the literature search

Currently, there is no standard definition of elder abuse and the different dimensions in which it occurs available in the literature. But most of the definitions provided (see Figure 7) recognise an act as abusive if it results in harm of an older person.[4] In some of the definitions intention to harm (Bonnie & Wallace, 2002; Levenberg et al., 1983, p. 67), or the perpetrators will to harm is added as a condition of a case being elder abuse (O’Malley et al., 1979, p. 2.). Several definitions imply that there must be a relationship of trust between the perpetrator and the victim (See Figure 7). So does the definition used by the WHO that is often cited in the scientific discourse. Here elder abuse is defined as “a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (WHO, 2008a). This definition was originally established in 1993 by the UK Charity “Action on Elder Abuse”. In comparison with other definitions provided it mentions that the abusive act needs not to be repetitive and that the intention to cause harm is not a condition in order to define an act as abusive. According to the Definition of Johns et al. (1991) and Phillips (1983) not only perpetrator and the victim play a role when talking about elder abuse. The evaluation of an incident by a third person as an elder abuse case is crucial. Queen Sofía Center (2008) borders the definition of elder abuse by excluding accidental acts that result in harm of the older person.

The definitions of elder abuse found in literature describe various dimensions in which elder abuse can occur, and they differ as to the forms of abuse included. Most authors indeed agree (see Figure 8) that at least four dimensions of elder abuse exist: physical and psychological

[4] Lowenstein 2009, p. 258-259; O’Malley et al., 1979, p.2; Levenberg et al., 1983, p.67; Phillips, 1983, p.382; Hudson, 1989, p.16; Aravanis et al., 1993; California State Panel Code 15610.07; Queen Sofía Center, 2008; Families Commission New Zealand, 2002, p. 13; Bonnie & Wallace , 2002; Lowenstein, 2009, p.258-25

abuse, financial exploitation and neglect.5 The majority of these authors additionally separate sexual and physical abuse and include sexual abuse as a fifth dimension.6 In line with the different definitions of elder abuse the definitions of the single dimensions are also partially different. The WHO defines physical abuse as “the infliction of physical anguish”, for example hitting, kicking and force-feeding (Perel-Levin, 2008, p. 6). Sexual abuse is defined as “non-consensual contact of any kind with an older person” like suggestive talk or forced sexual activity. Psychological abuse is “the infliction of mental anguish”. Possible examples are verbal aggression, threats or humiliating statements. Neglect is defined as “intentional or unintentional refusal or failure of a designated caregiver to meet needs required for older persons’ well being”. Acts like failure to provide adequate food or medical care are included in this dimension. Financial abuse is “the illegal or improper exploitation and/or use of funds or resources” (Perel-Levin, 2008, p. 7). An example is forcing an older person to transfer his or her financial property to the caregiver's bank account.

Other definitions of elder abuse do not include neglect as a separate dimension.[7] Benton and Marshall (1991) argue that neglect is always a part of the other three dimensions and is thus no separate dimension of elder abuse. On the other hand, there are suggestions to add a medical (Delunas 1990) or a verbal dimension (Lowenstein et al., 2009, Cooper et al., 2008), which in the broadly agreed definition of four dimensions is only a component of the claimed forms of abuse (physical and psychological abuse, financial exploitation and neglect).

Some authors propose to add additional dimensions relating to legal domains (Coyne et al., 1993), limitation of freedom (Lowenstein et al. 2009), and violation of human rights (Shinan-Altman & Cohen, 2009; Delunas 1990) to emphasise the fact that the majority of abusive acts in caring situations offend legal definitions and rights available to every citizen. Coyne et al. (1993) suggest adding a social dimension for discriminating acts in social life. However, the underlying behaviour is not exactly defined.

There is a minor part of literature that only includes physical and psychological abuse (Alf, 1994; Wiliamson & Shaffer, 2001; Meeks-Sjostrom, 2004).

Definition	**Source**
“The **wilful infliction** of physical pain, injury, or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to maintain physical health”	O’Malley et al., 1979, p. 2
“**active intervention** by a caretaker such that **unmet needs** are created **or** sustained **with resultant physical, psychological, or financial injury**.”	O’Malley et al., 1983, p. 1000

5 Lowenstein et al, 2009; Perel-Levin, 2008; Shinan-Altman and Cohen, 2009; Cooper, 2009; Wang et al., 2007; Fisher 2003; Lay, 1994; Peri et al., 2002; Jayawardena and Liao 2006; Canadian task force, 1994; Podnieks, 1993; Delunas 1990; Families Comission New Zealand, 2008

6 Lowenstein et al. 2009; Shinnan-Altman & Cohen, 2009; Cooper et al. 2009; Fisher 2003; Perel-Levin, 2008; Peri et al. 2002; Families Commission New Zealand 2008

7 Oliveira & Rodriguez, 2008; Meeks-Sjostrom, 2004; Wierucka & Goodridge, 1996; Williamson & Shaffer, 2001; Hydle, 1993; Jama, 1987; Benton & Marshall, 1991

"**An intentional overt act** which entails harm, or threatens harm, or curtailment of physical activities, or emotional battering (mental cruelty) directed at a person over 60 years and a noninstitutionalised person."	Levenberg et al., 1983, p. 67
"the degree to which the elderly individual **was perceived by an outside evaluator to be subjected to maltreatment by his related caregiver**."	Phillips, 1983, p. 382
Abuse is defined as "-destructive behaviour through the use of physical or psychological force -with improper or indecent use of an elder's person or property -resulting in harmful physical, psychological, economic and/or social effects -and unnecessary suffering in the elder"	Hudson, 1989, p. 16, build on Johnson's definition of elder mistreatment (1986)
"Abuse is **a social act**", "involving at least **two persons**, one of whom is violating the boundaries of the other. "The role of the witness is crucial in violent events. Actions are violent if they are **judged by someone to be illegitimate**."	Johns et al., 1991, p. 55-56
"Elder abuse is a single or **repeated act** or **lack of appropriate action** occurring within any **relationship** where there is an **expectation of trust**, which causes **harm or distress** to an older person."	Action on Elder Abuse, 1992 Adopted by the WHO (WHO/INPEA, 2002)
Violence comprised from neglect and abuse; while neglect is defined as passive and active neglect; abuse has sub-forms: physical and mental abuse, financial exploitation and restriction of the free will	Dieck, 1987
"Abuse shall mean an **act or omission** which **results in harm or threatened harm to the health or welfare of an elderly person**. Abuse includes **intentional infliction** of physical or mental injury; sexual abuse; or withholding of necessary food, clothing and medical care **to meet the physical and mental health needs of an elderly person** by one having **the care, custody or responsibility** of an elderly person."	The American Medical Association's definition of elder abuse (Aravanis et al., 1993)
Elder abuse " means either of the following: (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment with **resulting physical harm or pain or mental suffering.** (b) **The deprivation** by a care custodian of **goods and services** which are **necessary to avoid physical harm or mental suffering**."	California State Panel Code 15610.07 (added 1994)
"Elder Abuse is **any voluntary** –i.e., **non-accidental**- act **that harms or may harm an elderly person**, or **any omission that deprives** an elderly person of the care they **need for their well-being**, as well as **any violation of their rights**. To be classified as elder abuse, such actors or omissions must take place within the framework of an **interpersonal relationship in which one expects trust**, **care, convicencia** ("living together") or **dependency**. The perpetrator can be a family member, staff from an institution, "a hired caregiver, a neighbour or a friend"	Queen Sofía Center, 2008
"Elder abuse and neglect is usually committed by a person known to the victim with whom they have a relationship **implying trust**. A person who abuses an older person usually **has some sort of control or influence** over him/her. Family members, friends, staff in residential facilities or anyone the older person relies on for basic needs, may be abusers."	Families Commission New Zealand, 2008, p. 13, citing Age Concern New Zealand Inc., 2005
"Elder abuse has been described as **intentional actions that cause harm or risk of harm** or **as a caregiver's failure** to **satisfy** the elder's **basic needs** and **safe living conditions**"	National Academy of Sciences. Bonnie & Wallace , 2002
Elder Abuse can be defined as **destructive and offensive behaviour** inflicted on an elder person **within the context of a trusting relationship**. This behaviour occurs consistently and **with such severity and frequency** that it produces physical and psychological pain, social or financial harm to the older person's quality of life".	Lowenstein, 2009, p. 258-259 (build on Hudson's definition, 1989)

Figure 7: Various definitions of elder abuse

Authors \ Dimensions	physical abuse	emotional/psychological abuse	financial explotiation	neglect	sexual	verbal	over and -undermadicating	violation of human rights	limitation of freedom	legal	discriminatory abuse	self nelect	sociological
Lowenstein et al. (2009)	X	X	X	X	X	X			X				
Shinan & Cohen (2009) cited Joshi & Flaherty (2005)	X	X	X	X	X			X					
Cooper et al. (2009)	X	X	X	X	X								
Gaioli & Rodrigues (2008)	X	X											
Cooper et al. (2008)	X	X	X	X		X							
Wang et al. 2007	X	X	X	X									
Perel-Levin (2008)	X	X	X	X	X								
Meeks- Sjostrom (2004)	X	X											
Fisher (2003)	X	X	X	X	X								
Wiliamson & Shaffer (2001)	X	X											
Wierucka & Goodridge 1996	X	X								X			X
Lay (1994)	X	X	X	X									
Alf (1994)	X												
Hydle (1993)	X	X	X										
Benton & Marshall (1991) cited Coyne et al. (1993)	X	X	X										
JAMA (1987)	X	X	X										
Peri et al (2002)	X	X	X	X	X								
Cooper et al. (2008)	X	X	X	X							X		
Jayawardena and Liao	X	X	X	X								X	
Shugarman et al. (2003)	X	X	X										
Lachs & Pillemer (2004)	X	X	X	X	X								
Canadian task force (1994)	X	X	X	X									
Podnieks (199)	X	X	X	X									
Delunas (1990)	X	X	X	X			X	X				X	
Canadian Families Comission 2008	X	X	X	X	X								

Figure 8: Dimensions included in definitions

Conclusion - Definition adopted for the MILCEA project

As a result of the analysis of literature MILCEA adopts the definition of the WHO: Elder abuse is defined as “a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (WHO, 2008).

The project partners agree on the definition that is used by the WHO. The main argument is that this definition is cited by many other experts in the field of elder abuse and that it is important to find a common ground. It also contains the main element, namely that a certain action

or lack of action can be labelled as elder abuse if it leads to harm or distress of an older person. This element is generally included in most of the definitions of elder abuse (see Chapter 2.2.1 Figure 7). Additionally, the WHO presupposes that the relationship between perpetrator and victim must be based on trust. This condition is delimiting the phenomenon of elder abuse from other criminal acts that may affect older people without being specifically related to their age and life situation.

One criticism voiced by experts interviewed as part of the EUROPEAN partner project was that financial abuse by criminal organisations that lure older people into transferring money to their bank accounts is not included in this definition (Maria van Bavel et al., EUROPEAN, 2010). Such abuse is directed towards older people exploiting their credulity. This should also be taken into account in a general definition of elder abuse. For the purposes of the MILCEA project, a relationship of trust must exist since MILCEA addresses older people in need of LTC.

The expert teams of all participating countries of the project were critical with regard to the fact that the WHO definition does not differentiate between intentional and unintentional abuse. Such a differentiation is needed, however, because there are some forms of unintentional behaviour which cause harm to the older person but cannot be consciously controlled. If, for example, a nurse stumbles and falls, thereby hurting a resident, it is in the opinion of the project partners, no case of elder abuse, but be labelled as such according to the WHO definition. On the other hand there are forms of unintentional abuse that should, in the opinion of the project partners, be definitely included. If a caregiver frequently but unintentionally causes harm to an older person because of a lack of knowledge, this action comes close to the phenomenon of abuse. In this case the harm-causing behaviour has not happened by accident and preventive measures are needed and were in practice not taken from the organisation where the nurse in our example is employed (this an organisational default counts as elder abuse). As a proposal for a further development of the WHO definition, unintentional acts might be limited to those not happening by accident.[8]

As to the differentiation between the various dimensions of elder abuse MILCEA also follows the WHO definition. A difference is made between physical, psychological and sexual abuse, financial exploitation and neglect. Other dimensions of an abuse described in literature, such as an inadequate administration of medicaments, violation of human rights, limitation of personal freedom and social discrimination are seen as significant aspects of elder abuse while not being considered as dimensions of an abuse in their own right. For instance, the inadequate administration of medicaments will be counted as physical abuse or neglect. An act of neglect may not only be directed against another person but also against the own person. So-called “self-neglect” thus is also an important form of abuse but not considered for the pur-

[8] The limitation of those acts not happening by accident was already part of Queen Sofía Center’s (2008) definition of elder abuse. They further limited it to those acts that happened voluntarily, thus excluding enforced behaviour.

poses of the MILCEA project as in the focus here is the relationship between an older person and his or her caregiver. It has to be taken into account that self-neglect involves other risk factors and indicators than neglect by a caregiver.

The different dimensions of elder abuse with which the MILCEA project is dealing are summarised in Figure 9.

Physical abuse *is "the infliction of physical anguish" to an older person, for example by hitting, kicking and force-feeding.*

Sexual abuse *is defined as the "non-consensual contact of any kind with an older person", like suggestive talk or forced sexual activity.*

Psychological abuse *is "the infliction of mental anguish". Possible examples are verbal aggression, threats or humiliating statements.*

Neglect *is defined as the "intentional or unintentional refusal or failure of a designated caregiver to meet needs required for older persons' well being". Acts like failure to provide adequate food or medical care are included in this dimension.*

Financial abuse *is the "illegal or improper exploitation and/or use of funds or resources". An example is forcing and older person to transfer his or her property to the caregiver's bank account.*

Figure 9: Dimensions of elder abuse (Perel-Levin, 2008, p. 6)

2.2.2 Need for nursing care and LTC

The project focuses on the abuse of elderly persons receiving LTC. The target group thus includes older people who are in need of nursing care. In the context of this project it is therefore necessary to apply the term of "abuse" or the definition of an "abuse" to the system of LTC after having put that term and its definition in more concrete word. Unlike for the term "abuse" there is no uniform definition of the term "need for nursing care" in the European Union. In Germany, for instance, the need for nursing care has been determined by the benefit criteria which the Act on Nursing-Care Insurance stipulates. This definition has been heavily criticised for quite a few years in view of its primary focus on somatic aspects. For a monitoring system to be developed in Germany this definition would exclude from being monitored some major part of those persons who have to permanently rely on the support by others and thus run an increased risk of becoming victims of abuse since they do not need nursing care as defined in the law. With regard to the group of persons to be covered by a monitoring system the project therefore agreed to introduce comprehensive definitions of the terms "need for nursing care" and "LTC" that are not based on individual national definitions and regulations. **LTC** is defined by WHO as the system of "activities undertaken for people requiring care by informal caregivers (family, friends and/or neighbours), by formal caregivers, including professionals and auxiliaries (health, social and other workers), and by traditional caregivers and volunteers." "The goal of LTC is to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest

possible degree of independence, autonomy, participation, personal fulfilment and human dignity" (WHO, 2000, p. 1). According to the OECD (2005), a prerequisite of "long- term care" is that the person is "dependent on help with basic activities of daily living (ADL) over an extended period of time. Such activities include bathing, dressing, eating, getting in and out of the bed or chair, moving around and using the bathroom. These LTC needs are due to long-standing chronic conditions causing physical or mental disability" (OECD, 2005, p. 20). This "is frequently provided in combination with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care" (OECD, 2005, p. 17). LTC includes both informal and formal support systems (OECD 2005). Thus, there are three care settings[9] that have to be taken into account for the purposes of the project. The following three care arrangements have to be focused in the course of the project: 1.) informal home care 2.) professional or formal home care 3.) institutional care setting. MILCEA adopts also OECD's definitions of informal and formal care and caregiver that are listed in the following.

Formal care/formal caregivers:
Formal care is provided by formal caregivers, who are "either professionally trained care assistants, such as nurses, or untrained care assistants" (OECD, 2005, p. 17). They are employed at public or private organisations that offer care services. "These services can be provided in institutions like nursing homes, as well as care provided to persons living at home" (OECD, 2005, 17).

Informal care and informal caregiver:
"Informal care is the care provided by informal caregivers", "such as spouses/partners, other members of the household and other relatives, friends, neighbours or others, usually but not necessarily with an already existing social relationship with the person to whom they provide care" (OECD, 2005, p. 17). Informal care is for the most part unpaid, but this is not a prerequisite.

Institutional care:
Nursing and personal care "provided in an institution which at the same time serves as a residence of the care recipient." "Institutional care should be distinguished from short-term care provided in institutions such as respite care." (OECD, 2005, p. 17). "**LTC institutions** are places of collective living where care and accommodation is provided as a package by a public agency, non-profit or private company. Residents may or may not be charged separately for care services and accommodation." (OECD, 2005, p. 17).

(Professional) home care:

[9] Within a care setting, care is organised and arranged the same. For example in the informal care setting, care is provided by informal caregivers (see OECD's definition of informal caregiver).

OECD defines home care as being referred to “LTC services that can be provided to patients at home” (OECD, 2005, p. 17). These services can be provided by professional home-nursing organisations and home-help services (Teperi et al., 2009). It includes care provided at day-care centres and “respite services” (OECD, 2005, p. 17).

The OECD’s definition of home care only includes professional services, although in public discourse of care matters it is often used as including both, formal and informal care. In the following, to avoid any confusion, the term “professional” will be preceding home care. The OECD defined in their study professional home care as LTC services. Instead, in general public discourse professional home care services can also refer to short-term services, for example receiving care because of a temporary illness. In the following literature analysis it has to be considered that professional home care services possibly encompass other services than long-term.

Consequences for the definition of elder abuse adopted in the project

Since the project is focusing LTC, the definition of elder abuse has to be limited to older persons in need of LTC. The definition is as follows: Elder abuse is “a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (WHO, 2002) in need of LTC.

As explained above, by focusing on abuse of older persons in need of LTC, three arrangements of care have to be taken into account (informal care, professional home care and institutional care). In the following specific care arrangements will be assigned to three different settings. Within a setting, care is organised and arranged the same.

Informal care setting: Care is provided by informal caregivers at the care receiver’s home (see OECD’s definition of informal care and informal caregiver). Other formal services than nursing-care services might also be received by the care recipient (e.g. health care services).

Professional home care setting: Care is provided at least partially by formal caregivers to clients at home (see OECD’s definition of home care). Other formal services than nursing care services might be also received by the client (e.g. health care services).

Institutional care setting: Care is provided according to the OECD’s definition of institutional care described above. Other formal services than nursing-care services might be also received by the care recipient (e.g. health care services).

It will be the task of the individual project partners, however, to consider the differences between WHO’s and OECD’s definition of LTC as used in the project and the existing national definitions of “need of LTC”. The differentiation by individual settings made in this connection is of great importance for the description of national structures.

2.2.3 Monitoring system of elder abuse in LTC

Since no monitoring system of elder abuse exists in the field of LTC in any of the Member States of the EU, it had been necessary to specify the characteristics and requirements such a monitoring system of elder abuse has to meet before commencing the structural analysis. To this end, major requirements of a monitoring system were determined in focus group discussions at both national and international levels (see Appendix A, Question 12). The results of the discussions were considered when defining a monitoring system as explained below.

"To monitor" is, according to the Oxford English Dictionary, to "observe and check the progress and quality of (something) over a period of time". Wikipedia describes "monitoring" as the collective designation for "all types of direct systematic recording (protocoling), (observation) or (supervision) of an event or process by technical means or other types of observation systems". Repetition is a central element of any monitoring in order to arrive at conclusions based on a comparison of results. "Monitoring" means observing a process and intervening if it fails to develop as planned or if specific threshold values are exceeded. Monitoring thus is a special type of protocoling.

When applied to the subject matter of the project, monitoring means a constant observation or evaluation of the care-giving process, in order to detect either an actual abuse case or a risk situation. When an abuse has taken place or may be imminent, concrete action must be available that can be initiated to protect the older person in need of care. The function of a monitoring thus is the prevention of elder abuse and protection of the older person against such abuse. Given the fact that several actors are involved in the care of older persons within the LTC system, these several actors must be involved in monitoring.

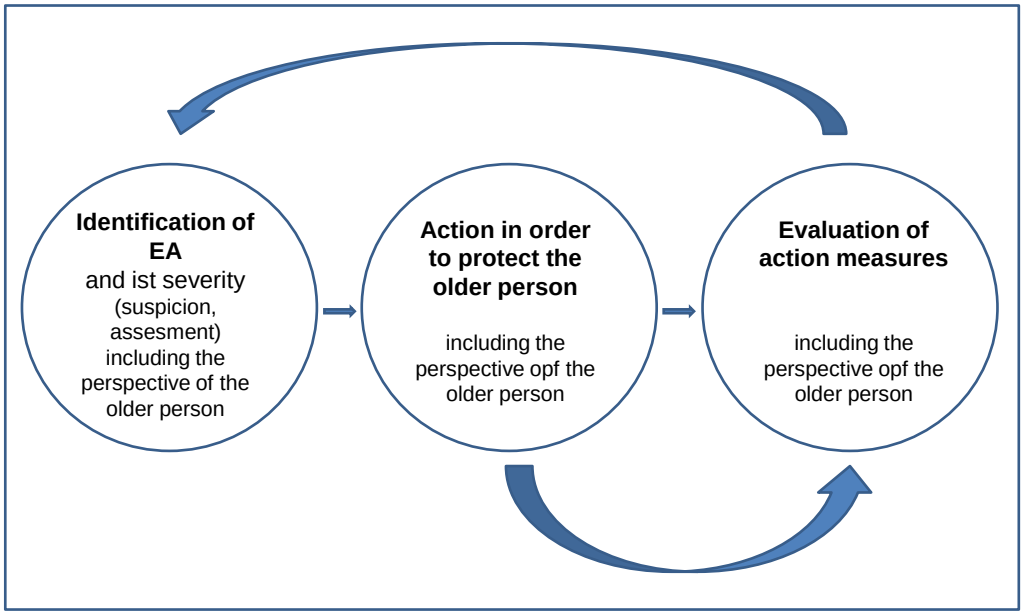


Figure 10: Essential elements of a monitoring system

The first step in identifying elder abuse is to ensure that actors who are in regular contact with potential victims are aware of indicators and risk factors of elder abuse. Risks for elder abuse must be checked and monitored on a regular basis. To this end, specific screening and assessment instruments are required to facilitate the identification of abuse. Second, a range of actions should be available, with measures that are appropriate and suitable to protect the (potential) victim. Such actions may include raising the suspicion of elder abuse with some other institution that is responsible for questions of abuse. After any action is taken, the effectiveness of the measure(s) has to be evaluated – i.e. whether protection of the older person is ensured. If not, further action must be undertaken.

This definition of the essential elements of a monitoring system provided the basis for describing existing structures in monitoring and preventing elder abuse in LTC in the participating countries. It was not seen as a static definition, but evolved in the course of the project in line with the empirical results.

2.3 Operationalisation of the subject matter

Theoretical models of the causes of elder abuse – risk factors of elder abuse

For identifying relevant risks, literature provides theoretical models for predicting potential elder abuse. There are various theoretical models trying to explain elder abuse (Perel-Levin, 2008; Fulmer et al., 2004; Wolf, 2000; Institute of Medicine, 2002; Aravanis et al., 1993). The **situational theory**, for example, points out the stress arising in a care situation on the side of the caregiver. Another model is the **theory of intergenerational transmission**. It states that behaviour learned throughout the childhood will influence an adult's behaviour. Thus, if a person experienced or witnessed violence in the past exerted by a parent, he or she may be more prone to use abusive behaviour toward a dependent parent than other people without a similar experience. The **exchange theory** also addresses the relationship between caregiver and care-receiver and primarily the dynamics in the relationship. The theory assumes that abuse can occur within a framework of tactics and responses in family life and points out the reciprocity and dependence between the abused and the perpetrator. The theory of **intra-individual dynamics** stresses the significance of the mental and emotional state of a caregiver for becoming an abuser. A further theory emphasises the relatively high **dependency of older persons,** resulting from an increased probability of physical and cognitive impairment of older persons. Thus, the higher dependency on the help of others is connected to a higher risk of elder abuse.

Other approaches highlight power and political structures in society. **Feminist theories** claim the power structures to be important within relationships, hypothesising that men use violent behaviour to show their higher position and power. **Political economic theories** state that structural forces and the marginalisation of elders can cause elder abuse (Perel-Levin, 2008; Fulmer et al., 2004; Wolf, 2000; Institute of Medicine, 2002; Aravanis et al., 1993).

The diversity of theoretical models shows that not just one single theory can explain what causes elder abuse. **The ecological model** is an example of a broader approach to the topic elder abuse based on the social ecological theory of Hawley (1950). On the one hand it claims that individual characteristics like personal history and interpersonal relationships play a role why someone tends towards abusive behaviour. On the other hand it stresses the relevance of characteristics of the community the person lives in and existing social norms and policies (Perel-Levin, 2008).

The various theories of elder abuse which stress different reasons indicate that there must be several risk factors of elder abuse. The theories were related to different categories of causes, like the relationship between caregiver and care-receiver, psychological variables in the caregiver and structural characteristics. It can be assumed that risk factors of elder abuse can be found within these categories. There is a multitude of studies concentrating on the influence that different risk factors have on the probability of an abuse occurring. Some of them make direct reference to the mentioned theories while others deal with the predictive power of specific risk factors independent of a defined theoretical foundation. In this chapter, the results of an analysis of literature with regard to factors that enhance the probability of an abuse will be described.

Risk factors of elder abuse had to be analysed separately for each of the different care settings (see Chapter 2.2.2), since underlying conditions of the risk to become a victim of abuse may differ between the settings. So, it is to be noted that institutional characteristics in nursing homes, for example, may influence the probability of elder abuse.

2.3.1 Risk factors in informal care setting

There is extensive literature devoted to risk factors in informal setting by now, mainly of a qualitative nature. There are also several quantitative studies conducting multivariate analyses and investigating the influence of other variables (see Figure 11 and Figure 12). Nevertheless the number of subjects often is rather small, and nationwide studies are missing. In this chapter the risk factors of elder abuse in family care settings are described as identified in literature. Finally, the significant risk factors determined with statistical methods will be summarised in a list (see Figure 13). This list fulfils the goal of Phase 1 to identify relevant risk factors of elder abuse. It will be used, together with a list of indicators, as basis for Phase 2.

Different categories of risk factors of elder abuse can be found in literature. These are: Characteristics of the caregiver and the care-receiver, relationship between the caregiver and care-receiver, structural characteristics. These categories take account of the mentioned variables, e.g. psychological variables (see Chapter 0).

Characteristics of the caregiver and the care-receiver

There are several characteristics of the caregiver and care-receiver that may influence the probability of elder abuse. Demographic, physical and psychological characteristics of the

caregiver and care-receiver have been examined in literature concerning the risk of elder abuse (see Figure 11 and Figure 12).

As described in 0, there is the theory that the health situation of the care-receiver is crucial concerning a risk of elder abuse. The findings regarding the physical health situation of the care-receiver are heterogeneous, though. Cohen et al. (2006) could not find that restraints of the elderly person in activities of daily living were related to the risk of becoming a victim of abuse. Lowenstein et al. (2009) were able to determine that having more ADL needs and a more problematic health situation[10] influences the risk of elder abuse. Cooper et al. (2006) found that even receiving more hours of family care was a protective factor concerning elder abuse. This result could be confirmed again by Cooper et al. (2008). Less physically impaired elders had a higher risk of becoming a victim of abuse, than more physically impaired. Concerning cognitive impairment[11] of older people, Cooper et al. (2006, 2008) found significant positive effects on elder abuse.

Disruptive and aggressive behaviour of the care-receiver, connected to the psychological condition of the care-receiver, has been examined by Pillemer & Suitor (1992) regarding its' risk for elder abuse. They explored care receivers' fear to act abusively when the patients themselves show disruptive and aggressive behaviour. They conducted a logistic regression based on interviews of 236 older persons with dementia and their caregivers. Disruptive and aggressive behaviour of the older person proved to be significant, and besides a low self-esteem of the caregiver played a role whenever a caregiver feared to commit abuse. Cooper et al. (2006) could identify a significant effect of a higher depression level of the care-receiver on elder abuse.

Psychological characteristics of the caregiver have been explored by other authors. Lowenstein et al. (2009) found that demographic and psychological characteristics of the caregiver differ regarding the types of abuse. 1042 older people who were participants of a national survey in Israel were interviewed together with their principal caregivers. Perpetrators of financial exploitation of elderly people are usually adult children, often addicted to drugs, unemployed or having emotional and mental health problems. Perpetrators of physical and sexual abuse are mostly spouses with physical, functional and mental health problems. The results confirm again the importance of psychological and behavioural variables, which seem to enhance or weaken stress situations.

Cohen et al. (2006) examined caregiver and care receiver characteristics concerning the risk of becoming abused at the same time. Furthermore, they included a variable of the quality of

[10] Problematic health situation was measured by Lowenstein et al. (2009) through several questions regarding general health condition, hospitalisation, medical treatments (questions are not defined in detail)
[11] Dementia severity measured by Cooper et al. (2006) by means of the Cognitive Performance scale (CPS) (Morris et al., 1997). Severity of cognitive impairment measured by Cooper et al. (2008) by means of Mini Mental State Examination (MMSE) (Folstein et al. 1975)

the relationship between both persons in the care situation. The most important predictors were the following caregiver characteristics: Behaviour or emotional problems and material or familial problems. The same variables, beside isolation and missing social support network of the care-receiver, were related to abuse, but they showed to be less significant than the caregiver characteristics. Alcohol misuse of the caregiver could also be identified by several authors to be a significant risk factor (Anetzberger et al. 1994; Reay & Browne, 2001; Wolf & Pillemer 1989). Williamson & Shaffer (2001) found that family caregivers with higher levels of depression are more likely to commit elder abuse, compared with less depressed caregivers. The results support the theory of intra-individual dynamics that emphasises the importance of the mental and emotional state of a caregiver relating to elder abuse.

The situational theory, like the intra-individual model, points out the psychology of the caregiver relating to elder abuse. However, it focuses mainly on the stress that is connected with the care-giving role. The results of Cooper et al. (2008) are in line with this theory. They interviewed 86 family caregivers and the patients who were part of a longitudinal study for Alzheimer's diseases and measured abusive behaviour of the caregiver, the help needed with ADLs and cognitive impairment of the care-receiver, demographic variables and caregiver burden. Perceived burden of the caregiver showed to be crucial concerning elder abuse.

Results for the effects of demographic factors of the care-receiver on elder abuse are mostly not equivocal or significant. Lowenstein et al. (2009), Cohen et al. (2006) and Shugarman et al. (2003) could not find age and gender of the care-receiver to be a significant predictor of abuse. Shugarman et al. could not find a significant effect of a lower education of the care-receiver either. Instead, Lowenstein et al. (2009) could find a higher risk for less educated older people to become a victim of verbal abuse. Shugarman et al. (2003) and Cooper et al. (2006) could not find the marital status of the care-receiver to be a significant predictor. Likewise, the findings of Pillemer & Suitor (1992) are that spouses do not fear more often than adult children that they might be abusive support these results.

As to demographic factors of the caregiver, results are either ambiguous or not significant. There are, for example, no significant results on age and the level of education as predictors of elder abuse (Cooper et al., 2008; Cohen et al. 2006). Cooper et al. (2008) found significantly more men to commit abuse than women. In contrast with these results, Cohen et al. could not find a significant influence of the gender on elder abuse.

Relationship between the caregiver and care-receiver

Other stress that the quality of the past relationship between caregiver and care-receiver is important with regard to potentially harmful behaviour (Finkelhor 1983; Williamson & Shaffer, 2001, Steadman et al. 2007). Williamson & Shaffer (2001) interviewed in their study 142 spousal caregivers and measured variables like amount of help needed by the patient, the reports of caregiver's abusive behaviour, symptoms of depression in caregiver and the quality of the past relationship between caregiver and patient. They found family caregivers with

higher levels of depression to be more likely perpetrators compared with less depressed caregivers. Beside the influence of the depression rate on caring behaviour it was found that depression rates in caregivers were dependent on the quality of the past relationship between the caregiver and the care-receiver. If the caregiver describes the past relationship as more communal in respect of each other's needs, depression rates were lower and potentially harmful behaviour less frequent. The quality of the past relationship might also interfere with other variables. There were some cases, where children care for a parent, since they are dependent on the parent's financial support although the past family relationship has been hostile and problematic (Pillemer & Finkelhor, 1989). It may be assumed that such cases have an increased risk of elder abuse.

Another study of Steadman et al. (2007) shows that the burden of those giving care to people with dementia is depending on the quality of the past relationship. If the caregiver was satisfied with the premorbid relationship, that burden was significantly lower than in less satisfying relationships. Various variables referring to the health situation of the elder person, e.g. ADL impairment, disease severity and frequency of memory problems were included as control variables. The results showed that the impact of the premorbid relationship on the caregiver's burden remains, even if the health situation is more problematic.

It may be assumed that the quality of the past relationship can also buffer the reaction of the caregiver to disruptive and aggressive behaviour of the older person, leading to a less pronounced or enhanced stress situation.

Structural characteristics

One major structural characteristic that can be found in literature is social isolation (Alf 1994). Elderly people without social network seem to be more likely to becoming a victim than people that have such a network (Lachs et al., 1994; Pillemer & Finkelhor, 1989). It may be assumed that perpetrators fear less to be suspected, because of the fewer people close that could witness harmful situations and might provide help. In almost all national expert rounds of the project partners, social isolation was mentioned as being connected to a higher risk of elder abuse in informal care settings (see Appendix A, p. 10-11). Cohen et al. (2006) also found a significant influence of social isolation and missing social support network on the occurrence of abusive behaviour. Besides, they found another structural risk factor to be related to elder abuse. Being financially dependent on the care-receiver has been identified as a significant risk factor by Cohen et al. (2006). Pillemer & Suitor (1992) found the caregiver's fear to commit abuse to be higher if he/she lived together with the care-receiver.

According to the ecological model, structural characteristics of the community the person lives in and of existing social norms and policies may stand in a relationship with the prevalence of elder abuse (Perel-Levin, 2008). This was barely examined in literature by now, perhaps mainly because of methodological problems with measuring the influence of these variables.

Nevertheless, the social structure of communities, prevailing social, cultural and political norms and their likely effect on elder abuse should be kept in mind.

STUDY	**Authors**	**Pillemer & Suitor (1992)**	**Wiliamson & Shaffer (2001)**	**Cooper (2008)**	**Lowenstein et al. (2009)**	**Cohen et al. (2006)**	**Shugarman et al. (2003)**	**Cooper et al. (2006)**
	Country	**USA**	**USA**	**USA**	**Israel**	**Israel**	**USA**	**11 Member States of the EU**
	Participants	**236 family caregivers of elder people dementia**	**142 spousal caregivers**	**86 family caregivers of elders with Alzheimer's disease and older people**	**1042 older people (and principal caregivers)**	**108 people (and principal caregivers) who were hospitalised**	**701 older people**	**Nearly 4000 older people receiving health or social care services**
	Recruiting of participants/Setting	**Referred to elder people with diagnose in dementia**	**recruiting from community sources and medical facilities**	**Part of longitudinal study of Alzheimer disease**	**National representative sample of community dwellers age 65 and older living at home**	**who were hospitalised, cognitively confused people were excluded**	**Referred to people seeking home and community- based services in Michigan**	**Referred to people receiving health or social community services (108 people were living in care homes)**
	Dependent variable	**Fear of family caregivers acting abusive**	**Spousal caregivers using abusive behaviour**	**Spousal caregivers using abusive behaviour**	**Principal caregivers (family members or care workers)**	**Family members using abusive behaviour**	**Principal caregivers (family or friends, no care workers)**	**Family members or other caregivers (not velar if care worker is included**
	Dimensions included	**Asked if caregivers tried to hurt them, dimensions not exactly determined**	**physical Psychological**	**physical Psychological Neglect**	**Physical (and sexual abuse) Verbal abuse neglect Financial exploitation Limitation of freedom**	**Physical abuse Neglect Psychological Material exploitation**	**physical emotional Neglect**	**Physical psychological Neglect**
	Instrument to detect abuse	**Created their own measure based on CTS- Scale**	**CTS- Scale (Strauss 1979)**	**MCTS (Beach et al. 2005) CTS- Scale (Strauss 1979)**	**CTS2- Scale (Strauss et al 1996)**	**E-IOA**	**MDS**	**MDS observer measure**
	Statistical procedure	**Results of logistic regression**	**Multivariate (path) analysis**	**Results of logistic regression**	**Results of logistic regression**	**Results of discriminate analysis**	**Results of logistic regression**	**Results of logistic regression**
Independent variables								
CARE RECIEVER	Demographic variables				• **Age** • **Gender** • **Familial status (Being Married)** • *** with a lower educational level (concerning only verbal abuse**	• **Age** • **Gender**	• **Age** • **Gender** • **Marital status** • **Lower education**	• **Age** • **Gender** • **Marital status**
	Psychological and behaviour variables	• *** Disruptive and** • *** aggressive behaviour** to measure stressors a shortened version of George's index of disruptive behaviour were used (George and Gwyther, 1986)		• *** more Cognitive impaired** Mini Mental State Examination (MMSE) (Folstein et al., 1975)	**Financial exploitation and verbal abuse:** • *** Feeling neglected**[12]	• *** Behaviour problems** [13] • *** Psychological or emotional problems** [14]	• *** Having a short-term memory** Instrument not defined • **Cognitive performance** MDS Cognitive Performance Scale (CPS) (Hartmaier et al., 1995; Morris et al. 1994) • **Depression/Anxiety** [15] • ***Any Psychiatric illness** (Measurement not defined) • **Alcohol abuse** [16]	• *** Higher CPS score (dementia severity) (Morris et al., 1997)** • *** Higher depression levels** The MDS- Depression scale (Burrows et al., 2000) • **pre-existing diagnosis of dementia**
	Physical variables	• **limitation in activities of daily living** • **needed help** (a modified version of ADL- scale by Fillenbaum and Smyer (1981)) was used)	• **Amount of help provided** Caregivers responded to 18 items adapted from the ADL instrument (ADL; Older American Resources and Services, Duke University, 1978)	• *** Less Physical impaired** The Alzheimer's disease Cooperative Study Inventory- Activities of Daily Living (ADCS ADL- scale) (Galasko et al., 1997)	• *** problematic health situation** Several questions regarding general health condition, hospitalisation, medical treatments (not exactly defined) • **having more ADL needs**[17]	• **having more ADL needs** ability to perform five basic activities of daily living (ADLs) and instrumental activities (source not exactly defined)	• **physical functioning**[18]	• *** Receiving more hours of family care was protective factor**
	Situational factors	• **Social isolation** Number of people respondent indicated to question with whom he is most likely to get together with or talk to on the phone			• *** needing economic support** needs in handling financial issues (exact measure is not provided)	• *** Social isolation** Attends activities outside, meets friends, people come to him/her • *** Missing social support network** • *** Material, familial problems**	• ***less Social functioning and support** [19]	**Social functioning variables** • **loneliness** • *** openly Expressing conflict with family and friends** • **Ease interacting with others** **Measures weren't exactly defined**

Figure 11: Care-receiver risk factors in informal care setting

[12] Neglect was measured by five ADL-measures and the frequency of situations in which help was needed (personal care, household chores, food supply, personal hygiene, help in getting a doctor and in obtaining needed devices such as eyeglasses) (Lowenstein et al., 2009)
[13] Sub-indicators of behavior problems: Has outbursts; commits to his/her obligations; engages in conflicts with family friends or neighbors; has poor family functioning, blames external forces for his/her situation; angry and bitter towards his/her environment (Cohen et al., 2006)
[14] Sub-indicators of psychological and emotional problems: expresses helplessness; expresses dependence; irritable or nervous, thinks that person harass him/her, or are unfair; exaggerated, inappropriate, or fluctuating emotional reactions; paranoid ideations; is confused or disoriented; has memory problems (Cohen et al., 2006)
[15] Depression measured by MDS-HC measurement: any of six MDS-HC measures of mood in the week before the assessment: feeling sad, persistent anger with self/others, repetitive anxious complaints/concerns, sad/pained/worried facial expressions, recurrent crying/tearfulness, or withdrawal from activities of interest"
[16] "Alcohol abuse was measured as the older person feels the need or has been told by others to cut down on drinking or the older person has have a drink first thing in the morning or has been any sort of trouble because of drinking" (Shugarman et al., 2003, p. 26)
[17] Needs in ADL measured by needs in daily functioning in three major domains: personal care and hygiene, household activities and outdoor mobility and tasks (Lowenstein et al., 2009)
[18] Physical functioning was measured by ADL impairments in the areas hygiene, dressing, toileting, locomotion, transferring, bed mobility and eating. Furthermore measures of bladder incontinence and bowel incontinence were included (Shugarman et al., 2003, p. 26)
[19] Social functioning was measured by for variables: 1. Is not at ease interacting with others, 2. Expresses conflict with family and friends, 3. Indicates feels lonely, 4. Brittle support system (Shugarman et al., 2003, p. 26)

STUDY	**Authors**	**Pillemer & Suitor (1992)**	**Wiliamson & Shaffer (2001)**	**Cooper (2008)**	**Lowenstein et al. (2009)**	**Cohen et al. (2006)**	**Shugarman et al. (2003)**	**Cooper et al. (2006)**
	Country	**USA**	**USA**	**USA**	**Israel**	**Israel**	**USA**	**11 Member States of the EU**
	Participants	**236 family caregivers of elder people dementia**	**142 spousal caregivers**	**86 family caregivers of elders with Alzheimer's disease and older people**	**1042 older people (and principal caregivers)**	**108 people (and principal caregivers) who were hospitalised**	**701 older people**	**Nearly 4000 older people receiving health or social care services**
	Recruitment of participants/Setting	**Referred to elder people with diagnose in dementia**	**recruiting from community sources and medical facilities**	**Part of longitudinal study of Alzheimer disease**	**National representative sample of community dwellers age 65 and older living at home**	**who were hospitalised, cognitively confused people were excluded**	**Referred to people seeking home and community- based services in Michigan**	**Referred to people receiving health or social community services (108 people were living in care homes)**
	Dependent variable	**Fear of family caregivers acting abusive**	**Spousal caregivers using abusive behaviour**	**Spousal caregivers using abusive behaviour**	**Principal caregivers (family members or care workers)**	**Family members using abusive behaviour**	**Principal caregivers (family or friends, no care workers)**	**Family members or other caregivers (not velar if care worker is included**
	Dimensions included	**Asked if caregivers tried to hurt them, dimensions not exactly determined**	**physical Psychological**	**physical Psychological Neglect**	**Physical (and sexual abuse) Psychological Restriction of freedom**	**Physical abuse Neglect Psychological Material exploitation**	**physical emotional Neglect**	**Physical psychological Neglect**
	Instrument to detect abuse	**Created their own measure based on CTS- Scale**	**CTS- Scale (Strauss 1979)**	**MCTS (Beach et al. 2005) CTS- Scale (Strauss 1979)**	**CTS2- Scale (Strauss et al 1996)**	**E-IOA**	**MDS**	**MDS observer measure**
	Statistical procedure	**Results of logistic regression**	**Multivariate (path) analysis**	**Results of logistic regression**	**Results of logistic regression**	**Results of discriminate analysis**	**Results of logistic regression**	**Results of logistic regression**
Independent variables								
CAREGIVER	Demographic variables	• **Spouse or adult child** • **age**		• *** being male** • **Age** • **Level of education**	**Financial exploitation:** (Only results of correlations) • **mostly adult child** • **unemployed** **Physical and sexual abuses:** (only correlation) • **mostly spouses**	• **Age** • **Gender**		
	Psychological and behaviour variables	• *** Low self esteem** Self- esteem was measured by Rosenberg (1965) Self-Esteem-Scale	Theory: past communal behaviour effects • *** Symptoms of depression** CES-D scale (Radloff, 1977)	• *** Caregiver burden (22 items self report questionnaire)** The Zarit Burden Scale (Zarit et al., 1980)	**Financial exploitation:** (Only results of correlations) • **Were often addicted to drugs or alcohol** • **Had mostly emotional and mental problems** [20] **Physical and sexual abuses:** (Only results of correlations) • **Had mostly functional** (see variable having more ADL needs of older person)**, physical and mental health problems**[21]	• *** Behaviour problems (see above)** • *** Psychological or emotional problems (see above)**	**Not** **Included**	**Not** **included**
	Physical variables							
	Situational factors	• *** Living with care receiver**				• *** Material or familial problems (see above)** • *** Financial dependency** Has satisfactory means for living		
RELSAH	**Relationship variables**		• **Past communal behaviour (between caregiver and care receiver)** 10-item Mutual Communal Behav-					

[20] Emotional and mental problems measured by general questions to mental health condition, hospitalisation, medical treatments and about personal feelings of safety and feelings of loneliness (Lowenstein et al., 2009)

[21] Physical and mental health problems are measured by several questions regarding general health condition, hospitalisation, medical treatments (measure instrument not exactly defined) (Lowenstein et al., 2009)

T I I P O N			iours Scale (MCBS, e.g., William-sonon and Shaffor, 1996)					

Figure 12: Caregiver and relationship risk factors in informal care setting

Summary of risk factors in informal care setting

In the following list, the variables that turned out to be significant risk factors of elder abuse as described above are summarised. Since there are no clear findings on the influence of physical restraints as described above, this has been left out of account (Cohen et al., 2006; Lowenstein et al., 2009; Cooper et al., 2009). Studies dealing with the impact of demographic variables like age, marital status and educational level of the caregiver and care-receiver do not come up with an unequivocal result. This is due to demographic variables not having a direct influence but instead moderating the impact that further variables have on elder abuse, e.g. lifestyle and social isolation. Furthermore, there is a variable added to the list that was identified in two national expert meetings of the partners as a risk factor of elder abuse (see Appendix A, p. 10-11). This is the lack of skills and knowledge of the caregiver regarding care issues.

	Risk factors (informal care)
Structural characteristics (situation)	• social isolation of older person – except from the person with whom he/she may be living • shared living situation with caregiver • financial dependency of caregiver
Characteristics of caregiver	• symptoms of depression • mental illness/emotional difficulties (e.g. paranoid ideations) • addiction to drugs or alcohol • familial or marital problems • lack of skills and knowledge of caregiver concerning care issues
Characteristics of (potential) victim	• disruptive and aggressive behaviour • symptoms of depression • cognitive impairment
Characteristics of relationship between caregiver and older person	• poor relationship in the past

Figure 13: Risk factors in informal care setting

2.3.2 Risk factors of elder abuse in institutional settings

There has been less comprehensive research into risk factors of elder abuse in nursing homes than in informal settings so far. Much like in an informal setting, risk factors of elder abuse in nursing homes can be related to various categories. Wierucka & Goodridge (1996) suggest that there are three main categories closely related to elder abuse. Environmental factors, client and caregiver characteristics can contribute to the risk of elder abuse. Their concept of environmental factors is thereby including both structural and interpersonal elements. To keep the structure of analysis of family settings, Wierucka & Goodridge's category of environmental factors here is split up in its two elements.

Client Characteristics

As crucial client characteristics Wierucka & Goodridge (1996) suppose that poor health and greater dependence on the professional caregiver might enhance the risk of elder abuse. In a literature review, one of the best predictors of non-voluntary weight loss among nursing home residents that can also be an indicator of neglect is the need for help with eating (Goodridge et al, 1996). There is also evidence that physically or mentally frail elderly persons receive less humane and respectful treatment from staff because they show greater dependency (Gubrium, 1975). However more comprehensive quantitative studies that would examine the influence which the physical impairment of nursing home residents has, are still missing, so that any reliable conclusions in that matter are not possible. In addition, results concerning the influence of physical impairment of the care-receiver on elder abuse in family care settings are unequivocal[22]. On the other hand, there are findings that nursing home patients with dementia or cognitive decline run an increased risk of abuse (Hawes & Kayser-Jones, 2003). Among home care patients, psychological impairment was also identified as a risk factor of elder abuse. It should be considered that challenging behaviour of dementia patients might be a risk for elder abuse. Many dementia patients – according to international studies from 38% to 76% – demonstrate a provocative behaviour (KDA, 2006). This describes behaviour such as increased motor activity with "walking around", loud calling and aggressiveness; these attitudes are frequently seen as a great burden by those giving care and support to dementia patients (KDA, 2006). Pillemer (1991) and Coyne et al. (1993) found aggression by residents to be one of the strongest predictors of violence by staff in nursing homes. Swedish researchers conducted a survey with nursing home staff who reported all incidents of aggressive behaviour of the residents. Wierucka & Goodridge (1996) assume that also clients who suffer from depression might be at a greater risk of becoming a victim. These results are in line with the results on the influence of aggressive and disruptive behaviour in the informal care setting.

[22] Insignificant result: Cohen et al. (2006); significant result: Lowenstein et al. (2009); significant result, but negative influence: Cooper et al. (2006, 2008)

The use of physical restraints on residents is also linked to cognitive impairments of the older person. The probability of the use of physical restraints[23] by professional caregivers increases if the resident shows signs of dementia. The use of physical restraints is still common practice in the nursing-home care of older people with dementia, but there are differences in the frequency of usage between nursing homes and countries[24]. Reports of restraint prevalence internationally vary from 15% to 66% (Meyer et al., 2009).

Professional caregiver characteristics

A further category is the caregiver characteristics. Many researchers claim the stress on caregivers to be an important risk factor of elder abuse. Pillemer & Moore (1989) interviewed 677 nurses and nursing aides from different nursing homes about how often they observed physical and psychological abuse and how often they committed abuse in one year. They found that abuse was associated with burnout symptoms and lower work satisfaction of staff. This supports the situational theory that claims the stress of the caregiver to be crucial concerning elder abuse. Further important predictors were an aggressive behaviour of patients (as stated under client characteristics), the belief of staff that patients are like children[25] and staff frequently thinking about quitting. So it may be assumed that burnt-out staff clashing with an aggressive resident results in a high risk of elder abuse. Schneider (1990) surveyed 205 administrators and nursing staff selected by administrators from different nursing homes and asked them how often they observed/were involved in abuse. He also found a significant influence of the work and life satisfaction on the use of abusive behaviour.

In contrast to the situational theory which puts emphasis on the stress of the caregiver, the intra-individual model points out the importance of the general mental and emotional state of a caregiver for the risk of elder abuse. Research into risk factors in informal care settings found significant results of the caregiver being addicted to alcohol or drugs and mental illness of the caregiver. These risk factors concerning the caregiver seem also to be connected with elder abuse in nursing homes (Lindbloom et al., 2007).

Relationship quality between the professional caregiver and the care-receiver

There are no results regarding the influence of the quality of the relationship between the caregiver and the care-receiver himself/herself by now. However, as described in care-receiver characteristics, aggressive and disruptive behaviour showed to be a significant risk factor of elder abuse (Pillemer, 1991; Coyne et al., 1993). It may be assumed that this kind of behaviour affects the quality of the relationship between the caregiver and the client and is

[23] Physical restraints are defined as any limitation of an individual's freedom of movement and include those worn by the person (belt, chest, and arm/leg), those attached to beds (full-enclosure bedrails) or chairs (locked table) (Hantikainen, 1998)

[24] The participating partner countries agree that the use of various types of physical restraints (such as bedrails, bed belts and wheelchair belts, board inserts and so-called fixing blankets) is to be considered elder abuse, although legitimised, e.g. in Germany, by court decision.

[25] The belief of staff that patients are like children was measured by their answers to the question how far they agree with the statement:“Nursing home patients are like children, they need discipline from time to time“ (Pillemer & Moore,1989, p.318)

thus increasing the risk of an abusive response by the caregiver. As mentioned under caregiver characteristics, the belief of staff that patients are like children seems to be connected with a higher risk for elder abuse. It may also be assumed that beliefs of the caregiver regarding their clients are related to the quality of their relationship.

Structural characteristics of institutions

According to Wierucka & Goodridge (1996) not only the relationship between caregiver and client but also the institutional characteristics in which the interaction takes place have to be taken into account[26]. There are several institutional risk factors formulated in a discussion paper on Abuse and Neglect of Adults Living in Institutional Settings, released by Health Canada (1994). They identified ten risk factors of institutional characteristics. For example the standardisation of services, treating clients as a homogenous group, hierarchical power structures and formalised standards of the quality of care that do not include quality of life and satisfaction enhance the probability of elder abuse. In a similar manner, formal lines of institutions act as barriers to an easy and open communication, and institutions are often separated from the community. This can lead to a greater risk for elder abuse (Health Canada, 1994).

In literature, the heavy burden resulting from a care situation and the underlying stress on the caregiver are often mentioned as a paramount explanation of elder abuse (as in the situational theory, see 0). Stress and burnout of the caregiver can be caused fully or partly by stressful working conditions. It has been shown that shift work, lack of flexibility in work, low payment and professional status and workload are strongly related to the risk of using abusive behaviour (Chappel & Novak, 1992).

Also the number of staff relative to the number of residents might cause stress on the caregiver and influence the probability of elder abuse. Schneider (1990) also found the staffing level to be an important predictor of elder abuse. In a postal survey conducted in Germany, 361 nurses of nursing homes were asked how often they committed different forms of elder abuse (BMFSFJ, 2009). The number of confused, incontinent and bedridden residents and residents reliant on a wheelchair per registered nurse proved to be a significant predictor of elder abuse.

It should be pointed out again here that physical restraints are used more often when the workload of the nursing staff is excessive, the number of staff inadequate and the nursing personnel have an insufficient gerontopsychological competence. Specific knowledge and competence is required in order to be able to meet the needs and requirements of dementia patients in a manner other than applying physical restraints or administering pharmacological sedation (Huizing et al., 2007).

[26] Wierucka and Goodridge (1996) summarise both characteristics under the category environmental factors.

Further structural characteristics of institutions were examined in literature as potential risk factors of elder abuse in nursing homes. Several researchers found that a poorer quality of care is provided by smaller facilities (Gottesman, 1974; Lee, 1984; Weihl, 1981) and for-profit facilities (Lee, 1984; Green & Monahan, 1981). However, in the telephone survey of Pillemer & Moore (1989) there was no significant influence of for-profit and smaller facilities on elder abuse.

Shinan-Altman (2009) used a psychological approach to explain how structural characteristics in an institution and the structure of a position can influence the probability of elder abuse. According to the authors, shaped attitudes of staff in nursing homes play an important role in whether an abuse of a resident occurs or not. As underlying model a simplified version of the "Theory of planned behaviour" by Ajzen (1988) is applied. Thus the intention of committing a particular behaviour is building prior to the actual behaviour. Intentions are formed by attitudes of a specific type, which are in turn developed by behavioural, control and normative beliefs. The behaviour is evaluated by its outcome: Whether it is admissible in one's own opinion and is admissible in the eyes of the environment and what control is perceived when adopting a particular behaviour.

Shinan-Altman & Altman (2009) simplified the model and tried to explain attitudes of nursing aides in dependence of demographic variables (gender, education and income), work-stress factors and perceived control of their work. As work-stress factors the ambiguity, work overload and role conflict were included. 199 nursing aides of nursing homes were interviewed, of whom 57% women and 43% men. The results of the multiple regression analysis showed that a higher rate of role conflict, role ambiguity, work overload and burnout contribute significantly to a higher level of condoning abusive behaviour among nursing aides. Here burnout is partially mediating the influence of work stressors on the attitudes of elder abuse. Demographic variables, perceived control and work overload played no significant role in explaining attitudes condoning abusive behaviour.

Summary of risk factors of elder abuse in institutional setting

In the following list, based on the literature analysis above, risk factors of elder abuse in the institutional setting are summarised. This should be noted again here that to get a more precise picture of risk factors of elder abuse in nursing homes research into this field has to be extended. The characteristics of institutions that may enhance the probability of elder abuse as identified by Health Canada (1994) such as the standardisation of services are not included in the list. Since studies, which would examine these characteristics methodologically, are missing so far, no clear statement can be made on their influence. For the same reason, "physical health" of the care receiver is not included.

Working climate was added as a risk factor of elder abuse since the German, Dutch and Austrian expert teams pointed to the working climate as an important risk factor of elder abuse.

	Risk factors
Structural characteristics (situation)	Institutional risk factors: • inadequate staffing level • working climate • stressful working conditions (shiftwork, lack of flexibility in work, low payment and high workload) • social isolation of older person
Characteristics of professional caregiver	• poor job and life satisfaction • view patients as childlike • frequent thoughts about quitting • work load and burnt-out employees • mental illness • dependence on drugs or alcohol
Characteristics of (potential) victim	• behaviour problems (disruptive and aggressive behaviour or active resistance to care) • depression • cognitive impairment (e.g. dementia)

Figure 14: Institutional risk factors

2.3.3 Risk factors of elder abuse in professional home care setting

The research into risk factors of elder abuse in professional home care has been much less extensive so far than that into risk factors of abuse in a family setting. Lowenstein et al. (2009) dealt in their study with risk factors in professional home care in conjunction with risk factors in a family care setting. Results obtained also show that abuse by professional caregivers of home care services is far less prevalent than abuse by family members (p. 264). But the results concerning risk factors cannot be applied unequivocally to professional home care settings, since the sample only contains a small ratio of actual abuse cases in professional home care, compared to informal care settings.

In a postal survey in Germany, 503 staff members of home care services were asked, inter alia, to report their own behaviour and the behaviour of colleges towards the clients (Rabold & Görgen, in BMFSFJ, 2009). In a binary logistic regression, risks of a staff member to be engaged in abuse, dependent on several characteristics of the caregiver and the client were analysed. As in the other settings, the results showed a significant influence of aggressive behaviour of the client, measured by physical, verbal and sexual attacks towards the caregiver. Furthermore, alcohol intake as a strategy used by the staff member to cope with challenging work load, the average amount of persons with dementia the caregiver has to care for and a negative evaluation of the quality of the professional home care service influence the risk of elder abuse significantly.

Since the professional home care service, like the nursing home, provides formal organised care, the project partners assume structural characteristics of the home care service to be important risk factors of elder abuse. It is suggested that inadequate staffing level and working climate are, as in the institutional care setting, risk factors of elder abuse. Otherwise, support and care by caregivers of home care services involves the risk – unlike in institutional care – that the care-receiver frequently lives alone and the danger of being spotted during an abuse thus is comparatively smaller. Thus, it is assumed that in a professional home care setting social isolation of the care-receiver is an important risk factor of elder abuse.

Besides the structural characteristics, it is assumed that risk characteristics of the professional caregiver in institutional settings can be applied to the professional home care setting. As described above (under **Risk factors of elder abuse in institutional settings)**, Pillemer & Moore (1989) and Schneider (1990) found significant results for lower work and life satisfaction of professional caregivers working in institutions. Pillemer & Moore (1989) also found burn out symptoms of staff, the belief of staff that patients are like children[27] and employees frequently thinking about quitting in order not to be related with elder abuse.

It is also assumed that mental illness or dependence on drugs and alcohol of the caregiver and psychological characteristics of the potential victim (e.g. depression) may lead to a higher risk of elder abuse, as this is the case in the other two settings.

Summary of risk factors of elder abuse in professional home care setting

In the list below possible risk factors in professional home care settings are listed. Since, there are fewer scientific studies on risk factors in professional home care settings so far, the list shows preliminary results, mainly based on assumptions and derivations from the results obtained for risk factors in the other two settings. Further research in this field is needed to prove the following characteristics to be risk factors of elder abuse in a professional home care setting.

	Risk factors
Structural characteristics (situation)	Institutional risk factors: • inadequate staffing level (average amount of persons with dementia a caregiver has to care for) • working climate • social isolation of older person
Characteristics of professional caregiver	• poor job and life satisfaction • view patients as childlike • frequent thoughts about quitting • work load and burnt-out employees

[27] The belief of staff that patients are like children was measured by their answers to the question how far they agree with the statement:"Nursing home patients are like children, they need discipline from time to time" (Pillemer & Moore,1989, p.318)

	• mental illness • dependence on drugs or alcohol
Characteristics of (potential) victim	• behaviour problems (disruptive and aggressive behaviour or active resistance to care) • depression • cognitive impairment (e.g. dementia)

Figure 15: Risk factors in professional home care setting

2.3.4 Assessment instruments and indicators of elder abuse

One essential prerequisite for protecting older people against abuse is to detect the occurrence of an abusive act in its different dimensions. A number of instruments were developed for this purpose to quantitatively record elder abuse.[28] There are also guidelines and checklists with instructions on how to record elder abuse by means of interviews, observations, physical checks and psychological tests, or by a mixture of these approaches. Existing instruments and guidelines differ with regard to the indicators considered, their fields of application and the time required for the exercise. Instruments based primarily on what the applying person observes and perceives contain more observable indicators, for instance referring to the physical or psychological condition. If an interview of the older person or care-receiver is chosen as instrument to record abuse, indications of elder abuse can be obtained by direct questioning about the different dimensions of an abuse, questioning about psychological well-being or the behaviour of the caregiver. Depending on the environment of the recording exercise a number of instruments were developed, e.g. for application in professional home care (Reis & Nahmiash, 1998; Morris et al., 1997), or for identifying abusive acts in a hospital setting (Fulmer, 2003; Yaffee et al., 2008). It should be explained in this connection that some instruments pertain to both risk factors and indicators (Reis & Nahmiash, 1998).

Figure 16 gives an overview of the quantitative instruments available for recording elder abuse. A distinction is made between the different types of users of the corresponding instrument (e.g. physicians), the ambient settings in which the instrument is customarily used, the dimensions of elder abuse being measured, the identification of elder abuse and the advantages and disadvantages the authors find in the respective instrument.

The Appendix B contains a detailed list of existing quantitative instruments, also showing the individual elements of the instrument that the authors consider subordinate to the different dimensions of elder abuse. This list provides an overview of how accurately a specific instrument records abusive acts and which types of abuse remain out of consideration. It has to be noted that during the processing of MILCEA the University of Siegen and the Catholic University for Applied Sciences Berlin started to develop a screening an assessment instrument to

[28] The major part of instruments are not purely quantitative as data is recorded quantitatively (e.g. by a scale from 1 to 5) while the identification of an abusive act ultimately depends on the judgment of the user.

detect elder abuse in an early state and provide support strategies for its prevention.[29] Since the instrument is still in its development it is not added to the list.

[29] PURFAM (Potenziale und Risiken in der familialen Pflege) www.uni-siegen.de/fb2/zank/forschung/ and www.khsb-berlin.de/

Instrument	EAI	EASI	IOA	BASE	CTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis & Nahmiash (1998)	Reis & Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hwalek & Sengstock (1986)
Who applies it?	Clinicians who have suspicion are screening older person	Physicians who have suspicion are screening older person	Completed by trained practitioners in health and social service; agencies assess older people and caregiver	Completed by trained practitioners by screening caregivers or care-receivers	All kinds of professionals can be interviewers; caregiver is respondent (based on self-reports)	Clinical professionals; training is needed; based on assessment and reports of older people	Practitioners and nurses screening only older people
Setting –where it is conducted	All clinical settings	In a clinical assessment	Usually after a 2 to 3-hour in-home assessment	Clinical settings	(Not specific to the elderly) all settings	In-home assessment	Can be used in emergency or professional home care setting (Fulmer et al., 2004)
Assessed forms of elder abuse	Originally 40 items to allow physical assessment, determination of level of independence in lifestyle, social assessment, medical assessment	6 items to measure abuse; includes physical, psychological abuse, financial exploitation and neglect	Originally 48 items; includes risk factors of elder abuse of the caregiver and care-receiver	Only five questions; can be completed in a minute, does not include self-neglect	Originally comprises 19 items; includes physical and psychological abuse, does not include neglect or financial exploitation	Consists of 5 items; neglect, physical and psychological abuse are measured	Originally 15 items measuring physical abuse, vulnerability and potential abusive situations; revised version comprises 6 items (Hwalek ,1991)
How can elder abuse be determined?	There is no score, results depend on the interpretation by the care-receiver	Reports of people and physicians' interpretation	There is a cutoff score for elder abuse	Reports of caregiver and care-receiver and interpretation by practitioners	Self-report of abuse	Self-report of elder abuse and interpretation by interviewer	Answers of elder people and interpretation by interviewer
Advantages	Elder abuse teams and nurses applied it successfully (Fulmer et al., 2000)	Can be used quickly	It showed great potential as an instrument with high internal and external constancy (Fulmer et al., 2004)	Instrument has an 86% to 90% agreement by trained practitioners; may be useful in clinical settings (Fullmer et al., 2004)	Showed relatively high reliability (0.88) and content validity (0.80 Cronbach alpha) (Mc Guire and Earls, 1993)	Relatively short	Quick screen; can be also used in emergency settings
Disadvantages	Since there is no score or cutoff point the assessment of elder abuse depends strongly on the clinician's opinion	Some forms of abuse are not measured	It is rather long and complex	Training is needed before it can be used	Does not include neglect and financial exploitation	Financial exploitation is not included	Does not cover all dimensions of abuse

Figure 16: Instruments assessing elder abuse

Indicators of elder abuse

Another goal of Phase 1 was the identification of indicators of elder abuse. Such indicators allow the detection of potentially abusive acts. The individual appearance of physical and psychological characteristics of an older person may reveal whether that person has experienced an abuse of one of the five dimensions. As previously explained, the majority of the instruments available are applicable for interviews with the older person, the caregiver or both. In view of the purpose for which the list of indicators is to be used in Phase 2, observable indicators form the greater part of the list. Elements of interview are largely left out of account.[30] Many indicators are of a medical-diagnostic character. Furthermore, the behaviour of an older person, of the caregiver and the conduct of both towards each other can be indicative of an abuse having occurred.

Research into indicators of elder abuse is generally less common than that into risk factors. While there are quite a few articles devoted to indicators of elder abuse, their findings are based primarily on the experience of and subjective assessment by the authors or individual case studies (Lachs & Pillemer, 2004). The Elder Assessment Instrument (EAI) is one of the few that consider physical, psychological and situation-dependent indicators. What is more, this instrument – unlike the majority of the other existing instruments and guidelines – has already been used successfully by nursing staff of emergency wards in the USA (Fulmer et al., 2004, p. 300). It was tested on a sample of 501 older adults in emergency department settings, and the items of the instrument showed to be appropriate to measure elder abuse (Cronbachs alpha was reported at 0.84) and repetitions of the measurements mostly lead to the same results (test/retest reliability reported at 0.84).

The EAI was used as a basis on which the following list of indicators of elder abuse was compiled. Additionally, literature was searched for further indicators. In the process, it was found that the indicators named by the EAI meet with widespread agreement and are also listed by many other authors. Further indicators that surfaced in the search of literature were included in the list. They are marked in the list with the corresponding source reference.

Method	Indicators and warning signs
Physical examination and/or	**Physical abuse:** 1. bruises, lacerations (especially old and new bruises; shape may suggest implement, e.g. iron or belt[31 32]) 2. fractures

[30] In Phase 2, the monitoring systems of elder abuse in LTC existing in the various countries will be analysed, in order to determine which indicators and risk factors are already routinely recorded and documented. The list of indicators will focus – for its major part – on observable indicators as their recording in daily practice is easier and requires less time. Furthermore, it is assumed that routine interviews targeted at detecting abusive acts are not or hardly customary so far in most countries. However, interviewing is seen to be an essential element of a monitoring system, and this will play its role in Phase 3, when a monitoring system is developed.

[31] Lachs & Pillemer, 2004

[32] Fulmer et al., 1984

observation	3. burns[33] 4. bilateral injuries[34] **Explanations of caregiver or older person** 5. implausible, bizarre, inconsistent, or vague explanation of injury[35] **Sexual abuse:** 7. unexplained venereal disease or genital infection[36] 8. bruises or bleeding in external genitalia, vaginal or anal areas[37] 9. torn or bloody underwear[38] **Neglect:** 10. contractures 11. decubiti 12. skin turgor, or other signs of dehydration[39] 13. malnutrition 14. poor hygiene[40] 16. urine burns 17. inappropriate clothing (e.g. dirty clothing) 18. inappropriate medication (over/under): *possible indicators: changes in mental ability or physical activity and decline in general health status, e.g. confusion, poor balance, falling, depression, recent incontinence and/or agitation*[41] 19. caregiver shows indifference to the elderly 20. repetitive hospital admissions due to probable failure of health care surveillance **Psychological abuse:** 21. poor eye contact, withdrawn nature 22. depression 23. fearful interaction with caregiver **Financial abuse:** 24. inability to account for money/property 25. properties and money of an older person are disappearing **Might be indicators for all dimensions:** 26. Caregiver is overly protective, not allowing privacy[42] 27. both the offender/perpetrator and the victim try to keep professional help outside[43]

Figure 17: Indicators and warning signs

[33]Kleinschmidt KC, 1997
[34] Cochran & Petrone 1987
[35] Levine, 2003
[36]American Medical Association, 1993
[37] Fulmer et al., 1984
[38]Gorbien & Eisenstein, 2005
[39]Lachs & Pillemer, 1995
[40]Fulner et al., 1984
[41]Council Against Abuse of Older Adults et al. www.seniors.alberta.ca.
[42] Brandl & Horan, 2002
[43] This indicator was result of two expert meetings (the German and the Dutch expert meeting). Find the summary of the expert meeting in Appendix A.

2.4 Summary and conclusion

Phase 1 of the project was devoted to defining essential basic terms by analysing the current state of literature on these topics. Furthermore, a brief excursion on cultural aspects of the topic elder abuse was given. Definitions of elder abuse that were already available were viewed and compiled. Although there is no uniform definition as yet, a majority of the experts support the WHO definition whose salient point is that there must be a relationship of trust between the perpetrator and the potential victim. If this is the case, according to the WHO (2008) elder abuse can be defined as “a single or repeated act or lack of appropriate action”, “which causes harm or distress to an older person”. Distinction is made between physical abuse (e.g. hitting or kicking), psychological abuse (e.g. threats), sexual misuse (forced sexual contact), financial exploitation (e.g. theft of property) and neglect (e.g. inadequate supply with food and beverages). For the purposes of the project the definition of elder abuse was concretised for the field of LTC. According to the OECD (2005) the essential characteristic of persons receiving LTC is that they depend on the assistance by others with their activities of daily life (ADL) for a protracted period.

To approach the project goal of a recommendation for a monitoring system for elder abuse it was necessary first of all to define such a system. Relying on the opinions of national as well as international experts a monitoring system for elder abuse means the systematic interlinking of the identification of abuse and measures to protect an older person in need of care.

Following the definition of basic terms of the project’s subject matter and the environment to be considered, the various forms of elder abuse were operationalised. To this end, the latest research into predictors and risk factors of elder abuse was reviewed. Predictors are such indications which may point to an incidence of actual abuse, e.g. pressure ulcers and black spots, but also a fearful and shy attitude of an older person. A burn-out syndrome of professional caregivers in institutional care or a negative relationship between the caregiver in informal care and the older person that existed in the past may increase the probability of elder abuse occurring. The results were analysed for the three different care settings. For subsuming significant predictors instruments available for the assessment of elder abuse were compiled and predictors of elder abuse identified on their basis.

While Phase 1 concentrated on the definition of basic terms, Phase 2 will now be devoted to the analysis of structures existing in the participating countries for the monitoring of “elder abuse”. The following chapter explains the further procedure in Phase 2 and presents first results.

3 How do the participating countries deal with elder abuse? (Phase 2)

In order to come up with a proposal for what a system to monitor elder abuse should ideally look like, we had to answer the subordinate question of how the various people involved in LTC in the participating countries deal with elder abuse or with the risk of elder abuse. Therefore two approaches were used. The first meant analysing the legal regulations governing the prevention of elder abuse (Chapter 3.1). The second approach involved describing and analysing the different national LTC systems, in an effort to find out how those people engaged in the care of older persons in the different care settings deal with monitoring and preventing elder abuse (Chapter 3.2). The results should provide suggestions for improvements in the prevention of elder abuse in the EU Member States.

3.1 Analysis of the legal regulations

Each participating country has different conditions for monitoring elder abuse – simply because of the different care systems and the different legal frameworks. The goal of this section is to highlight the differences in these conditions and to draw some conclusions for existing and future monitoring structures.

3.1.1 Methods

One focal point of Phase 2 of the MILCEA Project was the analysis of the legal basis existing in the participating countries as far as it is essential for a monitoring system to prevent elder abuse and abuse of people in need of nursing care. The underlying idea was that each actor expected to perform acts within a monitoring system for preventing elder abuse must be in a position to effectively take such action in the form of direct or indirect interference with the life situation of the victim and perpetrator of elder abuse. Any such interference with the rights of other persons requires a legal basis in a democratically organised constitutional state. It was therefore necessary to look at the existing outline conditions when analysing structures already in place and to examine their regulatory contents.

In this process it has been regarded as imperative for all partner countries to describe

- the current legal foundation focusing the protection of elder people and persons in need of nursing care.
- the legal tasks, competences, responsibilities and possibilities of the existing institutions.
- the already existing infrastructural characteristics with a perspective to construct a framework to detecting and preventing elder abuse and abuse of people in need of nursing care

To allow a comparison between countries, a guideline for the analysis of legal outline conditions was designed and agreed by all partners (see Figure 18). Each partner country was then to determine the legal outline conditions through desk research by following the questions of the guideline. This analysis aimed at finding out whether the introduction of the project's monitoring system can be based (Oliveira & Rodriguez, 2008; Meeks-Sjostrom, 2004; Wierucka & Goodridge, 1996; Williamson & Shaffer, 2001; Hydle, 1993; Jama, 1987; Benton & Marshall, 1991) on the legal framework that already exists. The results of objectives and functions of the existing institutions provides important clues as to which information is already collected and how it should be centralised and compressed. The results of the analysis supplies clues to answer the question why in one state certain data are collected and in others not.

Analysis of the legal outline conditions

Q1: In democratic, social and constitutional states basic rights of citizens are laid down in the constitution. Especially frail and dependent citizens, like older people in need of care, are protected in particular ways.
How are these rights expressed in the constitution of your country?

Q2: Are there special laws protecting the rights of older people, people in need of care and mentally impaired persons?

Q3: Legal outline conditions specifically related to LTC
Q3.1: What kind of measures/actors protects the rights of older people in need of care?
Q3.2: Are there specific laws in the field of LTC that ensure the protection of the rights of older people in need of care?

Q4: Are there gaps concerning the effective and sustainable protection of the rights of older people and people in need of care?

Q5: Is the existing administrative infrastructure sufficient to enforce the rights of the already existing laws/norms?

Q6: Which infrastructure must be build up for an effective and sustainable monitoring system for detecting and preventing abuse of older people in need of care?

Figure 18: Guideline analysis of legal outline conditions

3.1.2 Summary of the results of the analysis of legal outline conditions

This overview of results follows the order of questions determined in the Guideline. Find the detailed results for each partner country with a comparison in a chart in Appendix C.

The first question (Q1) was meant to find out to what extent basic rights of persons in need of assistance and care exist in the corresponding country to strengthen the protection of older people in need of care. Investigations by the partners revealed that the protection against

discrimination, the principle of equality of treatment, in particular equal treatment of men and women, are anchored in the constitutions of the participating partner countries. Protection of privacy is a constitutional right in some countries, as is the right to physical integrity. In the Netherlands and Spain there is a constitutional right to receive health care which also deals with state responsibility for health provision and promotion as well as the availability of and access to high-quality affordable care services. The Spanish constitution explicitly refers to the protection of older people.

Q2 asked about specific laws that aim at the protection of vulnerable groups, such as older people, persons in need of care or with cognitive impairment. To find answers, the partners searched criminal and public law in their countries for provisions meant to protect old people in need of care. The criminal laws of all countries sanction leaving a frail person in a helpless situation or alone. The misuse of defenceless people is a criminal act in all countries. In some countries there is also a law that defines the abuse and torturing of helpless and frail people who reside at a nursing institution or receive care in a household as a criminal act (Austria, Germany and the Netherlands). Similarly, the sexual abuse of ill, handicapped and dependent persons in institutions is punished as a criminal act in nearly all participating countries. Euthanasia, incitement of suicide and active medicide are punished in all partner countries. The abuse of old persons in need of care is decidedly not a criminal act in any of the partner countries.

Public law further differentiates the legal protective mechanisms. In Austria, Spain and Luxembourg there are laws to protect against abuse in the family and abuse of women. In Germany and in the Netherlands, laws have already been enacted that stipulate reports on the quality of care facilities; such laws are planned in Spain. Obligatory quality assurance for care facilities is regulated by law in all partner countries, except Luxembourg. However, all requirements of quality assurance and auditing yardsticks fail to include the question of an abuse of older people and persons in need of care; what is more, when predictors are investigated, the question of whether an abuse was involved is not an issue. It should be mentioned in this respect that all partner countries have provided for the risk of a person requiring care by special regulations of social insurance. In Austria, Spain and the Netherlands, there are laws dealing with the subject of complaints raised by patients in health care matters as well as laws on equality of treatment. Austria has the social assistance law that guarantees that everybody has access to the basic necessities of living, such as food, clothing and residents. In some autonomous regions of Spain, the protection of older people is a subject matter of laws.

Q3 focused on recording legal outline conditions for LTC. Q3.1 was to determine those measures and actors that protect the rights of older persons in need of care. In all countries, it is the police and the courts which – as law enforcement agencies – are responsible for the matter. In all countries the police are authorised to temporarily ban the perpetrator of abuse (also depriving him of his property). So-called arresting measures are to be approved by a

court in Germany, Austria and Spain. As mentioned in Q2 there are legally stipulated quality audits of LTC institutions in all partner countries. Special conditions or sanctions may be imposed on the grounds of such audits. In Germany and in the Netherlands, the results of the quality audit must be disclosed in a transparent report (in the Internet).

In all partner countries, there is an assistant or mentor caring for the legal matters of people who due to illness are (no longer) able to handle their own matters independently. In Germany and the Netherlands, institutionalisation of patients with psychiatric changes is regulated by law. Emergency hotlines that can be reached from a household have been set up in nearly all partner countries. A hotline on care and nursing exists in Austria, in parts of Germany and in Luxembourg. Also in Luxembourg, a social office is found which ensures individual help in order to maintain independence in old age. In the Netherlands, the support offices domestic violence can be called to report elder abuse and to receive advice. In Luxembourg and the Netherlands, a superordinate council determines whether all regulative measures planned by the government actually serve the interests of older people. Consulting offices supplying individual support are found in nearly all partner countries.

Q3.2 was meant to record those specific laws which exist in the field of LTC for the protection older people. Regional social laws in Austria and Luxembourg offer help in the event of abuse at home (limited stay in special accommodation, consulting). Those in charge of managing an LTC institution in Germany and the Netherlands are under a special responsibility defined by law for implementing standards and regulations. In Austria, Germany and the Netherlands, care facilities may have their licences revoked or they may be closed by the authorities if the interests and health of the inhabitants are at stake. In Spain, Germany and the Netherlands co-determination of the inhabitants must be guaranteed. The city of Vienna has a reporting obligation in place for social and out-patient services if an old person in need of care is in danger, e.g. through neglect by a third party.

Q4 was devoted to the question of whether there are any gaps in the effective and sustained protection of the rights of older people and persons in need of care. Some partner countries complained of a lack of coordination by health care actors, while in other countries there is criticism of the efficient exploitation of existing resources. The major deficiency noted with regard to elder abuse is the fact that the issue is not politically present, mainly for the home care setting and is widely neglected by legislators (exception: recent developments in the Netherlands).

Q5 asked whether the available administrative infrastructure is adequate to implement existing laws and standards. The partners agreed that an administrative infrastructure does exist for the most part in the participating countries; what lacks is the legal duty to protect against and prevent elder abuse.

Q6 was targeted at identifying structures that are still missing for the establishment of an effective monitoring system ready to record and prevent elder abuse. The replies received from

the partners were suggestions which concerned their national systems. One of the suggestions was to separate prevention and intervention at the organisational level (Germany, Luxembourg, Netherlands). Moreover, advanced training programmes were desired for health care staff (Luxembourg and the Netherlands). A strengthening of the cooperation between out-patient care service and social work is demanded by Spain and the Netherlands. In general, all participants call for a distinct reinforcement of the cooperation and netting between professional actors in LTC and informal actors (e.g. family, honorary workers, neighbours). Emergency telephones with qualified staff trained not only in old-age and care matters but also with regard to elder abuse is demanded by Spain and Germany. A uniform structure of hints and complaints and a binding uniform catalogue of measures are advocated as an essential ingredient by all partner countries. This is to create a door to a systematic monitoring that will cover the entire area of the EU countries.

3.1.3 Conclusion

In all partner countries, the constitution protects older people and persons in need of care either directly or indirectly, defining certain forms of elder abuse (such as the failure to provide assistance to a frail person in difficulty) as criminal acts. Similarly, the sexual mistreatment or abuse of older and dependent people is punishable in all participating countries. This protection is also codified in individual laws of the partner countries, albeit with differing points of emphasis. Nevertheless, it should be noted that all the participating countries lack laws that treat elder abuse (in all its various manifestations) as a criminal offence. Correspondingly, there is no law that directly defines responsibility for the prevention of elder abuse. The lack of legal regulation in this area highlights the fact that there are no institutions in the participating countries with direct responsibility for the prevention of elder abuse. On the other hand, account is taken of demographic developments in all the participating countries, and there are measures in place to deal with the need for care related specifically to increasing age. While the means of ensuring protection in the event of a permanent need of care differ, all countries have regulations and inspection agencies (in Luxembourg these are still under discussion) that focus on the quality of care as a service both in the home and in institutional settings. In all countries, shortcomings in the quality of care (e.g. malnutrition) are under discussion. In this context there should also be discussion about elder abuse (e.g. if an older person persistently suffers from malnutrition). Unfortunately, this discussion does not, as yet, take place in the majority of countries.

3.2 Analysis of existing monitoring structures in the participating countries

One essential part of the project was to include an examination of how the abuse of elderly people requiring care is handled within the long-term care systems of the participating countries. To this end, the different national systems of long-term care (and the people involved) were analysed and described in terms of their approach to the issue of abuse. The results of this exercise provide an essential basis for achieving the goal of MILCEA, i.e. developing a

system to monitor the prevention of abuse of elderly people who require care. Since it is not feasible to do this simply by changing certain behaviour by the actors or the institutions, an important aspect of the project has been to study the overall system of long-term care. Taking the indicators and risk factors, as well as the definition of a monitoring system as a yardstick (see Chapter 2.2.3), the project partners analysed the structures that are in place in their different countries to identify and prevent elder abuse and to protect potential victims. Key research questions were:

- Who are the stakeholders in LTC? Which actors already have legal responsibility in the prevention of elder abuse?
- What kind of responsibility do they have?
- Do they assess indicators and risk factors of elder abuse on a regular basis?
- What action do they take to protect a potential victim?
- What do the links between the actors look like?

3.2.1 Methods

In order to describe the existing monitoring structures and to answer the research questions, “actor analysis” was performed for each of the participating countries. This is a method that is used primarily in the field of political science and development sociology – e.g. in studies of international cooperation or in the context of environmental policy. Generally speaking, this method is most suitable wherever the planning and implementation of reform in specific settings is concerned. The method allows the relevance of actors or their potential for change to be demonstrated within a specific setting. In this case, at issue was the potential of professionals in the LTC system to prevent the abuse of older people who require care: to this end, the strengths and weaknesses of every actor were identified, and the communication/cooperation links between the individual actors highlighted.

The whole point was to pinpoint ideas to feed into concrete proposals for improvement, so that a monitoring system can be established. Since no such system exists in LTC in any of the EU Member States, the definition of a monitoring system for elder abuse that had been developed earlier was used when analysing the actors. In describing the relevant actors, therefore, while it was significant that recognition of elder abuse should take place on the basis of specific indicators or risk factors, an important question was also whether the information and data collected were channelled into action to protect the older person in need of care.

Actor analysis is based on a mixed approach, which means that different scientific methods are combined: focus-group discussions, expert interviews and analysis of documents. It should be noted that the description and systematisation of structures for the monitoring of elder abuse in LTC using actor analysis were carried out in this study from the perspective of the various actors, and not from the perspective of the older person in need of care or the potential victim of abuse. Here, the major challenge was to select an approach that was as open and exploratory as possible, yet at the same time to make the findings as accurate as

possible, so that knowledge gained nationally can be compared at the international level. In the following, the individual steps of the actor analysis are explained in more detail. The results obtained by this method, aggregated at the international level, are presented in Chapter 3.2.2.

Data collection

As a first step, the necessary data was collected to describe the various national structures. The project partners held focus-group discussions to identify – using snowball sampling at the national level – possible key actors in the LTC system who are involved in any system for monitoring elder abuse in LTC. At this stage in the research, they would be professionals in long-term care who are in regular contact with older people in need of nursing care, or else professionals outside the system who come into contact with the older person in need of care if abuse is suspected. The underlying assumption was that, as contact with the older person in need of care increases, so there will be greater chance of detecting elder abuse (or the risk of abuse) and then initiating or implementing measures to protect the victim. Action in this connection includes not only direct intervention in an abuse situation, but also the prompt transmission of information that will trigger an intervention. The partners agreed to focus on the professional level of institutions. This does not exclude informal networks and voluntary workers from being important actors in a system to monitor elder abuse; but for the purposes of regular and systematic assessment (and ultimately intervention), the professional network seems perfectly adequate.

The outcome was a list of relevant actors in each partner country, along with a definition of their tasks, in line with the regulations specific to each country. The results of this research work were correlated at the international level, and the actors identified were allocated to superordinate categories. Figure 19 lists those actors relevant for a monitoring system.

Emergency doctors (in hospital) and general practitioners
Institutions/actors who conduct quality audits in nursing homes and professional home care and nursing services (if they exist)
Nursing homes
Professional home care and nursing services
Day care facilities
Consulting services related to care issues
Home Supervisory Authority (responsible for supervising residential care)
Persons responsible for patient advocacy
Police
Legal guardian: Someone who handles the legal affairs of a person who has reached the age of majority (or here an older person) but is not able to cope with these matters on his/her own because

of physical or mental problems. The legal guardian could be a professional or a volunteer. Legal matters could include, for example, property issues, the decision on the place of residence, residential issues.
Guardianship judge: Decides on care matters, e.g. if the older person should move into a nursing home, or whether it is acceptable to restrain an older person .

Figure 19: Relevant actors

These actors provided the focus for a description of the structures in each of the partner countries. Since existing national structures in LTC vary from country to country, the project partners also described any additional actors who may be unique to a particular country but are important in terms of a system to monitor elder abuse in LTC. The suggestion was that these might feature in the development of a monitoring system at both the national and the international level.

Further actor analysis continued with an examination of documents that are publicly accessible on the Internet, in order to glean information on the various tasks and work processes, as well as on the legal framework. In tandem with this, selected contacts in the organisations concerned were questioned in semi-structured expert interviews. To this end, a set of guidelines was produced to assist in structuring the document analysis and the interviews (see Appendix D). It is one of the main tasks of this study to systematise the diverse structures. In order to describe existing structures, the interview guidelines for actors in LTC systems include questions designed to elicit information about the actors' organisational form or legitimacy, their organisational characteristics and resources, and their organisational environment. The characteristics of the organisational form which were considered included:

- the LTC setting in which the actor works
- the legal basis of that work
- the working method, focus of work in general
- the focus of work in connection with monitoring elder abuse, the frequency of contact with the client and the type of contact
- the level at which the work is undertaken (e.g. national, state or regional).

In terms of the definition of a monitoring system of elder abuse, it was especially interesting to learn what kind of information the actor collects on elder abuse and by which means. For this purpose, the actor was first asked if the organisation he/she works for uses an instrument to assess elder abuse. If not, the actor was asked if the organisation uses any other instrument that could contain indicators or risk factors of elder abuse. No matter which function the instrument has, the lists of indicators and risk factors identified in Phase 1 were queried with the data that is collected by this instrument. If no instrument is used, the interview partner was asked if there is any way of documenting contact with the older person in need of nursing care (in either standardised or non-standardised form). If there is some form of standardised documentation, the interviewee was asked which indicators and risk factors

from the list are part of it. It was assumed that standardised documentation of indicators and risk factors for elder abuse generally means that greater attention is paid to these indicators by the assessor than if there is no standardised documentation, where it depends more on the individual assessor whether an indicator or risk factor of elder abuse is spotted and documented. If there is no documentation at all, it is assumed that perception of these indicators and risk factors is generally very low.

In line with our definition of a monitoring system, the actors were also screened to ascertain the function of the documented information, as well as any consequences that might flow from it, and relevant processes inside and outside the organisation were analysed. These criteria allowed for a description of actors in terms of their potential to systematically monitor elder abuse in LTC in their particular country.

Separate guidelines were drawn up for doctors (general practitioners and emergency doctors), since they could have a specific role in monitoring and identifying elder abuse, thanks to their profession and the opportunity they have to examine the physical and mental state of an older person in need of care. They were asked, inter alia, whether the assessment of elder abuse is part of the anamneses of older people in need of care. A third guideline document was prepared for interviews with members of the police (see Appendix D). Although the police are not usually the first to raise suspicions of elder abuse, they do have a duty to check and, where necessary, to investigate any suspicion. Thus, the police play a crucial role in preventing first-time or repetitive abusive acts. The guidelines include questions about the circumstances under which elder abuse may be investigated and the procedure.

The data collection was completed in December 2010. In all, about 80 interviews were conducted.

Data analysis

As part of the data analysis, the information on the actors that had been extracted from the different data sources (documents, experts) was then condensed into actor profiles. This was necessary in order to highlight the relative importance of actors for the targeted goal of change – i.e. the prevention of abuse. Again, our definition of monitoring elder abuse was used in the creation of these actor profiles. In the following, we provide an example of a completed profile. Profiles developed in each country can be obtained from the various project partners. Figure 20 shows an example of such a profile.

Characteristics of institutions/actors	
Title of institution /actor	**Home Supervisory Authority**
Setting	☐ IH ☐ PH ☒ I **Remarks:** **Informal home care (IH), professional home care (PH), institutional (I)**

	setting,
Level of organisation	☐ federal ☐ state ☒ local
Main task	☐ provider ☒ authority ☐ other **Description main task:** 1. repeating inspections or inspections based on special-purpose (referring to the reason) of nursing homes: Legal basis of inspections is § 15 HeimG 2. consultancy (§4 HeimG) • of residents, relatives, legal guardians, advisory board of residents • of projective nursing homes before and during start-up of nursing homes how to eliminate lacks of quality of care
Frequency of contact with client	**Description:** repeating inspections once a year
Access to client	☒ initiative from institution ☒ initiative from client/others **Remarks:**
Elements of contact	☒ face to face contact ☐ over the phone ↳ ☒ conversation ☒ observation ☐ nursing care ☐ physical examination
Responsibility regarding EA (legal Mandate)	**Legal mandate:** ☒ yes ☐ no ↳ ☐ direct ☒ indirect; **Description:** Inspections are conducted to grant § 2 Abs. 1 of the Heimgesetz (HeimG): the dignity and interests and needs of residents in nursing. Home supervisory authority has the duty to proof, whether the requirements, put on the business of a nursing home through Heimgesetz § 11, are fullfiled: E.g.: nursing homes have to protect dignity, needs and interests of residents (§ 11 (1)) E.g.: nursing homes have to grant adequate quality of care (§ 11 (2))
Detection of EA	
Description of standardized documentation	**Documentation (of risk factors and/or indicators)** ☒ standardised ☐ unstandardised doc ☐ no documentation ↳ **1. Name of structured registration/instrument:** **1.1. Setting** ☐ IH ☐ PH ☐ I **1.2. standardized risk factor assessment** ☒ yes; ☐ no ↳ Put down risk factors at marked category ☒ structure**:** , ☐care-receiver**:** , ☐caregiver**:** , ☐relationship**:** **1.3. standardised indicator assessment** ☒ yes ☐ no ↳ Indicators of ☐ physical abuse, ☐ sexual abuse, ☐ neglect, ☐ psychological abuse , ☐ financial abuse **are included** **1.4. Do other institutions/actors have access to documentation:** ☐ yes ☐ no ↳

	Name of institutions/actors: **1.5. Function of documentation is** ☐ assessment of EA ☐ assessment of quality of care ☐ other ↳ **Description:** **2. Name of structured registration/instrument:** **2.1. Setting** ☐ IH ☐ PH ☐ I **2.2. standardised risk factor assessment** ☐ yes; ☐ no ↳ Put down risk factors at marked category ☐ structure**:** , ☐care-receiver**:** , ☐caregiver**:** , ☐relationship**:** **2.3. standardised indicator assessment** ☐ yes ☐ no ↳ Indicators of ☐ physical abuse, ☐ sexual abuse, ☐ neglect, ☐ psychological abuse , ☐ financial abuse **are included** **2.4. Do other institutions/actors have access to documentation:** ☐ yes ☐ no ↳ **Name of institutions/actors:** **2.5. Function of documentation is** ☐ assessment of EA ☐ assessment of quality of care ☐ other ↳ **Description:** **3. Name of structured registration/instrument:** **3.1. Setting** ☐ IH ☐ PH ☐ I **3.2. standardised risk factor assessment** ☐ yes; ☐ no ↳ Put down risk factors at marked category ☐ structure**:** , ☐care-receiver**:** , ☐caregiver**:** , ☐relationship**:** **3.3. standardised indicator assessment** ☐ yes ☐ no ↳ Indicators of ☐ physical abuse, ☐ sexual abuse, ☐ neglect, ☐ psychological abuse , ☐ financial abuse **are included** **3.4. Do other institutions/actors have access to documentation:** ☐ yes ☐ no ↳ **Name of institutions/actors:** **3.5. Function of documentation is** ☐ assessment of EA ☐ assessment of quality of care ☐ other ↳ **Description:**
Action	

Is there information exchange with other institutions/actors?	☒ yes; ☐ no ↳ **Setting, kind of relationship and name of linked institution/actor** ☐ IH ☐ PH ☒ I ; ☒ a ☐ b ☐ c **Name:** MDK ☐ IH ☐ PH ☒ I ; ☒ a ☐ b ☐ c **Name:** nursing home ☐ IH ☐ PH ☐ I ; ☐ a ☐ b ☐ c **Name:** ☐ IH ☐ PH ☐ I ; ☐ a ☐ b ☐ c **Name:** **Informal home care (IH), professional home care (PH), institutional (I) setting;** **cooperation, b) strong relationship, c) weak relationship**
Action	1. **Description** (in headwords): 2. • There is an obligation to register at public prosecutor's office. But there would be different procedures depending on the form and intensity of elder abuse. If physical abuse could be observed, public prosecutors has to be informed 3. • If less intensive case, e.g. psychological insults, it might be only discussed with leadership and concerned persons in nursing home 4. • Other persons to contact if EA is assessed are missing.
Guideline for action (interpretation)	☒ yes ☐ no

Figure 20: Example of an actor profile in the institutional care setting in Germany

Since we are concentrating on the overall system of long-term care, the actors were then considered together. As is customary with actor analysis, a so-called "actor map" was produced for each care setting. These maps present an overview of all the information on the relevant actors in the care setting. Thus it is possible to judge the relative importance of each actor and the "prevention potential" of the overall LTC system. It was also necessary to determine how information is relayed between the individual actors once abuse is suspected. The mapping of actors reveals how the actors overall meet the requirements of a monitoring system to prevent elder abuse and where exactly the various national LTC systems can be improved.

With the aim of giving the various different structures a uniform appearance, as a first step of the "actor mapping" a overview of the existing actors in the partner countries was made. The partners assigned the institutions/actors in their respective LTC systems to three different levels: the micro, the meso and the macro level .[44] The informal environment of an older person is defined as belonging to the micro level . The meso level includes all formal and non-authority actors (for example, the care service providers). The macro level comprises all formal institutions that are at the same time authorities, e.g. the LTC insurance system. In all countries and across all settings, the micro level includes the informal and close environment of family, friends, neighbours, etc. They play a role in a monitoring system, in that they can raise their suspicions of elder abuse with other institutions/actors. But since the focus of

[44] The assignment criteria of micro, meso and macro level used here were designed by the partners to represent existing monitoring structures in a simple way. These criteria do not conform to the sociological or economic science definition of the three levels.

MILCEA is on professional actors in LTC, the micro level only features in further analysis to the extent that there are linkages between the actors at the micro level and the professional care system. Figure 21 shows an example of such a map.

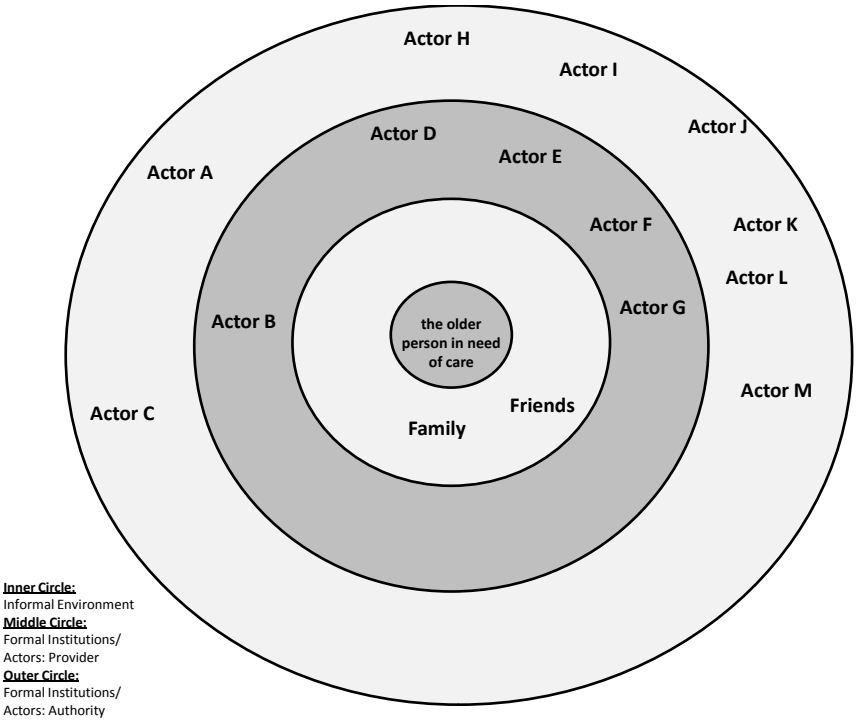


Figure 21: Map showing the actors in LTC at the micro, meso and macro levels – based on social proximity to the older dependent person

Besides that maps were drawn using different criteria that are relevant in preventing abuse. Actors were mapped according to the following questions:

- Are there regular contacts with the older person and what is the frequency of such contacts?
- What is the direction of such contacts (instigated by the older person or his/her relatives, or on the initiative of the professional actors) within the framework of providing care to the older person?
- Are any instruments regularly used to supply indicators and/or information on risk factors?
- What level of cooperation exists between the actors?
- Who would relevant actors turn to in the event of suspected abuse?

This result of this procedure is illustrated in Figure 22 below. This map shows the actors according to the criterion of "frequency of contact with the older person". The centre depicts the target of the intended change, i.e. the prevention of abuse. The more contacts an actor has with the older person, the closer he/she will be positioned to the centre of the circle. This ar-

rangement is based on the assumption that, as contact increases, so too does the potential to identify and prevent abuse. Nevertheless, frequent contact alone is not sufficient, and that is why the other criteria described above are also considered. The thickness of the frame surrounding an actor indicates his/her potential to identify abuse or the threat of abuse: the thicker the frame, the more indicators and/or risk factors are recorded by standard or non-standard procedures. In the example below, Actor I and Actor J, who have frequent contact with the older person and are thus placed within the inner circle, have less potential to identify abuse, since they do not apply any instruments. Conversely, someone in the outer circle – Actor D – records indicators and risk factors using standard methods, even though he/she is in contact with the older person infrequently (albeit regularly). This map might suggest improvements that could be made, such as an intensification in the cooperative relationship between Actor I and Actor D.

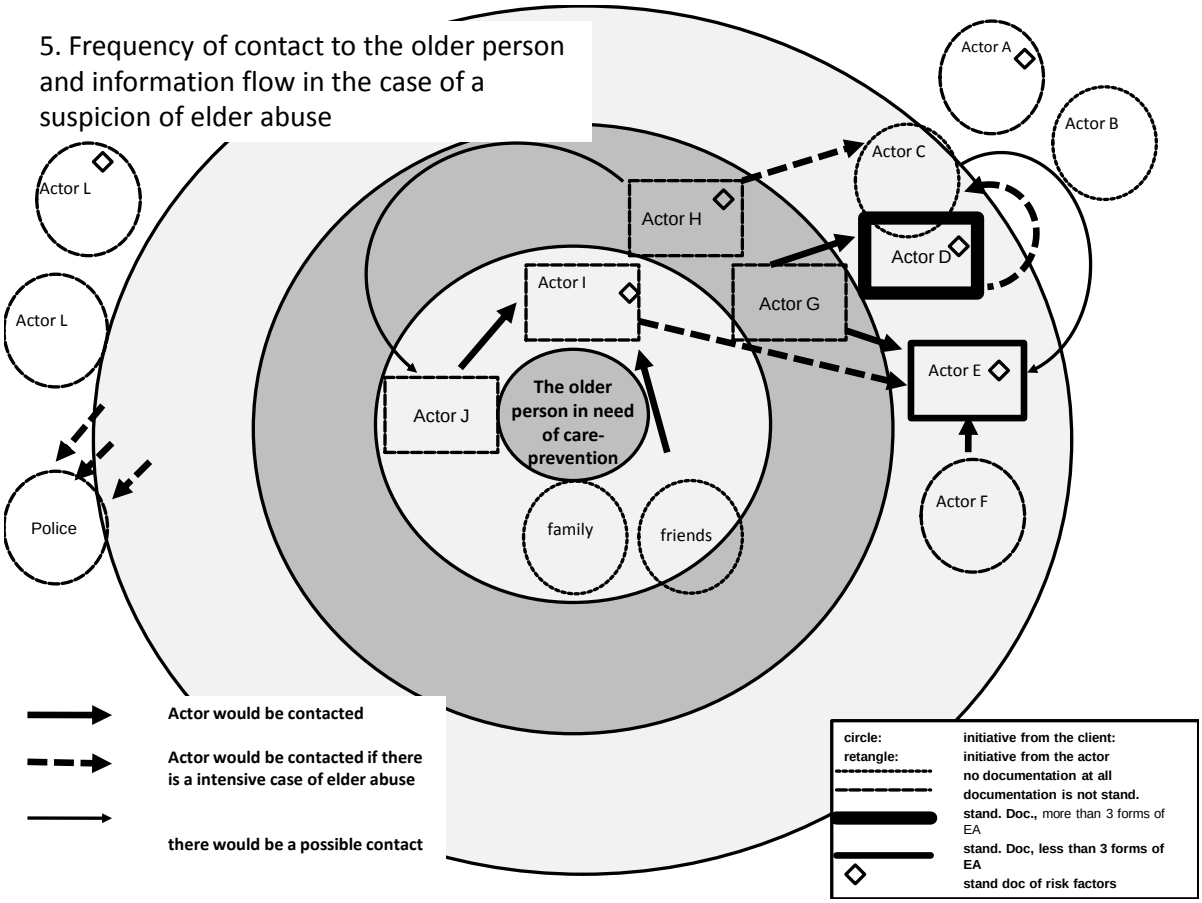


Figure 22: Actor map showing the actors in LTC at the micro, meso and macro levels, based on the criterion "Frequency of contact with the older person and information flow in the event of suspicion of elder abuse".

It is thus possible to assess the importance of the individual actors in meeting the defined goals of a monitoring system and to determine the "shape" of the shield that protects older people from abuse within the various countries' LTC systems. The maps designed by the partners can be found at Appendix E.

Armed with these maps, the partners held a second round of national expert meetings to analyse and interpret them. Together with national experts, the partners identified key actors in the existing structures, as well as a shortage (and sometimes complete lack) of structures. Summarising the results of the expert meetings and adding further analysis, each partner country prepared a written text, in which the existing national structures to monitor elder abuse were analysed. So that results could be compared across countries, this analysis was also based on a guideline document, which can be found at Appendix F. The next chapter informs about the results of this piece of work.

3.2.2 Results

On the basis of the maps and the profiles, the partners described the existing monitoring structures to be found in their countries in the form of a comprehensive report. These reports can be found on www.milcea.eu. In what follows, the various country reports will be summarised. Similarities and differences between existing LTC structures will be described, as will their strengths and weaknesses. The actors in LTC are described at two different levels (meso and macro) for each of the settings. The actors that make up the meso and the macro levels may differ between the settings and also from country to country.

It was possible to identify similar actors concerned with monitoring elder abuse in all the countries. Nevertheless, their specific legal basis and duties may vary, since these are governed by the corresponding national political and legal systems. Thus, they might be shaped and organised in a specific way, and this may also lead to different potentials to monitor and prevent elder abuse.

Overall it can be stated that in no partner country is there an institution that has the legal task of monitoring or preventing elder abuse. However, in each country there are institutions that have indirect legal responsibility. In some of the countries, service providers are directly responsible for ensuring that the well-being of the older person does not suffer over time. Since elder abuse crucially affects the well-being of an older person, clearly the implication is that elder abuse should be prevented.

Institutional care setting

At the meso level, there are, of course, LTC institutions and general practitioners in all countries. There are also advice centres for LTC issues, as well as legal guardians. The legal guardian is appointed by court for people who are not able to make decisions for themselves about their day-to-day lives. The advice services may be provided by, for example, non-profit organisations or they may be supported by government or the relevant ministry. In some countries, isolated examples are to be found of advice centres/services that focus on elder

abuse, but they are not nationwide. In all countries, the macro level includes the police, the court (of care) and nursing-home inspection bodies, which in all participating countries have a duty to assess the quality of care in institutions. In all countries, the responsible court decides on legal guardianship in care issues, while in some countries it also rules on the use of restraint.

Which actors in the institutional care setting have the potential to play a role in the monitoring system? All partner countries identified care service providers as potential key meso level actors in a system to monitor elder abuse. The staffs in institutions and home care services are in regular contact with their residents/clients, so that changes over time in the mental and physical state of the residents/clients can be observed. Nurses are obliged to use a care and nursing documentation system in all participating countries: it usually includes certain indicators and risk factors of elder abuse, even though they are usually not explicitly framed within the context of elder abuse. The main problem is that the perpetrator of elder abuse might also be a staff member. In nursing homes, there are no instruments either recommended or in general use that could help raise or confirm a suspicion of elder abuse. Interviews with nurses and nursing service managers conducted by the partners showed that defined chain of actions concerning a suspicion of elder abuse in LTC institutions or providers of home care services are either not existing at all, or not communicated properly.

At the meso level, general practitioners are also seen by all partners as important actors in a system to monitor elder abuse. Indeed, most partners even consider that they have a key role to play in monitoring elder abuse in the community (Germany, Austria, Netherlands and Spain). They generally have regular – perhaps even weekly – contact with clients in nursing homes or residential care facilities, and in the Netherlands they even play a central role in the care of residents. They are thus in a position to observe psychological and physical changes in an older person over a period of time. Through the medical examinations they conduct, they also have a chance to observe physical abuse. But again, as yet there is no assessment tool for elder abuse that is either recommended or in regular use. Likewise there is no defined sequence of actions if elder abuse is suspected. The general practitioner also has, by and large, a duty to maintain professional confidentiality. This creates problems if the older person does not want assistance. That said, if the well-being of the older person is threatened, patient confidentiality may be breached. The Austrian partners had the impression during the interviews that some general practitioners see asking questions about addressing elder abuse as intruding on the private sphere of their patient.

Also at the meso level, legal guardians might have the potential to identify elder abuse, because in all countries they have regular contact with their ward. Their potential also depends on the frequency of contact, which varies from country to country and sometimes even within countries. The tasks of the legal guardian are defined according to the specific needs of the older person. In Germany and Austria, the legal guardian must ensure and promote the well-being of the older person: prevention of elder abuse is thus indirectly included. In none of the participating countries does the legal guardian assess elder abuse using a standardised tool.

But they do have a kind of documentation system that may include indicators or risk factors of elder abuse. There is generally no defined chain of actions in the case of elder abuse or if there is any suspicion of elder abuse.

Finally at the meso level there are advice services on care issues in all countries, e.g. in the form of care hotlines, as in Austria. It is a feature of advice centres generally that the older person (or someone else) must actually get in contact with them. Thus older persons who do not actively seek help (or who do not receive help from the kind of people who might contact the advice service) cannot be reached through this approach. Yet, for those who do actively seek help, advice services may provide assistance and may arrange for help in the case of perceived or observed elder abuse. The problem is that (with only a few exceptions) these advice centres are, in most countries, not geared to the topic of elder abuse. In some countries (Germany, Spain and Austria) there are individual advice centres/services that focus on elder abuse, but these centres are not nationwide.
In the Netherlands, there are support offices for domestic violence that are also responsible for providing support in cases of (suspected) elder abuse at a local level and they also try to register cases of elder abuse for yearly national reporting. These centres however, deal mainly with elder abuse in the community.

What about institutions at the macro level? The potential of inspection bodies to monitor elder abuse depends greatly on the legal standing of the bodies in each country. What they have in common in all countries is that they have no direct legal responsibility for preventing elder abuse; instead, their duty is to assess the quality of care provided in nursing homes and by home care services. This may mean that elder abuse is not recognised, because it is not the focus of inspections up to now. Nevertheless, the two issues are in some cases connected: bad quality of care can provide evidence of elder abuse.

Another thing the inspection bodies in the participating countries have in common is that they conduct regular inspections of nursing homes. But the frequency of inspection varies from country to country (though usually it is no more than once a year). In the Netherlands (as in Austria), only a proportion of nursing homes are inspected each year; and usually in all countries not more than 10% of residents are interviewed annually. In Luxembourg, the introduction of quality inspections is a recent development and is still bedding in. Most countries do not have a standardised assessment tool or assessment strategy for quality of care (with the exception of Germany and the Netherlands), but focus on several quality criteria – for example, on structural, hygiene, falls, pressure ulcers, physical restraints and staff issues.. During the assessment, elder abuse indicators and risk factors might be assessed. In Germany there is a standardised assessment tool for quality inspections that includes indicators and risk factors of elder abuse, though these are not actually named as such.

It is a common feature of all countries' inspection bodies that there is no defined chain of actions for the staff of the inspection bodies to follow if there is any suspicion of elder abuse. In institutional care in Germany, aside from the MDK (the Medical Services of Compulsory

Health Insurance Funds), which assesses the quality of care in establishments that fall under the health care insurance remit, there is the Home Supervisory Authority at the federal level, which also conducts inspections of nursing homes. It is charged by the state with ensuring that the needs and interests of residents in nursing homes are considered and safeguarded. The interviews carried out in Germany showed that the Home Supervisory Authority is a potential key actor in monitoring and preventing elder abuse in institutional care, since most of the actors in LTC would inform the Home Supervisory Authority if there was any suspicion of elder abuse.

The police is an important actor at the macro level in all countries, in the sense that the police provides a referral point in the case of elder abuse. The police has the legal power to directly protect a victim of elder abuse. That said, interviews with the relevant institutions in LTC showed that the police in all countries are usually informed only if there is a concrete and severe case of elder abuse. According to an interviewed police officer in Austria elder abuse will not be reported to the police in the case the perpetrator is a staff member. The LTC- institutions “deal with the problem” by their own.

Also at the macro level, the court plays a role when application is made for legal guardianship. In this case, the court is in a position to prevent elder abuse by determining legal guardianship.

Professional home care setting

As in the institutional care setting, there are similar institutions to monitor elder abuse in the professional home care setting. However, these may vary in their specific legal standing and in their remit, and this may lead to a varying potential to monitor and prevent elder abuse.

As in the institutional care setting, in all participating countries the meso level includes general practitioners, advice centres for LTC issues and legal guardians (see Chapter 0). But instead of the institutional care facility, here the meso level includes the home care service provider. Part of the professional home care setting is also care that is provided in day care facilities. Here, the older person is cared for at home and receives professional services in a care facility only during the daytime.

At the macro level, the police and the court (of care) are included in all countries (see Chapter 0). The inspection bodies are, in most countries, responsible not only for quality inspections of nursing homes, but also for inspecting the quality of care provided by home care services and day care centres.

Which actors of this setting have the potential to play a role in the monitoring system? At the meso level, the staff of care service providers and day care centres are seen by all partners as important actors in a system to monitor elder abuse. The staff are in regular contact with their clients, so changes over time in the mental and physical state of clients can be observed and also suspect circumstances. In the case of home care, because they provide

care at home, nurses usually have contact with informal caregivers. Therefore they observe the daily routine of care at home, and may also witness abusive situations. In terms of day care centres, nurses also often have insight into the family situation and might observe changes over time in the older person. As in the institutional setting, nurses are obliged to use a care and nursing documentation system in all participating countries. Some indicators and risk factors of elder abuse usually form part of this system, usually not explicitly framed within the context of elder abuse. There are no instruments in use that assist in raising suspicion of elder abuse, nor are there defined chain of actions for dealing with such a suspicion in any of the partner countries. The problem here (as in the institutional setting) is that the perpetrator of elder abuse may also be a staff member. This might present an especially volatile situation if the perpetrator is a staff member with the home care service and the older person lives alone and has little contact with other people.

At the meso level, general practitioners also generally have regular contact with the older person and a high potential to detect and monitor elder abuse. What was said above about the potential of general practitioners to monitor or prevent elder abuse in an institutional care setting also holds true for this setting.

The monitoring potential of legal guardians is in general lower in this setting compared to the institutional care setting, where the legal guardian is often a family member. In this case, the legal guardian might be the perpetrator and thus the mechanism for monitoring and controlling would be missing.

At the meso level, advice centres can also be important in arranging help in the case of elder abuse in a professional home care setting. There are advice services concerning care issues in all countries, and in some countries there are even occasional advice centres that focus on elder abuse, as in the institutional care setting (see Chapter 0). As well as these services, all countries have institutions/services that provide support in case of domestic violence. These services might also be used by older women in the case of elder abuse. In the Netherlands, the municipalities are responsible for elder abuse in home care (formal and informal). They do so by the implementation of the domestic violence support offices. Unlike in the other participating countries, the domestic violence support offices in the Netherlands develop towards nationwide institutions to focus on elder abuse (it will be built up in each municipality).[45]

At the macro level in all countries, inspection bodies are responsible for assessing the quality of care provided by home care services, as well as in institutional care. The potential of inspection bodies to monitor elder abuse also varies from country to country in this setting. The description of the various categories relevant for monitoring presented in Chapter 0 is also valid here. In most countries there is no standardised assessment tool (the exception being

[45] In the frame of the action plan of the Dutch Ministry of Health, Welfare and Sport that was launched in 2011, the domestic violence support offices are to get more involved in the prevention of elder abuse in the Netherlands.

Germany and the Netherlands), but indicators and risk factors of elder abuse might be assessed during the quality inspections. As in the institutional setting, the frequency of inspection varies; it is usually carried out regularly, but not more frequently than once a year. In the Netherlands, only a proportion of organisations are inspected each year. In Austria, the supervisory authority of the provincial government has the right to examine the nursing-care documentation of the home care provider and to visit home care providers locally if there are any questions. But there is no regular assessment. Aside from this authority, Austria has the Competence Centre for Quality Assurance, which carries out random home visits of care allowance receivers to monitor whether professional and informal care at home is being conducted according to the needs of the patient. In Luxembourg, the introduction of quality inspections of care provided by home care services is (as in the institutional setting) ongoing. In no country is there a defined chain of actions for the staff of inspection bodies to follow if elder abuse is suspected. In Germany, the parallel structure of the Home Supervisory Authority and the MDK (explained in Chapter 0) does not exist in home care services. The Home Supervisory Authority is not responsible in this care setting.

At the macro level, the police and the court play the same role as in the institutional setting.

Informal care setting

In all countries, the informal care setting is rather problematic, since there are fewer monitoring structures than in the other two settings – e.g. professional care services and inspection bodies are not part of this setting. As in the institutional care setting, general practitioners, LTC advice centres and legal guardians form part of the meso level in all partner countries.

At the macro level, the police and the court (of care) are (as in the other two settings) included in all participating countries. In some countries, there are also institutions/services that have regular contact with older persons who receive financial care benefits (Austria and Germany).

Which actors of the informal care setting have the potential to play a role in the monitoring system? At the meso level, general practitioners are even more important in this setting, because they are often among the few professional actors who have regular contact with the older person and who know about his/her family situation. As with the institutional and the professional home care setting, medical examinations and the contact to the older person give the general practitioner the chance to observe physical abuse and raise attention for suspect circumstances. Furthermore, there is often a relationship of trust between the general practitioner and the older person. This puts the general practitioner in a position to spot other forms of elder abuse, e.g. psychological abuse. As in the other two settings, in no country is there either an assessment tool for elder abuse that is recommended or a defined chain of actions.

Like the general practitioner, the meso level advice centres for care issues or centres for domestic violence that exist in all countries can provide a link to the formal system, and thus

have potential in preventing elder abuse. In this setting, there are also some advice centres or care hotlines available as in the other two settings. Nevertheless, the older person (or someone else) has actually to get in contact with the advice centre. The support offices domestic violence in the Netherlands develops towards nationwide institutions to focus on registration and monitoring of elder abuse (they will be built up in each municipality).
Since, in all countries, at the meso level legal guardians are primarily relatives of the person concerned, the control mechanisms are lacking if the legal guardian is simultaneously the caregiver and the potential perpetrator of elder abuse. Even if this is not the case, legal guardians do not always fulfil their role properly in practice and are thus not always in a position to recognize and act in case of elder abuse.

At the macro level, the police and the court play the same role as in the institutional setting.

As was mentioned briefly above, Austria and Germany have institutions/services (at the macro level) that are in regular contact with people who receive financial care benefits and their caregivers. In Austria, the Competence Centre for Quality Assurance carries out random visits to the homes of older people who receive such allowances, in order to monitor whether informal care is being conducted according to the needs of the patients. In Germany, informal caregivers must be interviewed to ascertain that the care needs of the older person are being met, if financial benefits are being received. The interviews must be conducted regularly by a care organisation. The institutions and services both have the potential to identify elder abuse in an informal care setting, since they have access to the care situation of the older person.

Conclusion

By comparing the results of the partners on current monitoring structures, deficiencies were found across all participating countries. It has been shown that all settings have monitoring structures, but in the formal and the informal home care setting there are fewer structures than in the institutional care setting. Up until now, legal regulations concerning the monitoring of elder abuse are missing: no institutions have direct legal responsibility to prevent elder abuse. This confirms the results of the policy analysis, which showed an absence of legal regulations to combat elder abuse specifically. Responsibilities for the issue of elder abuse are not clearly defined or communicated. In only some countries specific screening tools for elder abuse used. The general assessment instruments that are used by some actors include only a few indicators and risk factors of elder abuse, and their focus is not primarily on elder abuse. All participating countries have established mechanisms to check the quality of LTC, and these include indicators and risk factors that may point to elder abuse. But the goal of these mechanisms is mainly to assess quality of care and not elder abuse.

All partners received the impression during the expert interviews that some nursing and health care professionals still are generally poorly attuned to elder abuse, its indicators and risk factors. This does not mean that health care professionals are not aware of the problem.

Rather, the results indicate an absence of clear structures, with the result that it is not always clear for staff members, how to react in the case of elder abuse.

4 Recommendations for a Monitoring System at the European Level (Phase 3)

To recap, Phase 1 of the project (which was devoted to defining the subject and to its operationalisation) is complete. In Phase 2, the legal framework and the existing national structures to monitor elder abuse were analysed, along with their strengths and weaknesses. Certain common strengths and weaknesses were found in the structures that exist in the different countries. This provided the basis for developing a framework for a monitoring system that goes beyond the national level, which is the main goal of MILCEA and is the task of Phase 3. This framework should be so constructed that it can be used by all EU Member States to put a monitoring system in place. Based on the common weaknesses of their structures, the partners defined certain prerequisites for prevention of elder abuse in EU Member States.

4.1 Methods

The results of Phase 2 provided a basis for all the conclusions concerning the need to improve existing monitoring structures and to put a monitoring system in place. The proposals are based on the definition of a monitoring system reached in Phase 1. A monitoring system for elder abuse involves the systematic linking of the identification of abuse, the actions taken to protect victims and evaluation of those measures. The description of existing monitoring structures showed that there are gaps in the participating countries between the requirements for monitoring and prevention and the existing structures. Given the results of the analysis of the legal framework, it is clear that the specific prerequisites for monitoring and preventing elder abuse have not yet been fulfilled. Now the goal became to identify and determine these prerequisites. Once again, an exploratory approach was needed: the partners discussed this issue in a focus group. As a result, a framework for monitoring elder abuse in EU Member States was drawn up. Since the final goal is to develop a framework for monitoring elder abuse in all EU Member States, it was necessary to involve a broad range of expertise in developing this framework. To this end, experts from EU Member States other than the partner countries were invited to a conference in Essen to evaluate the framework. This conference was held on 11 October 2011. The experts received the proposal for the framework ahead of the meeting and had to answer the following questions:

- Is the framework complete?
- Can the recommendations be put into practice?

- Are the recommendations precise enough?

At the conference, each expert answered the questions in the form of a statement. Crucial remarks and proposals for improvement were discussed. After the conference, the project partners incorporated the remarks into the final framework. We now present the framework for monitoring elder abuse, including the input of international experts.

4.2 Results – A framework for Monitoring Elder Abuse in EU Member States

4.2.1 Introduction

The ultimate goal of any system to monitor elder abuse is the protection of older people in need of care. Therefore elder abuse and the risk of elder abuse must be recognized as soon as possible, and appropriate action to prevent elder abuse must then be taken. In order to achieve this, several prerequisites need to be in place. All these prerequisites need to be high on the policy agenda at the local, regional and national level. Until "elder abuse in long-term care" is acknowledged politically, this social problem will remain a societal taboo. Thus, these conditions must be implemented and supported first and foremost at the political level.[46] Only then is it possible for both organizations in LTC and individuals[47] to be empowered to act in line with a monitoring system.

In what follows, these prerequisites are described within a framework that can be used as a guideline for European countries to establish monitoring structures. The task of European states will be to tailor the general prerequisites to their national context and to give the whole a concrete shape. To this end, existing structures should be closely involved.

For each element of a monitoring system – **awareness**, **identification**, **action** and **evaluation** – the framework defines the underlying prerequisites. We assume that awareness is the basic prerequisite for all the other elements in the framework, and that each subsequent element is dependent on the previous one(s). The central focus is on the older person him/herself, thereby taking the *European Charter of the rights and responsibilities of older people in need of long-term care and assistance* as a leading model.[48]

A comprehensive approach is used for all the elements of the monitoring system, including different strategies that finally lead to the prevention of elder abuse.

[46] It may be up to self-help and users' organizations, or voluntary organizations, to find allies among the political parties.

[47] By this we mean the professionals, family members and older people themselves.

[48] AGE Platform Europe, available at: http://www.age-platform.eu/images/stories/22204_AGE_charte_europeenne_EN_v4.pdf (accessed 24 October 2011).

Figure 23: Elements of a monitoring system

4.2.2 Awareness

There has to be awareness and knowledge of elder abuse at the level of society at large. There must be a positive view of old age and aging in society. The discussion of quality of care must include the issue of elder abuse.

Awareness at the general level of society is only possible if several prerequisites are met:

- The topic of EA must be included as part of the training of all healthcare professionals (e.g. nurses, general practitioners, occupational therapists, etc.) and social workers, and should even feature in vocational education.
- Further educational programmes on elder abuse (including aging, older people's rights, and stereotypes) have to be developed for nursing professionals and informal caregivers (and even for older people themselves), and existing programmes need to be implemented. Financial support must therefore be available. Finally, organizations in LTC must enable their employees to attend these educational programmes.

- A law needs to be passed, stating that older people – and specifically older people in LTC – should be protected against elder abuse. Connected to the issue of abuse, the quality of life[49] of older care-dependent persons (including people suffering from gerontopsychiatric disorders) must be an explicit goal of LTC and be enshrined in law. Government must take the initiative and support organizations in LTC to create, distribute and implement guidelines on how to deal with elder abuse, and also to raise awareness of the whole subject among the people involved.
- In the long term, nationwide public awareness campaigns dealing with elder abuse must be developed and launched in all the mass media. Some should focus on the empowerment of older people, by educating them in the various forms of elder abuse, the indicators and the risk factors. These campaigns should also provide information on older people's rights and on whom they can turn to in the event of elder abuse. Older people themselves should be involved in the development of these campaigns.

4.2.3 Identification

Awareness of elder abuse and knowledge of risk factors and indicators is a necessary prerequisite for identification of elder abuse. In addition to awareness-raising in each country, appropriate and validated screening/assessment instruments and/or signal cards should be available and should be incorporated into the monitoring system on a mandatory basis. A uniform screening/assessment instrument is not considered feasible, because different countries have different characteristics of settings, different organizational levels of long-term care and different systems of long-term care. This needs to be taken into account if the results of elder abuse research are compared for different countries. Nevertheless, there should be a uniform standard for the methodological quality of instruments (covering, for example, validity and reliability). Screening/assessment tools should help the user to confirm a first suspicion of elder abuse. To confirm it conclusively, more comprehensive instruments need to be used to assess the persons involved and the contextual factors in more detail.

Prerequisites

- At the policy level, the validation of screening/assessment instruments and signal cards to assess elder abuse should be encouraged. The use of such instruments and cards should be strongly recommended (or possibly even made obligatory) under regional or national regulations. Steps should be taken to ensure that all professionals in long-term care are trained in how to use a screening/assessment instrument.
- The actual employment of screening/assessment instruments and signal cards in daily practice should be defined by law, and their use should be scientifically evaluated.
- A working group of experts in the field of elder abuse should be created at the European level to oversee the evaluation of instruments and educational programmes, and to make

[49] As the quality of life of people in need of care gains more relevance, so elder abuse will also gain in importance.

the results transparent. There should be international guidelines concerning the methodological quality of instruments (validity, reliability) and education programmes. Further research is needed into the methodological quality of indicators and risk factors (instruments) – ideally at the international level – in order to ascertain how many and which indicators provide an accurate measure of elder abuse.

The responsibility of professional actors in LTC for identification of elder abuse must be laid down.

Prerequisites

- The requirements for professional care workers to identify elder abuse must be defined by law, and on this basis mandatory regulations for care providers must be formulated.
- Regular care and nursing assessments carried out by providers should contain indicators of all forms of elder abuse. This must be a quality criterion for nursing assessment instruments. Depending on the national structures, this needs to be confirmed by either regional or national regulations.
- There should be regular inspections of care providers by actors who are independent of them. These inspections should include indicators of all forms of elder abuse. This should be enshrined in law. In many European countries, there are inspection bodies that assess quality of care in nursing homes and home care services. Inspection bodies should include elder abuse in their audits (national level).[50]

Risk factors of elder abuse must be monitored and regularly reduced by care providers.

Prerequisites

- It needs to be set out in law that service providers (nursing homes, day-care centres and home care services) should include the topic of elder abuse in their internal quality-management system.
- During the hiring of care staff, a thorough check of qualifications should be carried out: Dutch-style “conduct certificates” for professional care staff might be made mandatory; paid care staff would have to be screened and be in possession of these mandatory conduct certificates.[51]
- Nursing providers should be bound to designate a person of trust for staff – someone to provide confidential support for staff members on all issues of elder abuse. In addition, there should be a person of trust (e.g. a residents’ advocate) available to the residents

[50] In most cases, they already include such indicators and risk factors, but these are not directly linked to elder abuse.
[51] Conduct certificates (VOG) will become mandatory for professionals in the long-term care sector when they enter the field or receive a new employment contract from a care provider. A handbook for the screening of personnel is also being developed (Dutch action plan – *Seniors in Good Hands*, Ministry of Health, Welfare and Sport).

and the service provider's clients, as potential victims. These persons of trust should be trained and should receive adequate protection (e.g. under employment law).
- Guidelines on how to act if there is a risk of elder abuse should be introduced by the care providers.

4.2.4 Action

In the event that elder abuse is suspected, the responsibility of all actors in terms of assessment should be clearly defined. In addition, it should be clear which actions should be performed by the various actors, and this should include defined responsibilities. Therefore, already existing structures and/or stakeholders should be involved. Once all responsibilities for taking action are defined, it is assumed that elder abuse (or the risk factors of elder abuse) will be approached in a comprehensive and multidisciplinary way.

Prerequisites

- First and foremost, it needs to be clarified at the national level which actor is responsible for specific actions at each level. Who are the key stakeholders and what are their duties in terms of acting to protect the potential victim?
- This task might be undertaken by a working group of advocates of the interest groups and associations of key stakeholders (multidisciplinary team) and other relevant social groups with a stake in the geriatric LTC system. Moreover interest groups of older people themselves should be included in the process. The working group should develop a set of *national guidelines* that define the responsibilities for taking specific actions.
- Stakeholders should be bound to implement the *national guidelines*. These guidelines define overall structures, such as which actor is responsible for reducing the risk of elder abuse, for further assessment and for the implementation of adequate steps to prevent elder abuse in the setting in question.
- All organizations that are stakeholders in this field should develop an explicit policy on preventing elder abuse, and should incorporate the *national guidelines* into internal guidelines that include an internal procedure to follow in case of elder abuse, with defined responsibilities within the organization. The various institutional stakeholders should have a clearly documented description of the responsibility for preventing elder abuse (here in the sense of taking action).
- One of the stakeholders should be nominated by the working group as "lead agency" for elder abuse; this agency should be locally based. The nomination of lead agency should be clarified in the *national guidelines*. The context will vary from country to country, and so different solutions for a lead agency for elder abuse might be considered: the integrative "one-stop shop solution" or the "compartmentalized solution":

The integrative "one-stop shop solution" integrates the functions of providing advice and of following up cases. On the one hand, the agency acts as a consultant for victims, witnesses and caregivers (e.g. provides an elder abuse hotline).[52] This means that the staff must be well trained in the topic of elder abuse, and must be able to provide clients with psychological assistance and referrals to other supporting institutions (if necessary). On the other hand, the agency would, if there is evidence or any suspicion of elder abuse, follow up cases and take steps to protect the older person. This agency would need special rights to intervene in the case of elder abuse, and would have to work closely with the police and the judicial system.

The "compartmentalized solution" might be a possibility, depending on the existing stakeholders in a country. This solution separates the responsibility for providing consultancy and assistance (e.g. a hotline) from the job of following up cases. If there is a suspicion of elder abuse, the advisory service would refer the matter to another agency, which would be responsible for following up cases and making sure that the older person is protected.

4.2.5 Evaluation

Confirmed elder abuse cases should be registered at the local/regional level (with the data later aggregated at the national level). The aims are a) to scope the problem of elder abuse; b) to introduce appropriate measures for prevention and to provide solutions for actual cases of elder abuse; and c) to evaluate the action(s) taken.

Prerequisites

- There needs to be a central register of cases of elder abuse to provide aggregated data. Such a system should be developed and implemented at the national level (and also be supported and facilitated at that level). The establishment of such a central registration system needs political will. It is therefore necessary to determine what kind of data should be collected, when and how. Existing structures in the countries should be used. There should be public access to the data and regular reports should be published.
- Service providers should be bound to document and evaluate all measures that have been taken to protect a potential victim. This also means that further measures need to be implemented, if protection of the victim is still not assured. Also cases where there is an uncorroborated suspicion of abuse should be documented.
- There should be a legal footing for issuing regular public reports at the national level.

[52] At this point, it should be noted that victims, caregivers and witnesses need to contact the consultancy service or hotline of their own accord, and that only some parts of the population are reached by this approach.

4.2.6 Specific recommendations for the informal care setting

Our framework refers mainly to the formal care settings, because informal care mostly takes place behind closed doors, and almost no formal actors have access to the private care environment. In our opinion, the only possibility of guaranteeing monitoring in the informal care setting is to use existing linkages to the formal system. The following are our recommendations:

Raising awareness in society at large (as described above under "Awareness") will encourage people in the informal care setting (and older persons themselves) to voice any suspicions they may have of elder abuse or to identify elder abuse.

General practitioners and other community healthcare and social work professionals are among the few actors who frequently have regular contact with older people in an informal care setting. This means that it is especially important to raise awareness of elder abuse among general practitioners and social workers, and to provide them with screening tools. European countries must create incentives for general practitioners to include an elder abuse check in the case histories of older patients, and for them to take appropriate steps.

A further linkage to the formal system would be the consultancy service for older people, their caregivers and witnesses on the topic of elder abuse (as outlined above under "Action".[53] Publicity campaigns should highlight these services.

Depending on the specific context of a country, there may be other actors who have regular contact with older people in the informal care setting. Government should support research to identify such actors and to find solutions that will put these actors in the position of being able to spot elder abuse and to implement appropriate measures.

4.2.7 Recommendations for the European Commission

The European Commission should urge implementation of the framework by the Member States by emphasizing that elder abuse is a violation of human rights. The European Commission should stimulate research into elder abuse indicators and risk factors (in all care settings), instruments and standards of data gathering for Member States. In addition, research into effective policies on elder abuse prevention should be supported.

4.3 The next step: Adapting the Framework in the partner countries

To help with disseminating the framework and to initiate a process of change in the prevention of elder abuse, the partners decided to produce a brochure for European governments and experts in the field of science and LTC. The project was extended by the European Commission to allow proposals to be drawn up on how to adapt the framework in the partici-

[53] It should be noted here that potential victims and /or older persons in need of care, caregivers and witnesses need to contact the consultancy service or hotline of their own accord, and that only some parts of the population are reached by this approach.

pating countries. The Dutch action plan “Seniors in Good Hands” served as a guide. This piece of additional work should encourage the EU Member States to put the framework into practice.

4.3.1 Austria

(written by Monika Wild, Charlotte Strümpel and Gudrun Haider; Austrian Red Cross)

Introduction

Generally, in Austria many different actors with different competencies and responsibilities are involved in each care setting (informal care, professional home care and institutional care). Many of them already carry out different tasks that correspond to different phases of the proposed monitoring system.

However, even for those within the system, it is not easy to know whom to turn to in which case. Thus, with respect to the final framework the participants of the national meetings agreed that it would be important to locate responsibilities for monitoring elder abuse either on national level or at least on the level of the provinces within one organisation. This organisation should be an already existing one and should also have a telephone hotline that victims and their families can contact and that can connect them to the institutions/ organisations they need to receive support for their individual case/ situation. Therefore, it is recommended that the responsibilities should be clearly defined and communicated.

Additionally, there is no institution that has an explicit legal mandate to prevent elder abuse in Austria. As in other countries, it is also recommended to develop legal regulations for monitoring and acting with respect to elder abuse that includes the roles and responsibilities of staff members as well the rights of potential victims.

Relevant stakeholders in Austria and their tasks

In the following Austrian stakeholders are described along the lines of the MILCEA final framework. Their current activities with respect to long-term care and elder abuse are described as well as their possible role in a monitoring system that is structured according to the MILCEA final framework.

Awareness

Status quo: Several Federal Ministries have already initiated campaigns and support structures for combatting violence and abuse in general. These also include awareness raising measures in the area of elder abuse. This is the Federal Ministry of Labour, Social Affairs and Consumer Protection, that for example has funded a brochure for family carers and the general population on abuse against people with dementia. It has also funded several national and regional research projects and networking initiatives to raise awareness and to improve structures in the area of elder abuse. The Federal Ministry of Economy, Family and Youth has been operating and funding a platform against violence within the family

("Plattform gegen die Gewalt in der Familie") for many years. Several (smaller) awareness raising activities have been run by members of the platform on preventing and combatting elder abuse. The Interior Ministry has founded a "Coalition against Violence" which also involves funding smaller projects and awareness raising activities. However, it is not quite clear yet, how much focus will be put on elder abuse. Until now these activities have been run individually and have not been coordinated well between the Ministries.

Future: One important measure with respect to a monitoring framework would be an improved coordination between the involved Federal Ministries. An "inter-ministerial" working group on Elder Abuse has been planned for some time, but has not started its work yet.

Status quo: In the areas of **institutional care and professional home care** the issue of elder abuse is a small part of some of the basic **training for staff members**, but this is not systematically the case. The exact contents and the level of detail depend largely on the initiative of the trainer/teacher. Several provider organisations have been developing and offering training courses for further education in this field. For example, the Austrian Red Cross for example has run two European projects called "Breaking the Taboo" with the aim to raise awareness among and train staff members in the field of professional home care on recognizing and acting with respect to violence against older women within the family. A representative of the patient advocacy in Vienna has been offering training on the issue for staff members of residential homes. The member organisations responsible for older people within the platform against violence within the family have launched and carried out several activities with the aim to raise awareness on elder abuse among the general population as well as among staff members in the field.

Future: The agencies responsible for Care allowance (public authority for social affairs, provincial government offices, social insurance agencies), as well as other organisations and the association of legal guardianship, the patients' advocacy organisations in each of the Austrian provinces should play a role in running awareness raising activities within a framework for a monitoring system in the future. With respect to **informal home care**, the advocacy organisation for informal carers could be involved in such activities. The agencies responsible for care allowance as well as the provider organisations that offer awareness raising and training for informal carers in general could be involved in awareness raising and training for informal carers in the field of elder abuse.

Identification

Status quo. With respect to the identification of abuse, there are general assessment instruments in the field of **institutional care and professional home care** in all provinces. However, these differ from province to province. In some cases, such as in the province of Styria and in Vienna the assessment instrument used by home care providers includes a few indicators and risk factors of abuse. The assessment instruments are authorized by the funding authorities which are part of the provincial governments and which generally provide stan-

dards and guidelines in the field. The supervisory authorities which are also part of the provincial governments conduct inspections in residential homes.

For **home care and professional home care** Agencies Responsible for the Care Allowances (public authority for social affairs, provincial government offices, social insurance agencies), have appointed the Social Insurance of the Famers to carry out the quality assurance for home care (Competence Centre for Quality Assurance), involving home visits with people receiving care allowance and living at home. A new assessment instrument has been developed to use during the home visits. The patient advocacy organisation can be called in any cases where there are difficulties with institutional care and professional care. However, to date they are not responsible for home care that does not involve any professional services. Also, they only react if they are called. In addition, there are long-term care hotlines run by some of the provincial governments as well as a central hotline run by the Ministry for Labour, Social Affairs and Consumer Protection. These focus mainly on issues such as care allowance, finding adequate care services etc. and are not specialised on elder abuse. Apart from that each province has a victim protection organisation, mainly geared towards domestic violence against women and children.

Pro Senectute is an association that offers training and consultancy in the area of long-term care that has been active in the field of preventing elder abuse for many years. They are currently installing a hotline for elder abuse in cooperation with the Ministry for Labour and Social Affairs.

Future: For the institutional setting, inspections could be improved to add indicators of abuse. Use of signal cards or other assessment instruments would be the responsibility of the provincial governments (funding agency). In households where there is no need for care or where family carers provide all the care, doctors and legal guardians would have to play a more important role in recognition and action in the case of elder abuse. In this case the Doctors' Chambers as well as the Association of Legal guardians should be involved. A central institution for recognition and action should be established either nationally or per province. If this would be organised by province, the tasks could be carried out by the provincial patient advocacy organisations. However, they would have to have their responsibility extended to include the informal home care setting. The care hotline within the Social Ministry could be augmented to include cases of abuse or the Pro Senectute hotline could be involved in this.

Action

Status quo: At the moment existing protocols and plans for action are regulated mostly at provincial level or provider level. While there are some rules how to proceed in case a patient/client is in danger there are no systematic plans of action how to proceed in cases of elder abuse. Currently the main involved actors in **institutional care** in cases of elder abuse are the provincial governments as funders and supervisory agencies as well as the patients' advocacy organisations in each province. In professional home care these are the provincial governments, the Competence Centre for Quality Assurance as well as the Agencies re-

sponsible for Care Allowance as well as the patients' advocacy organisations in each province. Currently in the field of informal care at home the Competence Centre for Quality Assurance as well as the Agencies responsible for Care Allowance are involved.

Future: With respect to putting together a national plan of action, the four Ministries: Federal Ministry of Labour, Social Affairs and Consumer Protection, Federal Ministry of Health, Federal Ministry for Internal Affairs, Federal Ministry of Economy, Family and Youth would need to coordinate their activities. As mentioned above an inter-ministerial working group is planned that would be useful for this endeavour.
In addition to the organisations already involved in this issue, it would be advisable to augment the patients' advocacy organisations role to also be responsible for informal home care. Also, doctors and legal guardians should be involved in a systematic way in taking action in the case of elder abuse.

Documentation and Evaluation

Status quo: Currently, several organisations are responsible for documentation and evaluation in the field of long-term care in general. For the field of **institutional care and professional home care** these are the provider organisations, the Funding and Supervisory Authorities (provincial governments), the Agencies Responsible for the Care Allowances (public authority for social affairs, provincial government offices, social insurance agencies) as well as the patient advocacy organisations in each province. In the field of **informal home care** these are the Agencies Responsible for the Care Allowances (public authority for social affairs, provincial government offices, social insurance agencies) as well as the Competence Centre for Quality Assurance.

Future: In the framework of the monitoring system – in addition to the above mentioned stakeholders - the evaluation and documentation on an aggregate level could be collected on provincial level by the provincial governments or by the patient advocacy organisations if they had the status of a central organisation responsible for elder abuse.

Framework: Possible steps in a monitoring system

Institutional and professional home care

Next to general actions (responsibility of care providers and doctors) related to screening of staff members, mandatory certificates of conduct, implementation of Elder Abuse guidelines including. the defined responsibilities within the clearly defined and communicated chain of action, implementation of an regular care assessment instrument, implementation of a screening instrument, instalment of support counsellors (person of trust for both, staff members and residents), sensitisation and education of staff members, the following is recommended:

Identification:

- Raising awareness of involved institutions/ organisations as well as of the general public (especially elder persons) concerning EA
- Raising awareness of the general public (especially elder persons) concerning the new central institution (e.g. hotline)
- Applying a validated regular care assessment instrument that contains indicators and risk factors of all forms of elder abuse (developed or commissioned by the Funding Agencies/ Provincial Governments)
- Applying a screening instrument especially for Elder Abuse that is easy to use and contains only a few items, but that should include all forms of abuse (e.g. EASI)
- Staff trainings on how to use the instruments (by care providers or NPOs)

Action:

- Legal regulations should contain the mandatory reporting of abuse against older people at federal level
- A central institution (e.g. hotline) on provincial level to contact for victims and their families should be established. Its duty would be to connect the client to the institution/ organisation they need for their individual case and setting. The new central institution should be linked to an existing hotline (e.g. supervisory authorities/ provincial government, patients' advocates).
- In case the suspected perpetrator is a staff member:
  - ➔ Immediate protection of all residents/ clients (suspension of work; eventually the staff member should get dismissed)
  - ➔ Resident/ client should get continuous and independent support by support counsellor
  - ➔ Mandatory report to the supervisory agency/ provincial government
  - ➔ In the case of severe physical abuse and/ or stalking the case must be reported to the police
  - ➔ Recording the incident in the certificate of conduct
- In case the suspected perpetrator is not a staff member:
  - ➔ Immediate protection and support of the victim
  - ➔ Mandatory report to patients' advocates or the new central institution
  - ➔ Possible involvement of the police (depending on the nature of the case)

Evaluation:

- Overall report to the supervisory agency/ provincial government (in case of abuse by staff members)
- Assessing the lessons learned and taking extra measures in the nursing home / organisation of care provider for home care
- Continuing to support the victim by a support counsellor

Additionally, for professional home care if perpetrator is not a staff member:

- Overall report to the Agencies Responsible for the Care Allowances, Competence Centre for Quality Assurance, patients' advocates or established central institution (e.g. hotline).

Informal Home Care

With respect to informal home care, the following is recommended:

Identification:

- Raising awareness of the general public (especially older people) concerning Elder Abuse
- Raising awareness of the general public (especially older people) concerning the new central organisation (e.g. hotline)
- Attention has to be paid to stimulating and supporting older people and their environment to report problems related to elder abuse.
- Applying a screening instrument especially for Elder Abuse that is easy to use and contains only a few items, but that should include all forms of abuse (e.g. EASI) [e.g. by general practitioners]
- Training on how to use the instruments (practitioners, legal guardians, Competence Centre for Quality Assurance, Agencies Responsible for the Care Allowances)

Action:

- Legal regulations should contain the mandatory reporting of abuse against older people at federal level
- A central institution (e.g. hotline) on federal level to contact for victims and their families should be established. Its duty would be to connect the client to the institution/ organisation they need for their individual case and setting. The new central institution should be linked to existing organisations and/or hotlines (e.g. supervisory authorities/ provincial government, patients' advocates, Social Ministry's care hotline).
- Immediate protection and support of the client (e.g. by a case manager)
- Mandatory report to the Competence Centre for Quality Assurance, Agencies Responsible for the Care Allowances, patients' advocates or established central institution (e.g. hotline)
- Possible involvement of the police (depending on the nature of the case)

Evaluation:

- Overall report to the Competence Centre for Quality Assurance, Agencies Responsible for the Care Allowances, patients' advocates or established central institution (e.g. hotline)
- Continuing to support the victim by support counsellor (e.g. by a case manager)

4.3.2 Germany

(written by Nadine Schempp, Uwe Brucker and Andrea Kimmel)

The framework recommended by MILCEA needs to be adapted as a national framework that is suited to Germany. The question of how to promote the subject in Germany, with due account taken of the existing context, surfaced back in 1993, when the German Association for Public and Private Welfare set up a forum at the 73rd German Welfare Convention[54] to deal with the subject "Long-term care of older people – a dependency that triggers abuse?". The ways that were suggested at the time to prevent abuse in long-term care can be included in the catalogue of requirements for 2012: no requirement has lost its topicality in the 19 years that have elapsed, because not a single one of the problems described below has been solved:

- Obligation of the different professions (mainly physicians) that have an insight into LTC conditions to ensure that attention is paid to elder abuse
- Checklist to identify relationships exposed to the risk of abuse
- Supervision and control also in home care? (questionable)
- Opportunity for family members who provide care to communicate and discuss their problems
- Presentation on how to encourage alternative behaviour
- Strengthening of the autonomy and competence of people requiring nursing care, as well as of those people providing such care
- Mediation of assistance
- Increasing the professionalism of full-time assistants.[55]

As part of a follow-up project to MILCEA, the MDS plans to develop a German model of a monitoring system designed to prevent elder abuse that also takes account of the historical context. There are different options for setting up such a system on the basis of existing responsibilities. The advantages and disadvantages are outlined below.

Introductory remark

Across Europe, the MILCEA project has identified various inadequate structures that need to be improved, in order to prevent the abuse of elderly people in need of nursing care. Germany is no exception to this. The positive and negative aspects for Germany can be summarised as follows:

- In all nursing-care settings there are rudimentary monitoring structures; these are found least of all in the purely informal nursing-care setting.
- There is no legal basis in Germany for the monitoring (supervision and evaluation) of the abuse of older people in need of nursing care. There is no institution that is directly responsible for preventing elder abuse.
- Responsibilities in the matter of elder abuse are neither regulated nor communicated.

[54] Deutscher Verein , 1994.
[55] Arnold, K., 1994.

- Professionals working in health care for the elderly have only a vague notion of the subject of elder abuse, or of the indicators and risk factors of such abuse.
- Existing procedures for identifying abuse in daily nursing care are not applied.
- Assessment instruments used by some providers (e.g. as part of internal quality management) only take account of some of the indicators and risk factors of abuse.
- While there are quality assurance mechanisms in place in Germany (Nursing Home Supervisory Authorities and Medical Service) for LTC that do include indicators and risk factors, the purpose of these mechanisms is to judge the quality of nursing care provided, rather than to identify abuse of older people in need of nursing care. Whether this present focus on the quality of nursing care clouds the view of elder abuse (rather than sharpens it) remains to be examined.
- As a result, there is widespread helplessness and lack of orientation among professional actors when elder abuse is identified. This leads to an accidental, rather than a targeted and systematic approach to the problem.

While child abuse is (rightly) an important subject debated by society, the abuse of people in need of care, and of senior citizens in general, is not so prominent. That is why a first step in preventing abuse is to alert those who have contact with possible victims of abuse in nursing care – i.e. professionals or voluntary assistants – to the problem: they must start to admit the possibility that abuse may occur in the environment in which they work. Comprehensive information and advanced training campaigns are therefore necessary, especially for members of the medical, social and nursing professions.

If abuse has occurred, the primary objective is to put an end to it. Responsibilities need to be defined and concepts for action need to be developed. Moreover, there must be points of contact that not only offer advice, but that can also arrange temporary accommodation, sleeping and nursing arrangements. In the Netherlands, this has already been introduced. In Germany, it would be opportune to include the many facets of the experience gained with shelters for battered women. Every situation that gives rise to abuse of an older person in need of care has to be analysed thoroughly, in order to identify the causes. Both the victim and the wrongdoer need help that highlights the alternatives and the prospects for a violence-free situation. If all these efforts turn out to be in vain, there must also be a legal mechanism for keeping the wrongdoer away from the victim. To this end, special competence for violence in the home environment should be granted to family courts, so that they can ensure rapid action that is in the best interests of the victim.

Suggestions now follow on how the recommendations of the framework can be implemented in Germany and on which actors could assume specific responsibilities in this process. Various options are introduced, and their implementation is critically debated.

Option 1 – The State Home Supervisory Authority as a monitoring agent

In the setting of full inpatient LTC, it is the legal duty of the State Home Supervisory Authority to protect the interests and welfare of the residents of nursing homes. So far, the state of

Hesse has been the only regional parliament to codify the right to receive nursing care free of abuse. The authority has administrative-law measures available to safeguard this right.

The advantage that the State Home Supervisory Authority has as a monitoring agent for elder abuse is its experience in handling precarious quality issues in long-term care and individual-case consulting, and its knowledge of the nursing-care trade. Moreover, it is authorised by administrative law to intervene to end situations that occasion abuse. To date, the State Home Supervisory Authority has not mounted any targeted investigations into elder abuse in nursing homes. This weakness may be addressed by measures that are relatively simple to implement: certain people who have contact with potential victims of elder abuse in the nursing home could be given an assessment tool to record risk factors and indicators of abuse. The information so gathered would be regularly transmitted to the State Home Supervisory Authority. The Supervisory Authority would provide the person who reports suspected abuse with feedback on its investigations within a fixed timeframe. The person who makes the assessment might be an informal representative of the interests of home residents (a so-called “home spokesperson”) or it might be the person who holds the position of “elder abuse officer”, to be newly created in each nursing home. The latter must be qualified in the subject, be employed by the home and be subject to professional confidentiality. Other possible assessors would be the staff of the medical service, physicians and pharmacists.

Taking a look at the more informal nursing-care setting (i.e. professional nursing support at an old person’s residence), we find there is no structure here that would parallel the one in the formal nursing-care setting, such as the State Home Supervisory Authority. There is no regular contact between a government supervising agent and those people who need care in their residential environment. This gap may be filled legislatively, simply by extending the competence of the State Home Supervisory Authority to include outpatient nursing care. Both the professional nursing care in the residential setting and the setting of informal care could be subject to supervision by the State Home Supervisory Authority if a case of elder abuse occurs; in the case of nursing care provided exclusively by family members, this might include the right/obligation for the State Home Supervisory Authority to approach the family court if it cannot gain access to investigate a suspicion of abuse.

In the case of nursing care provided at an older person’s home, it would be a good idea to give those people who have regular contact with potential victims an assessment tool. The information gathered would be sent at regular intervals to the Supervisory Authority.

The people concerned may be members of the social services, outpatient nursing services or volunteers who, in the course of their activities, come into contact with older persons in need of care. Again, the assessors of the medical services who visit these households and physicians, pharmacists and other people in regular contact should be familiarised with these assessment tools.

Option 2 – Nursing-care consultants and nursing-care bases

Nursing-care bases, which are currently being set up, are another monitoring agent to prevent the abuse of older people in need of care. The consultants and nursing-care bases have the advantage of being close to the old people and of being experienced in providing consultancy, as well as of being familiar with the nursing-care trade. However, there are some disadvantages: the bases are not spread evenly throughout the country; they report to different sponsors; and they are not everywhere accepted by the population. Even the impartiality of the consulting service provided by them is sometimes in doubt. The most important disadvantage appears to be that the main sponsoring bodies of these bases are unwilling to accept the additional burden.

Option 3 – The communal care centre with extended range of tasks (this centre needs to be redesigned)

The communal care centre network has proved its worth over many years and exists throughout the country. An extension of its tasks is under discussion in connection with the redesign of care-control law ("from judicial to social care"). If the task of acting as a monitoring agent was entrusted to the communal care centre, this would have the advantage that the agent is experienced in providing consultancy, is familiar with the older people in need of care from its previous tasks (e.g. production of social expert opinions for the guardianship court) and has experience of cooperation with the family court. Since it is a communal agency at the interface between social matters, health and the family court, it is also independent. The disadvantage is that communal care centres will generally not be in a position to handle the added task of monitoring elder abuse without extra personnel.

A short digression on staffing policy in the field of assistance to the elderly in certain municipalities

People get older and develop a need for nursing care in towns and municipalities. Politico-economic decisions have, in some regions of Germany, resulted in the old, traditional forms of trans-generational family nursing care no longer being feasible: older people (and others in need of care) cannot always be nursed by their children or other members of their family, as the requirements of the labour market and the need to be mobile and flexible mean that younger people have to live and work far away from their increasingly frail parents. There are scarcely any structures in place to support and nurse the parental generation and to provide it with care. Under their communal obligations to provide services to the public, those towns and municipalities in economically underdeveloped regions that have a reduced number of jobs available are faced with a growing problem, which is intensified by the trend towards the single-person household, where even a spouse or live-in companion is lacking.

In recent decades, towns and municipalities have been successful in their efforts to rationalise services – which has also entailed substantial cuts in personnel. In many instances, agencies that assisted senior citizens were slimmed down (or even abolished) in the wake of

the introduction of compulsory long-term care insurance. Much the same fate has befallen many points of contact and advice for old people and people in need of care in rural areas. In view of the demographically driven structural changes in towns and municipalities, the administrations of those towns and municipalities will have to ask themselves (or allow the question) how adequate their old (or new) control instruments are in responding to these demographic changes.

Whatever they may say officially about empty coffers, towns and municipalities will need to bite the bullet and introduce changes to the concept and the staffing of services for the elderly. Instead of resorting to the well-worn rhetoric of "depleted resources", local authorities will need to meet the task head on, with future-oriented concepts that are capable of withstanding the demographic challenge. It should make no essential difference whether the new tasks posed by an aging society that depends on support and assistance are handled in a town or municipality by an existing organisation or are focused in a new organisational unit.

Option 4 – "Agency for the Welfare of the Elderly and Applied Demographics"

The advantages of concentrating monitoring tasks in the hands of a new agency are evident: the traditional tasks of a municipality in the field of "service to the elderly and to seniors" are bundled in with the task that results from the "demographic challenge". It would thus be possible to adapt the communal tasks in the field of service to the public to the changed age structure of the population. Positive experience gathered by youth welfare services appears to be transferable to traditional services for the elderly, in terms of a redesign of the latter's tasks. As a consequence, the old and the newly defined tasks can be aligned. The synergies generated by an agency set up in this way should outweigh the red tape; at least this should be explored scientifically.

Option for a national agency for collecting and evaluating data with regular reporting

A monitoring agency with a proven track record working with the UN Convention on the Rights of Persons with Disabilities is the independent German Institute for Human Rights in Berlin.

Outlook for Germany

The recommendations resulting from the MILCEA project should be evaluated in Germany in a range of towns and municipalities with different structures. The four options described above should be considered as framework recommendations that can be adapted locally. It is necessary (and therefore desirable) that Germany should gather experience of the project as soon as possible, so that the country has a research basis on which to take further steps towards a system for monitoring and preventing elder abuse. Time and the distress of many elderly people are pressing issues.

4.3.3 Luxembourg

(written by Pierre Guernaccini)

Luxembourg doesn't currently have any structure or national plan to prevent or fight elder abuse. An action plan concerning people with dementia has just been developed by an inter-departmental group constituted by members of the Ministry of Family, Ministry of Health and Social Security. This plan includes a focus on abused demented persons and refers to the future conclusions of the MILCEA project. This plan hasn't been yet approved by the Government Council. The following text has to be considered as fictional:
The procedure will be structured around a central organ responsible for:

- gathering descriptions
- appoint a professional in charge of the evaluation
- appoint a professional in charge of the action
- gather documentation

The following procedure is centred on the person at risk and won't make any distinction whether the person is at home or in institutional care and whether the perpetrator is a professional or a private person. The gathered documentation will be the same for the person, not making any difference related to the person's situation or the perpetrator. Each step of the procedure will be realised with the participation of the victim and according to her choices.

Sensitisation to elder abuse – acknowledging the risk factors and indicators

Institutions in charge:

- Ministry of Family and Integration
- Ministry of Health
- Ministry of Education: integrate the topic in the caregiver trainings
- Ministry of Equity in the framework of struggling with domestic violence
- associations interested in the elder abuse topic: Superior Council of Elder People, RBS, AMIPERAS
- local structures: city social offices, senior clubs
- COPAS: organ representing the LTCgivers

Suspicion

Suspicion can come from any citizen (professional or not). Sensitisation campaign will alert everyone to the question and tell them which canal to use to report elder abuse, whether it happens at home or in institution whoever is the perpetrator.
Any suspicion will be documented, purely taking into account the life privacy legislation as well as personal data protection.

Assessment

The assessment will be performed by a professional called upon the organ collecting the descriptions. This professional could be:

- a doctor
- a social worker
- a professional from the health care network
- a professional from another structure
- an agent from an administration concerned by the problem (if this professional can guarantee its dispassion)

Any person performing an assessment will have previously be trained on how to use the assessment tool. Identification of the problem and its seriousness will be performed by the central organ. The action will be entrusted to “field professional”, trained to intervene in such situations. This professional could be:

- a doctor
- a social worker
- a professional from the health care network
- a professional from another structure
- an agent from an administration concerned by the problem

The action choice will be agreed with the victim. The effectiveness of the protection measures will be performed by the central organ, in collaboration with the victim and the agent who took these measures.

4.3.4 Spain

(written by Gema Perez and Javier Yanguas)

Introduction

Since 2010, the government of the Basque Country and the non-profit organisation INGEMA (associated with older and disabled people) have been working on the prevention of elder abuse and neglect. This work has involved several steps. Some have already been carried out, while others will be carried out as soon as possible. They will be described briefly below:

- knowing the prevalence of elder abuse in the Basque Country
- developing and launching a public-awareness campaign against elder abuse
- developing a hotline for elder abuse
- developing a strategic action plan
- developing and implementing training on the issue of elder abuse for professionals working with older people, informal caregivers and older people themselves
- developing and implementing intervention to prevent elder abuse by professionals and informal caregivers.

In the following paragraphs the actions are linked to the MILCEA final framework.

Awareness of EA, knowledge of risk factors and indicators:

Public campaign: In the Basque Country, the government and INGEMA have developed and launched a public-awareness campaign targeting elder abuse in the community and institutional setting. It is the first such campaign developed in Spain and has been carried in the mass media (television and radio) and on posters. The campaign tackled subtle manifestations of elder abuse (like violation of rights and treating the older person like an infant), rather than more explicit manifestations of physical abuse. It is important that other communities and institutions should develop other campaigns. Or perhaps a nationwide campaign could be launched.

Hotline for elder abuse: In the Basque Country a freephone number has been launched to raise awareness and to aid in the detection of elder abuse.

Identification

Prevalence studies: Spain has worked very hard on the identification of elder abuse. It has carried out various studies into the prevalence of elder abuse and risk factors. INGEMA and the government of the Basque Country have carried out a study, too, which shows a prevalence of 0.9% (in a sample of 1,207 people aged 60 years and above). It is thought that no further work is required on prevalence studies.

Risk factors: With respect to risk factors, the INGEMA training plan includes an assessment of risk factors among formal and informal caregivers.

Screening tool: In her dissertation, Gema Pérez Rojo carried out a validation of the Elder Abuse Suspicion Index (EASI). Only one elder abuse screening tool has been designed in Spain (EDMA). This is an observational tool applied by a professional to assess elder abuse and self-neglect. Screening tools are necessary to detect elder abuse, and there is a gap in Spain surrounding them. It is necessary to develop new tools or to conduct validation of the existing tools in Spain.

Hotline for elder abuse

Training: In Spain, different experts in elder abuse train other professionals who come into contact with older people; this will continue in the future. Moreover, the government of the Basque Country and INGEMA have included the topic of elder abuse in a training plan for professionals in contact with older people, informal caregivers and older people themselves. Educational programmes on the issue of elder abuse have been developed.

Action:

Programme on Neglect and Psychological Abuse in Madrid: This is an innovative programme undertaken by Madrid's Town Hall. It kicks in when social services suspect or detect actual elder abuse (neglect and psychological abuse) and refer the older person to this programme,

which treats the victim as responsible of elder abuse. A multidisciplinary team (a psychologist, a social worker and a nurse) work together in this programme, first of all confirming the elder abuse and then intervening and following up. Other communities would do well to replicate this programme.

Training: The training carried out by INGEMA empowers professionals to intervene in elder abuse situations and clarifies their duties to act to protect the potential victim.

Evaluation:
At the moment there is no central registration system in Spain for cases of elder abuse. There is currently no specific law on elder abuse.

Below, the framework is elaborated according to the three settings: long-term institutional care, professional home care and informal home care.

Long-term institutional care

Awareness

- Develop and launch a public-awareness campaign highlighting elder abuse.
- Develop a hotline for elder abuse.

Identification

- Develop a hotline for elder abuse.
- Know as a professional the prevalence of in the Basque Country.
- Know the elder abuse risk factor.
- Have expert professionals apply screening tools.
- Develop and implement training on elder abuse for professionals working with older people.

Action

- Develop a strategic action plan.
- Develop and implement intervention methods for professionals to prevent elder abuse.

Evaluation

- Make a full report to the Health Care Inspectorate (in case of abuse by professionals).
- Assess lessons learned and take extra preventive measures in LTC establishments.
- Provide continuing support for the victim by a trusted person.

Professional home care

Awareness

- Develop and launch a public-awareness campaign highlighting elder abuse.
- Develop a hotline for elder abuse.

Identification

- Develop a hotline for elder abuse.
- Know the prevalence of elder abuse by professionals in the Basque Country.
- Know the elder abuse risk factor.
- Have expert professionals apply screening tools.
- Develop and implement training on elder abuse for professionals working with older people.

Action

- Develop a strategic action plan.
- Develop and implement intervention to prevent elder abuse by professionals.

Evaluation

- Make a full report to the Health Care Inspectorate (in case of abuse by professionals).
- Assess lessons learned and take extra preventive measures in the home care services.
- Provide continuing support for the victim by a trusted person.

Informal home care

Awareness

- Develop and launch a public-awareness campaign on elder abuse.
- Develop a hotline for elder abuse.

Identification

- Develop a hotline for elder abuse.
- Know the prevalence of elder abuse in the Basque Country.
- Know the elder abuse risk factor.
- Have expert professionals apply screening tools.
- Develop and implement training on elder abuse for informal caregivers and older people themselves.

Action

- Develop a strategic action plan.
- Develop and implement intervention to prevent elder abuse by informal caregivers.

Evaluation

- Provide continuing support for the victim by a trusted person.

4.3.5 The Netherlands

(written by Michel Bleijlevens and Jos Schols)

Introduction

In April 2011 the new Dutch government launched a specific, comprehensive action plan 'Seniors in Good Hands' as part of the policy on the prevention of elder abuse and neglect. This plan involved 10 action point which will be described briefly below.

Action Point 1: Prevention

- A guide will be prepared for municipalities with regard to the prevention of elder abuse.
- A project on 'Preventing financial exploitation' will be developed.
- *Action Point 2: Targeted information regarding elder abuse*
- An information campaign about elder abuse is being developed specifically for elderly people themselves and their informal network.

Action Point 3: Screening of paid care staff, including mandatory conduct certificate (VOG) will become obligatory and incorporated in legislation

- A Certificate of (Good) Conduct (VOG) will become mandatory for every professional in the long-term care sector, upon entering the field or upon receiving a new employment contract from a care provider. A guide for screening personnel is also being developed.

Action Point 4: Development of toolkit for volunteer(s) organizations regarding elder abuse

- It will contain guidelines for putting the issue of elder abuse on the agenda, as well as for prevention of and communication about elder abuse.

Action Point 5: Mandatory reporting of elder abuse

- Mandatory reporting for abuse committed by health care professionals, incorporated in a new Mandatory Reporting Act as well as a new Framework Act for Care Institutions.
- Mandatory reporting (code or) protocol for abuse in the community (i.e. at home) incorporated in a new Mandatory Reporting Act.
- Guidelines on reporting and handling elder abuse will be developed for professionals.

Action Point 6: E-learning, training and education

- In collaboration with care industry and professional associations, a training course in the identification and reporting of elder abuse will be developed for professionals.
- A training course in 'elder abuse prevention' will be developed for the local policy infrastructure relating to the elderly.

Action Point 7: Elder-abuse hotlines or reporting points

- A formal hotline/reporting point for EA committed in the home (homely circle) environment will be affiliated with the already existing support offices (centers) of domestic violence.
- A separate elder abuse hotline/reporting point for EA committed by health care professionals is in operation within the Health Care Inspectorate (IGZ), since June 1th 2011.
- Research on the possibility of compulsory cooperation between the support offices of domestic violence and the IGZ, to get aggregated data ultimately.
- Elder abuse will be included in the Social Support Act Registration System and will subsequently provide the support offices of domestic violence with instructions about what to register about EA, to achieve a cumulative national registration.

Action Point 8: Aid and support for victims following a report

- Involvement of intermediary elder guardians after reports of elder abuse.
- Crisis shelters for victims of elder abuse must be arranged in the right way.

Action Point 9: Support for victims of disruptions in informal care

- Include urgency indications for professional care in the case of disruptions in informal care.
- Promote cooperation between support offices of domestic violence and informal care service (support) centers with regard to reports of elder abuse.

Action Point 10: Approach to perpetrators

- Judicial approach to perpetrators.
- Intensified monitoring of elder abuse in health care settings by Health Care Inspectorate (IGZ), starting from 2012.
- IGZ will develop an assessment framework for reports of elder abuse committed by health care professionals, including instructions for health care organizations about what to do in a case of EA committed by one of its professionals.

In the following paragraph the action points of the 10 step Dutch action plan are allocated to the MILCEA final framework and the corresponding responsibilities of the stake holders involved are described:

Awareness of EA, knowledge about risk factors and indicators: action points: 1, 2, 4, 6
Responsible parties: Ministry of Health, Welfare and Sport, municipalities (including support offices domestic violence), Movision, Dutch Organization volunteers, LPBO (National Platform Combatting Elder Abuse, professional organizations/bodies.

From Suspicion via Assessment to Identification: action points: 4, 5, and 6

Responsible parties: Movision, health care providers and their professionals (institutional and home care; e.g. nursing home physicians, general practitioners, nurses and social workers), Welfare organizations and their volunteers, professional organizations/bodies.

Action(s) related to victim and perpetrator: action points: 1(b), 5, 8, 9, and 10
Responsible parties: health care providers (including respite care facilities in cases of crisis), municipalities (crisis shelters), healthcare professionals, social workers, support counselors, police, Dutch Health Care inspectorate, and support offices domestic violence.

Overall documentation in all phases: action point: 7
Responsible parties: Support offices domestic violence (funded by municipalities) and Dutch Health Care Inspectorate being the report centers (hotlines). Healthcare providers, health care professionals, social workers, administrator offices (legal guardians).

In addition to the framework the government has introduced a general policy related to personnel (mandatory conduct certificates for professionals in health care settings, including LTC institutions and professional home care and how to act (mandatory reporting code / protocol) + report (mandatory reporting in case of elder abuse committed by a professional) in cases of elder abuse: action point 1, 3, 4, 5, 7, 9, 10.

Framework applied to Dutch situation in 3 settings:
In the last part the framework is elaborated according to the three settings: Long-term institutional care, professional home care and informal home care.

Long-term institutional care:
Next to general actions (responsibility by care providers) related to screening of paid care staff, including mandatory conduct certificates (VOG), implementation of EA guideline incl. signal cards, screening instrument, assessment protocol and possible case action strategies with determined responsibilities, (multidisciplinary) education of professionals, and installment of support counselors (persons of trust) (for both residents and personnel), the following has to happen:

Identification:

- Applying signal card by members of trained multidisciplinary teams (governed by nursing home physician (NHP);
- Applying screening instrument by members of trained multidisciplinary team (governed by NHP);
- EA assessment according to protocol derived from national guideline (with clear and distinguished responsibilities) by members of trained multidisciplinary team (governed by NHP)

If diagnosis is clear: NHP reports to management of Nursing home and there is mandatory reporting to Health Care Inspectorate in case of abuse by professional or to Support Office domestic violence in other cases.

Action(s):
In case perpetrator is professional:

- Immediate protection of resident (health care professionals, social workers, police)
- Resident gets continuous and independent support by person of trust (e.g. social worker)
- Relevant actions are performed by members of a trained multidisciplinary team (health care professionals, social workers), that eventually is supported by external experts
- Handling of perpetrator (in case of professional suspension of work and eventually the person gets fired
- Inspectorate comes into action (discussion, possible removal from professional register), if necessary report to police.

In case perpetrator is not a professional also:

- Report of elder abuse to support office domestic violence. Support office domestic violence should appoint case manager to organize actions.

Evaluation

- Overall report to Health Care Inspectorate (in case of abuse by professionals).
- Assessing lessons learned and taking extra preventive measures in institute.
- Continuing support victim by person of trust.

Professional home care:
Next to general actions (responsibility by care providers) related to screening of paid care staff, including mandatory conduct certificates (VOG), implementation of EA guideline incl. signal cards, screening instrument, assessment protocol, and possible case action strategies with determined responsibilities, (multidisciplinary) education of professionals and installment of support counselors (persons of trust) (for both clients and personnel), the following has to happen:

Identification

- Applying signal card by professionals of home care organization;
- Applying screening instrument by professionals of home care organization;
- EA assessment according to protocol derived from national guideline (with clear and distinguished responsibilities between nurses home care organizations, general practitioners, nurse practitioners and social workers).

*If diagnosis is clear: report to management of Home care organization and mandatory reporting to Health Care Inspectorate in case of abuse by professional or to Support Office domestic violence in other cases.

Action(s):
In case perpetrator is professional:

- Immediate protection of client (health care professionals, social workers, police).

- Client gets continuous and independent support by person of trust in the community. This could be a social worker or general practitioner. In this case both professionals would act like a case manager.
- Concrete actions coordinated by GP or social worker in collaboration with other healthcare providers (consultation team).
- Handling of perpetrator (in case of professional suspension of work and eventually the person gets fired; Inspectorate comes into action (discussion, possible removal from professional register), if necessary report to police.

In case perpetrator is not a professional also:

- Report of elder abuse to support office domestic violence. Support office domestic violence should appoint case manager to organize actions.

Evaluation:

- Overall report to Health Care Inspectorate (in case of abuse by professionals).
- Assessing lessons learned and taking extra preventive measures in community care.
- Continuing support victim by person of trust.

Informal home care:
Next to raising awareness of elderly themselves, their informal environment etcetera, a lot of attention has to be paid to stimulating and supporting elderly to report problems related to elder abuse, to install independent persons of trust (e.g. GP or social worker), to arrange facilities for crisis shelters, etc.

Identification:

- Conditions have to be formulated in which informal caregivers get aware of the problem of elder abuse and are able to recognize elder abuse. The threshold to report within a safe environment to a person of trust has to be lowered

Action(s):

- Report of elder abuse to support office domestic violence. Support office domestic violence should appoint case manager to organize actions (e.g. social worker)

- Immediate protection of victim (GP, social worker, police)
- Victim gets continuous and independent support by person of trust (case manager)
- Support for victims of elder abuse related to disruptions in informal care has to be arranged (e.g. via urgency indications for professional care, putting victim into crisis shelter or respite care facilities). The general practitioners or case manager (social worker) can initiate this.
- Handling of perpetrator (police, social worker)

Evaluation:

- Continuing support victim by case manager

5 Summary and view

The declared goal of MILCEA, as formulated by the European Commission, was to contribute to the systematic monitoring of elder abuse and, in addition, to develop a common, international framework for monitoring. While MILCEA has done this, monitoring of elder abuse was further defined within the special context of LTC. This also defines the meaning of prevention of abuse and also the requirements that all professional actors in LTC must meet, in order to protect older people against abuse. Prevention includes the recognition of elder abuse and the risk of elder abuse. But since MILCEA defines prevention as going beyond just the recognition of risk factors and indicators, it also includes, for the purposes of a monitoring system, concrete actions to protect the older person.

In order to focus on prevention of elder abuse, it has been necessary first to take stock of the status quo in the participating countries. The LTC systems in different European countries were therefore systematically analysed for the first time in terms of the prevention of elder abuse. A variety of scientific methods were used, including focus groups, actor analysis, literature analysis and interviews. The important point was to identify the strengths and weaknesses of existing structures in preventing elder abuse, so that recommendations could be drawn up for their improvement.

This international comparison revealed the following: monitoring structures already exist in all participating countries and in all care settings. Thus it is not necessary to develop new structures for the prevention of elder abuse; rather, in setting up a monitoring system, existing structures should be used. This is equally true of the informal setting. The family doctor is one of the few professional actors who see beyond the closed doors of the family household. The general practitioner therefore has a key position in the informal setting (though he/she may not yet be aware of it). A stronger positioning and a heightened awareness on the part of these professional actors will be necessary to ensure prevention in the informal setting, too.

So that a monitoring system can be developed on the basis of existing structures, a suitable legal foundation is necessary. Analysis in the different countries has shown that as yet legal regulations concerning the monitoring of elder abuse are absent: there are no institutions with direct legal responsibility for preventing elder abuse. Furthermore, responsibilities concerning elder abuse are not clearly defined or communicated. This is quite surprising, since the topic of quality of care has been discussed in recent years in all the participating countries.

Quality-control mechanisms are in place for LTC in all the participating countries. These include indicators and risk factors that may point to elder abuse; however, their goal is not to assess elder abuse, but to assess quality of care. Perhaps the focus on poor quality of care overall deflects attention from individual cases – e.g. some 10% of all those who receive LTC services suffer from malnutrition; at the individual level, malnutrition might well constitute elder abuse, where immediate action is needed to protect the older person.

On the basis of this stocktaking exercise, recommendations have been drawn up by the partners for how a systematic approach to prevention can be implemented, making use of the existing structures. The framework was developed for use in all countries of Europe, and this has been evaluated by several international experts in the field of elder abuse and/or LTC. The results of the MILCEA project also reveal that further research is necessary. Relevant actors, for example, should be scrutinised in more detail to find out how the issue of elder abuse and responsibilities for its prevention are handled within an organisation. To this end, a qualitative basic approach (e.g. narrative interviews with several representatives of an organisation) would be advisable as a starting point. This would allow the identification of any organisational barriers that stand in the way of a systematic approach to the issue of prevention. What is more, the question of the validity of existing instruments to measure elder abuse still needs to be conclusively answered. Further research is required in this field.

There is a further question surrounding the use of assistance and consultancy services (e.g. helplines) linked directly to elder abuse. Again, further research is necessary, as these services require the exercise of a degree of initiative: elderly people in need of care, family members who provide care, nursing personnel, etc. must get in touch of their own accord with a consulting point or hotline. Whether or not they do so depends on a number of factors. There should be some investigation into which parts of the population can be reached by making such services available and how the barriers that discourage other sections of the population from seeking help can be lowered. In addition, cultural differences in the perception and definition of elder abuse should be examined.

All these questions can only be answered if appropriate research activities are subsidised. The issue of preventing abuse must therefore be of serious concern to the EU Member States and the European Community. The knowledge derived can be used to advance the framework recommendations produced by the MILCEA project and make practical implementation easier. Thus MILCEA should not be seen as a final product, but rather as another

step towards implementing a systematic approach to prevention. It is this aspect that must be kept in mind if the protection and dignity of the older person are to be practical concerns shared by the whole of Europe.

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Appendix

Appendix A: Results of the national Expert meeting
Appendix B: Comparison of indicators used by quantitative instruments
Appendix C: Legal Framework Analysis – national results
Appendix D: Interview Guidelines and Announcement E-mail
Appendix E: National results of the actor analysis (actor maps)
Appendix F: Guideline for the evaluation of the maps and actor profiles

Appendix A: Results of the national Expert meetings

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	1. How is elder abuse perceived in society? Is it taken as a serious problem or are there tendencies to play down its existence? Please discuss hereby possible underlying particular interests
Austria	• Generally not perceived within general public • On expert and policy level the issue has been gaining in importance in the past few years: projects, working groups, campaigns • Opinions of experts depend on their organisational affiliation and experience with topic • Tension between acknowledgement of topic and actual possibilities of intervention • domestic violence against women is a topic that is arrived in the public, but elder abuse, including also men as victims is not a topic • Sexuality and sexual abuse in institutions is a taboo
Germany	• It is not a taboo subject anymore. Elder abuse as a topic has arrived in public discourse and the media. But it is rather limited to spectacular occurrences, mainly in nursery homes. • Elder abuse in families and respective risk conditions is still seldom discussed in public • In the science discourse elder abuse as a topic is arrived (sociology, psychology and gerontology). But Large-sized studies of prevalence, causes and risk factors of elder abuse are still missing. • In the field of politics it is still a minor topic; even the more spectacular occurrences of elder abuse in nursing homes don't influence politics in a long run. As a possible reason: close relationships between the politicians and the care sector • Sexual abuse against older people in need of care is still a taboo subject in public discourse.
Luxembourg	• Elder abuse is a very taboo topic in Luxembourg. It's almost never discussed in public and the mentality in Luxembourg is to keep everything within the familial circle (we use the expression "wash the dirty linen in family"). • At the politic level, the topic hasn't been seriously discussed yet nor has been approached as a "thematic" to discuss.
Spain	• Nowadays the society is sensitised regarding Elder Abuse. • The Knowledge about EA needs to be enhanced. Elder Abuse usually doesn't get detected. Hospital staff needs to be trained in the matter of Elder Abuse. There is lack of resources and knowledge on what to do. • Companies or Long-Term centres are aware of the issue. And they have real interest to prevent EA in order to, sometimes because they have real interest in coping with elder abuse and ongoing preventing actions in order to prevent complaints from users and their families • Low of consciousness of Care professionals about certain behaviours or omissions they do that could be considered elder abuse

The Netherlands	• In general there is interest nowadays, but especially related to the problem of domestic violence. With the action plan **seniors in good hands** there is a shift more towards elder abuse. • In LTC there is in general a lack of awareness, partly because of the taboo resting on EA in LTC-settings and partly because of closing the eyes to the problem, because of unbelief.

	2. How are old age and an old person perceived in your society?
Austria	• In society at large, deficit model predominates (physical and cognitive restraints connected with old age). • Positive and negative view of ageing at the same time • In research and on policy level, many initiatives on active and healthy ageing • Differences between rural and urban areas – city more isolation, urban areas, stronger role of family • General tendency to see ageing and older people in a more negative light than older people within one‘s family (e.g. grandparents)
Germany	• The image of old age is more flexible than in the past • Old Age is rather positive, whereby old people are also seen as a high financial burden (intergenerational contract) • The old age as a factor of discrimination is declining. This is partly the contribution of the gerontology. • But it depends on the fitness of old people. The ideal is still a young and athletic woman or man. Older people are rather seen as positive when there are physically and mentally in a good shape. Contrary: Older people with physical restraints or dementia are rather negatively seen.
Luxembourg	• There are no negative behaviours towards elder people in Luxembourg. They are very well integrated to the society. • Moreover, due to the geographic particularities of Luxembourg (very small country), the elder people are very often in contact with their children who take good care of them and so, are used to meet/respect elder people.
Spain	• The Social value that older people have is changing in the society. • Lack of social value in comparison with children for instance: Lack of respect to elderly persons autonomy, e.g., where to live, at home or in a nursing home.

The Netherlands	• There are two conflicting views of ageing and old age in the Netherlands. • According to the first view, ageing is an unavoidable process of diminishing involvement in the outside world. In this view, old age is equivalent to a decline in social activities and entering the final phase of life in preparation for departing this life. Not only do elderly persons themselves withdraw, but society also withdraws from them. These ideas about old age are known as the **'disengagement theory'** as propounded by Cumming and Henry (1961). • According to the other view, the elderly are by no means counted out; in fact, they are a match for younger adults in many areas. According to this view, the elderly population represents an untapped potential of knowledge and experience. As a result of their (early) retirement from the employment process and their increased life expectancy, they can fulfil new roles. A committed social life is not only good for elderly individuals themselves, but also for society as a whole. This positive view of old age is encapsulated in the **'activities theory'** (Havinghurst 1957).

	3. How are older persons dependent on long-term care perceived and valued in society?
Austria	• Differences between rural and urban area and socio-economic status • Pressure bigger in rural areas to care for relatives at home • In some areas legal regulations: institutional care only possible from fourth level of care • In some areas not enough provisions • People with higher SES and rural areas – more accepted get help • Lower SES – especially women are expected to care without help
Germany	• In general there is an expectation for family members to care for their frail and dependent parts. • The social pressure to care for an older parent or even parent-in-law is high. • Furthermore the priority of out-patient care before in-patient care is defined by law. • Close relatives often have internal conflicts to give up the caring for their older members. • Differences between rural and urban areas
Luxembourg	• It must be distinguished between the origin of the elder person • The citizens from Portuguese origin are used to take care of the parents because it's in their culture but also because they can't afford putting them in a specialised institution. • Concerning the Luxembourg people, they are not used to take care of their parents, so they rather place them in specialised institutions.
Spain	• Strong family ties: Family members must care for elderly relatives with disabilities. There is a strong moral obligation and the social pressure among family members is excessive. • Nursing Homes: The most requested social resource. The situations and conditions in nursing homes are not visible in the pub. Elder abuse gets rather only visible, when there are elder abuse cases on TV news. • Families and societies perception of nursing homes: Ideal and safe place. In reality: There is no exempt from dangers and accidents. There is a need of perception change.
The Netherlands	• Elderly indeed want to stay at their own homes as long as possible; even if they get frail and disabled. • Despite that, LTC is a generally accepted phenomenon in The Netherlands , as well as the reasons for admission to LTC, which are related to situations in which staying at home is not an option anymore!

	4. How do we deal with neglect as one dimension of elder abuse?
Austria	• All dimensions of violence named are important • Should be given as much attention as to other dimensions • Main difference between passive and active neglect is intention/ motivation • Intervention between active and passive neglect must be different • Consider both, but possibly do not differentiate for pragmatic reasons • Do not consider self-neglect
Germany	• Experts wouldn't recommend the terms „active" and „passive" abuse. Instead: It should be differentiated between intended and unintended abuse, since active abuse can be both (intended or unintended). • Neglect should have as much attention as the other dimensions, because it can have severe consequences on the health status • But prevention strategies should be examined separately
Luxembourg	• First of all we have to make a difference between active neglect and passive neglect. Active neglect can be considered as an intention to harm the person but passive neglect occurs way more than active neglect. • Passive neglect is not made on purpose but can be the consequence of a lack of training (for example). We believe neglect is a dimension of abuse, like physical or psychological abuse.
Spain	• There is a general acceptance in scientific literature of neglect as part of the elder abuse concept, self-concept is often not considered. But it is also an important part of abuse.
The Netherlands	• Neglect has to be defined related to bad quality of care and "derailed care". • Very important in this distinction is the issue of intention.

	5. In your opinion, what indicators and risk factors have to be considered in institutional settings and why?
Austria	• Behaviour of residents • Behaviour of staff • Reports by managers, staff, relatives, residents • Appearance • Sedation • Care documentation • Structural / framework conditions
Germany	• Leadership of the facility: how is the atmosphere • Staffing (share of professional caregivers relative to share of residents) • Schedule • Work overload and burnout (Frequency of sickness of staff may give information about work overload) • Own biography of the professional caregiver • Leadership of the facility: how is the atmosphere • Experts reminded to not only regard the caregiver as a “victim”, who is stressed and overloaded with work. Other aspects, independent from the stress situation (e.g. personal characteristics of the caregiver) should be considered
Luxembourg	• Physical and mantel fragility of the elder person are important risk factors. • We also have to consider the kind of pathology affecting this person (even more if it is dementia) and their social activity, to know if they are lonely or not.

Spain	• **Literature**
	  • Education and training needs
	  • Lack of knowledge
	  • Physical and chemical restrictions
	  • Issues increase dependence (diaper, wheel chair)
	  • Equipment, infrastructure
	  • Physical and cognitive dependence
	  • Burnout
	  • Lack of staff
	  • Long-term care
	• **New**
	  • Rules
	  • Overprotection
	  • Institution
	  • Working time (years in the same institution)
	  • Amount of hours worked per day
	  • Satisfaction with work.

The Netherlands	**Risk factors related to the older person:** • Increasing dependence on care by physical and mental (cognitive) deterioration. • Age: the older the person, the greater the chance of abuse. • Gender: women are often victims, especially if they are widowed. • Family History. • Major (life) events. • Social isolation. • Personality traits. • Lack of information. **Risk factors related to the perpetrator (incl. family, relatives, friends and (care) professionals):** • Being overloaded or overburdened. • Burnout. • Interdependency. • Bottlenecks in the etiquette with clients. • Lack of expertise and lack of education. • A negative attitude towards elderly and residents. • Personal problems: psychological problems, addiction problems, personality traits, work related problems, great need for control. **Risk factors related to the (care) organisation:** • Lack of effective policy. • Lack of control: people are not held accountable for the impact of their behaviour or leave. • Dynamics, working climate and culture. • Poor organisation of work. • The institutional regimen itself. • Staff shortages (staff over burdening). • Monitoring and physical structure of the institution. • Unequal gender relations (especially risky for sexual abuse). • Lack of financial means, lack of facilities. • Insufficient quality of care **Risk factors related to the society:** • Too high workload; • Education. • Cutbacks in health care. • Image and discrimination of elderly. • More demand on informal caregivers. **Indicators** • The older (victim) and/or perpetrator give inconsistent and contradictory explanations for physical injuries. • The offender shows himself indifferent to the elderly. • The offender shows signs of strain and stress. • There is cursing and screaming in the presence of the • Professional or (doctor) rescuer. • The older one is depressed and makes an anxious impression. • The older person looks shabby. • Properties and money of an older person are disappearing. • The older person gets no chance to talk to the professional(s) alone. • The parties try to keep professional help outside

	6. **Do you think relevant indicators and risk factors of elder abuse differ between professional home care and institutional settings and if yes, why?**
Austria	• In principle the participants were of the opinion that the relevant indicators and risk factors are mostly the same for all setting. However, some indicators or risk factors are more relevant in practice in certain settings due to the specific situation in each setting.
Germany	• Formal care settings have in common that the leadership of the facility or ambulatory nursing service can influence the quality of care and the risk for elder abuse. • But there are also possible specific risk factors in each care setting (e.g. social isolation is a specific risk factor of out-patient care). • There are specific risk factors of each care setting • Indicators do not differ between the care setting, but there are partially different organisations who come in contact with older people • The list of indicators, which can be examined, may differ
Luxembourg	• The fact to have a caregiver alone with the elder person can be a risk factor (no colleague to notice a potential mistreatment for example). If the caregiver in a home-care situation lacks some skills, it will be hard to notice it.
Spain	• There are possible specific risk factors in each care setting. For example, in institutional setting are the following risk factors: work climate, inadequate staffing levels, workload, lower job and so on and in informal setting are the following risk factors: shared living situation with caregiver, financial dependency of caregiver, family conflicts and so on.
The Netherlands	• In essence maybe no big difference! However: In institutional settings much more specific are the following risk factors: care policy, financial policy (lack of money?), work climate, organisational culture, organisation of work, physical design of institute, possibilities for monitoring and supervision, attention paid to quality of care and to HRM related aspects (incl. staff (shortages) and staff expertise), safety policy. • Moreover in institutions there may be the possibility of residents who may mistreat each other…

	7. In your opinion, what indicators and risk factors have to be considered in professional home care setting and why?
Austria	• Behaviour of client • Behaviour of relatives • Reports • Appearance • Structural/framework conditions • Care documentation **24 hours care:** • Behaviour/characteristics of caregiver • Appearance of client and environment • Structural/framework conditions • Other
Germany	**Formal care at home:** • 24-hour care • Isolation • Lack of staff • Satisfaction with work
Luxembourg	• The client's pathology • The social isolation and the condition of the caregiver (burnout can lead to neglect and violent behaviour)
Spain	**Literature** • Lack of knowledge • Higher dependence of the care-receiver (diaper, wheel chair) • Physical and cognitive impairment • Burnout of staff • Lack of staff **New** • Overprotection • Working time (years in the same institution) • Amount of hours worked per day • Satisfaction with work
The Netherlands	• Here, the risk factors at the level of victim, perpetrator and organisation play also a role; e.g. Health problems of the elderly, caregiver strain, low support / lack of knowledge and professional skills, policy and culture of home care organisation etc.

	8. In your opinion, what indicators and risk factors have to be considered in informal care settings and why?
Austria	• Behaviour of person in need of help and care • Behaviour of relatives • Appearance of person in need of help and care • Isolation • Issues within the family • Financial aspects • Structural / framework conditions
Germany	**Informal home care:** • Subjective perceived aggression and defence of the client • Negative evaluation of the care service • Living situation, for example tight premises • Extent of disturbed sleep at night • Caring for an older person for a long period dependent on clinical picture (dementia, cancer) • At the beginning of an illness it is very difficult: to change the roles and to accept that the personality of the relative is changing • Relationship in the past and present is often the conflict in informal settings (e.g. negative relationship to parent) • Only one person is taking over the care of a relative • Close relationships to the older person, high expectations and wishes • No possibility to get released by another person, time pressure • Problem to cope with the death, to be confronted with death over a long period • Social isolation • Financial motivation to care for a relative
Luxembourg	• Living situation, for example tight premises • Social Isolation • Issues within the family • Skills of caregiver

Spain	• **Literature** – Education and training needs – Lack of knowledge – Increase dependence (diaper, wheel chair) – Physical and cognitive dependence – Burden – Stress – Social support – Resources – Isolation – Pattern of family violence – Family conflicts – Depression – Anxiety – Economic dependence by abuser – Abuse of substances • **New** – Motive of providing care – Overprotection – Values: family ties – Longer period of providing care can be a risk – Satisfaction with providing care – Economic help by Law on the Promotion of Personal Autonomy and Care for Dependent Persons
The Netherlands	• The particular risk levels of victim, offender and family play a role here, including health problems of the elderly, caregiver overload, lack of support, lack of knowledge and skills of the informal caregiver, powerlessness, history of violence, problems in the relationship, loyalty, changing roles in the family….

	9. **Who is organising formal home care in your country? Are there possible differences between existing forms of formal home-care concerning risk of elder abuse?**
Austria	• Participants were of the opinion that there were no substantial differences between existing forms of home-care concerning risk of elder abuse. Formal home care is provided mostly by non-profit organisations and administered, funded and overseen by the provincial governments.
Germany	• There are private and public supplier of ambulatory nursing services • As already mentioned before 24 hours services have a greater risk for abuse. • People from eastern countries are often employed in 24- hour services in Germany. Here possible risk factors are: The person is often living together with the person in need of care; language problems
Luxembourg	• Most of the home care is performed by 3 help and care networks. (see second question)
Spain	• There are private, non-profit making organisations and public providers.
The Netherlands	• Currently, next to the traditional home care providers there are more and more new home care providers especially commercial ones! • In the last 3 years more reports have been made in the media and by the Health Care Inspectorate that there are problems related to the quality of care of these new providers (including cases of EA!)

	10. Do we have to consider an illness related perspective concerning risk factors for elder abuse?
Austria	• Certain diseases are perceived as being risk factors for abuse in themselves: dementia, stroke, mental illness, chronic illness, high level of care
Germany	• Because the time was running out this question was left over. Our answer: Illness like dementia are possible risk factors itself • One explanation therefore is that people who had a stroke or have dementia are maybe more dependent on help than others. • But there are also specific risk factors of a specific kind of illness. For example: a person with dementia probably needs a high extent of supervision, whereby a person who is having cancer doesn't need much supervision. • Therefore we think it is important to have a look to the specific risk factors dependent on the kind of illness.
Luxembourg	• Yes, mainly dementia.
Spain	• Yes, e.g. mental illness, substance abuse, etc.
The Netherlands	• In fact every chronic disease may predispose for EA because of the dependency of the patients suffering from them. • Certain diseases can cause challenging behaviour that is difficult to handle; e.g. explicitly aggressive behaviour, claiming behaviour, constantly saying or doing the same thing etc. This can be due to dementia or stroke, but not every older person with dementia or a stroke exhibits this behaviour.

	11. Do you think that indicators/risk factors have to be seen in the context of national background?
Austria	• No country specificities perceived, however difference between rural and urban areas
Germany	• We think that some national specialties have to be taken into account. In Germany there is for example still a high pressure on family members to care for their older parts. This might be a risk factor for abuse.
Luxembourg	• Risk factors must be considered regarding the cultural environment. For example, several behaviours can be considered in relation with a specific religion or geographic area. The whole environment must be considered in order to clearly identify the indicators and risk factors.
Spain	• There are no studies in Spain dealing with this question, but there might be differences depending on cultural differences
The Netherlands	• Social and cultural factors may influence the occurrence of EA in different countries. • Each country may differ with regard to e.g. legislation, individualisation, economics, the way in which care is regulated, how the perception is of older people, how family relationships are, what the norms and values are etc. • But no country will be free of elder abuse….

	12. What do you think are the goals of a monitoring system? What functions have to be fulfilled by a monitoring system of elder abuse?
Austria	• Monitoring system has to be developed together with general system of quality assurance • Development of monitoring system has to be seen in the context of concrete steps of intervention • Definitions of boundaries between abuse and bad quality of care • Staff has to know where to go if they perceive abuse against an older person • Information on which steps to take needs to be improved • Training staff on issue of elder abuse • Organisations / institutions need to have a clear point of view on violence prevention
Germany	• A monitoring system should recognise and prevent abuse in an early state. It should function as a control mechanism. • Development of a monitoring system which is orientated on the probability of elder abuse **Existing Monitoring-Systems:** • checklist for doctors • statistical data • autopsy • police • helpline, institutions for consultancy
Luxembourg	**It must gather elder abuse data in order to :** • Inform and make aware the public, associations, health care networks, caregivers (in the same way it is already done in the childhood field) • Participate to actions enabling the protection of vulnerable elder people • Report to political institutions what is the current situation • Participate to scientific researches • Help people to understand what they have to do if they face a situation of abuse and who they have to contact • This system must absolutely NOT be a “suspicion tool” triggering a “witch-hunt”

Spain	**Objectives of a monitoring system:**
	• Dissemination information and training, Previous sensitisation
	• Protocol to identify risk factors through indicators:
	  • Should take into account all the stakeholders. Multidisciplinary. Flexible.
	  • To establish risk groups (high, moderate, low) Different interventions with health professionals once identified all the risk groups.
	  • Timetable and resources to apply the protocol Suspected abuse ≠ actual abuse
	  • Process: detection, confirmation, intervention, follow up
	• Sanitary and social settings:
	  • Common and different items
	  • The same with different professionals
	• Easy application
	  • Nursing Homes
	• Multidisciplinary groups.
	• Common criteria.
	• Detection elder abuse

The Netherlands	• Registration: to know how often it occurs (whom, where, how, etc).
	• Identifying and addressing the problem: to stop the violence and to offer help and support…
	• To develop policies aimed at prevention and treatment.
	• According to the **"Noord Hollands EA protocol"**:
	• Suspicion
	  − Mapping of signals; screening on EA
	• Consult
	  − Colleague, supervisor, support office domestic violence
	• Gather information
	  − Observe, register, check, appoint case manager and prepare action
	• Action
	  − Organise help
	• Evaluation and aftercare
	  − Suspicion underpinned, tailor-made step-by-step-plan

	13. Who is getting in contact with older people and/or perpetrators and is in position to detect elder abuse?
Austria	• Neighbours • Relatives • Staff members of home care services • Other residents • Representatives of associations and trade unions • GP‘s / doctors were seen as an especially important group. They frequently report cases.
Germany	**Actors that might be relevant in all Settings** • Helpdesk, information centre for care issues • General practitioner • Legal agent (gesetzlicher Betreuer) • Guardianship magistrate (Betreuungsrichter) • Professional home care • MDK (inspections) • Clergymen • Social psychiatric service • Meals on wheels • Clergymen **Professional institutional care** • PFK • MDK • Home supervisory authority • Volunteers • Public health department • Guardianship judge • Speech therapist, ergo therapy
Luxembourg	• Mainly the doctor. Other actors such as parents, informal caregivers can also detect an abuse situation but the doctor is usually in the best position to do it. • But it would be relevant to set up a dedicated institution able to step in this area to notice some situation that other actors could miss.
Spain	• Neighbours • Family • Friends • Other residents in institutions • Professionals in contact with older people: Inspectors, Staff members of home care services, Health professionals such as GP‘s, nurses • Hospital staff, Social services, Banker, and so on.

The Netherlands	**All professionals who work with (frail) elderly people and may face the problem of EA:** • Professionals in social work, mental health, • Nursing home staff • General practitioners • Elderly consultants, elderly workers • Home care workers • Local health workers • Caregiver and nurses, police • Support centres for informal care and family care • Informal caregivers • Neighbours • Bystanders etc.

Appendix B: Comparison of indicators used by quantitative instruments[1]

Instruments	EAI	EASI	BASE	MCTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis and Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hawlek (1986)
Type of abuse						
Physical abuse/ Sexual abuse	Possible abuse indicators: Bruising, lacerations, fractures, various stages of healing of any bruises or fractures, evidence of sexual abuse, statement by older adult related to abuse	It is asked whether anyone touched older person in ways he or she did not want, or if anyone hurt the person physically. Doctor's assessment: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last	It is asked if there is a suspect for abuse and if yes, it should be indicated which kind of abuse is suspected (physical abuse is one option)	(1) whether the carers had been afraid to might hurt them (2) whether they had withheld food (3) whether they had hit or slapped them (4) whether they had shaken or (5) handled them roughly in other ways	If older person expresses, either verbally or through behaviour, fear toward a family member or caregiver It is assessed if unexplained injuries, broken bones or burns that do not fit the clinical picture or realm of reasonable possibility given the circumstance.	It is asked if anyone tried to hurt or harm the older person recently. It is asked if someone forced the person to do things he or she didn't want to and if person trusts most family members.

[1] The classification of the several abuse indicators of the presented instruments to the various abuse types is based on the opinion of the authors of this report.

Instruments	EAI	EASI	BASE	MCTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis and Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hawlek (1986)
Type of abuse						
Psychosocial abuse	Dimension not included	Person is asked if someone talked to person in a way that made her/him feel shamed or threatened	It is asked if there is a suspect for abuse and if yes, it should be indicated which kind of abuse is suspected (physic-social abuse is one option)	5 measures: (1) Screamed or shouted at the care receiver (2)Used a harsh tone of voice, insulted, sworn at, or called them names (3)Threatened to send them to care home (4)Threatened to stop taking care (5) threatened to use physical force on them	Whether older person expresses, either verbally or through behaviour, fear toward a family member or caregiver	It is asked - whether person is often sad or lonely - whether person feels uncomfortable with anyone in his/her family - whether he/or she feels that nobody wants him/her around - if someone makes person stay in bed or tell person is sick when he or she knows it's not true - if anyone told person gives them too much trouble - whether person has enough privacy at home

Instruments	EAI	EASI	BASE	MCTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis and Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hawlek (1986)
Type of abuse						
Neglect	Contractures, decubiti, dehydration, Diarrhoea, depression, impaction, malnutrition, urine burns, poor hygiene, failure to respond to warning of obvious disease, inappropriate medications (over/under), repetitive hospital admissions due to probable failure of health care surveillance, statement by older adult related to neglect **possible abandonment indicators:** evidence that a caretaker has withdrawn care precipitously without alternate arrangements	Person is asked whether someone has prevented him/her from getting food, clothes medication, glasses, hearing aids or medical care, or from people person wanted to be with	It is asked whether there is a suspect for abuse and if yes, it should be indicated which kind of abuse is suspected (neglect is one option)	Dimension not included	Whether the older person had a serious or life-threatening situation or conditions go untreated or appropriately acknowledged. The situation may put the person at risk of death or complications that impinge on physical and mental health	Dimension not included

Instruments	EAI	EASI	BASE	MCTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis and Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hawlek (1986)
Type of abuse						
Neglect	evidence that an older adult is left alone in an unsafe environment for extended periods of time without adequate support, statement by older adult related to abandonment					

Instruments	EAI	EASI	BASE	MCTS	MDS-HC	H-S/EAST
Source	Fulmer (2003)	Yaffe et al. (2008)	Reis and Nahmiash (1998)	Strauss (1978)	Morris et al. (1997)	Hawlek (1986)
Type of abuse						
Financial exploitation	a) Misuse of money b) evidence c) Reports of demands for goods in exchange for services d) inability to account for money/property e) statement by older adult related to exploitation additional comments:	It is asked whether anyone tried to force person to sign papers or use person's money against his or her will	It is asked if there is a suspect for abuse and if yes, it should be indicated which kind of abuse is suspected (financial exploitation is one option)	Dimension not included	Dimension not included	If anyone has taken things that belong to person without his or her ok

Appendix C: Legal Framework Analysis

Analysis of the legal outline conditions

Q1: In democratic, social and constitutional states basic rights for its citizens are verbalised in the constitution. Especially frail and dependent citizens, like older people in need of care are protected in particular ways.
How are these rights expressed in the constitution of your state?

Q2: Are there special laws protecting the rights of older people, people in need of care and mentally impaired persons?

Q3: Legal outline conditions specifically related to long-term Care
Q3.1: What kinds of measures/actors protect the rights of older people in need of care?
Q3.2: Are there specific laws in the field of long-term care that ensure the protection of the rights of older people in need of care?

Q4: Are there gaps concerning the effective and sustainable protection of the rights of older people and people in need of care?

Q5: Is the existing administrative infrastructure sufficient to enforce the rights of the already existing laws/norms?

Q6: Which infrastructure must be build up for an effective and sustainable monitoring system for detecting and preventing abuse of older people in need of care?

Summary of the analysis of the legal outline conditions

Legal Frame	A	E	G	LU	NL
Q1: Constitutional Protection					
All citizens are equal before the law	X	X	X	X	X
No discrimination of any disability	X	X	X	X	X
Equality of women and men	X	X	X	X	X
right to respect for privacy		X		X	X
right to inviolability of the body			X		X
right to health care, implicating a responsibility (duty to exercise) of the government on health protection and health promotion (incl. prevention), availability and accessibility of care, quality of care and financial accessibility of care		X			X
State ensures, by suitable and up to date periodical pensions, the economic capacity of elder people. Independently of the familiar duties it will promote their well-being by a social services system that assists their specific problems (health, housing, culture and leisure)		X			X
Mention or protection of older people?	no	YES	no	no	no
Q2: laws to protect rights of older people, people in need of care and mentally impaired persons					
Criminal Code (forbidden and sanctioned by law):					
Abuse of defenceless person (ill, frail etc)	X	X		X	X
Crude mistreat or crucify a defenceless or frail person living in a care home or in the same household or in duty of care	X	X	X		X
To abandon a frail person in a helpless situation	X	X	X	X	X
Sexual abuse of a helpless and ill person in a hospital or care facility	X		X		X
Sexual abuse of a person who is entrusted to care due to his/her disability, mental or physical disease	X		X		X
Issuing of false medical certificate, e.g. related to the cause of a death	X				X
Violating confidentiality by professionals such as doctors		X		X	X
Offences against life: euthanasia, incitement to suicide, assisted suicide	X	X		X	X
Public code:					
Law on the Gender Violence/Family violence	X	X		X	not
Law on the (regulation of) medical treatment contract, with the associated patient rights, including the representation of patients who are not able to give informed consent	x		X		X
Planned law: Mandatory reporting act and Framework Act for care		X	X		X
Protection of the personal freedom of vulnerable	X	X	X		X

persons who are in need of care due to their age, illness or disability regulating the conditions and the provision of checks regarding restrictions of freedom in homes					
Care Allowance Act provides for home calls with regard to quality assurance in order to check whether the care allowance recipient receives adequate care	X	X	X	X	
Legal regulations for physicians/ health and nursing care act: designed to protect older people in need of care since they stipulate the duty of disclosure in case of grievous bodily harm or death		X			X
Law protecting children	X	X	X		X
Law protecting older persons in need of care	X		-	X	-
Social Support Act	-			-	X
Act regulating Complaint(s) Health Care Clients	X	X			X
Care Quality Act for Health Care Institutions with demands on healthcare providers regarding the quality of their care	X	-	X		X
The Medical Research Involving Human Subjects Act = related to scientific research with human beings		X			X
Law on Organ Donation (transplantation)	X		X		X
Law on the medical preventive examination of the population		X			X
Equal Treatment Act	X	X			X
The right of elder persons to receive nourishment	X				
Law for the Promotion of Personal Autonomy and Care for Dependent Persons		X			
In some autonomous regions, like Andalucía and Castilla y León, there are laws for the protection of elder people		X			
In each region: Social Services Law to protect the rights of all people included vulnerable groups		X			X
Q3.: Legal outline conditions specifically related to long-term care					
Q3.1.: What kinds of measures/actors protect the rights of older people in need of care?					
The police and consequently the courts take care of the criminal prosecution	X	X	X	X	X
Police can evict the perpetrator from the property and prohibit him or her to enter the premises as well as court assistance and advisory service for the victim	X	X	X	X	X
Police can evict the perpetrator from the property and prohibiting him or her to enter the premises		X	X	X	
The district court is responsible for checking whether a restriction of personal freedom of movement is legal (only for Home Residents)	X	X	X		

Social insurance carriers are in charge of	X		X	X	X

implementing quality assurance measures by controlling it					
Inspectors assess the quality standards are met	X	X	X	X	X
Legal guardianship	X		X	X	X
Mentorship for adults		X			X
Psychiatric Hospitals (Compulsory Admissions) Act			X		X
In-house emergency call	X		X	X	
Regional centres of animation and assistance		X		X	
The Social Office: aims at ensuring that every person receives the adequate, individualised services to maintain autonomy				X	
Senior hotline	X		X	X	not
Mediator with the mission to receive claims of every person thinking being harmed because of the State administration		X		X	
Elder People Superior Council: Notify each governmental measures in the interests of elder people Advise policy makers about the national plan concerning “third and fourth aged people”; Promote seniors’ rights				X	X = anbo
Q3.2.: **Are there specific laws in the field of long-term care that ensure the protection of the rights of older people in need of care?**					
Regional Social welfare laws provides for assistance in case of domestic violence, special temporary accommodation facilities as well as support and consulting services offering help in order to cope with the violence experienced and to develop new life perspectives	X			X	
Management of LTC facilities have a general responsibility of the law related policies in their organisations, the execution of guidelines and directives		X			X
The norms regulating the organisation of homes for the elderly and nursing homes pertain to quality standards. Authorities have of the right to supervise and monitor homes in order to inspect these homes and their quality of care. If the residents' life or health is endangered, the operating license can be withdrawn and the home has to be closed	X		X		X
Management of LTC facilities must guarantee a climate in which clients/ residents can execute a participating role in the organisation		X Some regions			X
Each health care professional must work according to the rule of their organisation		X	X		X
Each health care professional must work according to the health care professions act which aims to monitor and promote professionals practice and quality including a legal disciplinary jurisdiction		X			X
Funding norms aiming at mobile care and support services: the care organisations have to meet certain criteria in order to receive funding. Except for the Social Vienna funds' norm concerning the obligation to inform the authorities in case the client	X				

is endangered, there are no other norms which deal with the topic of protection against violence against older people who receive care. The Social Vienna funds' norm stipulates how to proceed in case the person in need of care is endangered, e.g. by third party negligence. It addresses organisations which receive funding from the Social Vienna funds'.					
Treatment contract signed by the client			X	X	X
Visits of health Care inspectorate with obligating recommendations and possibility of sanctions	X	X	X		X
Visits of Medical Advisory Service (MDK) with recommendations and possible sanctions of the LTC Insurance		X	X		
Transparent reports, web published (critically discussed and under reconstruction in Germany)			X		X
Institutions which serve as contact centres and take on patients' legal representation. They provide assistance for citizens on the basis of the Federal states' laws. There are, for example, a health and patients' legal representation in the Burgenland and respectively a care and patients' legal representation in Vienna which take care of protecting patients' rights and interests in all fields of the health care system and deal with complaints filed in homes for the elderly and nursing homes	X	X	X	X	X
Q4: *Gaps concerning the effective and sustainable protection of the rights of older people and people in need of care?*					
lack of coordination between the actors			X	X	
lack of efficient use of the existing capital/resources		X		X	
Concerning elder abuse: the major lack is the non-conceptualisation of the topic, mainly elder people at home			X	X	
Q5 *Is the existing administrative infrastructure sufficient to ensure existing laws and norms?* The partners agree that existing administrative structure is largely sufficient. But the legal mandate to protect elder abuse is missing.	X				
Q6: Infrastructure to be build up for an effective and sustainable monitoring system for detecting and preventing abuse of older people in need of care					
separate prevention and intervention of elder abuse			X	X	X = planned
set up trainings and tools which can be used by health care providers				X	X = planned
collaboration between home care networks and social workers		X		X	
foresee a dedicated structure able to collect all the		X			X =

abuse claims and perform an effective and efficient follow-up					planned
Each autonomous region has norms to warrant the rights of people that live there		X			
The majority of institutions have complaint mailboxes, statutes, rights letters etc		X			X
It is necessary a change in the assistance model and a change in social and professional attitudes to elder people		X			X = planned
Collecting in formations, when elder abuse is suspicious: GP, nurses, emergency staff, inspectors, researchers, family, friends, neighbours	X	X	X	X	X
Training of Call centre staff of emergency numbers		X	X		
Identify signs and symptoms of elder abuse. And moreover it is necessary a register which allows the following of the case and develop an agile derivation system to suitable professionals		X	X		X = planned

Appendix D: Interview Guidelines and Announcement E-mail

Raster of the Announcement e-mail:

Dear Sir or Madam,

The “Name of your institute/organisation” is involved in a European Project aiming at preventing elder abuse.
Currently we are gathering information about “e.g. German” organisations that are getting in contact with older people in need of care and might have the potential to recognise elder abuse.
We thought that as X (role of the person) in the institution Y, you might be able to give us some relevant information on this topic. It would be of great help for us if you answered our questions? The interview would take about 20 minutes. We will call you in this matter in the next few days.
For additional information, please visit our website at www.milcea.eu.

Yours truly,
Name of Project Partner

Interview guideline / document analysis:

Please inform yourself before you start with the interview in which setting the organisation is working (informal home care, professional home care, and institutional care). If the organisation is working in several settings, please go through the guideline for each setting, because the answers could differ between the settings.

Introductory Text

(Introduce yourself) ... I'm working on the EU Project MILCEA. Have you received our E-mail?

If Yes:	**If No:**
As we wrote in our Email we are surveying institutions or persons who come in contact with older people in need of care and are able to detect elder abuse. In this context we would like to make an interview with you over the phone. It takes about 10 minutes and the data will be kept anonymous. Would you take part in an interview?	**Let me please shortly describe the European project MILCEA. The topic of our project is elder abuse in long-term care. The Goal is to contribute to the recognition and monitoring of elder abuse. Currently we are surveying institutions that come in contact with older people in need of care. In this context we would like to make an interview with you. It takes about 10 minutes and the data will be kept anonymous. Would you take part in an interview?**

If Yes:	**If No:**
When would you prefer to have the interview? We can start right now or make an appointment.	**Can I ask why you don't like to take part? (see possible doubts and possible reactions on it)**

Subject	Example	Possible Reactions to persuade the Participant
Privacy Matters	The person is worried about giving information and this information can be tracked to the person.	Try to ensure the participant that the data will be kept anonymous.
Integrity and Security Matters	Person is worrying that the interviewer is not telling the truth.	Pass him/her the web address on and offer to call later again when he/she has informed himself/herself about MILCEA.
Duration of the Interview	Person thinks Interview might be too long/not enough time for it.	Point out the importance of the interview for MILCEA and the development of a monitoring system of elder abuse.
Insufficient Knowledge to answer/not the right Person	Person thinks that he/she is not the right person to ask in this interview.	Ensure yourself if you have the right person on the phone and he/she is in the possibility to ask the questions. Otherwise ask for the name of the person who should be interviewed instead.

Interview Guideline for Organisations/Actors in LTC:

Type of Organisation: _____
Position of the Respondent: _____

1.) Who are your clients? (older people in need of care, older people in general, people that are dependent on care in general, caregiver)

2.) What's the main task of your organisation/work?

3.) What is the responsibility of your organisation with respect to monitoring elder abuse in long-term care? Is there a legal basis that demands your action in monitoring/recognising abuse of older people in long-term care?

4.) On what level is your organisation working? (e.g. federal level, state level)

5.) Dou you use an instrument/guideline that assesses elder abuse? If not, do you use an instrument which includes indicators or risk factors of elder abuse (e.g. an instrument to assess quality of care)?

If no, skip questions 5.1. to 5.6. and continue with question 6.).

5.1.) What kind of instrument do you use? What kind of procedure is used (face-to face interview, interview over the phone, observation, physical examination) Can you describe the function of the instrument shortly?

5.2.) In the following I'm going to read out a list of indicators for elder abuse. Which of these indicators are assessed by the instrument/guideline?

5.3.) In the following I'm going to read out a list of risk factors for elder abuse. Which of these risk factors are assessed by the instrument/guideline?

5.4.) Is there a documentation of the data? Who has access to the data (e.g. public access, access only for particular groups or institutions, please name these particular groups or institutions)?

5.5.) Are you exchanging information with other organisations?

5.6.) What would you do if there is a suspicion of elder abuse? Is there someone you would contact inside or outside your organisation?

STOP INTERVIEW (Place for further Remarks of the Respondent on the last page)

If Answer of question 5 is No:

6.) Do you have a contact sheet that includes facts about the older person and his/her life situation?

If no, continue with question 8

6.1.) In the following I'm going to read out a list of risk factors for elder abuse. Which of these risk factors are assessed by the contact sheet (read out risk factors of the list)?

6.2.) What would you do if there is a suspicion of elder abuse? Is there a person or position in your organisation that should be informed when there is a suspicion of elder abuse? What institution should be contacted outside your organisation?

7.) Do you have any documentation of your contact to the older person/caregiver? If yes is there a specific raster of the documentation? Can you describe it, please?

STOP INTERVIEW (Place for further Remarks of the Respondent on the last page)

If Answer to 6.) is no:

8.) Do you have any documentation of your contact to the older person/caregiver? If yes, is there a specific raster of the documentation? Can you describe it, please?

8.1.) What would you do if there is a suspicion of elder abuse? Is there a person or position in your organisation that should be informed when there is a suspicion of elder abuse? What institution should be contacted outside your organisation?

Other Remarks of the Respondent here:

_____

_____

_____

_____

Interview guideline Policy:

All of the following questions should be asked in the interview:

Position of the respondent: _____
Setting: _____

1.) Under which conditions do you start to investigate elder abuse?

2.) On how many cases on elder abuse are you investigating during the year in average?

3.) Who informs you usually about a suspicion on elder abuse?

4.) If you get the information that there might be a case of abuse, how would you start with your investigation? Can you describe the procedure of your investigation?

Further remarks of the respondent:

_____
_____
_____
_____

Interview guideline doctors (general practitioners, emergency doctors):

All of the following questions should be asked in the interview:

Position of the respondent: _____
Setting: _____

1.) Is the assessment of elder abuse part of the anamneses of older people in need of care?

2.) Is there a legal basis for your action in monitoring or detecting elder abuse in long-term care?

3.) Is there a guideline for doctors that can/should be used in the assessment of elder abuse? How does it look like?

4.) Do you have a contact sheet that includes facts about the older person and his/her life situation?

If no, skip question 4 and continue with 5.

4.1.) In the following I'm going to read out a list of risk factors for elder abuse. Which of these risk factors are assessed by the contact sheet (read out risk factors of the list)?

5.) What would you do if there is a suspicion of elder abuse?

Further remarks of the respondent:

_____

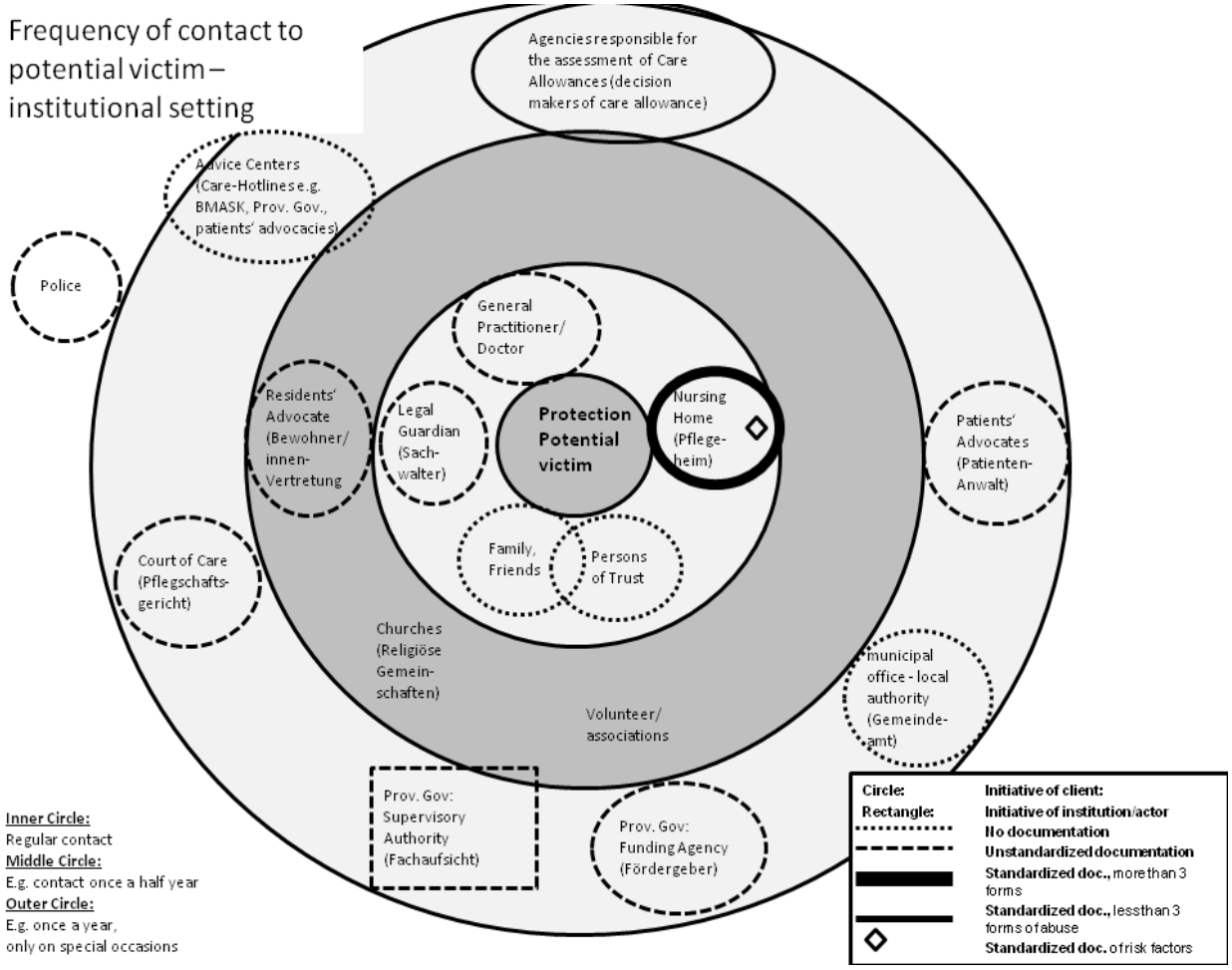
_____

_____

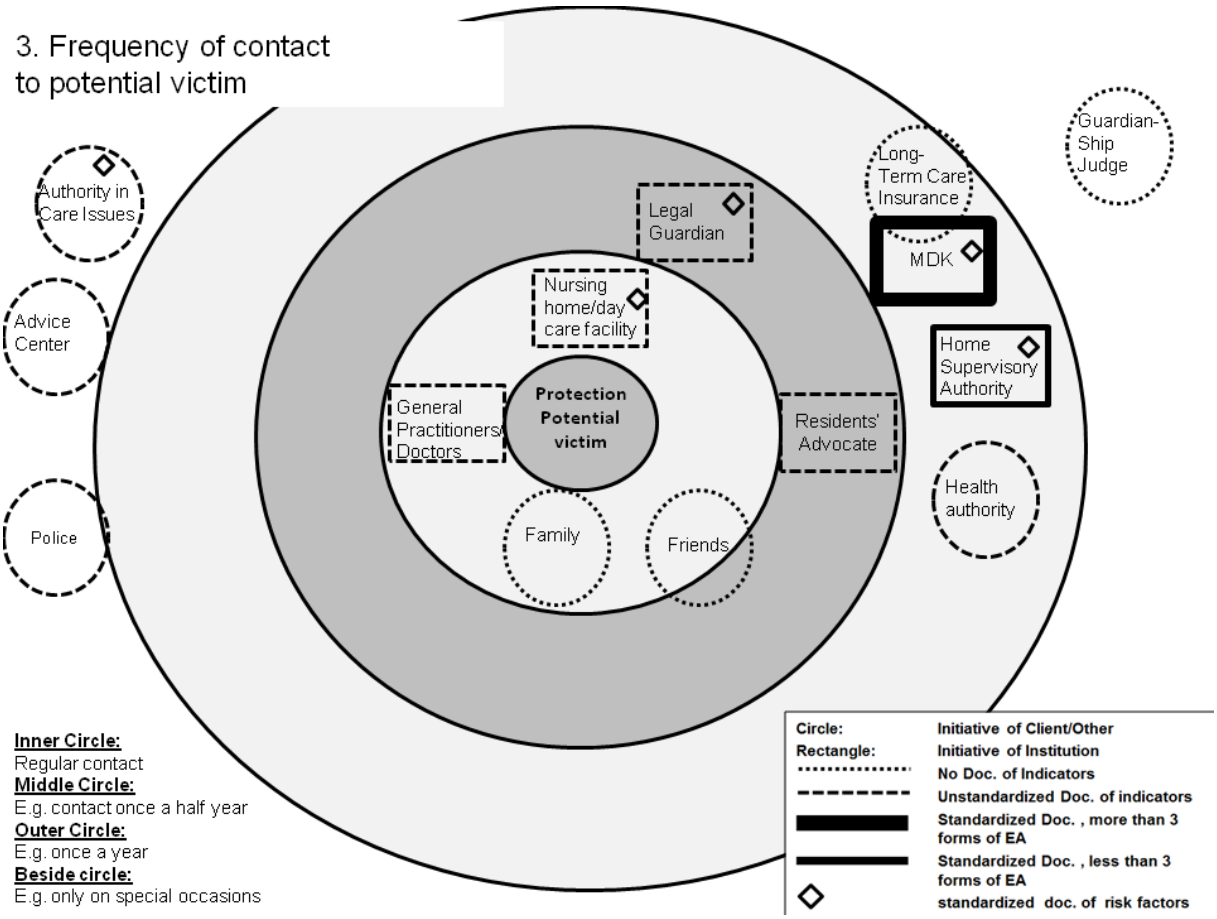
_____

Appendix E: Relevant institutions pictured in "Actor Maps"

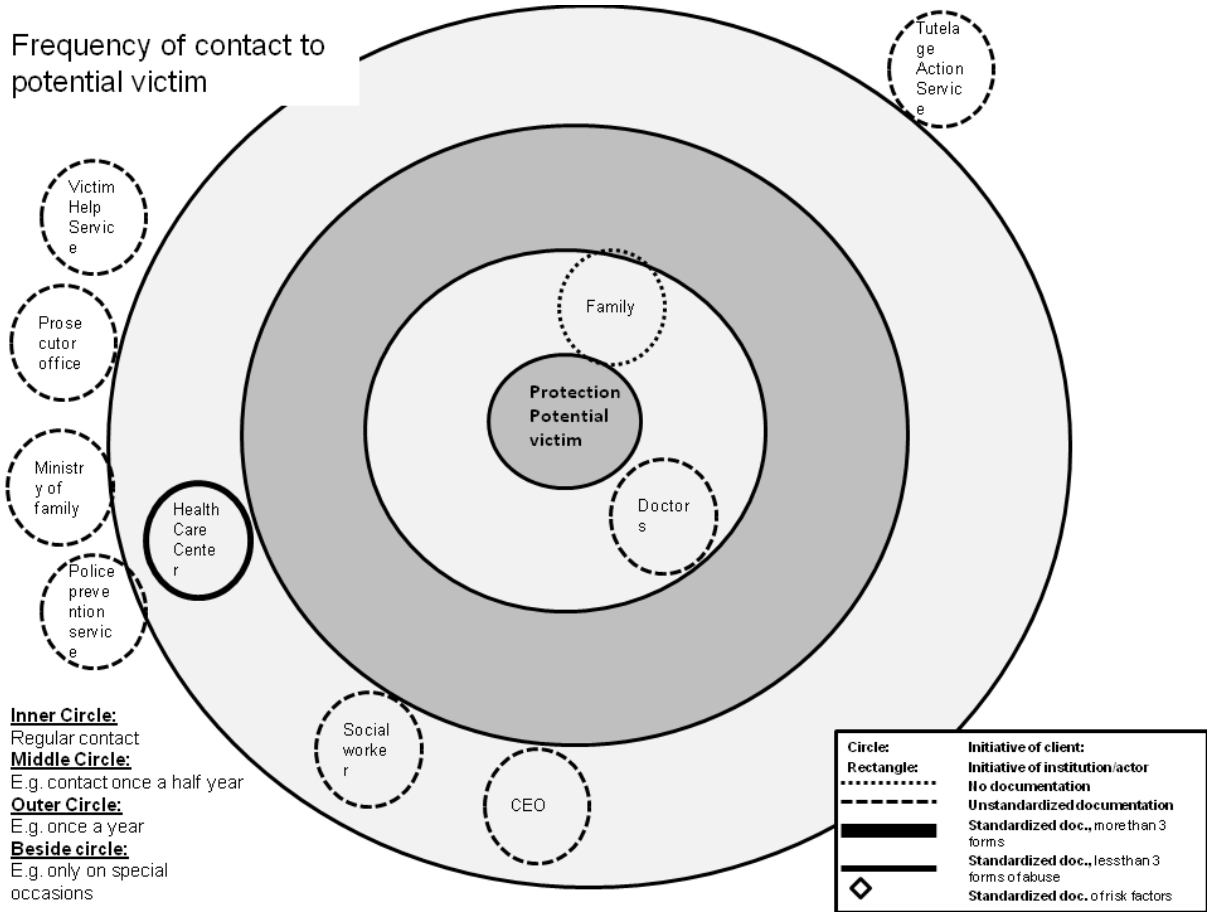
Austrian institutions/actors in institutional care setting



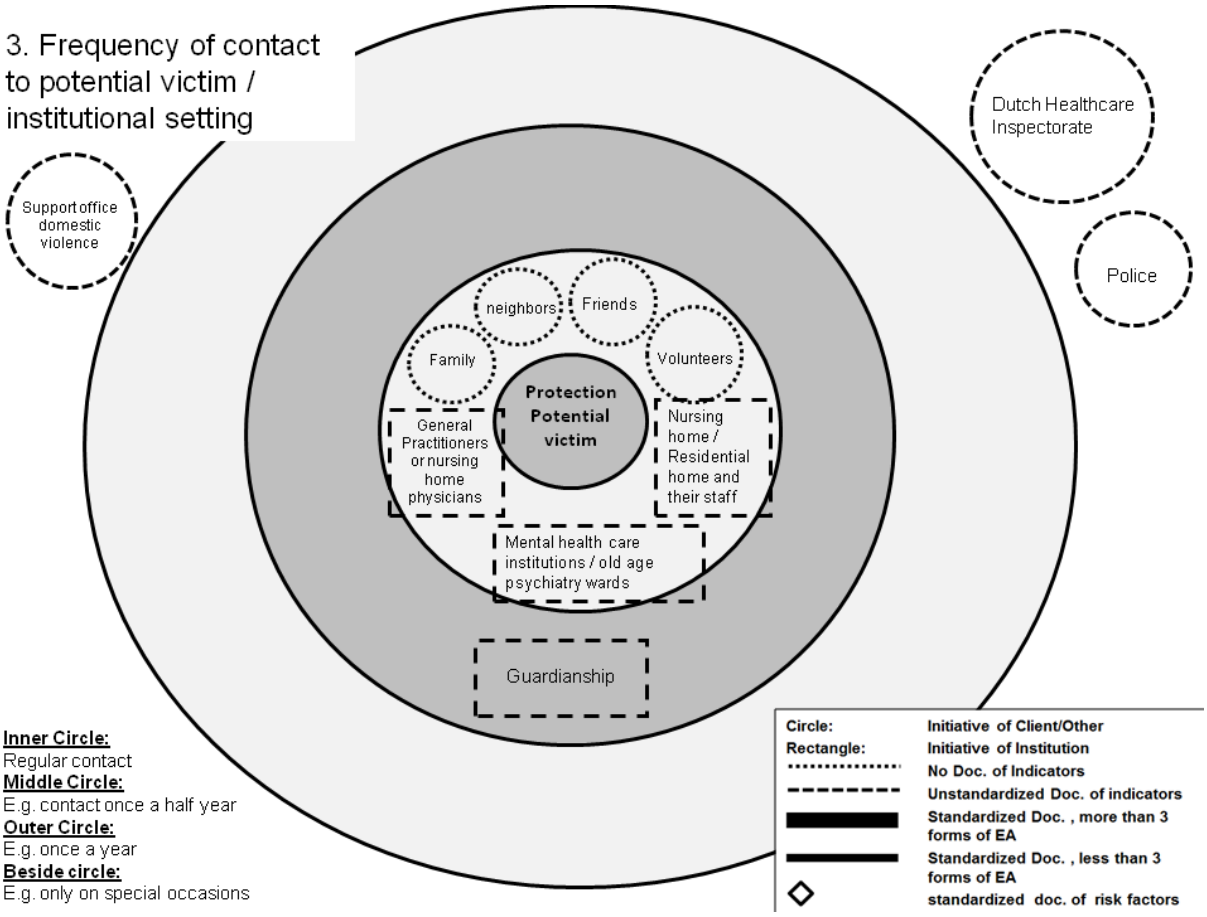
German institutions/actors in institutional care setting



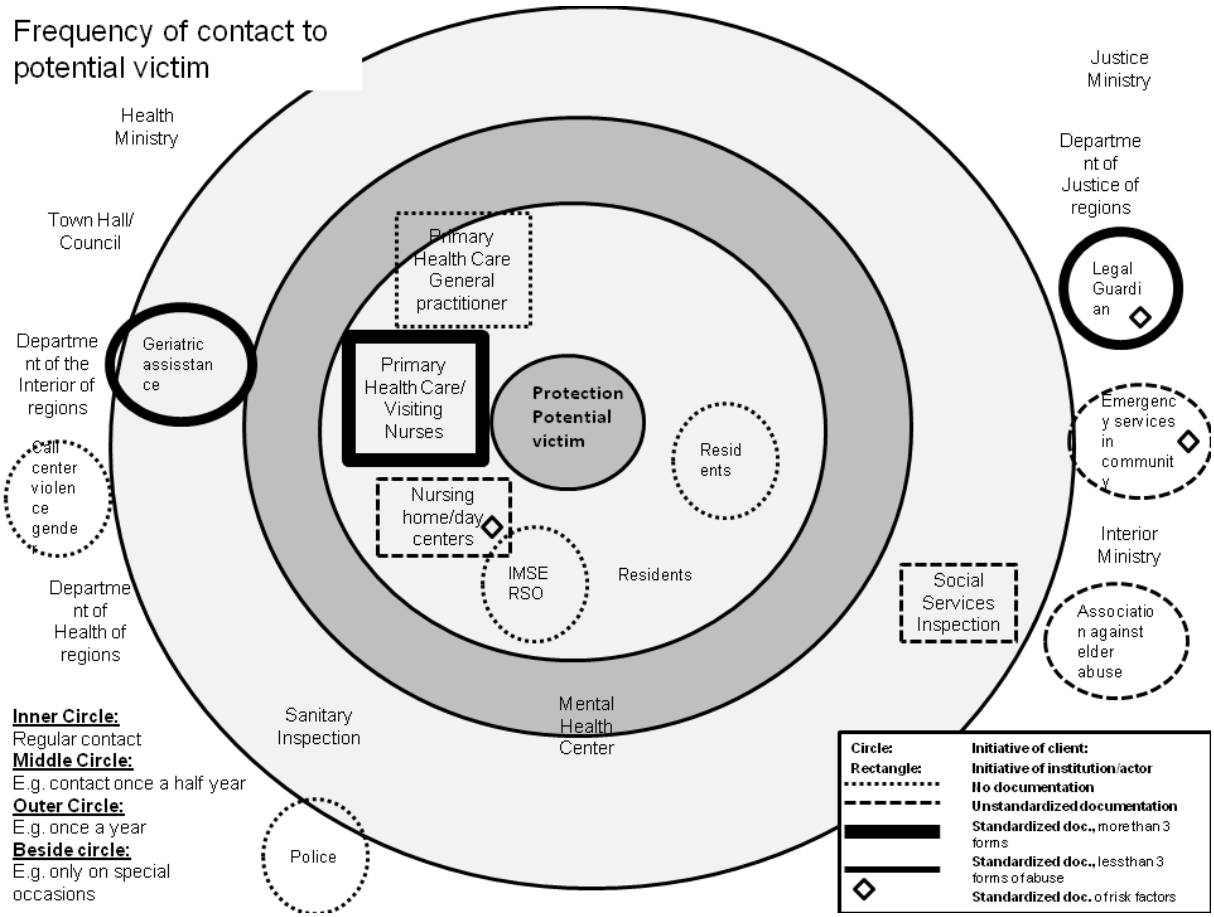
Luxembourgish institutions/actors in institutional care setting



Dutch institutions/actors in institutional care setting



Spanish institutions/actors in institutional care setting



Appendix F: Guideline Evaluation Interviews and Document Analysis

There are two parts of the evaluation.

1. The description of current monitoring structures of elder abuse in your country

- By using the maps and profiles

2. The proposal for a monitoring system:

- This must include suggestions for improvements of existing monitoring structures in the respective country
- The results of the last expert meeting should be used

The guideline should provide a structure for evaluation. Since the evaluations should be comparable between the countries, the guideline should be followed and answered as **precise and short as possible**!!! The description of current monitoring structures should be done by interpreting the map and the profiles. The proposal for a monitoring system should be build up on existing monitoring structures in the respective country. All the partners already had their expert meetings and discussed weaknesses and strengths of existing monitoring structures and already gathered suggestions for improvements. These results should be used to answer the questions under part 2.

The deadline for the preparation of the written text is the

24th of June.

The main results to the two parts should be presented at our next Partner Meeting in Maastricht on the 7th and 8th of July. Therefore each partner organization will have 15 minutes to answer the questions for their country:

How do the monitoring structures regarding elder abuse look like at the present?

What would you (and your expert team) propose to improve and systematize existing structures?

1. The description of current monitoring structures of elder abuse in your country.

Please write down the information following the guideline, this has to be done for all the three settings seperately: informal care, professional home care and institutional care

- Which institutions belong to the Micro-, Meso-, Macro-level? When writing down these institutions, give a short description about the main task (in profile) of the institution that are specific in your country. *Give a short reasoning why these institutions belong to the respective level. (Micro Level: informal actor; Meso-Level: Formal Institutions, Service Provider; Macro Level: Formal Institutions, Authorities).*

- Are there any institutions/actors that have the legal job assignment to monitor or prevent elder abuse? (*Describe these institutions and their legal job assignment*

concerning elder abuse shortly) .If not, summarize shortly the actors that have indirect the legal mandate to protect older people from elder abuse and describe this legal mandate and the relation to elder abuse shortly. Therefore, have a look at the profiles (Responsibility regarding EA) again.

- Describe shortly which institutions have standardised documentation of indicators and/or risk factors of elder abuse. Put down whether these institutions assess more than three, or three and less than three forms of elder abuse through indicators (the same categories were used in the map). Put down if also risk factors are documented standardized. *Please Note: the institution is also relevant here when the goal of the assessment is not to detect elder abuse. Goal of the assessment could, for example, be the monitoring of quality of care. But this has to be mentioned.*

In the following, these institutions named should be further evaluated concerning other aspects:

- Describe whether the institution regularly searches contact to the potential victim, or whether the potential victim or others have to inform or search contact to this institution (for example a consultancy service). E.g.: An institution assesses indicators and risk factors of elder abuse standardised: here it is decisive to mention whether the institution assesses without being asked and if the assessment is on a regularly basis.

- Describe how often it comes to a contact between the institution and the victim – This aspect can be of relevant information, e.g. when an institution assesses regularly indicators of elder abuse and so seems to be a good example for monitoring elder abuse, but in fact assesses the potential victim only twice a year.

- Describe what happens to the data after the assessment. Describe whether there is a fixed plan for action or not when elder abuse is suspected.

- Put down if there are other meaningful aspects of these institutions concerning their role in a monitoring-system.

Describe which institutions assess elder abuse unstandardised. *This means indicators and risk factors might be documented, but there is no instrument or guideline that includes these indicators and risk factors.* Describe if there any further factors that raise the meaning of the institution concerning the institution's role in a monitoring system of elder abuse

- E.g.: Is the institution in regular contact to the potential victim without having to get informed first?

- E.g.: Is the contact to the potential victim in frequent intervals?

- E.g.: Allows the kind of access/contact to the client to observe physical indictors (e.g. doctors, nurses)

- Are there any other important factors?

- Describe what happens to the data after the assessment. Describe whether there is a fixed plan for action or not when elder abuse is suspected.

Describe which institutions do not have a documentation of indicators and risk factors at all, even not unstandardised. Describe if there any further factors that raise the meaning of the institution concerning the institution's role in a monitoring system of elder abuse

- E.g.: Is the institution in regular contact to the potential victim without having to get informed first?
- E.g.: Is the contact to the potential victim in frequent intervals?
- E.g.: Allows the kind of access/contact to the client to observe physical indictors (e.g. doctors, nurses)
- Are there any other important factors?
- Describe whether there is a fixed plan for actions or not when elder abuse is suspected.
- Describe which institutions have the opportunity to introduce measures that directly lead the protection of the victim. *Please, describe also these measures.*
- Describe, if there is an institution that is currently used or seen as a contact „place to go" in case of suspected, observed, or experienced elder abuse.
- Describe in two to three sentences your conclusion: Describe which institutions provide a good basis for a monitoring system and why. Describe what the main weaknesses of the existing monitoring structures are.

2. Proposal for a monitoring system

The two following questions should be answered for each setting separately**!!!**

- Are there further strengths and weaknesses (to these already identified in the part 1) of the existing monitoring structures identified by the national expert rounds?

- What proposals can be given to improve the existing monitoring structures and to build up a monitoring- system of elder abuse? Give concrete proposals how existing weaknesses could be put away and how strengths can be used? Your answer of 2.2. should contain the main points and should not exceed two pages.

Element of the proposal should be answers to the following questions:

Which actors would be the most appropriate to monitor elder abuse? Which modifications are necessary to grant regular monitoring by these organizations?

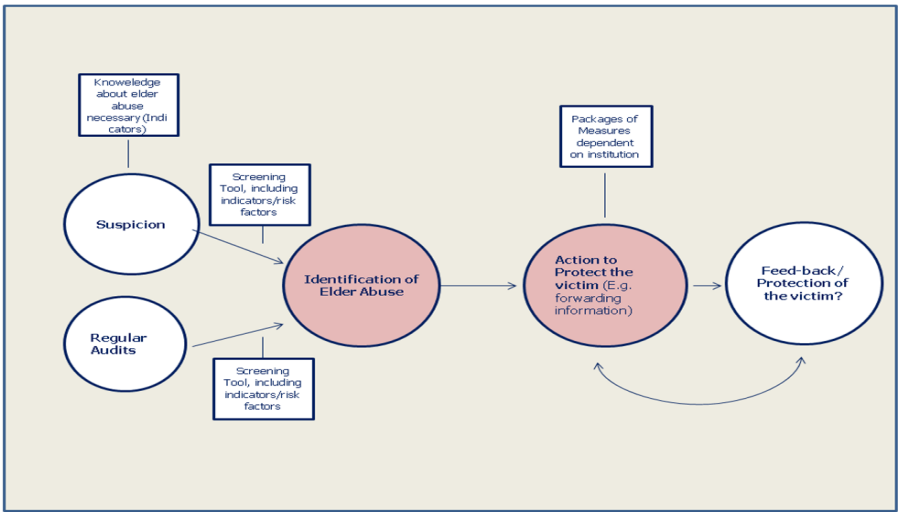
Is there an institution that should be referred to when elder abuse is suspected, observed or experienced? When the institution already exists, are there any modifications necessary (e.g. legal modifications)?

Which institution could collect data concerning elder abuse? And what should be happening with this data?

Which institutions should rather pass on information, which institutions should act immediately? How can these acts/measures to prevent elder abuse look like?

Are there legal modifications necessary to grant your proposals?

By answering the question keep in mind our definition of the functions of a monitoring system has to fulfill



The main Elements of a monitoring system are the identification of elder abuse and the implementation of actions/measures to protect the victim from first elder abuse or its repetition.

Example for Germany:

Note, that it is not complete, there are only several ideas listed up to give an example how to prepare a proposal:

In the institutional care setting: *The home supervisory authority has the legal job assignment to protect interests and the well-being of resident in long-term care institutions. The home supervisory has the regulatory resources to protect older people from elder abuse (e.g.: extreme case: nursery home can be closed). But the home supervisory authority is not assessing specifically elder abuse and is usually only once a year checking one institution. This weakness can be eliminated by:*

A determined person in a nursing home that has contact to the residents, e.g. a voluntary residents advocate (this will be defined more precise) who is assessing elder abuse in regular intervals by a screening tool

The screening tools will be collected by the home supervisory authority, who is giving a feedback to the residents' advocate in determined intervals

In the professional home care setting: *The home supervisory is not responsible for the professional home care setting and there is no comparable institution. There is no regular contact of a state supervision institution. The legislator could expand the area of responsibility of the home supervisory authority also to the professional home care setting:*

In the informal care setting: *The same shall be deemed to the informal care setting. The legislator could expand the area of responsibility of the home supervisory authority also to the professional home care setting (is not precise enough yet)*